CCME

2019 External Quality Review

EASTPOINTE

Submitted: December 19, 2019

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

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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 the Eastpointe. This report contains a description of the process and the results of the 2019 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the North Carolina Medicaid (NC Medicaid).

Goals of the review are to:

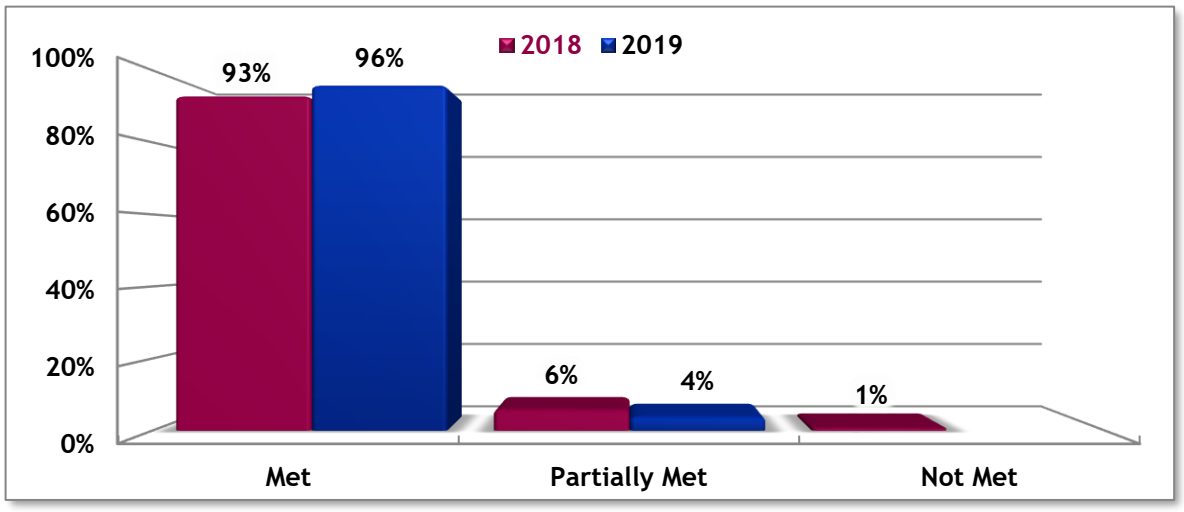
- Determine if Eastpointe complies with service delivery as mandated by their *NC Medicaid Contract*
- Provide feedback for potential areas of further improvement
- Verify the delivery and determine the quality of contracted health care services

The process used for the EQR was based on the Centers for Medicare & Medicaid Services (CMS) protocols for EQR of Medicaid Managed Care Organizations (MCOs) and PIHPs. The review includes a desk review of documents, a two-day Onsite visit, compliance review, validation of performance improvement projects (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

The 2019 Annual EQR reflects that Eastpointe achieved a “Met” score for 96% of the standards reviewed. As Figure 1 indicates, 4% of the standards were scored as “Partially Met”. Less than .5% of the standards were scored as “Not Met”. Figure 1 provides a comparison of Eastpointe’s 2018 review results to 2019 results.

Figure 1: Annual EQR Review Comparative Results



B. Overall Recommendations

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

Administration

Three Recommendations were made during last year's EQR. Eastpointe implemented and maintained these changes. As a result, no concerns were noted during this year's EQR of Eastpointe's policies, Organizational staffing and management, and confidentiality practices.

Eastpointe has implemented various processes to address encounter submission denials attributed to provider taxonomy, encounter acceptance rate improvement, and NCTracks enrollment discrepancies. Eastpointe addressed concerns raised from last year's ISCA and is submitting secondary diagnosis codes, including physical health codes. Four months in 2018 had very low encounter acceptance rates but it was mostly due to the timing of submitting voided claims or submitting denials related to duplicate claims. Eastpointe has addressed these issues and currently Eastpointe's encounter data acceptance rate is approximately 99%.

Eastpointe's claim processing system is capable of capturing up to 24 ICD-10 diagnosis codes for Institutional claims and up to 12 ICD-10 diagnosis codes for Professional claims. The provider web portal for Institutional claims has been updated to receive up to 24 ICD-10 diagnosis codes. Even though Eastpointe is capturing 24 ICD-10 diagnosis codes in AlphaMCS, PIHP is only able to submit up to 12 codes due to a limitation in NCTracks. As discussed at the previous Onsite, NCTracks is capable of capturing up to 25 diagnosis codes for Institutional claims and 12 diagnosis codes for Professional encounters. Eastpointe has been submitting encounters successfully by dropping extra diagnosis codes from their encounter submissions. They are advised to work with the state on correcting this issue to help improve accurate capture of encounter data for reporting and research purposes.

Provider Services

In the Credentialing/Recredentialing area at the last EQR, there were four items requiring Corrective Action and four Recommendations. Eastpointe addressed three of the Corrective Action items and partially addressed the fourth and addressed three of the four Recommendations. The partially addressed Corrective Action item is related to the Credentialing Committee meeting minutes and regarding conflicting language across some documents, as outlined in this report. The unaddressed Recommendation, which has now become a Corrective Action item, is about ensuring providers are recredentialed within three years. In the Provider Services area, there was one item requiring Corrective Action and there were four Recommendations. Eastpointe addressed the Corrective Action item and two of the Recommendations. One Recommendation was partially addressed, and one Recommendation was not addressed. The partially addressed item pertains to correcting references to the Basic Medicaid Billing Guide, which was corrected in the Provider Manual, but not corrected in *Policy Q-6.3.27*. The unaddressed Recommendation was due to incorrect links which persist in the "Getting Started" document.

Eastpointe met 96% of the Provider Services standards in the current EQR. There are two Corrective Action items and five Recommendations in the Credentialing and Recredentialing area, one Corrective Action item and one Recommendation in the Provider Education area, and one Recommendation in the Practitioner Medical Records area.

Enrollee Services

Eastpointe "Met" 100% of the standards. There are three Recommendations. Two of the Recommendation are within the Provider Directory and one is to update the letter sent to enrollees when their provider is terminated from the network. There were five Corrective Actions in the last EQR that were implemented and maintained. There were four Recommendations. Two Recommendations were implemented and maintained and two were not implemented and are included in the Recommendations again this year.

Quality Improvement

Eastpointe met 94% of the standards. 4% of the standards scored "Partially Met". There were no standards scored as "Not Met". There is one Corrective Action and two Recommendations. The Corrective Action involves a correction to a Performance Improvement Project (PIP). The Recommendations are in the areas of over and underutilization monitoring and sharing the ECHO Survey results in more areas for a broader provider reach. There were four Corrective Actions and five Recommendation that were followed and maintained from the last EQR.

Utilization Management

The EQR of Utilization Management (UM) involves review of the PIHP's service authorization processes and Care Coordination functions. Care Coordination encompasses Intellectual/Developmental Disabilities (I/DD), Mental Health/Substance Use (MH/SU), and Transition to Community Living Initiative (TCLI) Care Coordination. Overall, Eastpointe met 96% of the UM standards.

The EQR of the service authorization decisions and related documentation resulted in three Recommendations. Recommendations for the UM Department were aimed at clarifying documentation addressing financial incentives, the over and underutilization process, and completeness of the UM record.

Within the Care Coordination EQR, two Corrective Actions and four Recommendations were issued regarding concerning patterns within Care Coordination documentation. CCME noted patterns of late and incomplete progress notes, HCBS monitoring tools, Quality of Life surveys, In-Reach Tools, etc. As these concerns were noted in previous EQRs, there is a need for a comprehensive monitoring plan that would include monitoring for the timeliness, completeness and quality of all Care Coordination documentation.

Similarly, there was a pattern of poor follow up activities by Care Coordination staff. Specific cases were discussed during the Onsite and Eastpointe reported they have increased departmental resources to address this weakness. CCME is recommending that Eastpointe capitalize on those resources and provide additional clinical staffing opportunities for Care Coordination staff to help identify proactive and needed interventions with enrollees.

Grievances and Appeals

Eastpointe met 75% of the grievance and appeal standards for this year's EQR. The grievance section includes two Corrective Actions and five Recommendations were made. Two Corrective actions were made to further clarify who can file a grievance and the terms "complaint", "grievance", and "concern" across Eastpointe's policies, procedures, and all written materials. One corrective action was aimed at adding details regarding extended grievances to Eastpointe's grievance policy. Four Recommendations were made

to further bolster Eastpointe's documentation of their internal steps for resolving, storing, and reporting grievances.

In the previous year's EQR of appeal functions, Eastpointe received six Corrective Actions and seven Recommendations, primarily targeting inconsistent and incorrect information in their appeals documentation, including *Policy C-3.2.6, Appeal of UM Adverse Benefit Determination*, Eastpointe's *Provider Operations Manual* and *Enrollee/Member and Family Handbook*, and enrollee appeal notifications.

While some revisions were made in the past year, primarily to the *Enrollee/Member and Family Handbook*, Eastpointe struggles to ensure appeal information is consistent within and across appeals documents and that revisions occur in a timely manner. As a result, Eastpointe received ten Corrective Actions and five Recommendations in this year's EQR. All but two of the Recommendations are aimed at correcting Eastpointe's appeal documentation.

The remaining two Recommendations target concerns noted in the appeal file review. Eastpointe is imposing an arbitrary, 30-day timeframe for receiving a written appeal when an enrollee submits an appeal orally. The timeframe is more restrictive than the 60 days enrollees are allowed to file an appeal.

Concern was also noted in the lack of documentation within the appeal record of the internal steps taken by staff to protect the enrollee's Protected Health Information (PHI). Eastpointe's appeal policy also provides little guidance to staff regarding what steps should be taken. For example, staff should document who requested the clinical rationale of the appeal decision, referrals to the Medical Records Department, steps taken to confirm guardianship, and any efforts taken to secure releases of information.

Delegation

Eastpointe met 100% of the Delegation standards for this year's EQR, with no items requiring Corrective Action. There are no Recommendations. During the review period for the current EQR, Eastpointe had fully executed Delegation Agreements and Business Associate Agreements with all four delegated entities. The Delegation Agreement with Prest was effective December 4, 2018, and the Delegation Agreement with BHM ended effective March 31, 2019. Eastpointe conducted a pre-delegation assessment with Prest. Eastpointe receives regular monitoring reports from its delegates and conducts annual assessments of delegates. Oversight is reported to the Executive Leadership Team, which decides on continuation of Delegation Agreements.

Program Integrity

Eastpointe's case files were 100% compliant with applicable elements reviewed and Eastpointe met 100% of the Program Integrity standards in this year's EQR. All Recommendations made from last year's external quality review have been addressed for the current review period. One Recommendation made in this year's review is related to beneficiary-specific fraud and abuse. The Recommendation is to add details, such as providing the provider's connection with billing entities, documenting the original allegation that triggered the investigation, the timeframe of the investigation, and locations of providers, etc. to a beneficiary-specific fraud and abuse policy.

Financial Services

The 2018 EQR of Eastpointe's Financial Services identified two policy enhancements and one procedure improvement that were needed. The first policy change related to adding the five-business day requirement for Risk Reserve payments to *Policy B-2.2.24*. CCME also recommended that Eastpointe add the 10-year requirement to their record retention policy. The third Recommendation was that Eastpointe implement a process to ensure that all risk reserve payments are made within 5 days of receipt of capitation payment. All the 2018 Recommendations were satisfactorily completed.

In this year's EQR, it was highlighted that, while Eastpointe's Medicaid funds are properly segregated through the chart of accounts in the general ledger and the percentage Medicaid incurs does not differ materially from one fiscal year to another, CCME recommends that Eastpointe recalculate this percentage on at least an annual basis.

Encounter Data Validation

One issue noted related to the consistency of diagnosis codes being reported to NC Medicaid for Professional claims. Although the additional diagnosis codes do not impact adjudication, the codes are key for reporting, evaluating member health, and factors that will be used in a value based payment model. Eastpointe should review and revise their 837 mapping immediately. Eastpointe should also take action to ensure they are capturing and reporting valid procedure codes for Institutional claims when required for the reported revenue code.

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 October 1, 2019, CCME sent notification to Eastpointe that the annual EQR was being initiated (see *Attachment 1*). This notification included:

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

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

The review consisted of two segments. The first was a desk review of materials and documents received from Eastpointe on October 23, 2019 and reviewed in the offices of CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, care coordination, case management, and appeal files.

The second segment was a two-day, Onsite review conducted on November 20, 2019 and November 21, 2019, at Eastpointe corporate office in Beulaville, North Carolina. CCME's Onsite visit focused on areas not covered in the desk review and areas needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's Onsite activities included:

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

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

FINDINGS

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

A. Administration

CCME conducted an Administration function review focusing on Eastpointe's policies, procedures, staffing, confidentiality practices, information system, encounter data capture, and reporting. Three Recommendations were made during last year's EQR. Eastpointe implemented and maintained these changes.

Policies & Procedures

Administrative review of Eastpointe's policies and procedures includes review of the individual policies and procedures, the Policy and Procedure List, the 2019 Policy and Procedure Manual, and Eastpointe's *Policy Q-6.5.3 Development of Policies and Procedures*. The review showed all policies and procedures were accounted for and demonstrated annual review with an active revision process. In the previous year's EQR, it was recommended that Eastpointe reconcile the Policy and Procedure List and the Policy and Procedure Manual, as there was some disconnect between the two lists of policies. Eastpointe addressed this Recommendation and now both lists align.

Organizational Staffing/ Management

Review of Eastpointe's Organizational staffing and management showed, at the time of the Onsite, four current positions were vacant, but no significant functions were impacted by these vacancies. Additional positions were recently added to the Care Coordination Department to further support the management and function of that department.

In the previous year's EQR, Dr. Doniparthi, Associate Medical Director, was not adequately represented on the Organizational Chart. Eastpointe has since added her to this document. The oversight and responsibilities outlined in her contract with Eastpointe are also appropriately designated on the Organizational Chart.

Another Recommendation from last year was to include staff licensure, credentials, certifications, etc. on the Organizational Chart to demonstrate positions within

Eastpointe are staffed within the contractual requirements. Eastpointe added this detail to their Organizational Chart for this year's EQR.

Confidentiality

Eastpointe is a Covered Entity under the Health Insurance Portability and Accountability Act (HIPAA). CCME reviewed Eastpointe's policies regarding the management and protection of consumer confidentiality. Eastpointe has a complete set of policies and procedures that address both state and federal requirements for preserving enrollee confidentiality and protecting health information.

Eastpointe *Policy CC-1.7, Compliance Training Policy* specifies that new staff are trained on the Eastpointe Code of Ethics and Compliance Program and that existing employees receive an annual training on these topics, as well.

No concerns were noted during this year's EQR of Eastpointe's policies, Organizational staffing and management, and confidentiality practices.

Information Systems Capabilities Assessment

Island Peer Review Organization (IPRO), in contract with CCME, and as recommended by CMS' Encounter Data Validation protocol, conducted the yearly review of Eastpointe's ISCA.

Eastpointe, like many other PIHPs in North Carolina, uses the AlphaMCS transactional system, a hosted system environment produced by Wellsky (formerly known as Mediware). Wellsky modifies the user interface and conducts backend programming updates to the system. During the Onsite, it was mentioned that all PIHPs who use AlphaMCS are part of a user group that shares updates and system issues.

Prior to the Onsite, Eastpointe completed the 2019 ISCA tool and submitted supporting documentation, workflows, and procedures. IPRO reviewed the responses and followed-up on areas requiring clarification via interviews and a systems walkthrough at the Onsite.

Enrollment Systems

Eastpointe experienced a decrease in enrollment over the past three years. The year-end enrollment was 195,379 in 2016, 170,303 in 2017, and 155,365 in 2018. During the Onsite, Eastpointe verified the decrease in enrollment could be explained by Nash County and Columbus County moving from Eastpointe to Trillium prior to 2019.

The ISCA tool and supporting documentation for enrollment systems loading processes clearly defined the process for enrollment data updates in the AlphaMCS enrollment

system. During the ISCA Onsite review, Eastpointe provided a demonstration of the AlphaMCS enrollment system. The system maintains a member's enrollment history and demographic data (race, ethnicity, and language). Global Eligibility File (GEF) files are imported daily into a SQL database by Wellsky. The 834 file is loaded on a monthly basis and the quarterly GEF file is loaded when it is received by Wellsky. The daily eligibility file is compared to existing eligibility in the AlphaMCS. The member enrollment records are processed and checked against the existing data in the database. An edit code that identifies if the member record needs to be added, changed, or deleted is applied.

Eastpointe stores the Medicaid identification number received on the GEF. Eastpointe's eligibility system is able to merge multiple member records and link the member's historical claims. As explained during the Onsite, cases in which a new ID number may be needed is when a member is in the AlphaMCS system and has an ID from the state GEF but is then adopted.

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

Claims Systems

Eastpointe's claims are processed in the AlphaMCS 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. Eastpointe demonstrated the AlphaMCS claims processing system during the Onsite review.

Table 1: Percent of claims with 2018 dates of service that were received via Electronic (HIPAA, Provider Web Portal) or Paper forms.

Source	HIPAA File	Paper	Provider Web Portal
Institutional	84%	.5%	15.5%
Professional	79.5	.5%	20%

It should be noted that paper claims are received for out-of-network services. Eastpointe staff stated at the Onsite that paper claims submissions have decreased the past two

years, with only 140 claims manually-entered during that time. All manually-entered claims are audited.

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

Eastpointe adjudicates claims on a nightly basis. Eastpointe auto-adjudicated 95.4% of 2018 Institutional claims and 99% of 2018 Professional claims in comparison to the 20% of 2017 Institutional claims and 80% of 2017 Professional claims they reported on the ISCA the prior year.

Eastpointe processes claims within 18 days of receipt of a claim and pays them within 30 calendar days after receipt. As stated in the ISCA, Eastpointe pays 90% of clean claims within 30 calendar days of the date of approval and 99% of clean claims within 180 days of date of receipt. Claims submitted past 90 days of the date of service are denied for exceeding the timely filing requirements required by the state unless stated differently for the provider as per their contract. The top claim denial reasons are duplicate claims, timely filing issues, invalid services, and clinician not valid for the service billed. For invalid provider types, the Provider Contracts Department checks if the provider is contracted, valid, and works to get the system updated appropriately with the correct provider information.

ICD-10 procedure codes and DRGs are accepted by Eastpointe if the values are included by the provider on an 837I. Eastpointe's provider web portal has the capability to receive the DRG code. However, Eastpointe does not utilize DRGs for payment.

At the Onsite, staff stated that Eastpointe's AlphaMCS system can capture up to 12 ICD-10 diagnosis codes for Professional claims and up to 24 ICD-10 diagnosis codes including the principal diagnosis code for Institutional claims. At the Onsite, staff presented an example Institutional claim in the AlphaMCS system that captured up to 17 diagnosis codes. Eastpointe's provider web portal can capture up to 12 diagnosis codes for Professional claims and up to 24 diagnosis codes for Institutional claims. Eastpointe is submitting physical health secondary codes on claims. Twenty-five ICD-10 diagnosis codes is the maximum number of diagnosis codes that may be submitted on an 837I and 12 ICD-10 diagnosis codes is the maximum number of diagnosis codes that may be submitted on an 837P. Updates to address last year's Corrective Action Plan were made in the AlphaMCS system to capture and submit more diagnosis codes on encounter submissions. The PIHP discussed that AlphaMCS has been set up to receive and submit up to 29 diagnosis codes on Institutional claims. However, they have seen that encounters

submitted with greater than 12 diagnosis codes were getting denied by the state, so currently Eastpointe is only submitting up to 12 diagnosis codes for Institutional and Professional encounters.

To show proof Eastpointe does capture and submit HCPCS codes and revenue codes on lab, diagnostic, and radiology service encounters, the PIHP presented a sample lab claim from their system at the Onsite review.

Eastpointe conducts audits of claims processed on a monthly and quarterly basis. Eastpointe staff audit 3% of all claims processed during a one-month period and high dollar claims over $5,000 on a monthly basis. Claims that are pended are manually processed and audited. Claims that are overwritten are audited.

Reporting

Eastpointe's data warehouse captures all the enrollment, provider, claims, and authorization information captured in the AlphaMCS. AlphaMCS stores data in a Microsoft SQL Server database. Eastpointe maintains an internal database and data warehouse for reporting. The database is refreshed with data from the AlphaMCS on a daily basis through a backup copy of the database from Wellsky. Eastpointe compares the number of records in the AlphaMCS to the number of records loaded in Eastpointe's data warehouse to verify the completeness of data. Eastpointe staff also run queries against the data warehouse to ensure that correct and valid data is available for reporting. Up to 7 years of claims data is available in the on-line AlphaMCS system, as well as Eastpointe's data warehouse for reporting.

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

Eastpointe provided a *Business Continuity and Disaster Recovery Plan* prior to the Onsite audit for review. Post-Onsite, Eastpointe provided Wellsky's AlphaMCS Systems and Applications security document to demonstrate how their vendor safeguards their data. Eastpointe was affected by the hurricane in September 2018. Eastpointe stated at last year's audit and at this year's that the hurricane had very little impact to business and there was no disruption of business processes and services.

Encounter Data Submissions

Eastpointe has a defined process in place for their encounter data submission, with 837 files submitted to NC Medicaid, and 835 files received back from NC Medicaid through the NCTracks system. Encounters that are approved and paid by Eastpointe are submitted to NCTracks. The 835 file from NCTracks is utilized to review denials. The extraction,

submission, and reconciliation of encounter data are fully automated. Resubmission of encounter data that were denied by NCTracks is performed manually.

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

Table 2 shows the breakdown of encounter data acceptance/denial rates provided for the 2018 year, with a comparison to 2017 data.

Table 2: Volume of 2017 and 2018 Submitted Encounter Data

2018	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	146,460	25,459	18,152	190,071
Professional	1,573,805	166,435	308,124	2,048,364
2017	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	98,319	18,114	2,458	118,891
Professional	1,558,893	161,105	165,957	1,885,955

The total volume of submitted encounters has increased from 2017 to 2018, although enrollment numbers have decreased slightly in the same period of time. The percentage of Institutional and Professional encounters submitted that were initially accepted dropped from 83% in 2017 to 77% in 2018. February, March, July, and August of 2018 had very low encounter acceptance rates. IPRO requested if Eastpointe could provide a summary explanation of why these four months had low encounter acceptance rates. Table 3 is a summary of the findings.

Table 3: Eastpointe Summary Table for Select Months of Low Encounter Acceptance Rates for 2018

Month/Year of Encounter Submission	Approval Rate	Issue	Total Dollar Amount	Eastpointe's Reason for Low Encounter Acceptance Rate
February 2018	72%	51,767 denials related to duplicate claims	$5,881,605	Upstream suspensions resubmitted in error.
	44%	106,341 denials related to duplicate claims	$12,412,503	
	66%	13,235 denials related to duplicate claims	$1,468,743	
March 2018	73%	24,462 denials related to duplicate claims	$2,995,137	Timing issues regarding submission/receipt of void and replacement files being sent upstream. Void files are now sent on Monday prior to remaining claims.
July 2018	84%	6,115 claims denied for duplicate	$749,846	
	60%	9,468 claims denied for duplicate	$1,137,625	
August 2018	32%	49,224 denials for (3406) History Record Not Found for Adj/Void	$14,473,963	Attempted to correct the void/replacement claim issue. A void file was submitted, however there were no history records found when the claims were processed upstream. Wellsky has put a process in place to not create voids until 835 has been processed.

Eastpointe provided a performance improvement project form as part of the pre-Onsite documentation which shows the PIHP's aim to meet NC Medicaid data quality standards for encounter data submissions. The issues listed in the table above are addressed in the document and Eastpointe is proactive in correcting issues they identify with their data submissions. February 2019 to June 2019 encounter submission rates indicate Eastpointe has a 99% encounter acceptance rate, showing significant improvement from last year's submissions.

Currently, Eastpointe has edits in place to verify the accuracy of taxonomy codes prior to submission of encounters and advises providers to correct and resubmit claims. Claims newsletters are sent to providers to further educate them on submitting clean claims.

During last year's Onsite, Eastpointe stated that 25% of all encounters submitted in 2016 were denied and not resubmitted to NCTracks. This was due to NC Medicaid's advice to Eastpointe to not resubmit the encounters because of system edits in place that would deny all encounters. A status on encounters that are submitted and not yet submitted are provided in Table 4.

Table 4: Volume and payment totals of 2016 denied encounters pending resubmission to NCTracks

	Distinct Header Count	Total Claims Paid
Sent to NCTRACKS	539,943	$160,405,228.03
Not Sent to NCTRACKS	75,872	$37,511,684.79

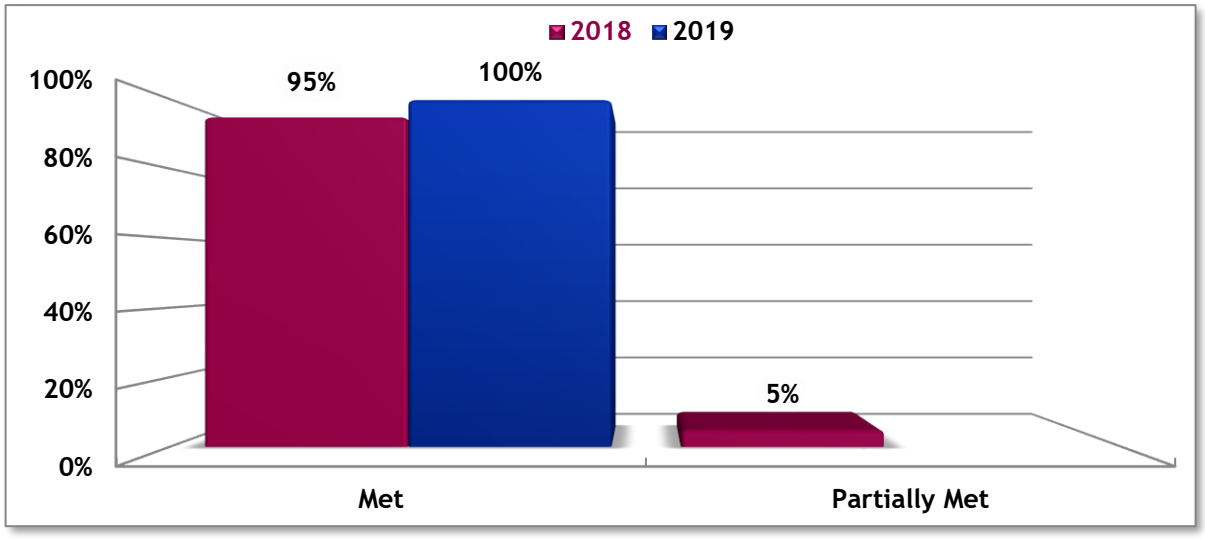
On average, it takes Eastpointe 15 days to correct and resubmit an encounter to NC Tracks. When a claim denial is returned to Eastpointe from NCTracks via the incoming 835 file, depending on the denial reason code Eastpointe Encounters Team coordinates with other departments and the billing provider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

Currently, Eastpointe is not submitting all secondary diagnosis codes to NCTracks. For both Institutional and Professional encounters, Eastpointe is only submitting up to 12 diagnosis codes. Twenty-five ICD-10 diagnosis codes for Institutional encounters and 12 ICD-10 diagnosis codes for Professional encounters are the maximum number of diagnosis codes that may be submitted on an 837I or 837P, respectively, and the maximum number captured by NC Tracks. Eastpointe is not capable of submitting all 837I and 837P diagnosis codes because of a limitation with NCTracks denying any encounters that have greater than 12 diagnosis codes. In response to last year's corrective action, Eastpointe stated they have made changes in AlphaMCS and are prepared to submit up to 29 ICD-10

diagnosis codes on the 837I submissions and 12 ICD-10 diagnosis codes for the 837P submissions once NCTracks is able to accept all codes on their submitted encounters.

Figure 2 provides a comparative of the Administrative EQR scores from 2018 and 2019.

Figure 2: Administration Comparative Findings



Strengths

- Eastpointe implemented and maintained three corrective actions issued in last year's EQR.
- Eastpointe has a comprehensive enrollment, claim processing, and reporting system.
- Eastpointe has the capability to merge multiple member records and is able to link the member's historical claims data to the merged member record.
- Eastpointe has an internal multidisciplinary workgroup which investigates encounter submissions that do not surpass 95% acceptance rate. Their current NCTracks encounter acceptance rate is approximately 99%.
- Enrollment, claims, and IT staff are knowledgeable about their processes and are dedicated to improving encounter data submissions and reducing the number of denials.
- Eastpointe has updated AlphaMCS in order to submit up to 29 ICD-10 diagnosis codes on Institutional encounters and 12 ICD-10 diagnosis codes on Professional encounters to NCTracks, and are currently submitting secondary physical health codes. If NCTracks accepts their encounters that have more than 12 diagnosis codes, Eastpointe will begin submitting all diagnosis codes captured on their encounters.

Weaknesses

- Eastpointe captures up to 24 ICD-10 diagnosis codes on Institutional claims submitted on an 837I and claims submitted through the provider web portal. 25 ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837I.
- Eastpointe has been advised by the State to halt resubmission of their pending 2016 denied encounters due to system and NCTracks changes.
- Eastpointe updated their encounter submission process to capture and submit up to 29 ICD-10 diagnosis codes on Institutional encounters and 12 ICD-10 diagnosis codes on Professional encounters. However, because of a limitation with NCTracks, Eastpointe is submitting up to 12 ICD-10 diagnosis codes on their encounters and dropping the rest of the codes from submission.

Recommendations

- Capture all ICD-10 diagnosis codes submitted by the provider on a claim and submit them to the State. NCTracks is capable of receiving up to 25 diagnosis codes, and Eastpointe has stated they can set up AlphaMCS to capture and submit up to 29 diagnosis codes on encounters. Currently, Eastpointe is submitting up to 12 diagnosis codes on encounter data submissions to avoid denials by NCTracks. Eastpointe should work with the State to resolve this issue.
- As Eastpointe is manually resubmitting corrected encounters, a process needs to be developed to allow the batch resubmission of specific denial reasons.

B. Provider Services

The Provider Services External Quality Review (EQR) is comprised of Credentialing and Recredentialing, and Provider Services, which includes Network Adequacy, Provider Accessibility, Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, and Practitioner Medical Records. CCME reviewed relevant policies, the *Provider Credentialing Operations Manual/Plan* (submitted as the Credentialing Program Description), credentialing/recredentialing files, provider orientation materials, the *Provider Operations Manual (Provider Manual)*, the *Credentialing Committee By-Laws* (*By-Laws*), Credentialing Committee meeting minutes, provider network information, the Clinical Practice Guidelines, the *Enrollee/Member and Family Handbook*, the *Eastpointe Human Services LME-MCO 2019 Community Mental Health, Substance Use and Developmental Disabilities Services Network Adequacy and Accessibility Analysis* (Gaps Analysis), and the Eastpointe website. CCME also conducted an Onsite interview with relevant staff.

There were four items requiring Corrective Action in the Credentialing/Recredentialing section of Provider Services at the last EQR. Eastpointe addressed three of the Corrective Action items and partially addressed the fourth, which is discussed later in this report.

At the last EQR, three of the four Recommendations in the Credentialing/Recredentialing section were related to missing documentation in some files, including evidence of all of the types of required insurance or of licensure or accreditation. These three Recommendations were addressed, but, in the current EQR, Eastpointe failed to conduct all of the credentialing/recredentialing processes for hospitals and a practice affiliated with a hospital/health system. This is discussed later in this report. Still unaddressed from the last EQR is the Recommendation to ensure providers are recredentialed within three years of the initial credentialing or the most recent recredentialing.

The two Recommendations in the Provider Education area at the last EQR were to correct the incorrect links in the "*Getting Started*" document and the incorrect link to the *Eastpointe Claims and Billing Manual* in the *Provider Operations Manual*. The "*Getting Started"* document still has several incorrect or inoperable links. Eastpointe removed the link to the *Eastpointe Claims and Billing Manual* from the *Provider Operations Manual*.

The sole Recommendation from the last EQR in the "Clinical Practice Guidelines for Behavioral Health Management" section was addressed. The one Recommendation in the "Practitioner Medical Records" section was to "Update/replace all references to *The Basic Medicaid Billing Guide,* which was replaced by the *NCMMIS Provider Claims and Billing Assistance Guide*". This was partially addressed, as the reference was deleted from the *Provider Operations Manual*, but remains in *Policy Q-6.3.27, Enrollee Medical Records Maintained by Providers*.

The *Provider Credentialing Operations Manual/Plan* (the *Credentialing Manual*), the *Credentialing Committee By-Laws,* and several policies guide the credentialing and recredentialing processes. Eastpointe has a delegation agreement with Medversant Technologies, a Credentials Verification Organization (CVO), for "Primary Source Verification (PSV) for pre-screening, initial credentialing, and re-credentialing and continuous monitoring of participating providers within the network." CCME's review of the credentialing/recredentialing files showed they were organized and contained appropriate information. Details regarding identified issues are contained in the Tabular Spreadsheet.

Eastpointe submitted initial credentialing files for one hospital and one practice that Eastpointe indicated is affiliated with a hospital/hospital system. Eastpointe submitted a recredentialing file for one hospital. For all of these providers, Eastpointe submitted a statement indicating a Certificate of Insurance is not required and submitted statements that "Criminal background reports are not required." Eastpointe also submitted statements for the initial credentialing file of the practice (affiliated with a hospital/ hospital system) and for the recredentialing file of the hospital that "Ownership reporting is not required." The initial credentialing file of the hospital included Ownership

Disclosure information for the officers, directors, managing employees and EFT Transfer personnel.

During Onsite discussion, Eastpointe indicated the "State" had notified them that they did not have to verify insurance. CCME asked for the written documentation of this, but it was not provided. As discussed during the Onsite, the *NC Medicaid Contract Attachment B, Section 7.7.3* indicates PIHPs can "Choose to accept DMA's credentialing of hospital licensed under Chapter 131E of the NCGS (including all facilities and sites enrolled with DMA and affiliated with the hospital/health system in the state's MMIS and all practitioners billing through the hospital/health system's NPI)." However, since Eastpointe has elected to credential/recredential hospitals, they must conduct the entire credentialing/recredentialing process, unless they obtain/retain documentation of exclusions from NC Medicaid. For example, Eastpointe must obtain verification of all of the required insurance, unless NC Medicaid has provided written exclusion from doing so.

Dr. Venkata Doniparthi, Associate Medical Director (AMD) and a board-certified psychiatrist, chairs the Credentialing Committee and is a voting member. In the event of a tie vote, Dr. Doniparthi breaks the tie. Eastpointe staff who are voting members of the committee are the Eastpointe Chief of External Operations, Director of Network Operations, and Provider Monitoring Director. The *Credentialing Committee By-Laws* indicate the committee composition also includes "at least three active participating Network Practitioners to represent Mental Health, Substance Abuse and Intellectual and Developmental Disabilities." During the majority of this EQR review period, there were four provider representative members of the committee. There were ten Credentialing Committee meetings between September 9, 2018 and June 28, 2019. A quorum of voting members was present at all meetings.

Since the last EQR, improvements were made to the Credentialing Committee meeting minutes. Further revisions are needed in meeting minutes and in several documents. This is discussed further in the Tabular Spreadsheet of this report.

The 2019 Gaps Analysis indicates Eastpointe met all choice and location standards, and no Exception Requests were filed. The Executive Summary of the 2019 Gaps Analysis states "Eastpointe supplements Opioid Treatment service delivery via a network of 25 DEA-registered prescribers contracted to deliver services to address opioid dependency." At the Onsite, Eastpointe staff shared information about several efforts to expand the availability and choice of services, including a Request for Information (RFI) process for expansion of substance use services in Duplin County and a Request for Proposal (RFP) process for Level III Residential Service for Dually Diagnosed Members and another for Community Support Team. Eastpointe added a forensic screener, added a "significant number of Peer Support Providers in the last year", and increased reimbursement rates "by over $1.1 million for peer support providers in the network." An additional $200,000

from Eastpointe helped support Opioid Task Forces and staffing for Drug Treatment Court.

In the Provider Services EQR, 96% of the standards were scored as "Met", 4% were scored as "Partially Met", and less than .4% of the standards were scored as "Not Met". The standards "Not Met" are not reported on the chart below due to this low %. There was one "Not Met" item and one "Partially Met" item in Credentialing/Recredentialing area. The other "Partially Met" score was in the area of Provider Education. *Figure 3, Provider Services Comparative Findings*, provides a comparison of the 2018 scores versus the 2019 scores.

Figure 3: Provider Services Comparative Findings

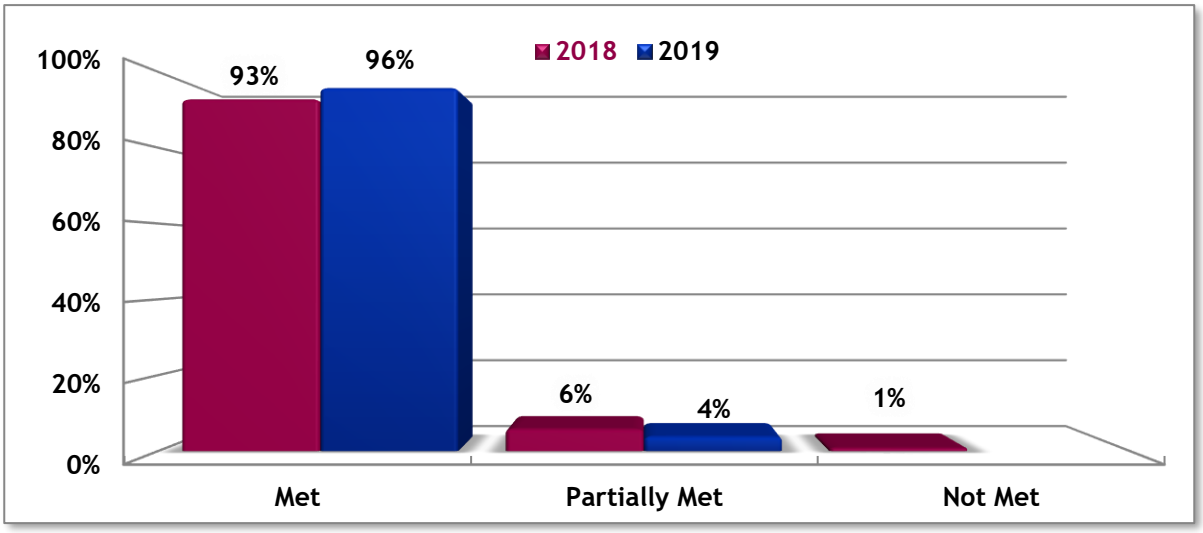


Table 5: Provider Services

Section	Standard	2019 Review
Credentialing and Recredentialing	Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	**Partially Met**
	Recredentialing every three years;	**Not Met**

Section	Standard	2019 Review
Provider Education	PIHP dispute resolution process;	Partially Met

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.
- After obtaining feedback from the Provider Council and from providers, Eastpointe completed a restructuring of the Network Operations Department. There are now Call Center Specialists for Providers in Network Operations, Claims, and Utilization Management (UM). Providers have the direct phone number for their assigned specialists.
- The *2019 Community Mental Health, Substance Use and Developmental Disabilities Services Network Adequacy and Accessibility Analysis* report indicates Eastpointe met choice and access standards for 100% of members.
- Eastpointe expanded access to Applied Behavior Analysis, Integrated Primary and Behavioral Health Services, Substance Use Services, Peer Support Services, Forensic Evaluations, and Residential Treatment-Level III for dual diagnosis.
- Eastpointe increased reimbursement rates for peer support providers and provided an additional $200K to help support Opioid Task Forces and staffing for Drug Treatment Count.
- Eastpointe (in combination with legacy agencies the Beacon Center and SER) has Conducted Crisis Intervention Team (CIT) Training since 2008, providing 90 classes as of June 2019, with over 1,200 first responder graduates.

Weaknesses

- Credentialing Committee meeting minutes are improved from the last EQR, but some issues remain. See information in the Tabular Spreadsheet.
- There is conflicting information regarding who chairs the Credentialing Committee, what constitutes a quorum, and other items in the Credentialing Committee meeting minutes, the *Provider Credentialing Operations Manual/Plan,* and the *Credentialing Committee By-Laws*. This was also an issue at the last EQR. See information in the Tabular Spreadsheet.

- The initial credentialing file for a hospital and the initial credentialing file for a practice (which Eastpointe indicated is part of a hospital system), and the recredentialing file for a hospital were missing evidence of the required insurance verification or waiver. Eastpointe submitted statements indicating verification of insurance is not required for the hospital or the practice that is part of the hospital system. This is incorrect.
- The initial credentialing file for a practice (that Eastpointe said was part of a hospital system) and the recredentialing file for a hospital lacked Ownership Disclosure information, and Eastpointe submitted statements that the information is not required for hospitals or practices affiliated with a hospital/hospital system. This is incorrect.
- The initial credentialing file for a hospital and the initial credentialing file for a practice (which Eastpointe indicated is part of a hospital system) were missing evidence of the required criminal background checks. Eastpointe submitted statements that "background reports are not required." This is incorrect.
- In the submitted recredentialing files, at least ten of the fourteen practitioners and one hospital were recredentialed late (by a range of one month to seven months after the three years specified in the Eastpointe *Credentialing Manual*). This was also an issue at the last EQR.
- There are several incorrect links in the *Getting Started* document that is sent to new providers and is posted on the Eastpointe website. This was also an issue at the last EQR.
- *Policy Q-6.4.2, Provider Violations and Disputes* and the *Provider Operations Manual* do not contain all of the same information regarding provider disputes/resolution, and the *Provider Operations Manual* does not clearly outline the process for provider disputes/resolution. Further, the *Provider Operations Manual* provides confusing and conflicting information about whether credentialing/recredentialing decisions are appealable.
- As was the case at the last EQR, *Policy Q-6.3.27, Enrollee Medical Record Maintained by Providers*, references the Basic Medicaid Billing Guide, as defined in the *NC Medicaid Contract Attachment B, Section 8.2*. However, The Basic Medicaid Billing Guide was replaced several years ago by the NCMMIS Provider Claims and Billing Assistance Guide.

Corrective Actions

- Ensure Credentialing Committee meeting minutes include complete documentation of items such as all (including any guests) who are present for meetings, and details of significant changes, such as changing the quorum requirement in the *By-Laws*.
- Revise the *Credentialing Committee By-Laws*, the *Provider Credentialing Operations Manual/Plan* and any other documents that detail credentialing processes, to

consistently reflect the Chair of the committee and committee processes. Ensure the correct Chairperson is listed on the meeting minutes for every Credentialing Committee meeting. Revise the *Provider Credentialing Operations Manual/Plan* to indicate a quorum of the Credentialing Committee is 50% plus one of the voting members.

- Ensure providers are recredentialed within three years of the initial credentialing or the previous recredentialing, in order to comply with the Eastpointe *Credentialing Manual*.
- Revise the *Provider Operations Manual* to clearly outline the required steps for provider disputes/resolution. Reconcile the language between *Policy Q-6.4.2, Provider Violations and Disputes,* and the *Provider Operations Manual*.
- Revise the language in the *Provider Operations Manual*, the *Credentialing Operations Manual* (and anywhere else the language might appear), to clearly indicate whether credentialing/recredentialing decisions can be appealed. See *NC Medicaid Contract Attachment B, Section 7.11, i.*

Recommendations

- Verify credentialing and recredentialing files contain proof of all required insurance coverage or relevant waiver or obtain and retain written exclusion documentation from NC Medicaid. See *NC Medicaid Contract Attachment B, Section 7.7.4.*
- Ensure credentialing and recredentialing files contain the required Ownership Disclosure or obtain and retain written exclusion documentation from NC Medicaid. See *NC Medicaid Contract Attachment B, Section 1.13, NC Medicaid Contract Attachment O,* and *42 CFR §455.106.*
- Conduct the required criminal background checks and retain the PSV or obtain and retain written exclusion documentation from NC Medicaid. See *NC Medicaid Contract Attachment B, Section 1.13.2.*
- Check the links in the *Getting Started* document and update the links that are incorrect.
- Update/replace all references to The Basic Medicaid Billing Guide, which was replaced several years ago by the NCMMIS Provider Claims and Billing Assistance Guide.

C. Enrollee Services

The Enrollee Services section covers Enrollee Rights and Responsibilities, Enrollee PIHP Program Education, Behavioral Health and Chronic Disease Management Education, and the Call Center.

There were five Corrective Actions issued in the last EQR that were implemented by Eastpointe. There were also four Recommendations given in last year's EQR. Two of these Recommendations were implemented by Eastpointe and two were not implemented and are Recommendations again this year.

Policy C-3.5.10, Protection of Consumer Rights and Responsibilities, explains all enrollee rights and the procedure Eastpointe uses to inform enrollees of these rights. *Policy C-3.5.14, Member Call Center Response to Enrollee/Member Services* revised 10-8-2019, states "Within fourteen days after an Enrollee is screened for services, Eastpointe's Call Center Department shall provide the new Enrollee with written information on the Medicaid managed care program." The Onsite interview confirms this policy is followed by Eastpointe staff.

The online Provider Directory was upgraded in early November 2019 during the time CCME was performing this year's EQR Desk Review. CCME reviewed the Provider Directory before the upgrade. All fields required by NC Medicaid for the Provider Directory are included in either the online or printed versions. Each provider's "Languages Served" is present in the online Provider Directory. The printed *2019 Provider Choice Directory* in the Desk Materials does not have a field for "Languages Served" and CCME recommends adding this field to the printed Provider Directory.

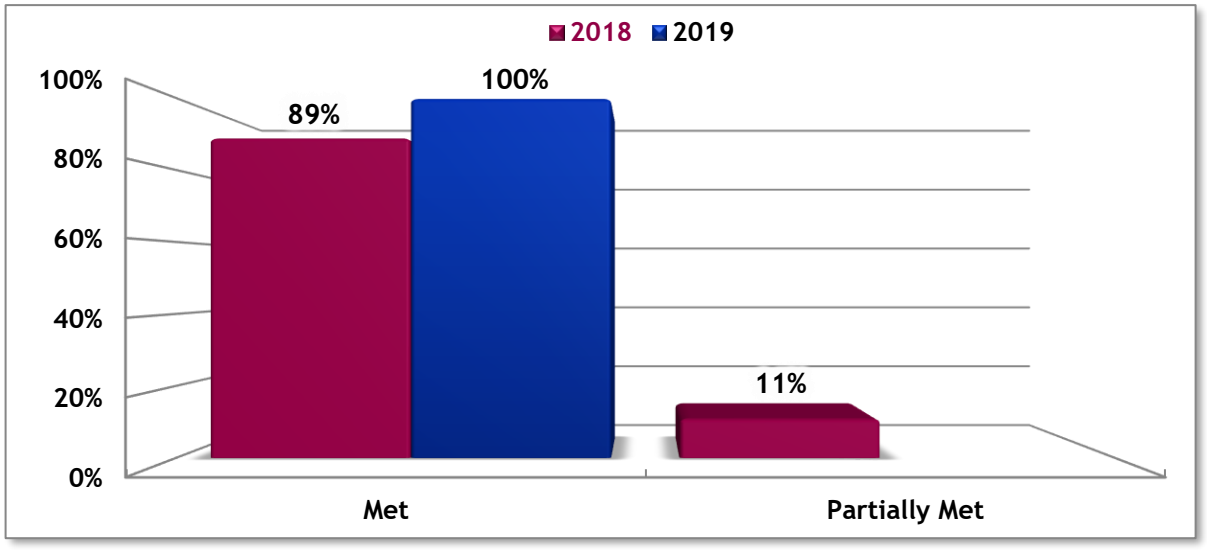
Five of Eastpointe's network providers were terminated in the last 12 months. Only one provider was seeing Eastpointe members at the time of the termination. Letters notifying this provider's enrollees of the termination did not inform enrollees of the date of termination from the network. Adding the provider's termination date was a Recommendation at the last EQR and continues to be recommended.

There was a Corrective Action issued in last year's EQR that targeted the need for improvement of the *Enrollee/Member and Family Handbook*. As a result of this Corrective Action, Eastpointe developed a plan to simplify and improve the information in the manual. These changes were implemented and have been maintained in the *Enrollee/Member and Family Handbook revised 10-8-2019*. As a result, the information provided within the manual is more clear and specific topics are easier to locate.

Eastpointe maintains a toll-free 24/7 Member Call Center phone number that can be used for any need or question from a member or caregiver. The Eastpointe Call Center Referral Coordinators and Clinicians are guided by Call Center policies and procedures, including *Policy C-3.5.7, Call Center Screening, Triage and Referral (STR) Process*. This policy ensures the enrollee is directed to the correct level of care. Call metrics remain adequate with average speed of answer and average abandoned call rates meeting Eastpointe's goals in *Policy C-3.5.8, Call Center Telephone Monitoring*.

Figure 4 provides a comparison of the 2018 scores versus the 2019 scores. The 2019 review shows 100% of the standards were scored as "Met." There were no standards that were "Partially Met" or "Not Met."

Figure 4: Enrollee Services Comparative Findings



Strengths

- Eastpointe researched several Cultural Competency tests and put five of them on the Eastpointe website for providers to access. Training was held at a provider meeting to make them aware if these optional training/tests.
- Eastpointe is increasing the use of Peer Support Providers in a specific county to assist enrollees with accessing their providers instead of over utilizing the hospital. Eastpointe surveyed Peer Support staff who could work nights and weekends to aid in this effort.

Weaknesses

- The printed 2019 Provider Choice Directory in the Desk Material does not have a field for "Languages Served."
- Letters notifying enrollees of their provider's termination from Eastpointe's provider network did not inform enrollees of the date the provider was terminated. This was a Recommendation at the last EQR and continues to be recommended.

Recommendations

- Add a "Languages Served" field to the printed Provider Directory.

- Ensure notifications to enrollees regarding their provider's termination from the Eastpointe's provider network inform enrollees of the date when the provider will no longer be in the network.

D. Quality Improvement

The Quality Improvement (QI) section covers the QI Program, QI Committees, provider participation in QI, the QI Annual Evaluation, performance measures, and Performance Improvement Projects (PIPs). The two Corrective Actions from last EQR were corrected and maintained for this review.

The *Quality Improvement Plan and Program Description FY2019* describes the formal quality improvement program. Page 14 of this document explains, "Annually, two adopted clinical practice guidelines will be reviewed to ensure practitioner adherence. Recommendations will be made by the Clinical Advisory Committee. Feedback and technical assistance will be provided as needed to provider agencies." The Clinical Practice Guidelines Workgroup minutes detail the work in this area. The workgroup met monthly and developed an Excel spreadsheet summary that shows the percentage of total authorizations that did not use clinical practice guidelines for Assertive Community Treatment (ACT), Community Support Team (CST), and Intensive In-Home (IIH). These three areas were also looked at last year and carried over to this year. Technical assistance is given to providers who need improvements.

Over and underutilization validation was conducted using a review checklist to verify that mechanisms are in place to monitor utilization and data are analyzed. Onsite discussion centered around data linking increased resources for peer support services to improved seven-day follow up appointment attendance, but outcomes as a result of that change are to be determined. CCME recommends continue monitoring over and underutilization to determine if the increased resources in peer support services improves seven-day follow up appointment attendance.

ECHO Survey reports were discussed with the provider members of Global Quality Improvement Committee (GQIC) during the 8/29/19 meeting. No ECHO Survey results were reported in the Network Provider Council minutes for the past year. The 2018 *ECHO Survey* results were not posted on the Eastpointe website. CCME recommends Eastpoint do both annually. Eastpointe worked with the Provider Council to create a project plan to address all areas for which Eastpointe was determined to be below the North Carolina average on the Child and Adult ECHO Survey. Eastpointe created the *2018 Satisfaction Survey Action Plan*. It documents lower scoring items from the *Child ECHO Survey* results, *Adult ECHO Survey* result, and *Provider Satisfaction Survey* results. Results are documented for years 2016, 2017, and 2018. Each lower scoring survey item is assigned to a staff member, and the status is updated on the *2018 Satisfaction Survey Action Plan* Excel document.

GQIC is the formal quality committee at Eastpointe. The committee is cross functional, and membership includes management representatives from each area of the organization, network providers, and a CFAC member. Ensuring that GQIC meets at regular intervals was a Corrective Action item in the last EQR that has been corrected. GQIC met 5 times from June 2018 – June 2019. Months of meetings were June 2018, August 2018, December 2018, February 2019, and June 2019. The October 2018 and April 2019 meetings were cancelled.

The *Eastpointe Provider Operations Manual*, effective 8/26/2019 states, "Provider agencies with the exclusion of Licensed Independent Practitioners (LIP's) and hospitals, shall develop and implement Quality Improvement Projects (QIPS) per fiscal year. The QI Department reviews the provider QIPs using a standardized check sheet and provides feedback to the providers. Technical assistance is offered to providers who fail to meet the benchmark. A Plan of Correction (POC) may be requested if scores fall below the established benchmark or a provider fails to submit." Onsite interview confirms this process is followed.

Creating a document that is specifically a written summary, assessment, and evaluation of the QI Program was a Corrective Action from the last EQR that has been corrected. *Quality Improvement Annual Report FY2019* includes analysis of the quality projects in FY2019 including progress made that year, barriers, interventions, and the strategy for FY2020. Key performance Indicators, over and underutilization, and overall summary of Provider and Enrollee Satisfaction Surveys are also included in the *Quality Improvement Annual Report FY2019.*

Performance Measure Validation

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

Table 6: (b) Waiver Measures

(b) WAIVER MEASURES	
A.1. Readmission Rates for Mental Health	D.1. Mental Health Utilization - Inpatient Discharges and Average Length of Stay
A.2. Readmission Rates for Substance Abuse	D.2. Mental Health Utilization
A.3. Follow-up After Hospitalization for Mental Illness	D.3. Identification of Alcohol and other Drug Services

(b) WAIVER MEASURES	
A.4. Follow-up After Hospitalization for Substance Abuse	D.4. Substance Abuse Penetration Rates
B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	D.5. Mental Health Penetration Rates

Table 7: (c) Waiver Measures

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

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

- Performance measure documentation
- Denominator data quality
- Validity of denominator calculation
- Data collection procedures (if applicable)
- Numerator data quality

- Validity of numerator calculation
- Sampling methodology (if applicable)
- Measure reporting accuracy

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

(b) Waiver Measures Reported Results

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

The measures' rates as reported by Eastpointe are included in the following tables. The follow up after hospitalization for mental illness, Facility Based Crisis (FBC) population, had a decrease of over 10% for outpatient visits within 7 days. The combined rates, however, both increased more than 10% for seven and 30-day follow ups. The engagement rate noted in the Initiation and Engagement of Alcohol & Other Drug Dependence (AODD) Treatment, for 13-17 year olds, decreased substantially. CCME recommends further investigation with internal data monitoring or a focused study into the Engagement of 13-17 year olds undergoing AODD Treatment. Validation worksheets based on the CMS protocol for validating performance measures for each of the (b) waiver measures is provided in Attachment 3. The current rate in comparison to last year's rate is presented in Tables 8 through 17.

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

30-day Readmission Rates for Mental Health	2017	2018	Change
Inpatient (Community Hospital Only)	9.3%	8.3%	-1.0%
Inpatient (State Hospital Only)	0.0%	0.0%	0.0%
Inpatient (Community and State Hospital Combined)	9.5%	8.3%	-1.2%
Facility Based Crisis	4.3%	9.1%	4.8%
Psychiatric Residential Treatment Facility (PRTF)	5.7%	8.0%	2.3%
Combined (includes cross-overs between services)	10.2%	9.3%	-0.9%

Note: Decrease in rate is improvement for readmission rates.

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

30-day Readmission Rates for Substance Abuse	2017	2018	Change
Inpatient (Community Hospital Only)	11.5%	9.0%	-2.5%
Inpatient (State Hospital Only)	0.0%	0.0%	0.0%
Inpatient (Community and State Hospital Combined)	11.3%	8.9%	-2.4%
Detox/Facility Based Crisis	2.6%	6.0%	3.4%
Combined (includes cross-overs between services)	9.3%	11.1%	1.8%

Note. Decrease in rate is improvement for readmission rates.

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

Follow-up after Hospitalization for Mental Illness	2017	2018	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	31.1%	37.7%	6.6%
Percent Received Outpatient Visit Within 30 Days	52.4%	54.1%	1.7%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	36.4%	20.0%	-16.4%
Percent Received Outpatient Visit Within 30 Days	36.4%	40.0%	3.6%
PRTF			
Percent Received Outpatient Visit Within 7 Days	21.5%	29.3%	7.8%
Percent Received Outpatient Visit Within 30 Days	49.2%	53.7%	4.5%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	8.9%	37.4%	28.5%
Percent Received Outpatient Visit Within 30 Days	25.4%	54.0%	28.6%

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

Follow-up after Hospitalization for Substance Abuse	2017	2018	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	9.1%	14.7%	5.6%
Percent Received Outpatient Visit Within 30 Days	17.6%	21.8%	4.2%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	24.6%	22.5%	-2.1%
Percent Received Outpatient Visit Within 7 Days	30.8%	27.2%	-3.6%
Percent Received Outpatient Visit Within 30 Days	42.1%	37.9%	-4.2%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	11.7%	21.2%	9.5%
Percent Received Outpatient Visit Within 30 Days	20.6%	30.2%	9.6%

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2017	2018	Change
Ages 13-17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	60.4%	53.9%	-6.5%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	49.4%	32.9%	-16.5%
Ages 18-20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	53.7%	55.7%	2.0%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	40.1%	39.2%	-0.9%

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2017	2018	Change
Ages 21-34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	57.5%	61.8%	4.3%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	51.4%	55.2%	3.8%
Ages 35-64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	61.9%	64.0%	2.1%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	52.6%	55.5%	2.9%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	72.3%	69.8%	-2.5%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	59.5%	52.3%	-7.2%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	60.2%	62.5%	2.3%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	51.5%	53.0%	1.5%

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

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		2017	2018	Change	2017	2018	Change
3-12	Male	0.3	0.2	-0.1	35.2	30.2	-5.0
	Female	0.2	0.1	-0.1	24.4	18.4	-6.0
	Total	0.2	0.2	0.0	31.4	25.0	-6.4
13-17	Male	1.1	1.0	-0.1	53.4	54.0	0.6
	Female	1.3	1.3	0.0	33.2	32.2	-1.0
	Total	1.2	1.1	-0.1	42.7	42.0	-0.7
18-20	Male	1.5	1.2	-0.3	9.0	15.9	6.9
	Female	1.3	1.3	0.0	11.3	10.3	-1.0
	Total	1.4	1.2	-0.2	10.1	12.9	2.8
21-34	Male	4.3	4.3	0.0	7.7	8.3	0.6
	Female	1.5	1.3	-0.2	7.2	7.5	0.3
	Total	2.1	2.0	-0.1	7.4	7.9	0.5
35-64	Male	2.9	2.6	-0.3	8.4	10.6	2.2
	Female	2.3	2.0	-0.3	7.8	8.5	0.7
	Total	2.5	2.2	-0.3	8.0	9.4	1.4
65+	Male	0.4	0.6	0.2	22.2	27.1	4.9
	Female	0.4	0.3	-0.1	15.9	18.7	2.8
	Total	0.4	0.4	0.0	17.9	22.6	4.7
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**	**1.3**	**1.2**	**-0.1**	**18.0**	**19.1**	**1.1**
	Female	**1.1**	**1.0**	**-0.1**	**12.7**	**13.2**	**0.5**
	Total	**1.2**	**1.1**	**-0.1**	**15.1**	**16.0**	**0.9**

Table 14: D.2. Mental Health Utilization -% of Members that Received at Least One 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		
		2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
3-12	Male	12.43%	12.96%	0.53%	0.24%	0.19%	-0.05%	0.68%	0.61%	-0.07%	12.26%	12.78%	0.52%
	Female	8.39%	9.04%	0.65%	0.15%	0.15%	0.00%	0.15%	0.15%	0.00%	8.36%	8.99%	0.63%
	Total	10.45%	11.04%	0.59%	0.20%	0.17%	-0.03%	0.42%	0.38%	-0.04%	10.35%	10.92%	0.57%
13-17	Male	13.78%	14.01%	0.23%	1.05%	1.05%	0.00%	0.59%	0.33%	-0.26%	13.61%	13.88%	0.27%
	Female	13.66%	14.13%	0.47%	1.22%	1.28%	0.06%	0.15%	0.14%	-0.01%	13.52%	13.96%	0.44%
	Total	13.72%	14.07%	0.35%	1.13%	1.16%	0.03%	0.38%	0.23%	-0.15%	13.57%	13.92%	0.35%
18-20	Male	9.63%	8.37%	-1.26%	1.09%	1.07%	-0.02%	0.00%	0.02%	0.02%	9.47%	8.17%	-1.30%
	Female	10.62%	10.74%	0.12%	1.14%	1.14%	0.00%	0.03%	0.00%	-0.03%	10.31%	10.48%	0.17%
	Total	10.16%	9.60%	-0.56%	1.12%	1.11%	-0.01%	0.01%	0.01%	0.00%	9.91%	9.37%	-0.54%
21-34	Male	23.00%	23.16%	0.16%	3.40%	3.63%	0.23%	0.05%	0.02%	-0.03%	22.64%	22.72%	0.08%
	Female	17.02%	16.97%	-0.05%	1.22%	1.24%	0.02%	0.01%	0.02%	0.01%	16.82%	16.83%	0.01%
	Total	18.34%	18.39%	0.05%	1.70%	1.79%	0.09%	0.02%	0.02%	0.00%	18.10%	18.19%	0.09%

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Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
35-64	Male	19.12%	19.15%	0.03%	2.28%	2.06%	-0.22%	0.02%	0.02%	0.00%	18.76%	18.96%	0.20%
	Female	22.41%	22.50%	0.09%	1.96%	1.58%	-0.38%	0.04%	0.03%	-0.01%	22.10%	22.07%	-0.03%
	Total	21.16%	21.21%	0.05%	2.08%	1.77%	-0.31%	0.03%	0.02%	-0.01%	20.83%	20.88%	0.05%
65+	Male	5.35%	6.33%	0.98%	0.35%	0.56%	0.21%	0.00%	0.00%	0.00%	5.31%	6.08%	0.77%
	Female	5.36%	5.88%	0.52%	0.38%	0.26%	-0.12%	0.01%	0.01%	0.00%	5.19%	5.78%	0.59%
	Total	5.36%	6.02%	0.66%	0.37%	0.35%	-0.02%	0.01%	0.01%	0.00%	5.22%	5.88%	0.66%
Unknown	Male	1.18%	0.00%	-1.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.18%	0.00%	-1.18%
	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	0.59%	0.00%	-0.59%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.59%	0.00%	-0.59%
Total	**Male**	**13.87%**	**14.12%**	**0.25%**	**1.04%**	**1.02%**	**-0.02%**	**0.40%**	**0.32%**	**-0.08%**	**13.67%**	**13.92%**	**0.25%**
	Female	**13.38%**	**13.66%**	**0.28%**	**0.95%**	**0.87%**	**-0.08%**	**0.08%**	**0.07%**	**-0.01%**	**13.21%**	**13.49%**	**0.28%**
	Total	**13.59%**	**13.86%**	**0.27%**	**0.99%**	**0.93%**	**-0.06%**	**0.22%**	**0.18%**	**-0.04%**	**13.40%**	**13.67%**	**0.27%**

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

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
3-12	Male	0.05%	0.03%	-0.02%	0.00%	0.00%	0.00%	0.02%	0.01%	-0.01%	0.04%	0.02%	-0.02%
	Female	0.04%	0.03%	-0.01%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%	0.04%	0.01%	-0.03%
	Total	0.05%	0.03%	-0.02%	0.00%	0.00%	0.00%	0.02%	0.01%	-0.01%	0.04%	0.01%	-0.03%
13–17	Male	2.52%	2.11%	-0.41%	0.01%	0.07%	0.06%	1.80%	1.35%	-0.45%	0.99%	0.95%	-0.04%
	Female	1.39%	1.14%	-0.25%	0.01%	0.06%	0.05%	1.01%	0.75%	-0.26%	0.43%	0.37%	-0.06%
	Total	1.97%	1.63%	-0.34%	0.01%	0.06%	0.05%	1.42%	1.06%	-0.36%	0.72%	0.67%	-0.05%
18–20	Male	3.74%	3.19%	-0.55%	0.28%	0.23%	-0.05%	1.81%	1.55%	-0.26%	2.42%	1.97%	-0.45%
	Female	2.99%	3.00%	0.01%	0.23%	0.18%	-0.05%	1.45%	1.39%	-0.06%	1.76%	1.96%	0.20%
	Total	3.34%	3.09%	-0.25%	0.25%	0.21%	-0.04%	1.62%	1.47%	-0.15%	2.07%	1.96%	-0.11%
21–34	Male	8.63%	8.99%	0.36%	0.87%	0.74%	-0.13%	1.95%	1.93%	-0.02%	8.07%	8.29%	0.22%
	Female	7.10%	8.25%	1.15%	0.49%	0.51%	0.02%	1.98%	1.79%	-0.19%	6.62%	7.72%	1.10%
	Total	7.43%	8.42%	0.99%	0.58%	0.56%	-0.02%	1.97%	1.82%	-0.15%	6.94%	7.85%	0.91%

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Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
35–64	Male	8.32%	8.28%	-0.04%	0.83%	0.91%	0.08%	2.69%	2.41%	-0.28%	7.54%	7.54%	0.00%
	Female	5.98%	6.34%	0.36%	0.33%	0.34%	0.01%	1.92%	1.92%	0.00%	5.51%	5.88%	0.37%
	Total	6.87%	7.09%	0.22%	0.52%	0.56%	0.04%	2.21%	2.11%	-0.10%	6.28%	6.52%	0.24%
65+	Male	1.68%	1.94%	0.26%	0.12%	1.36%	1.24%	0.47%	0.66%	0.19%	1.54%	1.51%	-0.03%
	Female	0.48%	0.60%	0.12%	0.03%	0.20%	0.17%	0.22%	0.21%	-0.01%	0.38%	0.51%	0.13%
	Total	0.84%	1.02%	0.18%	0.06%	0.56%	0.50%	0.29%	0.35%	0.06%	0.73%	0.82%	0.09%
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**	**2.96%**	**2.88%**	**-0.08%**	**0.24%**	**0.34%**	**0.10%**	**1.12%**	**0.98%**	**-0.14%**	**2.39%**	**2.35%**	**-0.04%**
	Female	**3.00%**	**3.21%**	**0.21%**	**0.18%**	**0.21%**	**0.03%**	**1.02%**	**0.94%**	**-0.08%**	**2.60%**	**2.84%**	**0.24%**
	Total	**2.99%**	**3.07%**	**0.08%**	**0.20%**	**0.26%**	**0.06%**	**1.06%**	**0.96%**	**-0.10%**	**2.51%**	**2.63%**	**0.12%**

Table 16: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Bladen	0.07%	0.00%	-0.07%	1.16%	0.87%	-0.29%	1.76%	2.37%	0.61%	4.72%	5.21%	0.49%
Columbus	0.02%	0.02%	0.00%	0.68%	0.85%	0.17%	2.32%	1.41%	-0.91%	6.01%	5.15%	-0.86%
Duplin	0.00%	0.00%	0.00%	0.23%	0.35%	0.12%	0.59%	0.64%	0.05%	3.00%	2.71%	-0.29%
Edgecombe	0.00%	0.02%	0.02%	0.88%	0.59%	-0.29%	1.90%	1.04%	-0.86%	4.42%	4.27%	-0.15%
Greene	0.06%	0.00%	-0.06%	0.25%	0.23%	-0.02%	2.84%	2.08%	-0.76%	3.90%	4.67%	0.77%
Lenoir	0.07%	0.05%	-0.02%	1.68%	1.43%	-0.25%	2.65%	3.36%	0.71%	8.23%	7.76%	-0.47%
Robeson	0.14%	0.03%	-0.11%	4.58%	3.30%	-1.28%	5.54%	5.02%	-0.52%	10.12%	11.90%	1.78%
Sampson	0.00%	0.02%	0.02%	0.30%	0.33%	0.03%	1.47%	0.89%	-0.58%	2.48%	2.51%	0.03%
Scotland	0.13%	0.02%	-0.11%	4.17%	2.34%	-1.83%	5.00%	3.61%	-1.39%	8.22%	9.45%	1.23%
Wayne	0.02%	0.01%	-0.01%	0.78%	0.77%	-0.01%	1.74%	2.23%	0.49%	4.97%	5.00%	0.03%
Wilson	0.01%	0.00%	-0.01%	0.76%	1.02%	0.26%	3.55%	2.52%	-1.03%	6.61%	5.73%	-0.88%

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		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	35-64			65+			Unknown			Total		
Bladen	3.91%	4.16%	0.25%	0.60%	0.50%	-0.10%	0.00%	0.00%	0.00%	1.94%	2.02%	0.08%
Columbus	4.05%	3.84%	-0.21%	0.61%	0.63%	0.02%	0.00%	0.00%	0.00%	2.12%	1.89%	-0.23%
Duplin	4.06%	4.23%	0.17%	0.56%	0.54%	-0.02%	0.00%	0.00%	0.00%	1.15%	1.15%	0.00%
Edgecombe	6.69%	5.68%	-1.01%	1.20%	1.20%	0.00%	0.00%	0.00%	0.00%	2.50%	2.17%	-0.33%
Greene	6.26%	5.99%	-0.27%	0.68%	0.66%	-0.02%	0.00%	0.00%	0.00%	1.91%	1.86%	-0.05%
Lenoir	9.70%	9.62%	-0.08%	1.34%	1.76%	0.42%	0.00%	0.00%	0.00%	3.82%	3.79%	-0.03%
Robeson	8.74%	8.43%	-0.31%	1.29%	1.20%	-0.09%	0.00%	0.00%	0.00%	4.53%	4.52%	-0.01%
Sampson	2.39%	2.44%	0.05%	0.31%	0.32%	0.01%	0.00%	0.00%	0.00%	0.91%	0.89%	-0.02%
Scotland	7.10%	6.75%	-0.35%	0.97%	1.47%	0.50%	0.00%	0.00%	0.00%	3.92%	3.72%	-0.20%
Wayne	6.55%	7.05%	0.50%	0.81%	0.65%	-0.16%	0.00%	0.00%	0.00%	2.25%	2.36%	0.11%
Wilson	9.35%	9.22%	-0.13%	1.46%	2.01%	0.55%	0.00%	0.00%	0.00%	3.31%	3.14%	-0.17%

Table 17: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Bladen	8.25%	9.08%	0.83%	12.06%	11.80%	-0.26%	10.54%	8.89%	-1.65%	11.64%	11.02%	-0.62%
Columbus	10.50%	11.03%	0.53%	13.76%	12.34%	-1.42%	7.61%	7.46%	-0.15%	11.18%	9.75%	-1.43%
Duplin	7.57%	7.66%	0.09%	13.05%	12.07%	-0.98%	8.63%	9.74%	1.11%	14.75%	14.05%	-0.70%
Edgecombe	7.09%	6.19%	-0.90%	10.37%	10.15%	-0.22%	5.78%	5.45%	-0.33%	9.30%	7.74%	-1.56%
Greene	7.06%	6.93%	-0.13%	14.02%	13.45%	-0.57%	10.82%	6.49%	-4.33%	14.60%	11.11%	-3.49%
Lenoir	11.80%	12.07%	0.27%	17.85%	17.65%	-0.20%	9.97%	10.34%	0.37%	15.49%	14.88%	-0.61%
Robeson	8.79%	9.90%	1.11%	11.94%	12.55%	0.61%	8.36%	8.58%	0.22%	12.85%	13.51%	0.66%
Sampson	7.72%	7.32%	-0.40%	11.09%	10.50%	-0.59%	8.35%	7.81%	-0.54%	9.32%	10.27%	0.95%
Scotland	9.77%	11.53%	1.76%	14.62%	15.41%	0.79%	7.73%	7.88%	0.15%	13.93%	12.68%	-1.25%
Wayne	8.47%	8.35%	-0.12%	16.64%	17.22%	0.58%	11.33%	9.92%	-1.41%	15.47%	15.01%	-0.46%
Wilson	10.13%	10.19%	0.06%	13.62%	13.95%	0.33%	9.96%	8.57%	-1.39%	13.26%	13.15%	-0.11%

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		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
	35-64			65+			Unknown			Total		
Bladen	14.77%	14.34%	-0.43%	6.22%	3.39%	-2.83%	0.00%	0.00%	0.00%	10.66%	10.27%	-0.39%
Columbus	12.83%	12.44%	-0.39%	5.07%	4.89%	-0.18%	0.00%	0.00%	0.00%	10.76%	10.35%	-0.41%
Duplin	21.68%	21.93%	0.25%	7.87%	9.38%	1.51%	0.00%	0.00%	0.00%	11.67%	11.69%	0.02%
Edgecombe	14.57%	12.37%	-2.20%	8.43%	6.66%	-1.77%	0.00%	0.00%	0.00%	9.51%	8.29%	-1.22%
Greene	19.13%	17.72%	-1.41%	7.67%	5.24%	-2.43%	0.00%	0.00%	0.00%	11.56%	10.22%	-1.34%
Lenoir	21.32%	20.88%	-0.44%	7.23%	6.45%	-0.78%	0.00%	0.00%	0.00%	14.61%	14.43%	-0.18%
Robeson	17.67%	17.29%	-0.38%	5.24%	4.36%	-0.88%	0.00%	0.00%	0.00%	11.28%	11.73%	0.45%
Sampson	12.63%	12.26%	-0.37%	6.49%	5.63%	-0.86%	0.00%	0.00%	0.00%	9.20%	8.91%	-0.29%
Scotland	17.14%	15.73%	-1.41%	10.33%	8.52%	-1.81%	0.00%	0.00%	0.00%	12.54%	12.57%	0.03%
Wayne	23.45%	22.83%	-0.62%	11.14%	11.14%	0.00%	0.00%	0.00%	0.00%	13.85%	13.64%	-0.21%
Wilson	20.00%	19.36%	-0.64%	9.16%	9.65%	0.49%	0.00%	0.00%	0.00%	12.90%	12.77%	-0.13%

(b) Waiver Measures Validation Results

The overall validation scores are "Fully Compliant" with an average validation score of 100% across the 10 measures. Data sources, programming logic, and edits to code to calculate rates were included in the documentation submitted and rates were accurately reported. The tables below display the validation scores for each of the ten measures as well as the overall average validation score for Eastpointe.

Table 18 contains validation scores for each of the 10 (b) Waiver Performance Measures.

Table 18: (b) Waiver Performance Measure Validation Scores

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

(c) Waiver Measures Reported Results

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

Table 19: (c) Waiver Measures Reported Results 2018

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals. IW D1 ISP	Annual	1036/1036 = 100%	85%
Proportion of Individual Support Plans that address identified health and safety risk factors. IW D2 ISP	Semi Annually	535/535 = 100%	85%
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need. IW D3 ISP	Annually	1036/1036 = 100%	85%
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	1034/1036 = 99.81%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	1034/1036 = 99.81%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	42/42 = 100%	85%
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required. IW G3	Quarterly	3/3 = 100%	85%
Percentage of medication errors resulting in medical treatment. IW G4	Quarterly	0/0 = N/A	15%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	973/973 = 100%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	6/6 = 100%	85%

* Latest reported rates are shown in Table.

(c) Waiver Measures Validation Results

Validation scores are fully compliant with an average validation score of 100% across the ten measures. The validation scores are shown in *Table 20, (c) Waiver Performance Measure Validation Scores*. Documentation on data sources, data validation, source code, and calculated rate for the ten (c) Waiver measures was provided. All rates met or exceeded state performance benchmarks. The validation worksheets offer detailed information on point deduction when validating each (c) Waiver measure.

Documentation file provided by Eastpointe: 'DHHS Monitoring Innovations Performance Measures FY 20 updated' Excel file.

Table 20: C Waiver Performance Measures Validation Scores

Measure	Validation Score Received
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals. IW D1 ISP	100%
Proportion of Individual Support Plans that address identified health and safety risk factors. IW D2 ISP	100%
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need. IW D3 ISP	100%
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%
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required. IW G3	100%
Percentage of medication errors resulting in medical treatment. IW G4	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 3: Validating Performance Improvement Projects Version 2.0, September 2012*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

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

PIP Validation Results

The PIPs validated for 2018 included: TCLI (individuals served), Percent of individuals who received 2nd service within or less than 14 days, Decrease state psychiatric hospital 30-day readmissions for high risk members, and ED Admissions. For 2018, there were four PIPs that were validated, and several documentation issues were noted in the review, including lack of information on interventions, lack of clear indicator definitions, and lack of results. For the 2019 review year, seven PIPs were validated, and the documentation reflected a marked improvement in reporting. All Corrective Actions from the 2018 review were resolved. Six out of seven PIPs scored in the High Confidence range of greater than 90%. Only one PIP scored in the Confidence scoring range and that was the new PIP regarding separation from TCLI housing. This newly initiated PIP is valuable in that it addresses an important social determinant to improve population health management for at-risk individuals. Interventions discussed during the Onsite included member education, and guidance tools to ensure that housing is maintained for these individuals. Given that Eastpointe is conducting a high number of projects, the commencement of additional PIPs is not recommended, but rather a more focused approach on intervention efforts within these projects to improve outcomes.

As shown, six out of seven (86%) projects received a score of “High Confidence in Reported Results”. Validation worksheets based on the CMS protocol for validating performance improvement projects are provided for each PIP in Attachment 3. Table 21 provides a summary of the validation scores for each PIP.

Table 21: PIP Summary of Validation Scores

Project Type	Project	2018 Validation Score	2019 Validation Score
Clinical	Increase number of individuals in the priority population served by a fidelity provider to 50% monthly	74/80 = 93% High Confidence in Reported Results	95/95 = 100% High Confidence in Reported Results
	Increase percentage of members who received a face to face service within 48 hours to 70%	Not Submitted	83/85 = 98% High Confidence in Reported Results
	Decrease state psychiatric hospital 30-day readmissions for high risk members	58/90 = 64% Low Confidence in Reported Results	84/85 = 99% High Confidence in Reported Results
	Increase the percentage of individuals who receive a 2nd service within or less than 14 days	51/80 = 64% Low Confidence in Reported Results	85/90 = 94% High Confidence in Reported Results
	Decrease Emergency Department admissions for active members to 20%	42/52 = 81% Confidence in Reported Results	90/91 = 99% High Confidence in Reported Results
	Decrease percentage of members who separate from Transition to Community Living Initiative (TCLI) housing to 20% or less annually	Not Submitted/Not Validated	42/47 = 89% Confidence in Reported Results
Non-Clinical	Increase approval rate of Medicaid Encounter Claims to 95%	Not Validated	95/95 = 100% High Confidence in Reported Results

Table 22 lists the specific errors for projects that require Corrective Action.

Table 22: Performance Improvement Project Errors and Corrective Actions

Project	Section	Reason	Corrective Action
Decrease percentage of members who separate from Transition to Community Living (TCLI) housing to 20% or less annually	Did the study use objective, clearly defined, measurable indicators?	Indicator is defined although baseline benchmark is reported at 100%. The goal is 20% and 100% is higher than the current reported rate of 63% in the rationale section.	Determine if 100% benchmark is correct rate. Revise baseline benchmark to a rate that is closer to or equal to the goal rate of 20% if applicable.

Table 23 list the specific errors for projects that have Recommendations.

Table 23: Performance Improvement Project Errors and Recommendations

Project	Section	Reason	Recommendation
Increase percentage of members who received a face to face service within 48 hours to 70	Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	Data collection methods are not clearly documented in Section C.2.	Include information on how data are collected.
	Was there any documented, quantitative improvement in processes or outcomes of care?	No, rates have not increased. They are steady around 30% which is well below the goal rate.	Continue evaluating interventions to ensure they are addressing all barriers to increasing the rate. Focus on fewer interventions to determine impact before adding additional interventions.
Decrease state psychiatric hospital 30-day readmissions for high risk members	Was there any documented, quantitative improvement in processes or outcomes of care?	The rate was above the goal of 6% in the most recent remeasurement.	Revise and/or continue interventions to decrease rate for readmissions by focusing efforts on those that appear most effective

Project	Section	Reason	Recommendation
Increase the percentage of individuals who receive a 2nd service within or less than 14 days	Was/were the study question(s) stated clearly in writing?	Two different research questions were documented, and one referred to engagement, although engagement does not appear to be an outcome of this project.	Clarify if PIP is monitoring initiation and engagement or just initiation. Revise report according to outcomes indicated in research question.
Decrease Emergency Department admissions for active members to 20%	Was there any documented, quantitative improvement in processes or outcomes of care?	Rates are not improving, as of latest available data for June 2019. The rate is above goal rate of 20%.	Continue new interventions focused on members and transition care to determine best way to reduce ED overutilization.

Figure 5 provides a comparison of the 2018 scores versus the 2019 scores. The 2019 review shows 94% of the standards were scored as "Met", and 6% of the standards were scored as "Partially Met." None of the standards were scored "Not Met."

Figure 5: Quality Improvement Comparative Findings

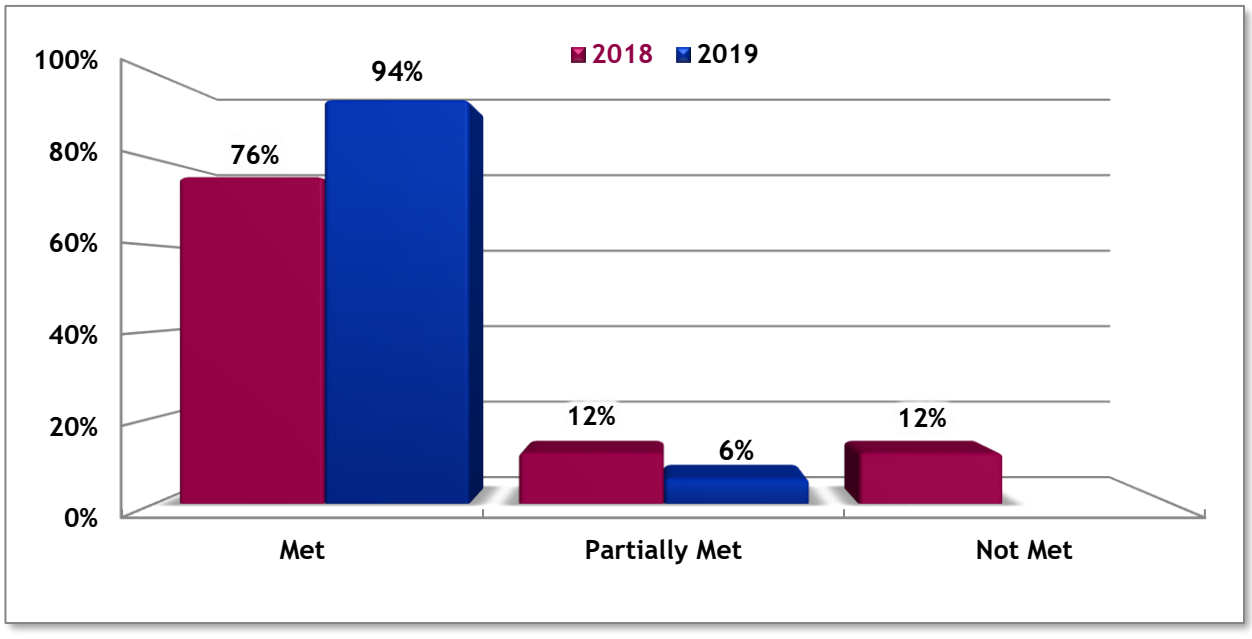


Table 24: Quality Improvement

Section	Standard	2019 Review
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	Partially Met

Strengths

- Each lower scoring enrollee survey item is tracked on the *2018 Satisfaction Survey Action Plan* Excel document. A staff member is assigned to each item and the status is updated as improvements are made to the item.
- The Quality Improvement (QI) Department reviews the provider QIPs using a standardized check sheet and provides feedback to the providers. Technical assistance is offered to providers who fail to meet the benchmark. A Plan of Correction (POC) may be requested if scores fall below the established benchmark or a provider fails to submit.
- Eastpoint created a QI Evaluation called the *Quality Improvement Annual Report FY2019*. This document is comprehensive including: analysis of the quality projects in FY2019, barriers, interventions, strategy for FY2020, Key Performance Indicators, over and underutilization, and overall summary of Provider and Enrollee Satisfaction Surveys.

Weaknesses

- More resources are being allocated to peer support services, but outcomes as a result of that change are to be determined.
- No ECHO Survey results were reported in the Network Provider Council minutes for the past year. 2018 ECHO Survey results were not posted on the Eastpointe website.
- The newly initiated PIP regarding separation from housing scored in the confidence range with a validation score of 89%.

Corrective Action

- Correct the errors in this PIP scoring "Partially Met". Decrease percentage of members who separate from Transition to Community Living (TCLI) housing to 20% or less annually. Table 24 displays this PIP and the specific Corrective Action. The specific corrections are also displayed on the PIP Worksheets in Attachment C.

Recommendations

- Continue monitoring over and underutilization to determine if the increased resources in peer support services improves seven-day follow up appointment attendance.
- Discuss ECHO Survey Results with the Network Provider Council and show the discussion in the meeting minutes. Put this on the QM Workplan to be reported to Network Provider Council annually. Post the ECHO Survey results on the Eastpointe website each year when the results are available.

E. Utilization Management

For the purpose of this year's review of Eastpointe's utilization management (UM) standards, Eastpointe submitted 50 service authorization files, which encompassed 25 approval decisions and 25 denial decisions across for mental health/substance use (MH/SU) services, intellectual and developmental disabilities (I/DD) services and services provided to enrollees involved with the Transitions to Community Living Initiative (TCLI). Multiple policies governing UM were also reviewed. This year's EQR resulted in CCME issuing two Corrective Actions and seven Recommendations.

The EQR of the service authorization decisions and related documentation resulted in three Recommendations. Recommendations were aimed at clarifying documentation prohibiting financial incentives for UM staff, describing Eastpointe's interventions on underutilization and overutilization services, and ensuring the completeness of the UM record.

Within the I/DD, MH/SU and TCLI Care Coordination EQR, two Corrective Actions and four Recommendations were issued regarding concerning patterns within files. In the files reviewed, I/DD, MH/SU and TCLI Care Coordination documentation was often incomplete, unclear, or submitted outside of the timeframes required by Eastpointe policies. For example, over 10% of the progress notes were submitted late by Care Coordinators, some as many as 17 months late. Similar issues with Care Coordination documentation have been noted in previous EQRs.

During the Onsite, Eastpointe acknowledged this documentation weakness and could explain upcoming initiatives designed at improving the overall quality of documentation. CCME is advocating that Eastpointe put a formal monitoring plan into place that reviews all Care Coordination and TCLI documentation (e.g., cases targeted for discharge, In-Reach tools, HCBS Monitoring Checklists, In-Reach Tools, Quality of Life Surveys, progress notes, follow up activities, etc.).

Additionally, CCME is advocating that Eastpointe enhance the current clinical staffing process available to I/DD, MH/SU and TCLI Care Coordinators. During the Onsite discussion, specific cases were discussed and CCME highlighted a pattern of poor follow

up activities by Care Coordinators. Additional support through clinical staffings would help Care Coordinators take more proactive steps in addressing topics such as, potential enrollee crises, barriers to service access, and imminent health needs.

The following graph provides the scoring information for the 2018 EQR Review. Figure 6 provides an overview of 2018 scores compared to 2019 scores.

Figure 6: Utilization Management Comparative Findings

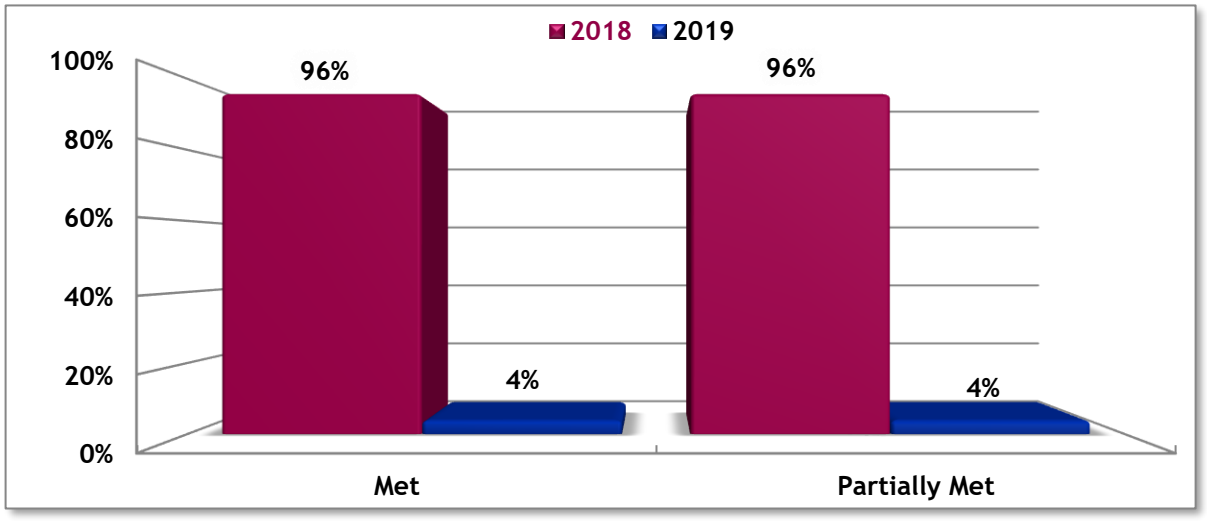


Table 25: Utilization Management

Section	Standard	2019 Review
Care Coordination	The PIHP applies the Care Coordination policies and procedures as formulated.	Partially Met
Transition to Community Living Initiative	A review of files demonstrates the PIHP is following appropriate TCL policies, procedures and processes, as required by NC Medicaid, and developed by the PIHP.	Partially Met

Strengths

- Eastpointe provided training to staff and network providers on the Child and Adolescent Needs and Strengths (CANS) assessment. The results of the training produced multiple Eastpointe staff and provider staff gaining certification as a CANS assessor.
- Care Coordination and TCLI staff explained several, upcoming initiatives designed to improve upon the quality, timeliness and completeness of documentation.

Weaknesses

- The review of UM Policies found no reference to *Policy C.C.-1.4, Financial Incentives*.
- The review of the Over/Under Committee Minutes found that Intensive In-Home Services was listed as underutilized, contradicting the UM Plan/Program Description, which stated it was an overutilized service.
- UM staff may have documented additional contacts on a "Communication Log", but this was not provided for this EQR.
- A review of I/DD and MH/SU Care Coordination files showed a pattern of poor follow up activities.
- There was evidence within three of the files reviewed that enrollees were discharged from Care Coordination without following the discharge protocols outlined in *Policy 3.4.12, MHSU Care Coordination Intensity of Need and Discharge Criteria*.
- The file review revealed 11% of I/DD progress notes and 15% of MH/SU progress notes were submitted outside of the timeframe outlined in *Policy C-3.6.4, Documentation of Care Coordination Activities*. Several Progress notes and HCBS Monitoring checklists were also lacked detail or were incomplete.
- A review of TCLI files showed a pattern of poor follow up activities.
- The review of TCLI files showed that two out of the 15 files were missing the 11-month QOL survey. It was also found some surveys were not implemented within the required timeframe and had incomplete documentation.
- The review of progress notes showed in the 15% of TCLI progress notes were not completed in the 7-day timeframe required in Eastpointe *Policy C-3.6.4, Documentation of Care Coordination Activities*.

Corrective Action

- Develop a comprehensive monitoring plan that will include a review of all Care Coordination documentation (cases targeted for discharge, progress notes, follow up activities, HCBS monitoring checklists, etc.). The monitoring plan should identify the frequency of monitoring and the scope (i.e., timeliness of documentation, completeness, quality, etc.).
- Develop a comprehensive monitoring plan that will include a review of all TCLI Care Coordination documentation (In Reach Tools, progress notes, follow up activities, etc.). The monitoring plan should identify the frequency of monitoring and the scope (i.e., timeliness of documentation, completeness, quality, etc.).

Recommendations

- Reference *Policy C.C-1.4, Financial Incentives*, in *Policy C-3.2.38, Medical Necessity First Level,* and *Policy C-3.2.39, Medical Necessity Second Level*.
- Revise the UM Plan/Program Description to include the process used to identify and intervene upon services that are underutilized and overutilized.
- Ensure all communications with providers, including attempts to obtain additional information for service authorization decisions, are captured within the complete UM service authorization record and submitted for any review or audit.
- Enhance the current, clinical staffing process to ensure staff provide proactive and needed interventions by I/DD and MH/SU Care Coordinators.
- *Update Policy 3.4.12, MHSU Care Coordination Intensity of Need and Discharge Criteria*, to include the requirement that cases must be staffed with supervisor prior to discharge.
- Enhance the current, clinical staffing process to ensure staff provide proactive and needed interventions by TCLI Care Coordinators.
- Develop a comprehensive monitoring plan that will include a review of Quality of Life Surveys. The monitoring plan should monitor the timeliness of surveys, as well as the completeness and quality of documentation within the surveys.

F. Grievances and Appeals

The Grievances and Appeals External Quality Review (EQR) for Eastpointe included a Desk Review of policies and procedures, 20 grievance and 21 appeal files, the Grievances and Appeals Logs, the *Provider Operations Manual* and the *Enrollee/Member and Family Handbook*. An Onsite discussion with Grievance and Appeal staff occurred to further clarify Eastpointe's documentation and processes.

Grievances

In the previous year's EQR, Eastpointe received five Recommendations. This year's review showed Eastpointe fully implemented and maintained two of these Recommendations. The remaining Recommendations were partially implemented. As a result, this year's EQR resulted in three Corrective Actions and five Recommendations in the grievance review.

Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaint/Grievance, is the overarching policy that guides Eastpointe staff through the grievance process. Based on a Recommendation from last year's EQR, *Policy Q-6.4.4*, was revised to accurately reflect the correct definition of a grievance. However, who can file a grievance is not consistently stated throughout the policy. The policy references "member/enrollees" and

"stakeholders" but does not define stakeholders or note that legal guardians or legally responsible persons (LRPs) can also file a grievance. This lack of detailed information leaves the grievance policy vague in describing the grievance process.

Based on a Recommendation from the previous year's EQR, *Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaint/Grievance,* was revised by Eastpointe to ensure consistent use of one term, "complaint/grievance". However, the policy is only approximately 75% consistent. There remain approximately 20 references to just "grievances", "complaints", or "concerns". This oversight continues to create a confusing and misleading policy.

The *Provider Operations Manual* also confuses these terms. There was also a Recommendation in last year's EQR to revise this manual to ensure consistency, but this Recommendation was not implemented by Eastpointe. As a result, there are 150 references to the grievance process, but the manual uses the term "grievance" 76% of the time, "complaint" 15% of the time, and "concern" approximately 9% of the time.

It was also recommended in last year's EQR to similarly revise the *Enrollee/Member and Family Handbook*. This Recommendation was addressed by Eastpointe and, as a result, the handbook uses the term "complaint/grievance" 96% of the time. There are only four references to the stand alone term "grievance".

Eastpointe *Policy Q-6.4.4* indicates Eastpointe is required to resolve and provide notice of the grievance outcomes within 30 days of the receipt of a grievance. This policy provides the conditions under which Eastpointe can extend a grievance resolution time frame. However, the policy does not include the information about the required notifications related to that extension. The policy is missing the requirement of Eastpointe to make reasonable efforts to give the enrollee prompt and, within two calendar days give the enrollee written notice of the reason for the decision to extend the time frame. The enrollee must also be informed of their right to file a grievance if she/he disagrees with the extension. This is required by *NC Medicaid Contract, Attachment M.6*.

Based on a Recommendation from last year's EQR, *Policy Q-6.4.4* was revised to add the steps staff take to address and resolve Quality of Care (QOC) concerns. The policy now states, "If the complaint/concern is a health and safety issue, grievance and appeals staff will immediately (within 1 business day) complete the Quality of Care QOC Form desk referral. Grievances related to health and safety concerns, including medical concerns, are reviewed by a physician as a part of the resolution process and Quality of Care Concern process." However, there was no additional information in *Policy C-6.4.4* about the internal steps staff take to make this referral, document the referral, and document the outcome of the committee and physician review.

Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaint/Grievance, also does not specify the time frame for maintenance of grievance logs. *NC Medicaid Contract, Attachment M, B.2*, requires PIHPs to maintain grievance records for five years following a final decision or the close of the grievance.

The 20 grievance files reviewed for this year's EQR showed the majority of the grievances were resolved within the required time frames with appropriate and timely notifications provided. One grievance was resolved and notification provided 31 days after the grievance was received. This is one day outside of the time frame required by Eastpointe's policy for resolution of grievances. This same file showed that the grievance acknowledgement letter was also sent outside of the five business day, time frame required by *Policy Q-6.4.4*.

Another grievance file reviewed showed the resolution time frame was extended by Eastpointe and permission from NC Medicaid to extend the grievance time frame was granted. However, there was no evidence of efforts by staff to inform the grievant of the extension. *NC Medicaid Contract, Attachment M6,* requires Eastpointe to make reasonable efforts to give the enrollee prompt notice and, within two calendar days, give the enrollee written notice of the reason for the decision to extend the time frame. The enrollee must also be informed of their right to file a grievance if she/he disagrees with the extension. By enhancing their current monitoring of grievances, anomalies seen in these files would be detected and remedied by Eastpointe.

While there was some evidence that Quality of Care (QOC) grievances were elevated to the QOC Committee, the QOC meeting minutes did not reflect the Medical Director's attendance, participation or feedback in the staffing of the QOC grievances. Documenting the attendance and participation by committee members and subject matter experts, including any physician, can better demonstrate oversight and review by the Medical Director of QOC grievances and close the loop on referrals from grievance staff to the QOC.

Eastpointe's Global Quality Improvement Committee GQIC reviews grievance data quarterly. Included in this data are percentage of grievances resolved timely, and trends of type of grievances. The minutes do not reflect any discussion, or any identification of steps Eastpointe can take to address concerning trends. A more robust review and discussion would help Eastpointe better identify important trends and quality improvement opportunities.

Appeals

In the previous year's EQR, Eastpointe received six Corrective Actions and seven Recommendations, primarily targeting inconsistent and incorrect information in their

appeals documentation, including *Policy C-3.2.6, Appeal of UM Adverse Benefit Determination*, Eastpointe's *Provider Operations Manual* and *Enrollee/Member and Family Handbook,* and enrollee appeal notifications. While some revisions were made in the past year, primarily to the *Enrollee/Member and Family Handbook*, consistency is still needed within and across documentation discussing appeals. As a result, Eastpointe received ten Corrective Actions and five Recommendations in this year's EQR. All but two Recommendations are aimed at correcting Eastpointe's appeal documentation. Specific concerns about Eastpointe's documentation are outlined in the *Tabular Spreadsheet, Attachment 4*. The two Recommendations issued relate to findings within the appeal files reviewed for this year's EQR.

Within the files reviewed, at least one file showed Eastpointe rendered the appeal as invalid, prior to the end of the 60 days allowed for enrollees to file an appeal. Eastpointe deemed the appeal invalid because a written request was not received within 30 days of the oral request submitted by the enrollee. Eastpointe's *Policy C-3.2.6, Appeal of UM Adverse Benefit Determination,* supports this practice and states that an oral appeal request "must be followed up with a signed reconsideration form within 30 calendar days." This is an arbitrary time frame imposed by Eastpointe that is more restrictive than the 60 days enrollees are allowed to file an appeal, per *42 CFR § 438.402 (d) 2 ii*. It is understood that it is unclear how PIHPs are to handle the multiple time frames governing the submission of appeal requests (i.e., *42 CFR § 438.406 (b)(3), 42 CFR § 438.402 (c) 3 ii*, and *42 CFR § 438.402 (b)(2*). However, guidance from the State's attorney indicated PIHPs need to develop an internal process that considers the enrollee's best interest when facing these divergent time frames. CCME recommends that Eastpointe, if faced with a choice of deeming an appeal "invalid" or processing a standard, oral appeal without a written appeal request, process the appeal within the required 30 day timeframe.

Also, within the appeal files reviewed, all but two of the required notifications were provided to enrollees within the required time frames. One file showed the appeal resolution notification was mailed on the 35th day. Staff noted in the file that the appeal was not received by the Appeals Department immediately, and Eastpointe started the appeal resolution time frame based on the date it was received by the Appeals Department. However, the date the appeal resolution time frame begins is when any Eastpointe staff or department receives the appeal. Eastpointe's appeals policy states, "Reconsideration result letter is sent…within 30 calendar days of the receipt of the reconsideration request."

Staff noted in the second file that no oral notification was provided to the enrollee regarding the denial of the request to expedite the appeal. In the expedited files where staff did provide the required oral notification, staff documentation of the notification was typically unclear, in short-hand form and did not indicate to whom oral notifications

were provided. As oral notifications of denied requests for expedited and expedited resolutions are required by *NC Medicaid Contract, Attachment M, Section H,* clear documentation within the appeal record is needed.

While appeals are tallied, categorized, and analyzed for trends then reported to the GQIC, invalid and withdrawn appeal numbers are not reviewed for potential improvement opportunities. This was a Recommendation from the previous year's EQR. Given Eastpointe rendered a third of the appeals received in this review year as "invalid", analysis and committee review is essential in identifying potential quality or compliance issues.

Eastpointe indicated in their *Utilization Management Plan (UM Plan) and Policy C-3.2.6, Appeal of UM Adverse Benefit Determination* that appeal data will be analyzed and reported to the GQIC Committee. However, the types of appeals data (e.g., appeals by provider, data from quality reviews of notifications, etc.) differ between the *UM Plan* and the appeals policy. Similarly, the GQIC minutes show different types of appeal data (e.g., percentage of timely appeal resolution) are reported in that meeting. Eastpointe should determine what appeals data should be trended that will result in a more meaningful process for identifying quality improvement opportunities.

Within the files reviewed, there was no evidence of staff documenting within the appeal record the internal steps taken to protect the enrollee's Protected Health Information (PHI). This was a Recommendation from the previous year's EQR. Eastpointe added to their policy "Medical record requests must go through the LME/MCO Medical Record Department". However, the Recommendation from last year was to, within the appeal policy, either list out the internal steps staff take to protect the enrollee's PHI, or reference the Eastpointe policy governing the release of medical records, *Policy Q-6.3.5, Release of Medical Records*. Directly referencing this policy within *Policy C-3.2.6, Appeal of UM Adverse Benefit Determination,* would better guide staff through the required steps of record release. This is particularly important as requests for the clinical rationale behind the UM and/or appeal decision are frequently requested from appeal staff, per the files reviewed.

Staff also need to thoroughly document within the appeal record all of the steps they take to protect the enrollee's PHI. For example, staff should document who requested the clinical rationale of the appeal decision, referrals to the Medical Records Department, steps taken to confirm guardianship, and any efforts taken to secure releases of information.

Figure 7 provides a comparison of the 2018 EQR Grievance and Appeals scores versus the 2019 scores. The 2019 EQR shows 75% of the Grievance and Appeals standards were

scored as "Met," and 25% of the standards were scored as "Partially Met." There were no standards scored "Not Met."

Figure 7: Grievances and Appeals Comparative Findings

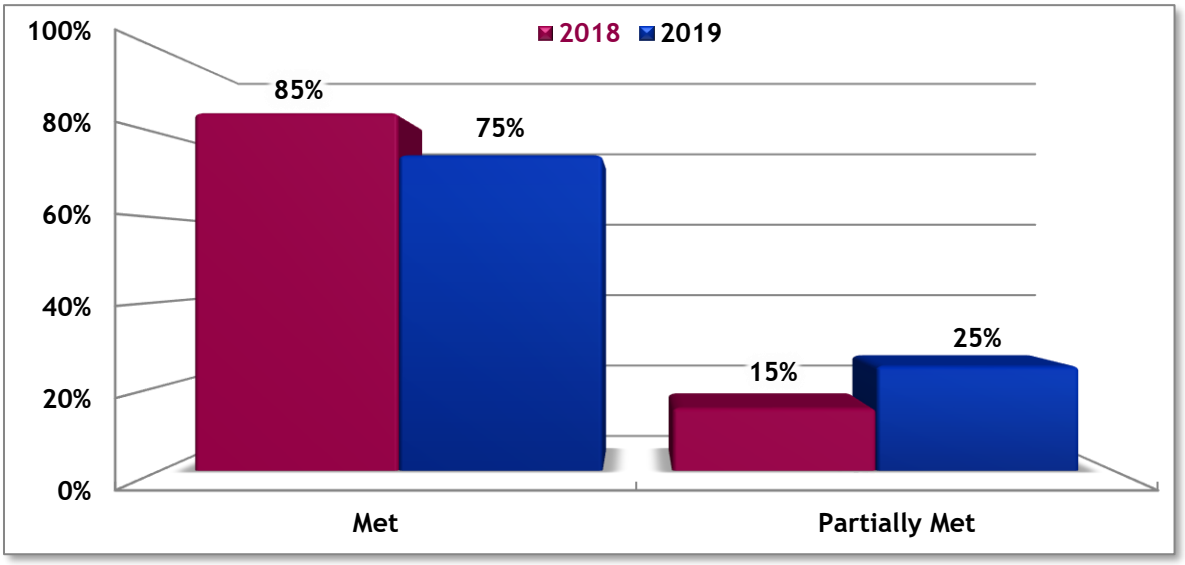


Table 26: Grievances and Appeals

Section	Standard	2019 Review
Grievances	Definition of a grievance and who may file a grievance;	**Partially Met**
	Timeliness guidelines for resolution of the grievance as specified in the contract;	**Partially Met**
Appeals	The definitions an appeal and who may file an appeal;	**Partially Met**
	Timeliness guidelines for resolution of the appeal as specified in the contract;	**Partially Met**
	Other requirements as specified in the contract.	**Partially Met**
	Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	**Partially Met**

Strengths

- Eastpointe's Quality of Care Committee is comprised of staff from multiple Eastpointe departments and, weekly, offers a variety of expertise that contribute to the review and input of Quality of Care grievances.
- In the past year, Eastpointe significantly improved the information within the appeal and grievance sections of the *Enrollee/Member and Family Handbook*.

Weaknesses

- *Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaint/Grievance,* references "member/enrollees" and "stakeholders" but does not define stakeholders or note that legal guardians or legally-responsible people (LRPs) can also file a grievance.
- *Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaint/Grievance,* is only approximately 75% consistent in explaining the difference between "grievances", "complaints" or "concerns". This oversight continues to create a confusing and misleading policy.
- *Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaint/Grievance,* is missing the required notifications when Eastpointe extends the resolution time frame of a grievance.
- *Policy C-6.4.4* does not include the specific, internal steps staff take to refer a grievance to the QOC Committee. Staff need guidance regarding how to make the referral, document the referral, and document the outcome of the committee and physician review.
- *Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaint/Grievance*, does not specify the time frame for maintenance of grievance logs.
- There were two grievances within the 20 files reviewed that were out of compliance with grievance notifications requirements.
- QOC meeting minutes do not identify the subject matter experts, including the Medical Director, participating in the staffing of QOC grievances.
- The GQIC minutes do not reflect any committee discussion or identify steps Eastpointe can take to address trends of grievances.
- Eastpointe has been imposing an arbitrary timeframe for the submission of a written appeal following an oral appeal. While it is understood there is a divergence of federal regulations that complicate the processing of oral appeals, Eastpointe has not been processing appeals with the best interest of enrollees in mind.
- *Policy C-3.2.6* and the *Provider Operations Manual* do not consistently explain who can file an appeal and act as a designee for an enrollee.

- The Expedited Appeal Acknowledgement letter does not clearly explain to enrollees the time frames in which the expedited appeal will be resolved.
- The Invalid Appeal notification has a statement in the first paragraph that implies the appellant's appeal will be processed.
- The Appeal Extension notification does not inform the appellant of their right to file a grievance if they disagree with Eastpointe's decision to extend the appeal resolution time frame.
- The *Provider Operations Manual* and the *Enrollee/Member and Family Handbook* do not clearly and consistently state that an expedited appeal will be resolved and notification provided within 72 hours.
- The *Provider Operations Manual* states an appeal must be filed within 30 days of the mailing date of the Adverse Benefit Determination notice. This incorrect time frame of 30 days is referenced three times on page 81, but the time frame allowed for filing an appeal is 60 days.
- There is contradictory, confusing, and/or incorrect information in specific paragraphs in the *Enrollee/Member and Family Handbook* (pg. 46) and *Provider Operations Manual* (pg. 82). The five corrections needed are listed on the tabular spreadsheet under *Standard 1.7*.
- *Policy C-3.2.6, Appeal of UM Adverse Benefit Determination* does not clarify that the date of the receipt of an appeal by any staff or department at Eastpointe begins the 30 day appeal resolution time frame, regardless of the date and time the Appeals Department receives the appeal.
- There was no evidence that invalid and withdrawn appeal data were analyzed nor were trends of invalid and withdrawn appeals reported or discussed in the GQIC.
- Eastpointe's *UM Plan*, *Policy C-3.2.6, Appeal of UM Adverse Benefit Determination*, and GQIC meeting minutes are inconsistent in identifying the appeal data that are analyzed and reported.
- There is no detailed process for guiding staff through the steps of releasing the enrollees appeal in a manner consistent with *Eastpointe's Policy Q-6.3.5, Release of Medical Records*, and in compliance with federal and state confidentiality statutes.
- There was no documentation by appeal staff within the appeal record that shows internal steps taken by staff to protect the enrollees PHI, such as, who requested the appeal record, communication or referrals to the Medical Records Department, steps taken to confirm guardianship, efforts taken to secure releases of information, and the outcomes of these internal steps.

Corrective Action

- Revise *Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaints/Grievances,* to either define stakeholders or clarify that legal guardians and/or legally responsible persons can also file a grievance.
- Revise *Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaints/Grievances*, and the *Provider Operations Manual* to consistently use one term for grievances.
- Add to *Policy Q-6.4.4* that when Eastpointe extends the grievance resolution time frame, Eastpointe must make reasonable efforts to give the enrollee prompt oral notice of the delay and, within two calendar days, give the enrollee written notice of the reason for the decision to extend the time frame and inform the enrollee of the right to file a grievance if she/he disagrees with the decision.
- Revise *Policy C-3.2.6* and the *Provider Operations Manual* to consistently explain who can file an appeal and act as a designee for an enrollee. Include in this clarification that a designee, with written permission from the enrollee, can act on behalf of an enrollee throughout the appeal process.
- Revise the Expedited Appeal Acknowledgement letter to accurately inform appellants that their appeal will be processed within 72 hours, with up to an additional 14 days if the expedited appeal resolution time frame is extended.
- Revise the Invalid Appeal notification to clearly and consistently reflect that the appellant's appeal will not be processed.
- Revise the Appeal Extension notification to inform the appellant of their right to file a grievance if they disagree with Eastpointe's decision to extend the appeal resolution time frame.
- Correct the *Provider Operations Manual* and the *Enrollee/Member and Family Handbook* to clearly and consistently state that an expedited appeal will be resolved within 72 hours.
- Correct the *Provider Operations Manual* to state an appeal can be filed within 60 days of the mailing date of the Adverse Benefit Determination notice.
- Correct the contradictory, confusing, and/or incorrect information in specific paragraphs in the *Enrollee/Member and Family Handbook* (pg. 46) and the *Provider Operations Manual* (pg. 82). These five Corrective Actions are listed on the tabular spreadsheet under *Standard 1.7*.
- Clarify in *Policy C-3.2.6, Appeal of UM Adverse Benefit Determination,* that the date of the receipt of an appeal by any staff or department at Eastpointe begins the 30 day appeal resolution time frame, regardless of the date and time the Appeals Department receives the appeal.

- Reference *Policy Q-6.3.5, Release of Medical Records,* in the appeals policy to guide staff through the required steps when providing the clinical rationale behind service authorization or appeal decisions.
- Ensure staff clearly document within the appeal record the internal steps taken to protect the enrollee's PHI. For example, document who requested the clinical rationale of the appeal decision, referrals to the Medical Records Department, steps taken to confirm guardianship, and any efforts taken to secure releases of information.

Recommendations

- Describe in *Policy Q-6.4.4* the internal steps staff take to make referrals to the QOC committee, to document the referral, and to document the outcome of the committee and/or physician review.
- Add to *Policy Q-6.4.4* that grievance logs are maintained for five years, as specified in the *NC Medicaid Contract, Attachment M, B.2.*
- Enhance monitoring of grievances for timeliness of acknowledgement and resolution notifications. Include monitoring of any grievances in which the resolution time frame was extended by Eastpointe, and check that the required oral and written notifications to the grievant occurred and are documented within grievance file.
- Ensure the QOC meeting minutes reflect the attendance and participation by committee subject matter experts, including any physician, to demonstrate appropriate oversight review of QOC grievances.
- Ensure GQIC minutes reflect discussion of grievance data and trends and use this discussion to identify opportunities for quality improvement.
- Revise *Policy C-3.2.6, Appeal of UM Adverse Benefit Determination,* to ensure enrollees are given 60 days from the mailing date of the Adverse Benefit Determination notification to file a written request. Reflect in the policy that, if an oral request is received and the end of the resolution time frame is nearing, Eastpointe will process the appeal even if the written request has yet to be received by Eastpointe. This process will ensure the appeal is processed with the enrollee's best interest in mind.
- Clarify in *Policy C-3.2.6, Appeal of UM Adverse Benefit Determination*, that Eastpointe is required "to make reasonable efforts to give the Enrollee prompt oral notice of the delay" and "within two (2) calendar days give the enrollee written notice of the decision to extend the time frame" when Eastpointe extends the resolution time frame of a standard or expedited appeal.

- Ensure staff provide all required oral notifications and clearly document in the appeal file the details of the oral notification (recipient, details of conversation, notification type, etc.).
- Include invalid and withdrawn appeals trends in the analysis of appeals to identify any potential quality improvement opportunities.
- Determine what appeals data can best indicate potential quality improvement opportunities and ensure the identified data categories are aligned within the Eastpointe's *UM Plan*, *Policy C-3.2.6, Appeal of UM Adverse Benefit Determination*, and the data reviewed and discussed in GQIC.

G. Delegation

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

At the last EQR, there was one Corrective Action item and no Recommendations. During the current EQR review period, Eastpointe addressed the Corrective Action item.

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

Eastpointe reported three delegated entities, but actually had four delegates during the review period for the current EQR, as evidenced in *Table 27 Delegated Entities*. Eastpointe had delegation agreements and Business Associate Agreements (BAAs) with each of its four delegates.

Table 27: Delegated Entities

Delegated Entities	Service	Methods of Oversight
Behavioral Health Management (BHM) (ended on March 31, 2019)	Clinical Peer Review Appeal Peer Review	Review of monthly reports
Prest (effective December 4, 2018)	Clinical Peer Review Appeal Peer Review	Review of monthly reports Annual Review with review tool
Medversant Technologies, LLC	Credentialing CVO Re-credentialing CVO	Review of monthly reports Annual Review with review tool
Cardinal Innovations	Screening, Triage and Referral	Written reports of all intake and counseling activities with clients Monthly reports (as applicable) Annual Review with review tool

The delegation agreement with Behavioral Health Management (BHM) ended on March 31, 2019. The current delegation agreement with Prest was effective December 4, 2018. Eastpointe completed a Pre-Delegation Assessment before entering into the delegation agreement with Prest. During Onsite discussion, Eastpointe reported they switched to Prest due to cost and that BHM was having an issue with its URAC accreditation.

Policy Q-6.5.2, Oversight of Delegated Functions, states "Eastpointe evaluates Delegate performance by conducting an annual assessment utilizing the appropriate Eastpointe Delegation Assessment Tool." During Onsite discussion, Eastpointe staff reported the delegate oversight is reported to the Executive Leadership Team, which decides on Delegation Agreement retention. For the current EQR, Eastpointe submitted the following evidence of delegate oversight/monitoring:

BHM: Quarterly reports from BHM with monthly concordance rates until the Delegation Agreement ended on March 31, 2019.

Prest: Delegation Agreement was effective on December 4, 2018, but Prest completed no reviews for Eastpointe until April 2019. An annual assessment was completed on October

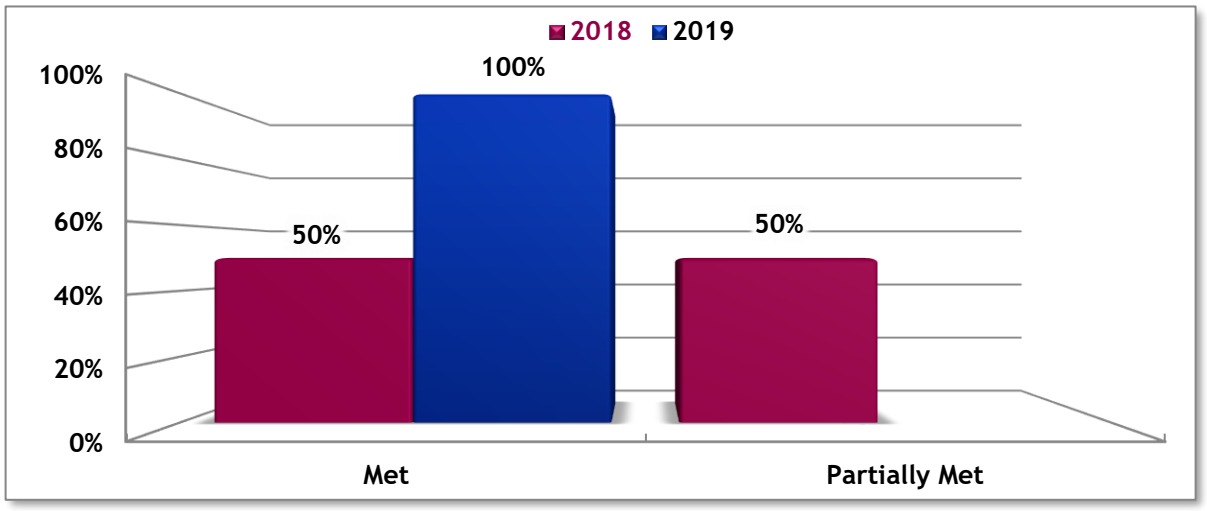
3, 2019. Eastpointe staff meet monthly with Prest. Prest submits monthly Concordance reports.

Medversant: a) *Annual Assessment* completed on August 8, 2019; b) verification of Medversant's National Committee for Quality Assurance (NCQA) accreditation as Credentials Verification Organization (CVO) until April 3, 2020; c) Eastpointe submitted a *Delegation Assessment Tool* completed on August 8, 2019 and reported to the Executive Team on August 12, 2019.

Cardinal Innovations: a) Eastpointe submitted detailed monthly reports from Cardinal of calls taken for Eastpointe. The reports include the answer rate, abandonment rate, and an action plan if the target goal is not met. b) Eastpointe submitted a report labeled "*Cardinal Annual Report FY19*", which is a report completed by the Cardinal Access Manager & Veterans Point of Contact (VPoC). c) Eastpointe submitted a *Delegation Annual Assessment Tool* dated April 12, 2019. The Eastpointe Call Center Director and the QA Director/Waiver Contract Manager are listed as "Auditors" on the Annual Assessment.

Figure 8, Provider Services Comparative Findings, provides a comparison of the 2019 scores versus the 2018 scores. Eastpointe met 100% of the standards in the Delegation EQR.

Figure 8: Delegation Comparative Findings



Strengths

- Eastpointe executed contracts and BAAs with its four delegates.
- Eastpointe submitted annual monitoring reports for its delegates.
- Eastpointe received regular performance information from its delegates.
- Eastpointe conducted a pre-delegation assessment before executing the current delegation agreement with Prest.

H. Program Integrity

As required by its contract with CCME, IPRO is tasked with assessing PIHP compliance with federal and state regulations regarding Program Integrity (PI) functions. The EQR includes review of Eastpointe's policies, procedures, training materials, organizational charts, job descriptions, committee meeting minutes and reports, provider agreements, enrollment application, workflows, *Provider Operations Manual*, *Enrollee/Member and Family Handbook*, *Employee Handbook*, newsletters, conflict of interest forms, and the *Corporate Compliance Plan*. Findings within the Desk Materials and PI files were discussed with the Compliance and Program Integrity personnel during the Onsite interview.

File Review

IPRO requested the universe of PI files from Eastpointe for the September 1, 2018 through August 30, 2019. From this selection, a sample of 15 files related to provider fraud/waste/abuse investigations were chosen with a two file oversample for a total of 17 files. These files were thoroughly reviewed to ensure Eastpointe investigates a credible allegation of fraud and provides NC Medicaid Program Integrity with the information required on a NC Medicaid approved template. There were no cases of enrollee fraud for the current review period.

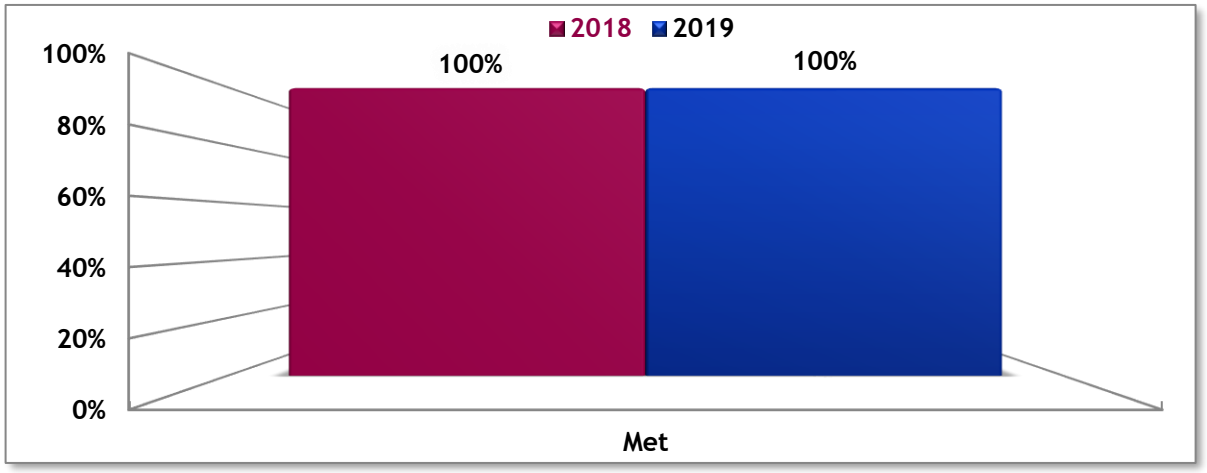
The file review showed that fifteen of fifteen files contained all of the required information. Ten files were cases closed by Eastpointe, subsequent to referral to the Medicaid Investigation Division (MID). These files were used as evidence to substantiate existing, open cases with MID. It is a regular practice for Eastpointe to consolidate repeat allegations into a larger investigation. Three files did not include the sample amount of funds and funds paid to the provider, as they were related to bribing members to consume services, rather than a payment-related allegation applicable.

Documentation

Review of Eastpointe's policies and procedures showed most contractually-required areas to be addressed. However, detailed information regarding reporting requirements of beneficiary fraud was not found in Eastpointe's beneficiary-specific fraud and abuse policy. An amendment to Eastpointe's contract with NC Medicaid became effective in August of 2018 and included additional reporting requirements. These requirements were specified in Eastpointe's policy addressing provider fraud, waste and abuse. However, Reporting requirements such as, providing the provider's connection with billing entities, documenting the original allegation that triggered the investigation, the timeframe of the investigation, locations of providers, etc. were not included in any beneficiary-specific fraud and abuse policy. It is recommended that Eastpointe include these reporting requirements in *Policy CC-3.4, Beneficiary Fraud and Abuse* as outlined in *NC Medicaid Contract, Amendment 4, Section 14.2.9* to address these requirements.

Figure 9 demonstrates that Eastpointe met 100% of the Program Integrity EQR standards and provides a comparison to the previous year's EQR.

Figure 9: Program Integrity Findings



Strengths

- Additional fraud/waste/abuse information was provided on the website for providers, including training materials related to fraud/waste/abuse, referral forms, etc.
- Eastpointe continues to foster relationships with other MCOs/PIHPs and work with them to get billing information as well as collaborate internally to prevent fraud, waste, and abuse.
- Since the last review period, Eastpointe has developed a way to internally streamline the process for recovery of funds from providers.

Weaknesses

- Reporting requirements such as, providing the provider's connection with billing entities, documenting the original allegation that triggered the investigation, the timeframe of the investigation, locations of providers, etc. were not included in any beneficiary-specific fraud and abuse policy.

Recommendation

- Add reporting requirements such as, providing the provider's connection with billing entities, documenting the original allegation that triggered the investigation, the timeframe of the investigation, and locations of providers to a beneficiary-specific fraud and abuse policy. *See Amendment 4, Attachment B-Scope of Work (SOW), Section 14.2.9 Provider Information to Division Program Integrity* for the full list of requirements.

I. Financial Services

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

CCME implemented a Desk Review of the following documentation:

- Financial policies and procedures
- Audited financial statements and footnotes dated June 30, 2018
- Balance sheet and income statements dated July 31, 2019 and August 31, 2019
- Medicaid monthly financial reports for July and August 2019
- Claims processing aging reports for July and August, as well as claims processing policies
- Accounting Department staffing structure
- Fiscal year budget for 2019-2020
- Risk reserve account reporting and bank statements

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

- Policies and procedures
- Staffing changes in the Finance Department
- Accounting system
- Budget variances and development
- Incurred But Not Reported Reserves (IBNR) calculation
- Medical loss ratio reporting

The 2018 EQR of Eastpointe's Financial Services identified two policy enhancements and one procedure improvement that were needed. The first policy change related to adding the five-business day requirement for Risk Reserve payments to *Policy B-2.2.25, Risk Reserve*. CCME also recommended that Eastpointe add the 10-year requirement to their record retention policy. The third Recommendation was that Eastpointe implement a process to ensure all risk reserve payments are made within five days of receipt of capitation payment. All the 2018 Recommendations were satisfactorily completed.

Per the EQR of Eastpointe's financial records, Eastpointe demonstrated ongoing financial stability. Eastpointe's audit report for June 30, 2018, received an overall unqualified

audit opinion on financial statements, which indicates that their auditors believe their audited financial statements present fairly, in all material respects the financial position of Eastpointe. Their independent auditors did not report any compliance or internal control findings in their testing of federal and state programs.

Eastpointe exceeded the contract benchmarks for current ratio and Medical Loss Ratio (MLR). Eastpointe's Medicaid current ratio is 4.76 total with a total current ratio of 3.37 in July 2019. The Medicaid current ratio is 4.91 total, with a total current ratio of 5.59 for August 2019. The benchmark is 1.00. Eastpointe's year-to-date MLR is 92.32% year-to-date as of July 31, 2019, and 91.68% year-to-date as of August 31,2019. The benchmark is 85%. Medicaid total assets as of July 31, 2019, are $142,269,349 and $140,695,819 for August 31, 2019. Eastpointe's net assets position was $87,902,518 as of June 30, 2018.

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

Eastpointe meets the requirement of retaining financial records for 10 years, as required by *NC Medicaid Contract, Section 8.3.2*. The PIHP is retaining financial records for 10 years from the last date of service, date of activity, or end of reporting period, as applicable. Eastpointe is moving to electronic storage of all financial records. Within Great Plains, records are not purged and remain accessible. The PIHP's *Policy B-2.2.26, Accounting by Funding Source,* states that Eastpointe shall follow all record retention policies, in accordance with *42 CFR § 433.32 (b)(c)(d)*.

Eastpointe's reviews and updates policies on their annual review date, or more often if changes are needed. Compliance 360 is the software used to update policies and communicate these changes to staff. Policies are reviewed and updated by the policy owner, Board of Directors and the Executive Team approve, and then staff are notified of policy changes.

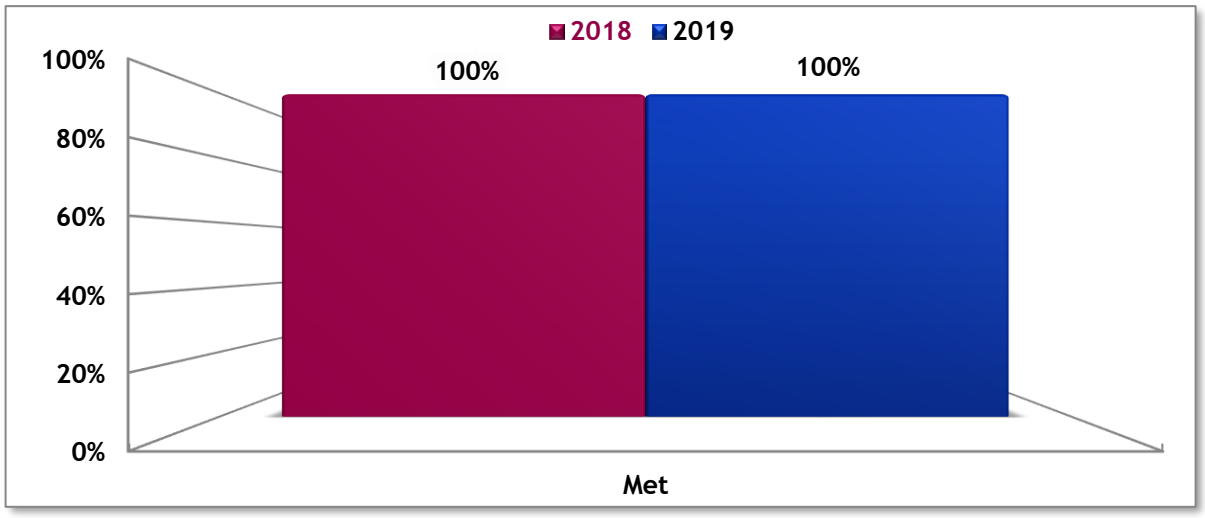
Eastpointe's *Cost Allocation Plan* meets the requirements for allocating the administrative costs between federal, state, and local jurisdictions based on revenue as required by *42 CFR § 433.34*. Eastpointe has no costs disallowed per the audit report and Onsite interview. Eastpointe submits a *Cost Allocation Plan* to NC Medicaid annually to determine the percentage of Medicaid's share of administrative costs. This percentage does not differ greatly from year-to-year, and Eastpointe used the same percentage as the prior fiscal year. The administrative expenses are recorded by expense type in the general ledger, and then allocated to the different funding sources based on a percentage of total year-to-date service revenues received. Eastpointe's Medicaid funds are properly segregated through the chart of accounts in the general ledger. While the

percentage Medicaid incurs does not differ materially from one fiscal year to another, CCME recommends that Eastpointe recalculate this percentage on at least an annual basis.

Eastpointe's Medicaid Risk Reserve account meets the minimum requirement of contributing 2% of the capitation payment per month required by the *NC Medicaid Contract, Section 1.9*. During the period in review, Eastpointe reached 14.2% of their required percentage of annualized capitation maximum (15%), with a balance of $36,427,167. Once Eastpointe receives the NC Medicaid capitation payment, the General/Administrative Contracts Manager breaks down the payment by Category of Aid, and the Finance Director reviews and pays the risk reserve contribution electronically to the risk reserve account at PNC Bank. All deposits are timely and there are no unauthorized withdrawals. Eastpointe provided CCME with bank statements demonstrating the risk reserve deposit and balance.

Figure 10 provides a comparison of the 2018 scores versus the 2019 scores and that Financial EQR standards were scored as 100% in both years.

Figure 10: Financial Services Comparative Findings



Strengths

- Eastpointe had successfully moved toward electronic accounting records by scanning invoices and documents into Great Plains with electronic approvals.
- Eastpointe's policies have references to NC Medicaid contract and EQR standards.
- Eastpointe has high solvency ratios.
- Eastpointe using technology to gain efficiencies through implementing Concur to process travel reports.

Weaknesses

- Eastpointe uses the prior fiscal year's percentage rather than recalculate their Medicaid administrative ratio on an annual basis.

Recommendations

- Update the *Cost Allocation Plan* calculation annually and submit to Medicaid.

J. Encounter Data Validation

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

The scope of our review, guided by the CMS Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid by Eastpointe for the period of January 2018 through December 2018. All claims paid by Eastpointe should be submitted and accepted as a valid encounter to NC Medicaid. Our approach to the review included:

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

Results and Recommendations

Issue: Procedure Code

The procedure code for Institutional claims should be populated 99% of the time. In the encounter data provided, 61% of the claims were populated with a revenue code instead of a valid procedure code. 6% of the Institutional claims missing a valid procedure code, require one based on the revenue code provided on the claim.

Resolution:

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

Issue: Other Diagnosis

Principal and admitting diagnosis was populated consistently where appropriate, however, additional diagnosis codes were not populated consistently Professional claims. This issue was present in the 2017 review. The Professional claims contained up to twelve diagnosis codes which is an improvement from the 2017 review in which only the principal and secondary diagnosis was provided. However, additional diagnosis codes were only populated 10% of the time, which is considerably low, especially in comparison to the consistency of the data in the Institutional claims which was 58%.

Resolution:

Eastpointe should educate providers and validate their 837 encounter mapping to ensure that providers are reporting all applicable diagnosis codes and the LME is reporting them.

Conclusion

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

One issue noted related to the consistency of diagnosis codes being reported to NC Medicaid for Professional claims. Although the additional diagnosis codes do not impact adjudication, the codes are key for reporting, evaluating member health, and factors that will be used in a value based payment model. Eastpointe should review and revise their 837 mapping immediately. Eastpointe should also take action to ensure they are capturing and reporting valid procedure codes for Institutional claims when required for the reported revenue code.

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 the State's MMIS is handling the encounter claims and could be reconciled back to reports requested from Eastpointe. The goal is to ensure that Eastpointe is reporting all paid claims as encounters to NC Medicaid.

ATTACHMENTS

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

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

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

October 1, 2019

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 2019 External Quality Review (EQR) of Eastpointe Behavioral Health (Eastpointe) is being initiated. The review will be conducted by us, The Carolinas Center for Medical Excellence (CCME), and is a contractual requirement. The review will include both a desk review (at CCME) and a two-day Onsite visit at Eastpointe's office in Beulaville, North Carolina that will address all contractually required services.

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

The CMS EQR protocols can be found at:

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

The CCME EQR review team plans to conduct the Onsite visit at Eastpointe on **November 20, 2019** through **November 21, 2019**. For your convenience, a tentative agenda for the two-day review is enclosed.

In preparation for the desk review, the items on the enclosed **Desk Materials List** are to be submitted electronically, and are due no later than **October 23, 2019**. As indicated in item 40 of the Desk Materials List, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted by the aforementioned deadline.

Further, as indicated on item 42 of the Desk Materials List, Encounter Data Validation (EDV) will also be part of this review. Our subcontractor, Health Management Systems (HMS) will be evaluating this component. Please read the documentation requirements for this section carefully and make note of the submission instructions, as they differ from the other requested materials.

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

The location for the file transfer site is:

https://eqro.thecarolinascenter.org

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 5

Cc: Tasha Griffin, NC Medicaid Contract Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager
Anna North, Eastpointe Waiver Contract Manager

External Quality Review 2019

MATERIALS REQUESTED FOR DESK REVIEW

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

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

3. Current Medical Director and Medical Staff job descriptions.

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

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

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

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

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

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

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

11. A current provider manual and provider directory.

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

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

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

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

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

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

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

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

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

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

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

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

23. A copy of the complete Grievances log for the months of September 2018 through August 2019. Please indicate on the log the nature of the grievance, the date received,

and the date resolved. If the grievance resolution timeframe was extended, please include who requested the extension.

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

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

26. Clinical Practice Guidelines developed for use by practitioners, including references used in their development, when they were last updated and how they are disseminated. Also, policies and procedures for researching, selecting, adopting, reviewing, updating, and disseminating practice guidelines. Results of the most recent monitoring of provider compliance with Clinical Practices Guidelines.

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

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

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

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

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

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

Required information includes the following for each measure:

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

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

c. Reporting frequency and format;

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

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

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

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

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

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

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

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

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

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

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

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

    i. Insurance:

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

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

from the provider agency, confirming the practitioner is covered under the agency insurance policies.

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

iii. Ownership disclosure information/form.

b. Recredentialing files for the 12 most recently recredentialed practitioners (should include 6 licensed practitioners who work at agencies and 6 Licensed Independent Practitioners, include the files of at least two MDs). Also, please include 4 files of network provider agencies and/or hospitals and/or psychiatric facilities, in any combination.

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

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

ii. Insurance:

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

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

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

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

v. Ownership disclosure information/form.

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

d. Ten MH/SU, ten I/DD and five TCLI files medical necessity denial files for any denial decisions made from September 2018 through August 2019. Include any medical information and physician review documentations used in making the denial determination. Please include all correspondence or notifications sent to providers and enrollees. Please select MEDICAID ONLY files and submit the entire file.

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

39. Provide the following for Program Integrity:

    a. File Review: Please produce a listing of all active files during the review period (September 2018 through August 2019) including:
        i. Date case opened
        ii. Source of referral
        iii. Category of case (enrollee, provider, subcontractor)
        iv. Current status of the case (opened, closed)
    b. Program Integrity Plan and/or Compliance Plan.
    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.
    e. All 'Attachment Y' reports collected during the review period.
    f. All 'Attachment Z' reports collected during the review period.
    g. Provider Manual and Provider Application.
    h. Enrollee Handbook.
    i. Subcontractor Agreement/Contract Template.
    j. Training and educational materials for the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
    k. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse.
    l. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees.
    m. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other State or Federal agency.
    n. Code of Ethics and Business Conduct.
    o. Internal and/or external monitoring and auditing materials.
    p. Materials pertaining to how the PIHP captures and tracks complaints.
    q. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
        i. NC Medicaid approved reporting templates.
    r. Sample Data Mining Reports.
    s. NC Medicaid Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
    t. Monthly reports of NCID holders/FAMS-users in PIHP.
    u. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
    v. Corrective action plans including any relevant follow-up documentation.

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

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

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

   c. A copy of the IT Disaster Recovery Plan.
   d. A copy of the most recent disaster recovery or business continuity plan test results.

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

41. Provide the following for Financial Reporting:
    a. Most recent annual audited financial statements.
    b. Most recent annual compliance report
    c. Most recent two months' State-required NC Medicaid financial reports.
    d. Most recent two months' balance sheets and income statements including associated balance sheet and income statement reconciliations.
    e. Most recent months' capitation/revenue reconciliations.
    f. Most recent reconciliation of claims processing system, general ledger, and the reports data warehouse. Provide full year reconciliation if completed.
    g. Most recent incurred but not reported claims medical expense and liability estimation. Include the process, work papers, and any supporting schedules.
    h. Any other most recent month-end financial/operational management reports used by PIHP to monitor its business. Most recent two months' claims aging reports.
    i. Most recent two months' receivable/payable balances by provider. Include a detailed list of all receivables/payables that ties to the two monthly balance sheets.
    j. Any P&Ps for finance that were changed during the review period.
    k. PIHP approved annual budget for fiscal year in review.
    l. P&Ps regarding program integrity (fraud, waste, and abuse) including a copy of PIHP's compliance plan and work plan for the last twelve months.
    m. Copy of the last two program integrity reports sent to NC Medicaid's Program Integrity Department.
    n. An Excel spreadsheet listing all of the internal and external fraud, waste, and abuse referrals, referral agent, case activity, case status, case outcome (such as provider education, termination, recoupment and recoupment amount, recoupment reason) for the last twelve months.
    o. A copy of PIHP's Special Investigation Unit or Program Integrity Unit Organization chart, each staff member's role, and each staff member's credentials.
    p. List of the internal and external program integrity trainings delivered by PIHP in the past year.
    q. Description and procedures used to allocate direct and overhead expenses to Medicaid and State funded programs, if changed during the review period.
    r. Claims still pending after 30 days.
    s. Bank statements for the restricted reserve account for the most recent two months.
    t. A copy of the most recent administrative cost allocation plan.
    u. A copy of the PIHP's accounting manual.
    v. A copy of the PIHP's general ledger chart of accounts.
    w. Any finance Corrective Action Plan
    x. Detailed medical loss ratio calculation, including the following requirements under CFR § 438.8:
        i. Total incurred claims

ii. Expenditures on quality improvement activities
iii. Expenditures related to PI requirements under §438.608
iv. Non-claims costs
v. Premium revenue
vi. Federal, state and local taxes, and licensing and regulatory fees
vii. Methodology for allocation of expenditures
viii. Any credibility adjustment applied
ix. The calculated MLR
x. Any remittance owed to State, if applicable
xi. A comparison of the information reported with the audited financial report required under §438.3 (m)
xii. The number of member months

y. A copy of the PIHP's annual MLR report.

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

a. Include all adjudicated claims (paid and denied) from January 1, 2018 – December 31, 2018. Follow the format used to submit encounter data to NC Medicaid (i.e., 837I and 837P). If you archive your outbound files to NC Medicaid, you can forward those to HMS for the specified time period. In addition, please convert each 837I and 837P to a pipe delimited text file or excel sheet using an EDI translator. If your EDI translator does not support this functionality, please reach out immediately to HMS.

b. Provide a report of all paid claims by service type from January 1, 2018 – December 31, 2018. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2019

MATERIALS REQUESTED FOR REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were uploaded since 10/23/19. Please submit in folder 15 and label subfolder "Recent committee minutes".
2. Credentialing Committee By-Laws. Please submit to folder *12. Program Descriptions*.
3. Please submit the project plan referenced on page 21 and 22 of the Quality Improvement Annual Report FY2019. In response to the Child and Adult ECHO Survey results, Eastpointe created with assistance from the Provider Council, a project plan to address all areas for which Eastpointe was determined below the North Carolina average. (folder 13)
4. Delegation monitoring reports for Prest from December 2018 through March 2019. Please submit to folder 30. Delegation Monitoring. (If Prest performed no delegated services during this timeframe, please submit a statement to that effect.)
5. Documentation of the request (Alpha notes, SAR comments, communication logs, etc.) for the clinical rationale for appeal files 13, 17, and 18 (appeal files referenced are labelled in SAR numerical order). Please upload into folder # 22 and label subfolder as "Clinical Rationale".
6. Any tools used in MH/SU, I/DD, and/or TCLI Departments that monitor the timeliness of progress notes, gaps in Care Coordination involvement, quality of progress notes, etc. Please place in folder #31 and label subfolder as "CC monitoring tools".
7. Any dashboards/data showing compliance with timeliness of progress note benchmarks in MH/SU, I/DD, and TCLI Departments. Please place in folder #31 and label subfolder as "Progress note benchmarks".

C. Attachment 3: EQR Validation Worksheets

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

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

- Performance Improvement Project Validation Worksheet
  - Increase number of individuals in the priority population served by a fidelity provider to 50% monthly
  - Increase percentage of members who received a face to face service within 48 hours to 70%
  - Decrease state psychiatric hospital 30-day readmissions for high risk members
  - Increase the percentage of individuals who receive a 2nd service within or less than 14 days
  - Decrease emergency department admissions for active members to 20%
  - Decrease percentage of members who separate from Transition to Community Living Initiative (TCLI) housing to 20% or less annually
  - Increase approval rate of Medicaid Encounter Claims to 95%

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**READMISSION RATES FOR MENTAL HEALTH**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	2019

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**READMISSION RATES FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	2019

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	2019

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	2019

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	2019

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**MENTAL HEALTH UTILIZATION- INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	2019

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**MENTAL HEALTH UTILIZATION**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	2019

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	2019

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**SUBSTANCE ABUSE PENETRATION RATE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	2019

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Eastpointe**
Name of PM:	**MENTAL HEALTH PENETRATION RATE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	2019

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N6. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator were complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N2. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N3. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N4. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

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

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	Proportion of Individual Support Plans that address identified health and safety risk factors
Reporting Year	2018-2019
Review Performed	2019

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications, and sources were documented.
G2. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator, Denominator, and Rate were in the Waiver Excel file.
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications.

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need.
Reporting Year	2018-2019
Review Performed	2019

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications, and sources were documented.
G2. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator, Denominator, and Rate were in the Waiver Excel file.
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications.

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available
Reporting Year	2018-2019
Review Performed	2019

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications, and sources were documented.
G2. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator, Denominator, and Rate were in the Waiver Excel file.
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications.

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	Proportion of beneficiaries reporting they have a choice between providers
Reporting Year	2018-2019
Review Performed	2019

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications, and sources were documented.
G2. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator, Denominator, and Rate were in the Waiver Excel file.
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications.

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	Percentage of level 2 and 3 incidents reported within required timeframes
Reporting Year	2018-2019
Review Performed	2019

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications, and sources were documented.
G2. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator, Denominator, and Rate were in the Waiver Excel file.
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications.

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.
Reporting Year	2018-2019
Review Performed	2019

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specification, and sources were documented.
G2. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator, Denominator, and Rate were in the Waiver Excel file.
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications.

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	Percentage of medication errors resulting in medical treatment
Reporting Year	2018-2019
Review Performed	2019

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specification, and sources were documented.
G2. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator, Denominator, and Rate were in the Waiver Excel file.
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications.

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	Percentage of beneficiaries who received appropriate medication
Reporting Year	2018-2019
Review Performed	2019

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specification, and sources were documented.
G2. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator, Denominator, and Rate were in the Waiver Excel file.
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications.

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Eastpointe**
Name of PM	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required
Reporting Year	2018-2019
Review Performed	2019

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specification, and sources were documented.
G2. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods were noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator, Denominator, and Rate were in the Waiver Excel file.
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications.

VALIDATION SUMMARY

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

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

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

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

AVERAGE VALIDATION PERCENTAGE & AUDIT DESIGNATION
100% FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Eastpointe**
Name of PIP:	**INCREASE NUMBER OF INDIVIDUALS IN THE PRIORITY POPULATION SERVED BY A FIDELITY PROVIDER TO 50% MONTHLY**
Reporting Year:	**2018-2019**
Review Performed:	**2019**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	State target is 13 per month or 50% and Eastpointe did not meet that target.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	This PIP addressed a key aspect of service.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	All enrolled populations were included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question was documented in PIP report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure was clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measure assessed processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Medicaid enrollees included in the study were documented.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Data collection captured all relevant data.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected was specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Data source was documented (TCLI Dashboard).
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of data collection was documented.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Instruments were consistent.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis plan was documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Qualifications of staff and personnel used to collect data were documented.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers are listed and interventions are documented in Action IV.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Data analysis was performed monthly.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Graph on page 13 does not contain accurate rate for Oct 2018. Post Onsite correspondence resolved this issue.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Initial and repeat measurements were included.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis was provided for measurement periods.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology was the same across measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Rate mostly met the 50% goal in FY2019.

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

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	**95**
Project Possible Score	**95**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**EASTPOINTE**
Name of PIP:	**INCREASE THE PERCENTAGE OF INDIVIDUALS WHO RECEIVED FACE TO FACE SERVICE WITHIN 48 HOURS TO 70%**
Reporting Year:	2018-2019
Review Performed:	2019

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	32% of enrollees over the last three quarters were not seen within 48 hours.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	Timely access to care is critical to protect member's health.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question was documented.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure was clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measure was related to processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population was clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Not Met**	Data collection methods were not clearly documented in Section C.2. ***Recommendation: Include information on how data are collected.***
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Instruments for data collection were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was clearly documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel used to collect data were listed in the report and were qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were documented in Action IV.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses are conducted each quarter and then annually.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results were clearly displayed.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Several measurements were presented.

Component / Standard (Total Points)	Score	Comments
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Conclusions were offered and revisions were made to increase success.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	No, rates have not increased. They are steady around 30%, which is well below the goal rate. ***Recommendation: Continue evaluating interventions to ensure they are addressing all barriers to increasing the rate. Focus on fewer interventions to determine impact before adding additional interventions.***
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	There was no reported improvement, thus, cannot be evaluated.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical tests were not conducted.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Improvement was not documented, thus, cannot be evaluated.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	83
Project Possible Score	85
Validation Findings	98%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**EASTPOINTE**
Name of PIP:	**DECREASE STATE PSYCHIATRIC HOSPITAL 30-DAY READMISSIONS FOR HIGH RISK MEMBERS**
Reporting Year:	**2018-2019**
Review Performed:	**2019**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Readmissions rates were above the statewide average for 50% of quarters.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	Addressed key aspect of enrollee care.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	Included all enrolled populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Study question was listed on page 1.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure were clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Indicator measured functional status and processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Enrollees were clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Data collection captured all enrollees to whom the question applied.

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

Component / Standard (Total Points)	Score	Comments
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Initial and repeat measurements were reported.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis included in report for recent rates.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology was the same across all measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	The rate was above the goal of 6% in the most recent remeasurement. ***Recommendation: Revise and/or continue interventions to decrease rate for readmissions by focusing efforts on those that appear most effective.***
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Improvement did not occur, as rate increased instead of decreasing.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses were not conducted due to non-sampling.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to evaluate as goal has not yet been met.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	84
Project Possible Score	85
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**EASTPOINTE**
Name of PIP:	**INCREASE THE PERCENTAGE OF INDIVIDUALS WHO RECEIVED A 2ND SERVICE WITHIN OR LESS THAN 14 DAYS TO 35%**
Reporting Year:	2018-2019
Review Performed:	2019

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Initiation and engagement rates were below goal.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	It is important to members because it ensures continuity of care, reduces utilization of crisis services, and promotes recovery.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Partially Met**	Two different research questions were documented, and one referred to engagement, although engagement did not appear to be an outcome of this project. ***Recommendation: Clarify if PIP is monitoring initiation and engagement or just initiation. Revise report according to outcomes indicated in research question.***
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure was clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measure was related to processes of care.

Component / Standard (Total Points)	Score	Comments
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population was clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was the intended population.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Data collection methods were clearly documented.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Instruments for data collection were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was clearly documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel used to collect data were listed in the report and were qualified.

Component / Standard (Total Points)	Score	Comments
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were documented in Action IV.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Findings were presented according to the timing of data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results were clearly displayed in bar charts or line charts.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Measurements were presented for baseline and repeat measurements.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Conclusions were offered and revisions were made to increase success.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Most recent rate showed improvement, although rate is still below goal rate of 35%.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement was related to interventions. New interventions forthcoming to continue working toward goal.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical tests were not conducted.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Improvement was documented, although goal rate has not been met, thus, unable to evaluate.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	85
Project Possible Score	90
Validation Findings	94%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**EASTPOINTE**
Name of PIP:	**DECREASE EMERGENCY DEPARTMENT ADMISSIONS FOR ACTIVE MEMBERS TO 20%**
Reporting Year:	**2018-2019**
Review Performed:	**2019**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	There were a high rate of members readmitted to ED.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	This PIP addressed key aspects of enrollee care.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	This PIP included all enrolled populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Study question was documented on page 1.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Indicator was defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures were related to health status and processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Enrollees were defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	PIP captured all enrollees to whom the question applied.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Design clearly specified data to be collected.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were specified.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Collection methods ere reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data collection instruments allow for accurate data.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Qualifications were documented for personnel involved in the study.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Initial and new interventions were documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses were conducted monthly.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results were presented in table and graph format.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Baseline and repeat measurements were included in the report.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Narrative analysis was conducted including opportunities for improvement.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology was the same at all timepoints.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	Rates are not improving, as of latest available data for June 2019. The rate is above goal rate of 20%. ***Recommendation: Determine if 100% benchmark is the correct rate. Revise baseline benchmark to a rate that is closer to or equal to the goal rate of 20%, if applicable.***
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Unable to evaluate due to lack of decrease in rate.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No statistical analysis conducted as study did not have sampling.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to evaluate.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	90
Project Possible Score	91
Validation Findings	99%

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**EASTPOINTE**
Name of PIP:	**DECREASE PERCENTAGE OF MEMBERS WHO SEPARATE FROM TRANSITION TO COMMUNITY LIVING HOUSING TO 20% OR LESS ANNUALLY**
Reporting Year:	**2018-2019**
Review Performed:	**2019**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	During FY 2019, 63% separated from housing.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	This PIP addressed key aspects of enrollee care and services.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	This PIP included all enrolled populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Study questions were documented.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Partially Met**	Indicator was defined although baseline benchmark is reported at 100%. The goal is 20% and 100% is higher than the current reported rate of 63% in the rationale section. ***Corrective Action: Revise baseline benchmark to a rate that is closer to or equal to the goal rate of 20%.***
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures were related to health status and processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Enrollees were defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	PIP captured all enrollees to whom the question applied.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Design clearly specified data to be collected.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were specified.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Collection methods were reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data collection instruments allowed for accurate data.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**NA**	Data not extracted yet, thus personnel involved are not yet determined or reported.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**NA**	Data and analysis not yet conducted. Start date was August 2019.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NA**	Analyses were not yet conducted.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NA**	Analyses were not yet conducted.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Analyses were not yet conducted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NA**	Analyses were not yet conducted.

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

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	42
Project Possible Score	47
Validation Findings	89%

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**EASTPOINTE**
Name of PIP:	**INCREASE APPROVAL RATE OF MEDICAID ENCOUNTER CLAIMS TO 95%**
Reporting Year:	**2018-2019**
Review Performed:	**2019**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Data source was documented (TCLI Dashboard).
6.3 Did the study design specify a systematic Method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of data collection was documented.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Instruments were consistent.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis plan was documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Qualifications of staff and personnel used to collect data were documented.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers were listed and interventions are documented in Action IV.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Data analysis was presented as monthly
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Data were presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Initial and repeat measurements were included.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis was provided for measurement periods.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same Methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology was the same across measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Rate has mostly met the goal in FY2019.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Rate was the result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analysis is not required for projects that do not utilized sampling.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**Met**	Sustained improvement occurred over the last 4 remeasurement months.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	**95**
Project Possible Score	**95**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

D. Attachment 4: Tabular Spreadsheet

CCME PIHP Data Collection Tool

PIHP Name:	Eastpointe
Collection Date:	2019

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A. General Approach to Policies and Procedures						
1. The PIHP has in place policies and procedures that impact the quality of care provided to Enrollees, both directly and indirectly.	X					The EQR showed all policies and procedures were accounted for, demonstrated annual review, and an active revision process. In the previous year's EQR, it was recommended that Eastpointe reconcile the Policy and Procedure List and the Policy and Procedure Manual, as there was some disconnect between the two lists of policies. Eastpointe addressed this Recommendation and now both lists align.
I. B. Organizational Chart / Staffing						
1. The PIHP's resources are sufficient to ensure that all health care products and services required by the State of North Carolina are provided to enrollees. At a minimum, this includes designated staff performing in the following roles:						Review of Eastpointe's Organizational staffing and management showed, at the time of the Onsite, four current positions were vacant, but no significant functions were impacted by these vacancies. Additional positions were recently added to the Care Coordination Department to further support the management and function of that department.
1.1 A full time administrator of day-to-day business activities;	X					Sarah Stroud continues in her role as Chief Executive Officer.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities.	X					Dr. Sid Hosseini serves as Eastpointe's Medical Director, and Dr. Venkata Doniparthi is Eastpointe's contracted Associate Medical Director.
2. Operational relationships of PIHP staff are clearly delineated.	X					In the previous year's EQR, Dr. Doniparthi, Associate Medical Director, was not adequately represented on the Organizational Chart. Eastpointe has since added her to this document and the responsibilities and oversight outlined in her contract with Eastpointe are also appropriately designated on the Organizational Chart.
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all PIHP staff positions, including those that are required by NC Medicaid.	X					A Recommendation from last year's EQR was to include staff licensure, credentials, certifications, etc. on the Organizational Chart to demonstrate positions within Eastpointe are staffed within the contractual requirements. Eastpointe added this detail to their Organizational Chart for this year's EQR.
I. C. Confidentiality						
1. The PIHP formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					CCME reviewed Eastpointe's policies regarding the management and protection of consumer confidentiality. Eastpointe has a complete set of policies and procedures that address both state and federal requirements for preserving enrollee confidentiality and protecting health information.
2. The PIHP provides HIPAA/confidentiality training to new employees and existing staff.	X					Eastpointe's *Policy CC-1.7, Compliance Training*, specifies that new staff are trained on the Eastpointe Code of Ethics and Compliance Program and that existing employees receive an annual training on these topics, as well.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I D. Management Information Systems						
1. Enrollment Systems						
1.1 The PIHP capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Eastpointe has defined processes in place for enrollment data updates. Wellsky uploads enrollment data received on the daily, and quarterly GEF, and the monthly 834 files. Eastpointe utilizes the monthly capitation file to reconcile the payment received per member and category on a monthly basis. Eastpointe also reconciles the monthly capitation file with the member eligibility records in the AlphaMCS to ensure accurate payment was received.
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					Demographic data is captured in the AlphaMCS system and Member IDs are unique to members. Historic enrollment information is captured for all members in the AlphaMCS system.
1.3 The PIHP's enrollment system member screens store and track enrollment and demographic information.	X					Eastpointe produces exception reports to verify the completeness of data following the GEF load.
2. Claims System						
2.1 The PIHP processes provider claims in an accurate and timely fashion.	X					Approximately, 95% of Institutional and Professional claims are auto-adjudicated. Auto-adjudication is performed daily. Claims in excess of $5,000 and Emergency Department claims are pended for manual review.
2.2 The PIHP has processes and procedures in place to monitor, review and audit claims staff.	X					Eastpointe audits a random sample of 3% of all claims processed in a one-month period on a monthly basis. Eastpointe conducts monthly

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						and quarterly audits on claims processed. Claims in excess of $5,000 and paper claims are audited for accuracy.
2.3 The PIHP has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 diagnosis codes received on an 837 Institutional and 837 Professional file. The PIHP has the capability of receiving and storing ICD-10 procedure codes on an 837 Institutional file.	X					Eastpointe captures up to 24 ICD-10 diagnosis codes for Institutional and 12 diagnosis codes for Professional claims. Eastpointe's provider web portal captures up to 24 ICD-10 diagnosis codes. Eastpointe's provider web portal captures up to 12 ICD-10 diagnosis codes for Professional claims. ICD-10 procedure codes and DRG codes received from the provider are also captured.
2.4 The PIHP's claim system screens store and track claim information and claim adjudication/payment information.	X					Onsite review of the claim system screens identified the capture of adjudication/payment information for the claims.
3. Reporting						
3.1 The PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Eastpointe captures all necessary data elements required for enrollment and claims reporting. Historical data is stored in the AlphaMCS system from the inception of Eastpointe.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.2 The PIHP has processes in place to back up the enrollment and claims data repositories.	X					Wellsky has processes in place that backup the enrollment and claims data in the AlphaMCS system. Eastpointe also has processes in place to back-up the copy of the database that is received from Wellsky on a nightly basis. A disaster recovery policy and procedure was provided along with the ISCA tool. Eastpointe was affected during the hurricane in September 2018. However, there was very little business impact and no disruption of business processes and services.
4. Encounter Data Submission						
4.1 The PIHP has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	X					Eastpointe has updated their encounter data submission process to allow for up to 29 ICD-10-CM secondary diagnosis codes submitted on an Institutional claim and 12 ICD-10-CM Professional 837 HIPAA file to be submitted to NCTracks. However, due to the issue that NCTracks denies Eastpointe encounters with more than 12 ICD-10-CM codes, Eastpointe submits up to 12 diagnosis codes on the encounters and drops the rest. ***Recommendation: Eastpointe does not submit all secondary ICD-10 diagnosis codes to NCTracks due to denials occurring for those encounters with greater than 12 diagnosis codes. It is recommended that Eastpointe submit all secondary ICD-10 diagnosis codes submitted by the provider on a claim to NCTracks, and work with the state to correct issues tied to submitting all secondary diagnosis codes.***

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 updates and maintains details on encounters that are submitted for encounter data submission on 837 files and also the details on the 999 response files. Eastpointe has staff dedicated to the research, correction, and resubmission of NCTracks denied encounters.
4.3 The 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. Eastpointe utilizes the Adam Holtzman paid and denied reports to research, correct, and resubmit denied encounters. The Claims Department is responsible to correct encounter denials and resubmit them. Eastpointe has a multidisciplinary group established to help investigate weekly encounter submissions that do not surpass the 95% encounter acceptance rate. ***Recommendation: As Eastpointe is manually resubmitting corrected encounters, a process needs to be developed that would allow the batch resubmission of specific denial reasons.***
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					Communications have been established between MIS and Claim Departments to address NCTracks encounter denials and submission of encounters that were not included in earlier encounter data submissions. As noted during the Onsite, no significant changes were made to the encounter submission process aside from including additional diagnosis codes to be submitted on encounters to NCTracks. Eastpointe Staff is well-informed and is dedicated to improving encounter data submissions and reducing the number of denials.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II. A. Credentialing and Recredentialing						
1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					The *Provider Credentialing Operations Manual/Plan* (*Credentialing Manual)*, the *Credentialing Committee By-Laws (By-Laws)*, and several policies and procedures describe the requirements and processes for credentialing and recredentialing network providers. Eastpointe has a delegation agreement with Medversant Technologies, a Credentials Verification Organization (CVO), for "Primary Source Verification (PSV) for pre-screening, initial credentialing, and re-credentialing and continuous monitoring of participating providers within the network."
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.		X				As was the case at the last EQR, there is conflicting information in various documents about who chairs the Credentialing Committee. Beginning with the March 22, 2019 meeting, the minutes list Victoria Jackson, LCSW, as the Chair. There was no Chair listed on the previous meeting minutes. The *By-Laws* indicate the Associate Medical Director is the Chair. Page 6 of the *Credentialing Manual* lists the Associate Medical Director as the Chair, while page 7 states, "A Chairperson who is an employee of the MCO may be chosen by the CEO of the MCO, and in consultation with the Associate Medical Director." This statement is inconsistent with the other statements that indicate the Associate Medical Director is the Chair. Onsite discussion confirmed Dr. Doniparthi is the committee Chair. There is conflicting information between the *Credentialing Manual* and the *By-Laws* about what constitutes a quorum. This was also an issue at the last EQR. Onsite discussion confirmed that a quorum is 50% of the voting members plus one, as indicated in the *By-Laws* revised in February 2019.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Meeting minutes are improved from the last EQR. Additional revisions are needed to ensure the minutes are complete. Examples of issues with meeting minutes: • A committee member (Glenda L.) was added at the 10/26/18 meeting. She was apparently present for the meeting, but is not listed among attendees. There is no documentation at that meeting, or at previous meetings regarding the plan to add a member. • The *By-Laws* were revised at the 02/8/19 meeting. Though the minutes reference an update to Dr. Doniparthi's title, and the addition of an Administrative Assistant, the minutes do not document the quorum change from 50% of voting members to 50% plus one. • Meeting minutes also include statements like this one from the March 22, 2019 Credentialing Committee meeting: "Review of Approvals by Medical Director- After review the Committee reported not having any questions or concerns about the Doctor Approvals.". However, Dr. Doniparthi, the Associate Medical Director, approves the "clean" applications. The Medical Director, Dr. Hosseini, does not review or approve the credentialing applications. The Credentialing Committee met monthly between September 2018 and June 2019, with a quorum present at each meeting. Eastpointe staff who are voting members attended between 80% (one member) and 100% (three members) of the meetings at which they were a member. Attendance of the four provider representative members was 20% (one member), 38% (one member), 60% (one member) and 100% (one member) of the meetings at which they were a member.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Corrective Actions: Ensure Credentialing Committee meeting minutes include complete documentation of items such as all (including any guests) who are present for meetings, and details of significant changes, such as changing the quorum in the By-Laws. Ensure the correct Chairperson is listed on the meeting minutes for every Credentialing Committee meeting. ***Revise the Credentialing Committee By-Laws, the Provider Credentialing Operations Manual/Plan, and any other documents that detail credentialing processes, to consistently reflect the Chair of the committee and committee processes. Revise the Provider Credentialing Operations Manual/Plan to indicate a quorum of the Credentialing Committee is 50% plus one of the voting members.***
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. The following issues were identified in the file review:
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					The initial credentialing file for a hospital and the initial credentialing file for a practice (which Eastpointe indicated is part of a hospital system) were missing evidence of the required insurance (see *NC Medicaid Contract, Attachment B, Section 7.7.4*) verifications or waiver. Eastpointe submitted statements indicating verification of insurance is not required for the hospital or the practice that is part of the hospital system. During Onsite discussion, Eastpointe staff indicated they were told "by the State" in the past that they did not need to obtain insurance information

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						for hospitals/hospital systems. CCME asked Eastpointe to submit any written documentation of this, but none was provided. Though *NC Medicaid Contract Attachment B, Section 7.7.3* allows the PIHP to "…choose to accept DMA's credentialing of hospitals…", Eastpointe has elected to credential hospitals. Therefore, all credentialing requirements apply, unless Eastpointe has written documentation of exceptions allowed by NC Medicaid. Missing insurance documentation was also an issue in the last EQR. ***Recommendation: Verify credentialing files contain proof of all the required insurance coverages or relevant waiver, or obtain and retain written exclusion documentation from NC Medicaid. See DMA Contract Attachment B, Section 7.7.4.***
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
3.1.3 Valid DEA certificate and/or CDS certificate;	X					
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					
3.1.5 Work History;	X					
3.1.6 Malpractice claims history;	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					The initial credentialing file for a practice (which Eastpointe indicated is part of a hospital system) was missing Ownership Disclosure. Eastpointe submitted a statement that "ownership reporting is not required". This is incorrect. The initial credentialing application for a hospital includes Ownership Disclosure for officers, managing employees and EFT Transfer personnel. Though *NC Medicaid Contract Attachment B, Section 7.7.3* allows the PIHP to "…choose to accept DMA's credentialing of hospitals…", Eastpointe has elected to credential hospitals. Therefore, all credentialing requirements apply, unless Eastpointe has written documentation of exceptions allowed by NC Medicaid. *NC Medicaid Contract Attachment B, Section 1.13* states "PIHP shall require all Providers to disclose names, social security numbers, dates of birth, addresses and any other information necessary to complete a criminal background check as outlined in Section 1.13.2 for each managing employee and persons with an ownership and control interest in the Provider at the time they apply or renew their applications for participation in the PIHP Closed Network or at any time upon request by the PIHP."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						NC Medicaid Contract Attachment O requires identifying information for owners and managing employees as defined in *42 CFR §455.101*. Though hospitals/hospital systems do not have owners, there are officers, managing employees, and EFT Transfer personnel, for whom Eastpointe should obtain the required information. ***Recommendation: Verify credentialing files contain the required Ownership Disclosure, or obtain and retain written exclusion documentation from NC Medicaid. See NC Medicaid Contract Attachment B, Section 1.13 and 42 CFR §455.101.***
3.1.16 Criminal background Check	X					The initial credentialing file for a hospital and the initial credentialing file for a practice (which Eastpointe indicated is part of a hospital system) were missing evidence of the required criminal background checks. Eastpointe submitted statements that "background reports are not required". This is incorrect. Though *NC Medicaid Contract Attachment B, Section 7.7.3* allows the PIHP to "…choose to accept DMA's credentialing of hospitals…", Eastpointe has elected to credential hospitals. Therefore, all credentialing requirements apply, unless Eastpointe has written documentation of exceptions allowed by NC Medicaid. *NC Medicaid Contract Attachment B, Section 1.13.2* requires criminal background checks of "providers, managing employees and persons with an ownership or control interest of five percent or more." ***Recommendation: Conduct the required criminal background checks and retain the PSV, or obtain and retain written exclusion documentation from NC Medicaid. See NC Medicaid Contract Attachment B, Section 1.13.2.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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. Issues identified in the file review are outlined in the following:
4.1 Recredentialing every three years;			X			The *Credentialing Manual* states, "At minimum, Eastpointe MCO must complete re-credentialing of each Network Provider no less than every 3 years." During Onsite discussion, Eastpointe staff indicated Eastpointe uses the "clean application date" as the effective date for credentialing and recredentialing. However, this date is typically a retroactive date and is not the date of the actual approval of the recredentialing. The application receipt date could be several months past expiration of the previous credentialing/ recredentialing. In ten of the fourteen practitioner files and in one hospital recredentialing file, the date of approval of the recredentialing was (by a range of one month to seven months) after the three years specified in the Eastpointe *Credentialing Manual*. This was also an issue at the last EQR. ***Corrective Action: Ensure providers are recredentialed within three years of the initial credentialing or the previous recredentialing, in order to comply with the Eastpointe Credentialing Manual.***
4.2 Verification of information on the applicant, including:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.1 Insurance Requirements	X					The recredentialing file for a hospital was missing evidence of the required insurance (see *DMA Contract, Attachment B, Section 7.7.4*) verifications or waiver. Eastpointe submitted a statement indicating verification of insurance is not required for the hospital. During Onsite discussion, Eastpointe staff indicated they were told "by the State" in the past that they did not need to obtain insurance information for hospitals/hospital systems. CCME asked Eastpointe to submit any written documentation of this, but none was provided. Though *NC Medicaid Contract Attachment B, Section 7.7.3* allows the PIHP to "…choose to accept DMA's credentialing of hospitals…", Eastpointe has elected to credential hospitals. Therefore, all credentialing requirements apply, unless Eastpointe has written documentation of exceptions allowed by NC Medicaid. Missing insurance documentation was also an issue in the last EQR. ***Recommendation: Verify recredentialing files contain proof of all the required insurance coverages or relevant waiver, or obtain and retain written exclusion documentation from NC Medicaid. See DMA Contract Attachment B, Section 7.7.4.***
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
4.2.3 Valid DEA certificate; and/or CDS certificate;	X					
4.2.4 Board certification, if claimed by the applicant;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.5 Malpractice claims since the previous credentialing event;	X					
4.2.6 Practitioner attestation statement;	X					
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event and query of the State Exclusion List;	X					
4.2.9 Requery of the SAM.	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (OIG LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.12 Query 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					The recredentialing file for a hospital was missing Ownership Disclosures. Eastpointe submitted a statement that "ownership reporting is not required." This is incorrect. *NC Medicaid Contract Attachment B, Section 1.13* states "PIHP shall require all Providers to disclose names, social security numbers, dates of birth, addresses and any other information necessary to complete a criminal background check as outlined in Section 1.13.2 for each managing employee and persons with an ownership and control interest in the Provider at the time they apply or renew their applications for participation in the PIHP Closed Network or at any time upon request by the PIHP." *NC Medicaid Contract Attachment O* requires identifying information for owners and managing employees as defined in *42 CFR §455.101*. Though hospitals/hospital systems do not have owners, there are officers, managing employees, and EFT Transfer personnel, for whom Eastpointe should obtain the required information. ***Recommendation: Verify recredentialing files contain the required Ownership Disclosure, or obtain and retain written exclusion documentation from NC Medicaid. See NC Medicaid Contract Attachment B, Section 1.13 and 42 CFR §455.101.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.3 Site reassessment if the provider has had quality issues.	X					Page 23 of the *Credentialing Manual* states, "During the Re-Credentialing Process, if information is revealed that is indicative of factors that may impact the quality of care or service provided to enrollees, Eastpointe shall conduct additional reviews and/or investigations of that provider. Site reassessments may be determined to be needed if the provider has quality issues. If determined, they will be conducted by the Provider Monitoring Department."
4.4 Review of provider profiling activities.	X					The reviewed practitioner recredentialing files include the *Quality Monitoring Review Tool For LME/MCO Re-Credentialing Application Process*, which includes queries from "Quality Management, Compliance, Utilization Management, and other MCO departments" as part of the recredentialing process. Provider Network staff are also "able to request reports from QM, including, but not limited to, provider grievances, profiles, good standing and quality of care or quality of service information."
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, and is accessible via a link in the *Eastpointe Provider Operations Manual*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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." The "Facility Credentialing and Re-Credentialing" section of the *Credentialing Manual* includes "Copy of License" in the items that represent a "completed application, for Medversant's purposes." The *Credentialing Manual* also states, "Prior to Medversant conducting PSV, they will conduct certain pre-screens that have been mandated by NC Medicaid that MCOs must conduct." That list includes the "North Carolina Division of Health Service Regulations, MH Licensure & Certification Section" in the "Pre-Screening Reviews."
II B. Adequacy of the Provider Network						
1. The PIHP maintains a network of providers that is sufficient to meet the health care needs of enrollees and is consistent with contract requirements.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 Enrollees have a Provider location within a 30 – mile distance of 30 minutes' drive time of their residence. Rural areas are 45 miles and 45 minutes. Longer distances, as approved by NC Medicaid, are allowed for facility based or specialty providers.	X					*Policy E-4.4.32, Adequacy of Provider Network*, confirms the 30 mile/30 minutes (urban) and 45 mile/45 minutes (rural) requirements, and addresses availability of providers to serve enrollees with "special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs." The *Eastpointe Human Services LME-MCO 2019 Community Mental Health, Substance Use and Developmental Disabilities Services Network Adequacy and Accessibility Analysis* (Gaps Analysis), indicates 100% of enrollees have the choice of two providers within 30/45 miles/minutes of their residences. During Onsite discussion, Eastpointe staff verified this information is accurate.
1.2 Enrollees have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the enrollee may utilize an out-of-network specialist with no benefit penalty.	X					This is addressed on page 32 of the *Enrollee/Member and Family Handbook*.
1.3 The sufficiency of the provider network in meeting enrollee demand is formally assessed at least annually.	X					Eastpointe conducts an annual gaps and needs assessment, as required by NC Medicaid.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.4 Providers are available who can serve enrollees with special needs such as, hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Eastpointe has in-network providers who serve individuals with special needs, and uses Single Case Agreements whenever services are not available within the network. During the review period for the current EQR, the *Provider Search* function on the Eastpointe website allowed searches by a variety of categories, including Cultures Served (which includes groups like Alaska Native, American Indian, Asian, Black/African American, as well as Deaf & Hard of Hearing, Military, Muslim, and others), Disabilities Served, Languages Served, Operating Hours (with the ability to search by Weekdays, Weekends, and Weeknights) Payors Served, Service Category and Specialty Served. The Specialty Served category includes Hearing Impaired and Visually Impaired. The Provider Directory Search function on the website has now been updated, with the initial search options being "Provider Agency/Facility Search" and "Practitioner Search". The 2019 Gaps Analysis reports Eastpointe has a full-time employee focused exclusively on children with complex needs within the Child Care Coordination Team. A Cultural Competency brochure, in English and in Spanish, is posted in the "Information, Manuals and Forms" section of the Provider section of the Eastpointe website. A *Cultural Competency Program Description for 2018-2019* (updated July 5, 2018) is also posted in that section of the website. During Onsite discussion, Eastpointe staff indicated the Customer Services Department annually updates the *Cultural Competency Program Description*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.5 The PIHP demonstrates significant efforts to increase the provider network when it is identified as not meeting enrollee demand.	X					During Onsite discussion, Eastpointe staff indicated that, for needed services, if a contracted provider in the area provides a similar service, Eastpointe will approach them to see if they are interested in adding the needed service. Eastpointe uses Single Case Agreements as needed. If further need exists and no contracted provider is interested in providing the service, Eastpointe will ask the Single Case Agreement provider if they are interested in being credentialed for the Eastpointe network. Eastpointe also issues RFIs or RFPs when there is an identified need.
2. Provider Accessibility						
2.1 The PIHP formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Timeliness guidelines for emergent, urgent, and routine care are included in the *Provider Operations Manual*, in *Policy C-3.5.7, Call Center STR Process*, and in the *Member Call Center Manual*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II C. Provider Education						
1. The PIHP formulates and acts within policies and procedures related to initial education of providers.	X					*Policy E-4.4.7, Provider Relations Program,* addresses new provider orientation. The Eastpointe website has a Training Calendar and offers several recorded trainings to providers. The Eastpointe website "Becoming a Provider" section includes a "Provider Orientation" sub-section that includes the *Welcome Letter*, the *Getting Started* document, and the *Eastpointe Provider Manual effective 070119*. There is also a link to a recorded *Provider Orientation Training Webinar*. The *Getting Started* document, found in the Provider Orientation section of the "Becoming a Provider" section of the Eastpointe website, has several incorrect links. As was the case at the last EQR, the link listed for *Eastpointe's Provider Meeting Documents/ Handouts* actually links to the *Authorization (UM) and Benefits Packages* section of the website, rather than to the *Meetings and Trainings* section of the website. The letter states "The link to the NCDMH/DD/SAS Manuals is http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/index.htm. This site includes the following manuals:", with a list of specific manuals. Some of those manuals are no longer included on the linked webpage. The *Getting Started* document also includes "the link to NC DMA's 'Medicaid Billing Guide April 2011' is http://www.ncdhhs.gov/dma/basicmed/index.htm." However, the *Medicaid Billing Guide* was replaced some years ago by the *NCTracks Provider Claims and Billing Assistance Guide*. ***Recommendation: Check the links in the Getting Started document and update the ones that are incorrect. This was also a Recommendation at the last EQR.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Initial provider education includes:						Information for the following standards is provided in the *Provider Operations Manual* and/or on the Eastpointe website unless otherwise indicated. The *Welcome Letter* informs providers of the orientation materials on the Eastpointe website, including the "*Getting Started*" document, which includes a variety of links for providers.
2.1 PIHP purpose and mission;	X					This information is included in the Eastpointe Vision, Mission and Guiding Principles section beginning on page 10 of the *Provider Operations Manual*.
2.2 Clinical Practice Standards;	X					Clinical practice guidelines are posted on the Eastpointe website and referenced in the *Provider Operations Manual*.
2.3 Provider responsibilities;	X					Provider responsibilities are addressed throughout the *Provider Operations Manual*.
2.4 PIHP closed network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability;	X					Included in the *Provider Operations Manual*.
2.5 Access standards related to both appointments and wait times;	X					Timeliness guidelines for emergent, urgent, and routine care and appointment wait times are addressed in the *Provider Operations Manual*.
2.6 Authorization, utilization review, and care management requirements;	X					Section V: Authorization, Utilization Review, Care Management And Benefit Package begins on page 59 of the *Provider Operations Manual*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.7 Care Coordination and discharge planning requirements;	X					Information is in Section IX: Care Coordination and Discharge Planning Requirements beginning on page 86 of the *Provider Operations Manual*.
2.8 PIHP dispute resolution process;		X				*Policy Q-6.4.2, Provider Violations and Disputes* addresses the right of providers to "dispute actions taken by Eastpointe", and outlines the steps and process. The *Provider Operations Manual* includes a section titled "Reconsideration (Appeal) Of Eastpointe Actions Taken Against Providers", beginning on page 76. However, the *Provider Operations Manual* does not contain the exact information included in *Policy Q-6.4.2*, and vice-versa. Further, the *Provider Operations Manual* does not clearly outline the process for provider disputes. The *Provider Operations Manual* provides confusing and conflicting information about whether credentialing/recredentialing decisions are appealable. "Reconsideration of Credentialing Decisions" on page 36 of the *Provider Operations Manual* states, "Credentialing decisions regarding a practitioner's entry into the Eastpointe Network are final and not appealable. Reconsideration only applies for adverse actions taken against a practitioner who is already a contracted provider with Eastpointe." The "Reconsideration Process for decisions made by Credentialing Committee" section on page 77 of the *Provider Operations Manual* has a section that states, "The Reconsideration process is a part of the Grievance and Appeals System managed by the Grievance and Appeals Department. Reconsideration of decisions of the Eastpointe Credentialing Committee is specifically noted in this section." The "Reconsideration of Eastpointe Credentialing Decisions" section on page 78 of the *Provider Operations Manual* outlines the process for reconsideration of Credentialing Committee decisions. However, the "Credentialing Determination Notification" on page 18 of the *Provider Credentialing Operations Manual/Plan* states "Credentialing decision regarding a practitioners or agencies entry

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						into the network are final and not appealable. Reconsideration only applies for adverse actions taken against a practitioner who is already a contracted provider with Eastpointe." During Onsite discussion, Eastpointe staff indicated only recredentialing decisions are appealable, for providers who are already in the network. However, that is not completely clear in the *Provider Operations Manual*. ***Corrective Actions: Revise the Provider Operations Manual to clearly outline the required steps for provider disputes/ resolution. Reconcile the language between Policy Q-6.4.2, Provider Violations and Disputes, and the Provider Operations Manual.*** ***Revise the language in the Provider Operations Manual, the Credentialing Operations Manual (and anywhere else the language might appear), to clearly indicate whether credentialing/recredentialing decisions can be appealed. See DMA Contract Attachment B, Section 7.11, i.***
2.9 Complaint investigation and resolution procedures;	X					The *Provider Operations Manual* includes "Section VIII: Grievances, Appeals, Reconsiderations, Investigations and Resolution Procedures."
2.10 Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements;	X					Page 72 of the *Provider Operations Manual* is named "Section VII: Claims and Reimbursement", which includes access to the *Eastpointe Claims and Billing Manual FY 18/19*, found on the Eastpointe website.
2.11 Enrollee rights and responsibilities;	X					Information is included beginning on page 102 of the *Provider Operations Manual*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.12 Provider program integrity requirements that include how to report suspected fraud, waste and abuse, training requirements as outlined in the False Claims Act, and other State and Federal requirements;	X					Both the *Provider Operations Manual* and the Eastpointe website address reporting fraud, waste, and abuse. Information on False Claims Act Compliance begins on page 52 of the *Provider Operations Manual*. The Eastpointe website lists choices of topics such as "Members and Families", "Provider", and "Contact". "Report Fraud and Abuse" is now included in these website menu choices. The "Report Fraud and Abuse" section includes a toll-free number for reporting fraud and abuse, a web-submission report form (which can be used for reporting fraud and abuse, either anonymously or not), and a toll-free number for reporting external fraud, waste, and abuse. The Program Integrity (PI) section of the website includes definitions of fraud, waste, and abuse, and includes a link to the Program Integrity Referral Form. Eastpointe offered an extensive Program Integrity Provider Network Training in Lumberton, NC on May 16, 2019 and in Rocky Mount on May 21, 2019. The training, titled "Statutes, Policies and Rules: What are they and why they matter for Fraud, Waste and Abuse", is posted in the Program Integrity section on the Eastpointe website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The PIHP provides ongoing education to providers regarding changes and/or additions to its programs, practices, enrollee benefits, standards, policies and procedures.	X					Most training information is accessed via the Meetings and Trainings sub-section of the *Provider* section of the website or the calendar on the main page of the Eastpointe website. The main page of the Eastpointe website has a News and Events section, with rotating entries of training events. A calendar at the bottom of the main page of the Eastpointe website displays items by date, including events for the community and trainings and information for providers. From the calendar listings, it is possible to: • Get more information by clicking on the name of the listing • Add the item to your own calendar • Send an email reminder • Register for items that require registration Providers can sign up to receive List Serv communications from Eastpointe. Eastpointe updates providers via *Communication Bulletins*.
II D. Clinical Practice Guidelines for Behavioral Health Management						
1. The PIHP develops clinical practice guidelines for behavioral health management of its enrollees that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					*Policy Q-6.1.19, Utilization of Clinical Practice Guidelines,* indicates the Clinical Advisory Committee reviews and approves each clinical practice guideline at least every two years. The Clinical Advisory Committee includes the Eastpointe Medical Director and Associate Medical Director, and currently includes ten licensed practitioners, representing a variety of disciplines and specialty areas. Information about the Clinical Practice Guidelines is contained in the *Provider Operations Manual*. The Clinical Practice Guidelines are accessed via the Authorization and Benefits Packages tab on the Provider section of the Eastpointe website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP communicates the clinical practice guidelines for behavioral health management and the expectation that they will be followed for PIHP enrollees to providers.	X					Page 131 of the *Provider Operations Manual* notes "The expectation is that when requests for services are submitted for medical necessity review with the identified diagnosis that the Clinical Practice Guideline will be followed and well documented within the Service Authorization Request (SAR)."
II E. Continuity of Care						
1. The PIHP monitors continuity and coordination of care between providers.	X					The Provider Monitoring Team monitors continuity and coordination of care between providers. This is part of routine monitoring, but also could be via other monitoring, such as targeted monitoring, quality of care concerns, or post payment reviews. Eastpointe is incorporating RNs, to bridge the physical health side. For example, an RN will look at medication lists and be able to communicate effectively with the physician.
II F. Practitioner Medical Records						
1. The PIHP formulates policies and procedures outlining standards for acceptable documentation in the Enrollee medical records maintained by providers.	X					The *Provider Operations Manual* includes General Medical Records Requirements/Treatment Records Standards, beginning on page 100. *Policy Q-6.3.27, Enrollee Medical Records Maintained by Providers*, provides information about enrollee record documentation standards. Page 5 of *Policy Q-6.3.27* references the *Basic Medicaid Billing Guide*, as defined in the *NC Medicaid Contract, Section 8.2*. However, as noted at the last two EQRs, the *Basic Medicaid Billing Guide was* replaced several years ago by the *NCMMIS Provider Claims and Billing Assistance Guide*. A Recommendation at the last two EQRs was to "*Update/replace all references to The Basic Medicaid Billing Guide, which was replaced by the NCMMIS Provider Claims and Billing Assistance Guide.*" Eastpointe revised the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Provider Operations Manual to delete the references to the *Basic Medicaid Billing Guide*, but did not revise *Policy Q-6.3.27*. ***Recommendation: Update/replace all references to The Basic Medicaid Billing Guide, which was replaced by the NCMMIS Provider Claims and Billing Assistance Guide.***
2. The PIHP monitors compliance with medical record documentation standards through formal periodic medical record audits and addresses any deficiencies with the providers.	X					*Policy E-4.2.1, Local Monitoring,* addresses medical record documentation monitoring. Medical record documentation is included in the standardized Routine Provider Monitoring and Post Payment Review tools completed by the Monitoring Team, in compliance with guidelines from the North Carolina Department of Health and Human Services.
3. The PIHP has a process for handling abandoned records, as required by the contract.	X					*Policy Q-6.3.12, Abandonment of Provider Records,* outlines the "procedural steps" Eastpointe will take upon notification that "records have been abandoned by a provider."

III. ENROLLEE SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III A. Enrollee Rights and Responsibilities						
1. The PIHP formulates policies outlining enrollee rights and procedures for informing enrollees of these rights.	X					*Policy C-3.5.10, Protection of Consumer Rights and Responsibilities,* explains all enrollee rights and the procedure Eastpointe uses to inform enrollees of these rights.
2. Enrollee rights include, but are not limited to, the right:	X					Pages 12-14 of the *Enrollee/Member and Family Handbook,* revised 10-8-2019, details the information regarding the sub-standards included in this standard.

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III B. Enrollee PIHP Program Education						
1. Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid waiver managed care program which they are contractually entitled, including:	X					*Policy C-3.5.14, Member Call Center Response to Enrollee/Member Services,* revised 10-8-2019, states "Within fourteen days after an Enrollee is screened for services, Eastpointe's Call Center Department shall provide the new Enrollee with written information on the Medicaid managed care program." All information in the sub-standards within this standard is provided to enrollees unless noted differently in the following sub-standards.
1.1 A description of the benefits and services provided by the PIHP and of any limitations or exclusions applicable to covered services. These descriptions must have sufficient detail to ensure the Enrollees understand the benefits to which they are entitled and may include a web link to the PIHP Benefit Plan. This includes a descriptions of all Innovations Waiver services and supports;						
1.2 Benefits include access to a 2nd opinion from a qualified health care professional within the network, or arranges for the enrollees to obtain one outside the network, at no cost to the enrollee;						Page 13 of the *Enrollee/Member and Family Handbook,* revised 10-8-2019, explains this right within the "What Are My Rights" section.
1.3 Updates regarding program changes;						Page 21 of the *Enrollee/Member and Family Handbook,* revised 10-8-2019, explains this in the section "How Do I Receive Updates Regarding Program Changes."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.4 A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;						Page 20 of the *Enrollee/Member and Family Handbook*, revised 10-8-2019, explains this in the section "What Is Early and Periodic Screening, Diagnosis and Treatment (EPSDT)."
1.5 An explanation of the Enrollee's responsibilities and rights and protection, as set forth in *42 CFR § 438.100*;						
1.6 An explanation of the Enrollee's rights to select and change Network Providers;						
1.7 The restrictions, if any, on the enrollee's right to select and change Network Providers;						Page 32 of the *Enrollee/Member and Family Handbook*, revised 10-8-2019, explains this in the section "Benefit Restrictions with an Out-of-Network Provider."
1.8 The procedure for selecting and changing Network Providers;						Page 30 of the *Enrollee/Member and Family Handbook*, revised 10-8-2019 explains this in the sections "How Do I Get a List of Providers in the Eastpointe Provider Network?" and "Can I Change My Provider."
1.9 Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request);						The online Provider Directory was upgraded in early November 2019 during the time CCME was conducting the Desk Review. CCME reviewed the Provider Directory prior to the upgrade. All fields required by NC Medicaid for the Provider Directory are included in either the online or printed versions. This item had a Corrective Action in the last EQR to include the "accepting new patients" field in the online and printed versions of the Provider Directory. The printed 2019 Provider Choice Directory has a field for "accepting new patients". The online Provider Search prior to the upgrade did not have a specific field for "accepting new patients." This field was added during the online upgrade. The printed 2019 Provider Choice Directory does not include provider qualifications. The online version, prior to the upgraded website, listed specialties served showing the provider's qualified areas. The

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						upgraded provider search has fields for "Degree", "Board Certification", "Discipline", "License", and Practitioner Specialties". Many of these new fields list, "Data not available at this time." Eastpointe explained that they continue to load data into the system.
1.10 The non-English languages, if any, spoken by each Network Provider;						"Languages Served" is a field within the online Provider Directory. The printed 2019 Provider Choice Directory in the Desk Material does not have a field for Languages Served. ***Recommendation: Add a "Languages Served" field to the printed Provider Directory.***
1.11 The extent to which, and how, after-hours and emergency coverage are provided, including:						Pages 28-30 of the *Enrollee/Member and Family Handbook*, revised 10-8-2019, explains this standard and all five of the sub-standards.
1.11.1 What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services in accordance with *42 CFR § 438.114* and EMTALA;						
1.11.2 The fact that prior authorization is not required for emergency services;						A Corrective Action issued in the 2018 EQR that was aimed at clarifying in the *Enrollee/Member and Family Handbook* that prior authorization is not required for emergency services. This Corrective Action was implemented by Eastpointe. As a result, it is clear throughout the *Enrollee/Member and Family Handbook*, revised 10-8-2019, that emergency services do not require prior authorization.
1.11.3 The process and procedures for obtaining Emergency Services, the use of 911 telephone services or the equivalent;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.11.4 The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract;						A Corrective Action issued in the 2018 EQR that required Eastpointe to provide additional information in the *Enrollee/Member and Family Handbook* about the locations where enrollees can access emergency and post stabilization services. This was corrected and maintained in this year's EQR. Examples of all the different venues enrollees can obtain emergency services and post stabilization services are clearly listed on pages 28-30 in the *Enrollee/Member and Family Handbook*, revised 10-8-2019. This includes Mobile Crisis, walk in clinics, Facility based crisis, and Hospitals.
1.11.5 A statement that, subject to the provisions of the NC Medicaid contract, the Enrollee has a right to use any hospital or other setting for Emergency care;						
1.12 The PIHP's policy on referrals for Specialty Care to include cost sharing, if any, and how to access Medicaid benefits that are not covered under the NC Medicaid contract;						
1.13 Any limitations that may apply to services obtained from Out-of Network Providers, including disclosures of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of Network Providers, and the procedures for obtaining authorization for such services.						This standard is addressed in the *Enrollee/Member and Family Handbook*, revised 10-8-2019, on pages 31-32 under the section "Can I receive services from an out-of-network provider" and "Benefit restrictions with an out-of-network provider."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.14 How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost-sharing;						
1.15 Procedures for obtaining out-of-area or out-of-state coverage of services, if special procedures exist;						There was a Corrective Action issued in the 2018 EQR that required Eastpointe to include additional information regarding accessing out-of-area or out-of-state coverage. This was corrected and maintained in this year's EQR. Page 31 of the *Enrollee/Member and Family Handbook*, revised 10-8-2019, has a new section "Obtaining care and coverage outside of Eastpointe's catchment area." This section explains out-of-area, out-of-state, and out-of-Network services.
1.16 Information about medically necessary transportation services by the department of Social Services in each county;						Page 30 of the *Enrollee/Member and Family Handbook*, revised 10-8-2019, has a section titled "Transportation to appointments" that addresses this standard.
1.17 Identification and explanation of State laws, rules and policies regarding the treatment of minors;						Page 14 of the *Enrollee/Member and Family Handbook*, revised 10-8-2019, has a section called "If I am a minor, do I have any rights?" explaining information for this standard.
1.18 The enrollee's right to recommend changes in the PIHP's policies and services;						
1.19 The procedure for recommending changes in the PP's policies and services;						The enrollee's procedure for recommending changes to Eastpointe's policies and services is stated on page 21 of the *Enrollee/Member and Family Handbook*, revised 10-8-2019.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.20 The Enrollee's right to formulate Advance Directives;						
1.21 The Enrollee's right to file a grievance concerning non-actions and the Enrollee's right to file an appeal if PIHP takes an action against an Enrollee;						Last EQR, CCME recommended Eastpointe consolidate documentation on grievances and appeals for the enrollee in the *Enrollee/Member and Family Handbook*. Eastpoint has completed this revision and information about grievances and appeals is found on pages 40-43 of the *Enrollee/Member and Family Handbook*, revised 10-8-2019.
1.22 The accommodations made for non-English speakers, as specified in *42 CFR §438.10(c)(5);*						
1.23 Written information shall be made available in the non-English languages prevalent in the PIHP's services area.						
1.24 The availability of oral interpretation service for non-English languages and how to access the service;						
1.25 The availability of interpretation of written information in prevalent languages and how to access those services						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.26 Information on how to report fraud and abuse;						
1.27 Upon an Enrollee's request, the PIHP shall provide information on the structure and operation of the agency and any physician incentive plans;						
1.28 Information on grievance, appeal and fair hearing procedures and information specified in *42 CFR §438.10 (g).*						
2. Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.	X					The annual process for notifying enrollees of their right to request and obtain written materials is in *Policy C-3.5.18, Member/Enrollee Education and Notification.* The letter called *Annual Enrollee Notice* is sent annually to each enrollee by the Medical Records Department.
3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in *CFR 438.10 (f) (61)* and *438.10 (g)* at least 30 days before calendar days before the intended effective date of the change; and (2) . termination of their provider within fifteen (15) calendar days after PIHP receives notice that NC Medicaid or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.	X					On page 21 of the *Enrollee/Member and Family Handbook,* revised 10-8-2019, *e*nrollees are notified in writing of any significant change in benefits and services, at least 30 days prior to the effective date of the change. Five of Eastpointe's network providers were terminated in the last 12 months. Only one provider was seeing Eastpointe members at the time of the termination. Letters notifying this provider's enrollees of the termination did not inform enrollees of the date the termination from the network. This was a Recommendation in last year's EQR and continues to be recommended in this year's EQR.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Inform the enrollees, in written communication, of the date when the provider will no longer be in the network. Add this date to the letter sent to enrollees.
4. Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation of prevalent non-English languages as required by the contract.	X					There was a Recommendation issued in last year's EQR for Eastpointe to change the light gray type on the website to an easier to read, darker color. This has been completed with a black type that is easy to see. There was a Corrective Action issued in last year's EQR that targeted the need for improvement of the *Enrollee/Member and Family Handbook*. As a result of this Corrective Action, Eastpointe developed a plan to simplify and improve the information in the manual. These changes were implemented and have been maintained in the *Enrollee/Member and Family Handbook*, revised 10-8-2019. As a result, the information provided within the manual is more clear and specific topics are easier to locate.
5. The PIHP maintains and informs Enrollees of how to access a toll-free vehicle for 24-hours Enrollee access to coverage information from the PIHP, including the availability of free oral translation services for all languages and care management services such as crisis interventions.	X					
III C. Behavioral Health and Chronic Disease Management Education						
1. The PIHP enables each enrollee to choose a Provider upon enrollment and provides assistance as needed.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP informs enrollees about the behavioral health education services that are available to them and encourages them to utilize these benefits.	X					The website has a Member Resources page listing The *Enrollee/Member and Family Handbook*, EOR Fact sheet and Manual, Substance Abuse/prevention and Suicide Prevention Brochures, and *System of Care Handbook*. There is a heading of Member Education that have mobile Applications available on Google Play or Apps Store. In-person member education includes Mental Health First Aid, resilience training, and opioid awareness in the community.
3. The PIHP tracks the participation of enrollees in the behavioral health education services.	X					
III D. Call Center						
1. The PIHP provides customer services that are responsible to the needs of the Enrollees and their families. Services include:	X					In the previous EQR, documentation in the *Enrollee/Member and Family Handbook* referred to the Call Center and Access to Care. There was a Recommendation to refer to the Call Center by the same name in all documentation. In the *Enrollee/Member and Family Handbook revised 10-8-2019,* "Call Center" is used except in the footer, where "24/7 Access to Care…" is used. Staff said they decided to keep this in the footer.
1.1 Respond appropriately to inquiries by enrollees and their family members (including those with limited English proficiency);	X					On page 6 of the *Member Call Center Manual*, revised 10-4-2019, the process assisting a member speaking a foreign language or who is deaf/hard of hearing is explained.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 Connect enrollees, family members and stakeholders to crisis services when clinically appropriate;	X					Triage is immediately initiated by Call Center staff. Mobile Crisis and law enforcement are called by staff, when appropriate. Eastpointe remains on the phone with suicidal members until the first responder arrives. Eastpointe calls to follow up that the member arrived safely to crisis service.
1.3 Provide information to enrollees and their family members on where and how to access behavioral health services;	X					
1.4 Train its staff to recognize third-party insurance issues, recipient appeals, and grievances and to route these issues to the appropriate individual;	X					When grievances are received by the Call Center, staff log the grievance into the system.
1.5 Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;	X					The Call Center is located in Eastpointe's Lumberton office and staffed from 8:00 a.m. – 5:00 p.m. Some Eastpointe staff work remotely (from home). Cardinal Innovations does after-hours and roll-over calls as an Eastpointe delegate.
1.6 Process referrals twenty-four (24) hours per day, seven (7) days per week; 365 days per year; and	X					
1.7 Process Call Center linkage and referral requests for services twenty-four (24) hours per day, seven (7) days per week, 365 days per year.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV A. The Quality Improvement (QI) Program						
1. The PIHP formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to enrollees.	X					The *Quality Improvement Plan and Program Description FY2019* describes the formal quality improvement program.
2. The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.	X					On page 14, the *Quality Improvement Plan and Program Description FY2019* describes, "Annually, two adopted clinical practice guidelines will be reviewed to ensure practitioner adherence. Recommendations will be made by the Clinical Advisory Committee. Feedback and technical assistance will be provided as needed to provider agencies." And, on page 24, "Provider Monitoring performs monitoring activities to ensure that required standards of care and LME/MCO practice guidelines followed by providers." The Clinical Practice Guidelines Workgroup minutes detail the work in this area. The workgroup met monthly and developed an Excel spreadsheet summary that shows the percentage of total authorizations that did not use clinical practice guidelines for Assertive Community Treatment (ACT), Community Support Team (CST), and Intensive In-Home (IIH). These three areas were also looked at last year and carried over to this year. Technical assistance is given to providers who need improvements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Over and underutilization validation was conducted using a review checklist to verify that mechanisms are in place to monitor utilization and data are analyzed. The current desk materials contained an updated policy, *Policy C-3.2.42*, to monitor over and underutilization and several utilization reports. Onsite discussion centered around data linking increased resources for peer support services to improved seven-day follow up appointment attendance, but outcomes as a result of that change are to be determined. ***Recommendation: Continue monitoring over and underutilization to determine if the increased resources in peer support services improves seven-day follow up appointment attendance.***
4. The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.	X					On page 34 of the *2019 Community Mental Health, Substance Use and Developmental Disabilities Services Network Adequacy and Accessibility Analysis,* opportunities for improvement were identified in both Child (11 items) and Adult (11 items) ECHO Surveys. Eastpointe worked with the Provider Council to create a project plan to address all areas for which Eastpointe was determined to be below the North Carolina average on the Child and Adult ECHO Survey.
5. The PIHP reports the results of the enrollee satisfaction survey to providers.	X					ECHO Survey Reports were discussed with the provider members of GQIC during the 8/29/19 meeting. No ECHO Survey results were reported in the Network Provider Council minutes for the past year. 2018 ECHO Survey results were not posted on the Eastpointe website. ***Recommendation: Discuss ECHO Survey Results with the Network Provider Council and show the discussion in the meeting minutes. Put this on the QM Workplan to be reported to Network Provider Council each year. Post the ECHO Survey results on the Eastpointe website each year when the results are available.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. The PIHP reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					Enrollee satisfaction survey results are reported in the GQIC 8/29/19 meeting minutes. Eastpointe created the *2018 Satisfaction Survey Action Plan*. It documents lower scoring items from the Child ECHO Survey results, Adult ECHO Survey result, and Provider Satisfaction results. Results are documented for years 2016, 2017, and 2018. Each lower scoring survey item is assigned to a staff member, and the status is updated on the *2018 Satisfaction Survey Action Plan* Excel document.
7. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, time frame for implementation and completion, and the person(s) responsible for the project(s).	X					The *Eastpointe Quality Improvement Work Plan FY 2019* was updated throughout the year.
IV B. Quality Improvement Committee						
1. The PIHP has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Global Quality Improvement Committee (GQIC) identifies and addresses opportunities for improvement of organizational operations and the local service system. The committee is granted authority by Eastpointe's Executive Team.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The committee is cross functional, and membership includes management representatives from each area of the organization, network providers, and a CFAC member.
3. The QI Committee meets at regular intervals.	X					Ensuring that GQIC meets at regular intervals was a Corrective Action item in last EQR that has been corrected. GQIC met 5 times from June 2018 – June 2019. Months of meetings were June 2018, August 2018, December 2018, February 2019, and June 2019. The October 2018 and April 2019 meetings were cancelled. Page 17 of the *Quality Improvement Plan and Program Description FY2019* states, "The committee meets at least quarterly."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Minutes are maintained that document proceedings of the QI Committee.	X					GQIC maintains minutes for all meetings including committee findings, recommendations, and actions. The minutes are approved by the committee and posted on the Eastpointe website.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					B and C waiver measures were consistent with requirements and specifications according to CMS protocol for validating performance measures.
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					All submitted PIPs were selected based on data analysis with a clear rationale for study objectives.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".		X				Six out of seven PIPs scored in the high confidence range. The newly initiated PIP regarding separation from TCLI housing scored in the confidence range with a validation score of 89%, resulting in a "Partially Met" score for this standard. ***Corrective Action: Correct the errors in this PIP scoring Partially Met. Decrease percentage of members who separate from Transition to Community Living (TCLI) housing to 20% or less annually. Table 21 displays this PIP and the specific Corrective Action. The specific corrections are also displayed on the PIP Worksheets in Attachment C.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV E. Provider Participation in Quality Improvement Activities						
1. The PIHP requires its providers to actively participate in QI activities.	X					Page 95 of the *Eastpointe Provider Operations Manual*, effective 8/26/2019 states, "Provider agencies with the exclusion of Licensed Independent Practitioners (LIP's) and hospitals, shall develop and implement Quality Improvement Projects (QIPS) per fiscal year. There projects are due annually by July 31st."
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Per the *Eastpointe Provider Operations Manual*, effective 8/26/19 and verified at the Onsite interview, "The Quality Improvement (QI) Department reviews the provider QIPs using a standardized check sheet and provides feedback to the providers. Technical assistance is offered to providers who fail to meet the benchmark. A Plan of Correction (POC) may be requested if score falls below the established benchmark or a provider fails to submit."
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Creating a document that is specifically a written summary, assessment, and evaluation of the QI Program was a Corrective Action item from the last EQR that has been corrected. *Quality Improvement Annual Report FY2019* includes analysis of the quality projects in FY2019 including progress made that year, barriers, interventions, and the strategy for FY2020. Key Performance Indicators, Over/Underutilization, and overall summary of Provider and Enrollee Satisfaction Surveys are also included in the *Quality Improvement Annual Report FY2019.*
2. The annual report of the QI program is submitted to the QI Committee and to the PIHP Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. The Utilization Management (UM) Program						
1. The PIHP formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					Eastpointe has multiple policies that address UM requirements and internal processes.
1.1 structure of the program;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines/standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					UM service decision timeframes are included within policies and procedures and the review of files indicates timely review. In last year's EQR it was recommended that Eastpointe add to *Policy C-3.2.38, Medical Necessity Review First Level*, the steps that staff take when an expedited service authorization request is transitioned to a standard review timeframe. It was also recommended that the process include documentation of when the notification to the provider occurs. Eastpointe implemented this Recommendation.
1.5 consideration of new technology;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.6 The appeal process, including a mechanism for expedited appeal;	X					
1.7 The absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					As required by *NC Medicaid Contract, Section 7.4.12*, Eastpointe's *Policy CC-1.4, Financial Incentives,* is in place that provides direction to UM staff and contractors regarding the acceptance of any incentives for the denial of services. This direction is also outlined in the *UM Plan/Program Description*. However, a review of UM Policies found no reference to *Policy CC-1.4 Financial Incentives*. Further support of this practice needs to be referenced in UM policies to ensure compliance by UM staff. ***Recommendation: Reference Policy CC-1.4, Financial Incentives, in Policy C-3.2.38, Medical Necessity First Level, and C-3.2.39, Medical Necessity Second Level.***
1.8 Mechanisms to detect underutilization and overutilization of services.	X					In the previous year's EQR, it was recommended that Eastpointe add to *Policy C-3.2.42 Over/Under Utilization Management*, information about the process of detecting over/under utilized services. Eastpointe implemented the Recommendation and updated the policy, but provided few details about the process of detecting over and utilized services. Further, It was found that the *UM Program Description* identified four services, such as Intensive In-Home Services that were over utilized, and targeted for intervention. However, a review of the Over/Under Committee Minutes found that Intensive In-Home Services was listed as underutilized, contradicting the *UM Program Description*. During the Onsite interview, staff explained in detail the process used to identify services that were underutilized and overutilized. It

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						was clarified that the service utilization is reviewed in the Over/Under Committee and that, based on billing reports, utilization of these services can change monthly. Staff also acknowledged that identifying specific services in the *UM Plan/Program Description* would be inefficient based on this fluctuation. CCME noted that detailing the process of identifying these services in the *UM Program Description* would better align with the Eastpointe policies, and would provide a detailed guide in how Eastpointe addresses services that are underutilized and overutilized. ***Recommendation: Revise the UM Plan/Program Description to include the process used to identify and intervene upon services that are underutilized and overutilized.***
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The *UM Organizational Chart*, *UM Plan/Program Description* and UM policies indicate that the Medical Director (MD) has significant oversight of the UM program. Oversight includes chairing multiple committees that involves Eastpointe's clinical decision support tools, development and training of staff and providers on clinical practice guidelines, identification of barriers to admission discharge and dispositions, and oversight of clinical decision making.
3. The UM program design is reevaluated annually, including Provider input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The *UM Plan/ Program Description* is reviewed at least annually.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Last year, it was recommended that Eastpointe update *Policy C-3.2.37, Clinical Decision Support Tool,* to include the requirement that providers use the Child and Adolescent Needs and Strengths (CANS) assessment for children ages 3 to 6 years. This Recommendation was implemented. Eastpointe also provided training to staff and network providers on the Child and Adolescent Needs and Strengths (CANS) assessment. The results of the training produced multiple Eastpointe staff and provider staff gaining certification as a CANS assessor. During the review of UM files, it was evident that decisions were made based on pre-determined standard/criteria set forth in Clinical Coverage Policies.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
4. Utilization management standards/criteria are consistently applied to all enrollees across all reviewers.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. Emergency and post stabilization care is provided in a manner consistent with contract and federal regulations.	X					
6. Utilization management standards/criteria are available for Providers.	X					
7. Utilization management decisions are made by appropriately trained reviewers	X					
8. Initial utilization decisions are made promptly after all necessary information is received	X					All UM approval decisions showed notification was provided to providers within the required timeframes.
9. Denials						
9.1 A reasonable effort that is not burdensome on the enrollee or the provider is made to obtain all pertinent information prior to making the decisions to deny services.	X					In 12 of the service authorization decision files reviewed, there was no evidence of UM staff attempting to obtain additional information from the provider prior to rendering a denial decision. Eastpointe clarified during the Onsite that all communications with the provider may not be in the AlphaMCS provider communication portal. UM staff may have documented additional contacts on a "Communication Log", which was not provided for the review. ***Recommendation: Ensure all communications with providers, including attempts to obtain additional service authorization information, are captured within the complete UM service authorization record and submitted for any review or audit.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					All UM denials reviewed for this EQR showed decisions were made by appropriate clinicians.
9.3 Denial decisions are promptly communicated to the provider and enrollee and include the basis for the denials of service and the procedure for appeal	X					All UM denials reviewed for this EQR showed decisions were rendered timely and notification provided within the required timeframes.
V C. Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					
2. The care coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 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					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					The review of MH/SU and I/DD care coordination progress notes showed on-going admission and discharge planning for enrollees admitted to Inpatient and/or crisis facilities.
2.8 Coordinate care with each Enrollee's provider;	X					The record review showed collaboration with providers to coordinate and monitor care for enrollees in MH/SU and I/DD Care Coordination.
2.9 Provide follow-up activities for Enrollees;	X					A review of I/DD and MH/SU Care Coordination files showed a pattern of poor follow up activities. During the Onsite, CCME discussed with staff other ways Care Coordinators could have been more proactive in addressing the barriers to service, client crises, etc. outlined in the progress notes reviewed. Eastpointe's Medical Director acknowledged that Care Coordinators, at times, lack innovation and creativity when finding the best way to ensure enrollees needs are met. Additional support to Care Coordination through clinical staffing would help Care Coordinators take more proactive steps in addressing issues such as, potential enrollee crises, barriers to service access, and imminent health needs. ***Recommendation: Enhance the current, clinical staffing process to ensure staff provide proactive and needed interventions by Care Coordinators.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						There was also evidence within three of the files reviewed that enrollees were discharged from Care Coordination without following the discharge protocols outlined in *Policy C-3.4.12, MHSU Care Coordination Intensity of Need and Discharge Criteria.* One enrollee was discharged from Care Coordination without follow-up with the provider because there was no consent between Eastpointe and the out of network provider. The two other enrollees were discharged based on the enrollee's report of engagement with a provider versus confirmation with the provider that the enrollee was actively participating in treatment. During the Onsite, staff described several initiatives to address this weakness, including the requirement by care coordinators to staff cases with their supervisor prior to moving an enrollee into discharged status. This practice should be included within the discharge policy and would improve the consistency of follow up and discharge activities by MH/SU Care Coordinators. ***Recommendation: Update Policy C-3.4.12, MHSU Care Coordination Intensity of Need and Discharge Criteria, to include the requirement that cases must be staffed with supervisor prior to discharge.***
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The PIHP applies the Care Coordination policies and procedures as formulated.		X				A Corrective Action was issued during last year's EQR for Eastpointe to include in *Policy C-3.6.4, Documentation of Care Coordination Activities*, how the monitoring of the notes occurs and the steps that are taken when late notes or trends of late notes by staff or departments are identified. Eastpointe updates to the policy was accepted. However, there were still concerns noted in this year's EQR related to Care Coordination documentation. For this year's file review of care coordination progress notes, it was found that 11% of I/DD progress notes and 15% of MH/SU progress notes were late. Some were more than 17 months late. This is not in accordance with Eastpointe *Policy C-3.6.4, Documentation of Care Coordination Activities,* that requires care coordinator note to be submitted in the electronic system to ensure that accurate and timely documentation occurs but not to exceed a seven-calendar day time frame from the date of service/contact. The policy also states that when a note is outside the seven calendar-day timeframe, it will be documented as a late entry. This was not always done by the Care Coordinator. While some of the progress notes reviewed contained good detail regarding the intent and outcome of Care Coordination contacts, there were also several notes that lacked enough detail to explain the Care Coordinator's intervention. For example, one note simply stated, "No Contact". Finally, a review of the I/DD HCBS monitoring checklist showed that care coordinators did not always complete it entirely and several checklists that were completed provided little to no detail about the enrollee's current needs. Eastpointe acknowledges the continued need to monitor the timeliness and quality of Care Coordination documentation. Care Coordination does work in collaboration with Eastpointe Quality Management Department to develop monitoring reports of note

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						submission. However, the degree to which those reports were used was unclear. Eastpointe staff also described several initiatives to address this weakness. However, this pattern has been identified in previous EQRs and a formal monitoring plan is needed to address the significant issues with untimely, missing, and/or incomplete documentation by I/DD and MH/SU Care Coordination. ***Corrective Action: Develop a comprehensive monitoring plan that will include a review of all Care Coordination documentation (cases targeted for discharge, progress notes, follow up activities, HCBS monitoring checklists, etc.). The monitoring plan should identify the frequency of monitoring and the scope (i.e., timeliness of documentation, completeness, quality, etc.).***
V. D Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					Eastpointe has multiple policies that address Care Coordination activities, which includes required functions of TCLI staff. TCLI also have policies, independent from Care Coordination, that outline requirements specific to TCLI functions.
2.1 Care Coordination activities occur as required.	X					A review of TCLI files showed a pattern of poor follow up activities. During the Onsite, CCME discussed with staff other ways Care Coordinators could have been more proactive in addressing enrollee crises. Additional support to Care Coordination through clinical staffing would help TCLI Care Coordinators take more proactive steps

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						in addressing issues such as, potential enrollee crises, barriers to service access, and imminent health needs. ***Recommendation: Enhance the current, clinical staffing process to ensure staff provide proactive and needed interventions by TCLI Care Coordinators.***
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					The review revealed that TCLI enrollee are receiving an array of services to support them in the community. TCLI enrollees can engaged in Assertive Community Treatment Team (ACTT), Transition Management Services (TMS), Community Support Team (CST), Peer Support Services (PSS), Individual Support (IS), Substance Abuse Intensive Outpatient Program (SAIOP), Psychosocial Rehabilitation Services (PSR), Supported Employment (SE), and In Reach services. *Policy C-3.7.19* discusses linkages to services including ACTT, TMS, CST, PSS, IS, SAIOP, PSR, SE and In Reach services.
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					
2.5 QOL Surveys are administered timely.	X					Eastpointe *Policy C-3.7.6, Quality of Life Surveys,* and the *NC Medicaid Contract Section 15.4* states that QOL surveys shall be administered prior to the enrollee transitioning out of the facility, eleven (11) months after the enrollee's transition out of the facility; and twenty-four (24) months after the enrollee's transition out of the facility.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The review of TCLI files showed that two out of the 15 files were missing the 11-month QOL survey. It was also found some surveys were not implemented within the required timeframe and had incomplete documentation. During the Onsite review staff acknowledge that at least one QOL survey was missing from the files. By monitoring the timeliness and completion of QOL Surveys, Eastpointe would ensure that TCLI staff are following Eastpointe policy and State requirements. ***Recommendation: Develop a comprehensive monitoring plan that will include a review of Quality of Life Surveys. The monitoring plan should monitor the timeliness of surveys, as well as the completeness and quality of documentation within the surveys.***
3. Transition, diversion and discharge processes are in place for TCLI enrollees 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					*Eastpointe Policy C-3.7.11, Internal Quality Assurance for Transition to TCL*, outlines the requirement of submitting monthly TCLI-related performance measures to the State. For this review, Eastpointe provided monthly dashboards beginning September 2018 through June 2019.
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	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
services for enrollees with limited English proficiency.						
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				A Corrective Action was issued during last year's EQR to ensure there was evidence in TCLI progress notes of discussion, referral, and linkage to B3 services, and when appropriate, including utilization of Supported Employment services. Eastpointe implemented and created a plan that included the retraining of staff on audit tools, monitoring and service linkage. The review of progress notes showed in the 15% of TCLI progress notes were not completed in the 7-day timeframe required in Eastpointe *Policy C-3.6.4, Documentation of Care Coordination Activities*. During the Onsite interview, Eastpointe acknowledges the continued effort to increase the monitoring of note for timeliness. Eastpointe staff also described several initiatives to address this weakness. However, this pattern has been identified in previous EQRs and a formal monitoring plan is needed to address the significant issues with untimely, missing, and/or incomplete documentation by I/DD and MH/SU Care Coordination. ***Corrective Action: Develop a comprehensive monitoring plan that will include a review of all TCLI Care Coordination documentation (In Reach Tools, progress notes, follow up activities, etc.). The monitoring plan should identify the frequency of monitoring and the scope (i.e., timeliness of documentation, completeness, quality, etc.).***

VI. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					*Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaint/Grievance,* is the overarching policy that guides Eastpointe staff through the grievance process.
1.1 Definition of a grievance and who may file a grievance;		X				Based on a Recommendation from last year's EQR, *Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaint/Grievance,* was revised to accurately reflect the correct definition of a grievance. However, who can file a grievance is not consistently stated throughout the policy. The policy references "member/enrollees" and "stakeholders" but does not define stakeholders or note that legal guardians or legally responsible persons (LRPs) can also file a grievance. ***Corrective Action: Revise Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaints/Grievances, to either define stakeholders or clarify that legal guardians and/or legally responsible people can also file a grievance.*** Based on a Recommendation from the previous year's EQR, Eastpointe revised *Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaint/Grievance,* to ensure consistent use of one term, "complaint/grievance". However, the policy is only approximately 75% consistent. There remain approximately 20 references to just "grievances", "complaints", or "concerns". This oversight continues to create a confusing and misleading policy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The *Provider Operations Manual* also confuses these terms. There was also a Recommendation in last year's EQR to revise the manual to ensure consistency but this Recommendation was not implemented by Eastpointe. As a result, there are approximately 150 references to the grievance process but the manual uses the term "grievance" approximately 75% of the time, "complaint" 15% of the time, and "concern" approximately 8% of the time. It was also recommended in last year's EQR to similarly revise the *Enrollee/Member and Family Handbook*. This Recommendation was addressed by Eastpointe and, as a result, the handbook uses the term "complaint/grievance" 96% of the time. There are only four references to the stand alone term "grievances". ***Corrective Action: Revise Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaints/Grievances, and the Provider Operations Manual to consistently use one term for grievances.***
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				Eastpoint *Policy Q-6.4.4* indicates Eastpointe is required to resolve and provide notice of the grievance outcomes within 30 days of the receipt of a grievance. This policy provides the conditions under which Eastpointe can extend a grievance resolution time frame. However, the policy does not include the information about the required notifications related to that extension. *NC Medicaid Contract, Attachment M.6,* requires Eastpointe to make reasonable efforts to give the enrollee prompt notice and, within 2 calendar days, give the enrollee written notice of the reason for the decision to extend the time frame. The enrollee

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						must also be informed of their right to file a grievance if she/he disagrees with the extension. *See NC Medicaid Contract, Attachment M.6.* ***Corrective Action:* Add to *Policy Q-6.4.4* that when Eastpointe extends the grievance resolution time frame, Eastpointe must make reasonable efforts to give the enrollee prompt oral notice of the delay and, within two calendar days, give the enrollee written notice of the reason for the decision to extend the time frame and inform the enrollee of the right to file a grievance if she/he disagrees with the decision.**
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					Based on a Recommendation from last year's EQR, Eastpointe revised *Policy Q-6.4.4* to add the steps staff take to address and resolve Quality of Care (QOC) concerns. The policy now states, "If the complaint/concern is a health and safety issue, grievance and appeals staff will immediately (within 1 business day) complete the Quality of Care QOC Form desk referral. Grievances related to health and safety concerns, including medical concerns, are reviewed by a physician as a part of the resolution process and Quality of Care Concern process." However, there was no additional information added to *Policy C-6.4.4* to guide staff through the internal steps of making this referral, documenting the referral, and documenting the outcome of the committee and physician review. ***Recommendations: Describe the internal steps staff take to make referrals to the QOC committee, to document the referral, and to document the outcome of the committee and/or physician review.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					*Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaint/Grievance,* does not specify the time frame for maintenance of grievance logs. **Recommendation: Add to *Policy Q-6.4.4* that grievance logs are maintained for five years, as specified in the *NC Medicaid Contract*, *Attachment M, B.2.***
2. The PIHP applies the grievance policy and procedure as formulated.	X					The 20 grievance files reviewed for this year's EQR showed one grievance was resolved and notification provided 31 days after the grievance was received. This same file showed that the Grievance Acknowledgement letter was also sent outside of the five business day, time frame required by Eastpointe's policy. Another grievance file reviewed showed the resolution time frame was extended and permission from NC Medicaid was granted. However, there was no evidence of efforts by staff to inform the grievant of the extension. *NC Medicaid Contract, Attachment M.6,* requires Eastpointe to make reasonable efforts to give the enrollee prompt notice and, within 2 calendar days, give the enrollee written notice of the reason for the decision to extend the time frame. The enrollee must also be informed of their right to file a grievance if she/he disagrees with the extension. By enhancing their current monitoring of grievances, anomalies seen in these files would be detected and remedied by Eastpointe. ***Recommendation: Enhance monitoring of grievances for timeliness of acknowledgement and resolution notifications. Include in monitoring any grievances where the resolution time frame was extended by Eastpointe, and check that the required oral and written notifications to the grievant occurred and are documented within grievance file.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						While there was some evidence that Quality of Care grievances were elevated to the QOC Committee, the QOC meeting minutes did not reflect the Medical Director's attendance, participation, or feedback in the staffing of the QOC grievances. ***Recommendation: Ensure the QOC meeting minutes reflect the attendance and participation by committee subject matter experts, including any physician, to demonstrate appropriate oversight and review of QOC grievances.***
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Eastpointe's GQIC reviews grievance data quarterly. Included in this data are percentage of grievances resolved timely, and trends of type of grievances. The minutes do not reflect any discussion or any identification of steps Eastpointe can take to address trends. A more robust review and discussion would help Eastpointe better identify important trends and quality improvement opportunities. ***Recommendation: Ensure GQIC minutes reflect discussion of grievance data and trends, and use this discussion to identify potential opportunities for quality improvement.***
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					In the previous year's EQR, Eastpointe received six Corrective Actions and seven Recommendations, primarily targeting inconsistent and incorrect information in their appeals documentation, including *Policy C-3.2.6, Appeal of UM Adverse Benefit Determination, the Provider Operations Manual, and the Enrollee/Member and Family Handbook*. While some revisions were made in the past year, While some revisions were made in the past year, primarily to the *Enrollee/Member and Family Handbook*, consistency is still needed within and across documentation discussing appeals. Specific concerns are outlined in the standards that follow.
1.1 The definition of an appeal and who may file an appeal;		X				Based on a Corrective Action in the previous year's EQR, Eastpointe revised *Policy C-3.2.36, Appeal of UM Adverse Benefit Determination* to state, "The Enrollee, legally responsible person (LRP) or a Provider or other designated personal representative acting on behalf of the Enrollee and with the Enrollee's sign consent, may file a PIHP internal appeal." This definition of who can file an appeal is in line with the definition in the *NC Medicaid Contract, Attachment M, Section G.1* and *42 CFR § 438.402 (b)*. However, the definition does not remain consistent throughout this policy. For example, under the Medicaid Appeals section on page seven of this policy, the definition changes to "The member or LRP must request a Reconsideration Request within 60 calendar days from the date on Eastpointe's notice of adverse benefit determination." This policy needs to be revised to maintain a consistent definition of who can file an appeal and serve as a designee for the enrollee throughout all of the potential steps of the appeal process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Similarly, the *Provider Operations Manual* does not clearly and consistently explain to providers that anyone, with written consent from the enrollee or legal guardian, can file an appeal and serve as the designee for the enrollee throughout the appeal process. This was also a Corrective Action last year for this standard and was not addressed by Eastpointe. The *Enrollee/Member and Family Handbook* was also targeted in the Corrective Action from the previous year's EQR on this matter. Eastpointe revised this document and it now provides clarity to Enrollees and legal guardians about the requirements for selecting a designee. ***Corrective Action: Revise Policy C-3.2.6 and the Provider Operations Manual to consistently explain who can file an appeal and act as a designee for an enrollee. Include in this clarification that a designee, with written permission from the enrollee, can act on behalf of an enrollee throughout the appeal process.***
1.2 The procedure for filing an appeal;	X					*Policy C-3.2.6, Appeal of UM Adverse Benefit Determination,* states that oral reconsideration "must be followed up with a signed reconsideration form within 30 calendar days". This is an arbitrary time frame imposed by Eastpointe that is more restrictive than the 60 days enrollees are allowed to file an appeal, per *42 CFR § 438.402 (d)(2) ii*. It is understood that it is unclear how PIHPs are to handle the multiple time frames governing the submission of appeal requests (i.e., *42 CFR § 438.406 (b)(3)*, *42 CFR § 438.402 (c)(3) ii*, and *42 CFR § 438.402 (b)(2)*. However, guidance from the State's attorney was PIHPs need to develop an internal process that considers the enrollee's best interest when facing these divergent time frames. CCME recommends that Eastpointe, if faced with a choice of deeming an appeal "invalid" or processing a standard, oral appeal without a written appeal request, process the appeal within the required 30 day timeframe.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendations: Revise Policy C-3.2.6, Appeal of UM Adverse Benefit Determination, to ensure enrollees are given 60 days from the mailing date of the Adverse Benefit Determination notification to file a written request. Reflect in the policy that, If an oral request is received and the end of the resolution time frame is nearing, Eastpointe will process the appeal even if the written request has yet to be received by Eastpointe. This process will ensure the appeal is processed with the enrollee's best interest in mind.
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					There was evidence that all appeal reviewers had the appropriate expertise to render decisions and were not involved in previous decision making of the service authorization request.
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	X					*Policy C-3.2.6, Appeal of UM Adverse Benefit Determination,* contains the criteria for expedited appeals, the internal process for accepting or denying expedited appeals, and the internal steps staff take to render a decision and provide notification within 72 hours.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				*Policy C-3.2.6, Appeal of UM Adverse Benefit Determination,* does not clarify the required notifications when Eastpointe extends a standard or expedited appeal. *NC Medicaid Contract, Attachment M, G.6* requires staff, "to make reasonable efforts to give the Enrollee prompt oral notice of the delay" and "within two (2) calendar days give the enrollee written notice of the decision to extend the time frame". This was a Recommendation from last year's EQR. *Policy C-3.2.6, Appeal of UM Adverse Benefit Determination,* does state that enrollees have the right to file a grievance if the enrollee disagrees with the extension to the resolution time frame.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Corrective Action: Clarify in Policy C-3.2.6, Appeal of UM Adverse Benefit Determination, that Eastpointe is required "to make reasonable efforts to give the Enrollee prompt oral notice of the delay" and "within two (2) calendar days give the enrollee written notice of the decision to extend the time frame" when Eastpointe extends the resolution time frame of a standard or expedited appeal.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.		X				The expedited acknowledgement template Eastpointe provided states that Eastpointe has "up to 45 days" to process an expedited appeal. This is incorrect and should be changed to 72 hours, with up to an additional 14 days if the expedited appeal resolution time frame is extended. See *NC Medicaid Contract, Attachment M, H.5* and *H.G.* ***Corrective Actions: Revise the Expedited Appeal Acknowledgement letter to accurately inform appellants that their appeal will be processed within 72 hours, with up to an additional 14 days if the expedited appeal resolution time frame is extended.*** Eastpointe's Invalid Appeal notification is misleading. The first page of this notification explains how the appeal will be processed and then a short statement on the second page explains that the appeal will not be processed. ***Corrective Action: Revise the Invalid Appeal notification to clearly and consistently reflect that the appellant's appeal will not be processed.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The Appeal Extension notification template does not inform the appellant of the right to file a grievance if they disagree with Eastpointe's extension to the appeal resolution time frame. See *NC Medicaid Contract, Attachment M, G.6 ii.* ***Corrective Action: Revise the Appeal Extension notification to inform the appellant of their right to file a grievance if they disagree with Eastpointe's decision to extend the appeal resolution time frame.*** The *Provider Operations Manual* erroneously says the time frame to resolve an expedited appeal is three days (pg. 85) and the time frame to file an appeal is 30 days. The incorrect time frame of 30 days is listed three times on pg. 81. Expedited appeals are required to be resolved and notice provided within 72 hours of the receipt of the appeal, and the time frame for an appellant to file an appeal is 60 days from the mailing date of the Adverse Benefit Determination notification. See *NC Medicaid Contract, Attachment M, G.2* and *H.5*, respectively. *The Enrollee/Member and Family Handbook* states the resolution notification of an expedited appeal will be mailed within 72 hours. However, notification (i.e., by phone) must be attempted within those 72 hours, as well. ***Corrective Action: Correct the Provider Operations Manual and the Enrollee/Member and Family Handbook to clearly and consistently state that an expedited appeal will be resolved in 72 hours and that an appeal can be filed within 60 days of the mailing date of the Adverse Benefit Determination notice.*** These were all Corrective Actions identified in last year's EQR. Materials to resolve these Corrective Actions were submitted and accepted in April of 2019, but were not finalized and implemented as

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						of the date of this year's Onsite. Concern was expressed during the Onsite at the amount of time it takes Eastpointe to revise, finalize, approve, and implement enrollee notifications. ***Recommendation: Ensure that Eastpointe's internal process for reviewing and approving enrollee notifications is a nimble and more timely process.*** Additional revisions are needed to address contradictory, confusing and/or incorrect information in paragraphs in the *Enrollee/Member and Family Handbook* (pg. 46) and the *Provider Operations Manual* (pg. 82). ***Corrective Actions: Ensure the following is correctly documented within the Enrollee/Member and Family Handbook and the Provider Operations Manual:*** • ***If criteria for expediting an appeal are not met and Eastpointe denies the request to expedite, prompt notice will be given to the enrollee.*** • ***Clarify that standard and expedited appeal resolution time frames can be extended for up to 14 days by either the enrollee, their designee, or (if certain conditions occur) by Eastpointe.*** • ***Add "Call our Appeals Department for more information about expedited and extended appeals, the required notifications from Eastpointe, and when an enrollee or their designee can file a grievance against Eastpointe."*** • ***Explain in both the manual and the handbook that the enrollee or designee has the right to examine the appeal record. A written request must be submitted to Eastpointe to obtain this record, and appropriate consents to release the information may be required, depending upon to whom the record will be supplied.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						• ***Ensure the Enrollee/Member and Family Handbook and the Provider Operations Manual do not state that enrollees must submit Eastpointe's Reconsideration Request form to initiate the standard appeal process. Any written request, so long as it contains enough information to show what is being appealed and by whom, can initiate the standard appeal process.***
2. The PIHP applies the appeal policies and procedures as formulated.	X					Within the 21 files reviewed, all but two of the required notifications were provided to enrollees within the required time frames. One file showed the appeal resolution notification was mailed on the 35th day. Staff noted in the file that the appeal was not received by the Appeals Department immediately. and Eastpointe started the appeal resolution time frame based on the date it was received by the Appeals Department. However, the date the appeal resolution time frame begins is when any Eastpointe staff or department receives the appeal. Eastpointe's appeals policy states, "Reconsideration result letter is sent…within 30 calendar days of the receipt of the reconsideration request." ***Recommendation: Clarify in Policy C-3.2.6, Appeal of UM Adverse Benefit Determination, that the date of the receipt of an appeal by any staff or department at Eastpointe begins the 30 day appeal resolution time frame, regardless of the date and time the Appeals Department receives the appeal.*** Staff noted in the other file that no oral notification was provided to the enrollee regarding the expedited appeal resolution. Additionally, staff documentation of oral notifications was typically unclear, in short-hand form and did not indicate to whom oral notifications were provided. Oral notifications of an expedited appeal resolution are required by *NC Medicaid Contract, Attachment M, H.7.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Ensure staff provide all required oral notifications and clearly document in the appeal file the details of the oral notification (recipient, details of conversation, notification type, etc.).
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					While appeals are tallied, categorized, and analyzed for trends then reported to the GQI Committee, invalid and withdrawn appeal numbers are not reviewed for potential quality improvement opportunities. This was a Recommendation from the previous year's EQR. Given Eastpointe rendered a third of the appeals received in this review year as "invalid", analysis and committee review is essential in identifying potential quality issues. ***Recommendation: Include invalid and withdrawn appeals trends in the analysis of appeals to identify any potential quality improvement opportunities.*** The descriptions of the appeal data that is tallied and analyzed by Eastpointe do not align within Eastpointe's *Utilization Management (UM) Plan*, *Policy C-3.2.6, Appeal of UM Adverse Benefit Determination*, and GQIC minutes. ***Recommendation: Determine what appeals data can best indicate potential quality improvement opportunities and ensure the identified data categories are aligned within the Eastpointe's UM Plan, Policy C-3.2.6, Appeal of UM Adverse Benefit Determination, and the data reviewed and discussed in GQIC.***
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.		X				Within the files reviewed, there was no evidence of staff documenting within the appeal record the internal steps taken to protect the enrollee's Protected Health Information (PHI). This was a Recommendation from the previous year's EQR. Eastpointe added to their policy "Medical record request must go through the LME/MCO

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Medical Record Department". However, the Recommendation from last year was to, within the appeal policy, either list out the internal steps staff take to protect the enrollee's PHI, or reference the Eastpointe policy governing the release of medical records, *Policy Q.6.3.5, Release of Medical Records*. Directly referencing this policy within *Policy C-3.2.6, Appeal of UM Adverse Benefit Determination,* would better guide staff through the required steps of record release. This is particularly important as requests for the clinical rationale behind the UM and/or appeal decision are frequently requested from appeal staff, per the files reviewed. Staff also need to thoroughly document within the appeal record all of the steps they take to protect the enrollee's PHI. For example, staff should document who requested the clinical rationale of the appeal decision, referrals to the Medical Records Department, steps taken to confirm guardianship, and any efforts taken to secure releases of information. ***Corrective Action: Reference Policy Q-6.3.5, Release of Medical Records, in the appeals policy to guide staff through the required steps when providing the clinical rationale behind service authorization or appeal decisions.*** ***Corrective Action: Ensure staff clearly document within the appeal record the internal steps taken to protect the enrollee's PHI. For example, document who requested the clinical rationale of the appeal decision, referrals to the Medical Records Department, steps taken to confirm guardianship, and any efforts taken to secure releases of information.***

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. Delegation						
1. The PIHP has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Eastpointe had Delegation Agreements and BAAs with its four delegates during the current EQR review period. Three of those are still in effect.
2. The PIHP conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the PIHP if the PIHP were directly performing the delegated functions.	X					*Policy Q-6.5.2, Oversight of Delegated Functions (revised 1.22.19),* which addresses oversight of delegates, states "Eastpointe's executive team evaluates the results of the annual delegation review to make a determination about the delegate's continued delegation status." Eastpointe receives regular reports and conducts regular oversight of its delegates, including conducting annual assessments.

VIII. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII A. General Requirements						
1. PIHP shall be familiar and comply with Section 1902(a)(68) of the Social Security Act, 42 C.F.R. Parts 438,455 and 1000 through 1008, as applicable, including proper payments to Providers and methods for detection of fraud and abuse.	X					
2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents' and subcontractors,' compliance with the requirements of this Section 14 of the NC Medicaid contract.	X					
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					*Policy CC-3.5, Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*, page 3, and the *Provider Operations Manual* explains that written agreements with providers address PI requirements of the Provider Network.
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					*Policy CC-3.5, Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA),* speaks to how grievances and/or complaints are vetted by Eastpointe to identify potential fraud, waste, or program abuse.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with 42 C.F.R. 438.608 that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the Contract Administrator on an annual basis.	X					The *2019 Corporate Compliance Plan* is designed to guard against fraud and abuse. During the Onsite, the PIHP confirmed that the *Compliance Plan* was submitted to NC Medicaid during the review period, in May 2019.
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of 42 C.F.R. 438.608 and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under NC Medicaid Contract in accordance with 42 CFR 438.608(a)(1)(iv).	X					The *2019 Corporate Compliance Plan* provides guidance regarding the required qualifications of the compliance officer, the compliance committee, and the PI training and education system.

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 *2019 Corporate Compliance Plan* describes the work plan of the special investigations unit.
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					
5. PIHP shall send staff to participate in monthly meetings with Division Program Integrity staff, either telephonically or in person at PIHP's discretion, to review and	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
discuss relevant Program Integrity and/or Regulatory Compliance issues.						
6. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information	X					*Policy CC-3.5, Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA),* discusses staff qualifications and attendance in meetings with NC Medicaid.
7. The Division recognizes that the scope of the PIHP's Regulatory Compliance Committee includes issues beyond those related to Program Integrity. Within seven (7) business days of a request by the Division, PIHP shall also make portions of the PIHP's Regulatory Compliance and Program Integrity minutes relating to Program Integrity issues available for review, but the PIHP may, redact other portions of the minutes not relating to Regulatory Compliance or Program Integrity issues.	X					
8. PIHP's written Compliance Plan shall, at a minimum include:						
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
Act as identified in Section 1902(a)(66) of the Social Security Act;						
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing and development of corrective action initiatives;	X					
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 promptly supplying all data in a uniform format provided by DHB and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by Division as provided in Section 13.2 – Monetary Penalties.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9. In accordance with 42 CFR 436.606(a)(vii), PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under NC Medicaid Contract, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under NC Medicaid Contract; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month. PIHP shall be penalized One Hundred Dollars ($100) for each overpayment that is not specified in an Attachment Y Report within the applicable month. In addition, PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					*Policy CC-1.17 Internal Compliance Auditing and Monitoring*, speaks to internal risk assessment, ongoing monitoring of compliance, and follow-up and corrective action planning in the event of noncompliance.

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					*Policy CC-3.5, Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*, provides an overview of the ways Eastpointe guards against fraud and abuse.
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse;	X					
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	X					*Complaints Tracking Workflow* provides the process for how incoming complaints are tracked and processed. This is also addressed in the *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*, which governs the workflow and contains the policies for recovery of overpayments due to Fraud, Waste, and Abuse.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
permitted to retain some or all of the recoveries of overpayments. This provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.						
10.3 In accordance with Attachment Y – Audits/Self-Audits/Investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an· overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					This standard is addressed in the *2019 Provider Operations Manual*, page 102, which describes the mechanisms by which the provider can report Fraud, Waste and Abuse and notify the PIHP of overpayment within 30 calendar days. Last year, the reviewer made a Recommendation for the PIHP to include on the provider webpage information about how providers can report overpayment and to include the self-audit and the refund check forms. These items are now included on the PIHP's provider-facing webpage.
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					Last year, the PIHP reported that overpayments and collections are tracked in Smartsheet so that staff can receive a trigger in 30 days to check the status of the payment. The Claims-Recoupment Process Flow describes the recoupment process. Additionally, amount recouped from overpayment is reported on Attachment Y, which was provided by the PIHP for the review period. Onsite, the PIHP confirmed that they still use Smartsheet to track overpayments.
10.5 Process for handling self-audits and challenge audits;	X					*Policy CC-3.3 Voluntary Provider Self Audit* and *Policy CC-1.17 Internal Compliance Auditing and Monitoring*, outline the process for handling self-audits and challenge audits.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.6 Process for using data mining to determine leads;	X					*Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*, describes Eastpointe's data mining processes.
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					*Policy E-4.2.1 Local Monitoring*, describes the process by which the PIHP will verify services billed by provided were rendered.
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	X					*Policy B-2.7.24 Provider Paybacks (Fund Recovery)*, addresses Eastpointe's process for obtaining financial information on providers to identify any outstanding financial issues between the provider and any State or Federal agency.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
by PIHP, subject to the 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					*Policy B-2.7.24 Provider Paybacks (Fund Recovery)* and *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)* speak to overpayment and underpayment processes followed by Eastpointe.
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:						Information describing PI reporting requirements was found in Eastpointe's *Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA).* Fifteen (15) of fifteen (15) files reviewed contained the required documentation.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.6 All communications between PIHP and the Provider concerning the conduct at issues, when available.	X					
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					
13.8 Total Sample Amount of Funds Investigated per Service Type.	X					
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 enrollee fraud were provided for the review period. Most of the standards in this section (14) were addressed in Eastpointe's *Policy CC-3.4 Beneficiary Fraud and Abuse*.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	X					
14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;	X					
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and	X					
14.7 The legal and administrative status of the case.	X					
14.8 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					Changes to Eastpointe's contract with NC Medicaid were effective in August of 2018 and included the requirement of reporting to Division Program Integrity "any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers." This reporting requirement also relates to Beneficiary fraud and abuse but was not added to Eastpointe's *Policy CC-3.4 Beneficiary Fraud and Abuse*. ***Recommendation: Add to Policy CC-3.4 Beneficiary Fraud and Abuse the requirement of Eastpointe to report to Division Program Integrity "any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers." See Amendment 4, Attachment B-Scope of Work (SOW), Section 14.2.9 Provider Information to Division Program Integrity for the full list of requirements.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.9 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					Changes to Eastpointe's contract with NC Medicaid were effective in August of 2018 and included the requirement of reporting to Division Program Integrity "Details that relate to the original allegation that PIHP received which triggered the investigation." This reporting requirement also relates to Beneficiary fraud and abuse but was not added to Eastpointe's *Policy CC-3.4 Beneficiary Fraud and Abuse*. ***Recommendation: Add to a fraud, waste or abuse policy the requirement of Eastpointe to report to Division Program Integrity "Details that relate to the original allegation that PIHP received which triggered the investigation." See Amendment 4, Attachment B-Scope of Work (SOW), Section 14.2.9 Provider Information to Division Program Integrity for the full list of requirements.***
14.10 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					Changes to Eastpointe's contract with NC Medicaid were effective in August of 2018 and included the requirement of reporting to Division Program Integrity "the timeframe of the investigation and/or timeframe of the audit, as applicable." This reporting requirement also relates to Beneficiary fraud and abuse but was not added to Eastpointe's *Policy CC-3.4 Beneficiary Fraud and Abuse*. ***Recommendation: Add to a fraud, waste or abuse policy the requirement of Eastpointe to report to Division Program Integrity "the timeframe of the investigation and/or timeframe of the audit, as applicable." Reference Amendment 4, Attachment B-Scope of Work (SOW), Section 14.2.9 Provider Information to Division Program Integrity for the full list of requirements.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.11 Information on Biller/Owner;	X					Changes to Eastpointe's contract with NC Medicaid were effective in August of 2018 and included the requirement of reporting to Division Program Integrity "Information on Biller/Owner." This reporting requirement also relates to Beneficiary fraud and abuse but was not added to Eastpointe's *Policy CC-3.4 Beneficiary Fraud and Abuse*. ***Recommendation: Add to a fraud, waste or abuse policy the requirement of Eastpointe to report to Division Program Integrity "Information on Biller/Owner." See Amendment 4, Attachment B-Scope of Work (SOW), Section 14.2.9 Provider Information to Division Program Integrity for the full list of requirements.***
14.12 Additional Provider Locations that are related to the allegations;	X					Changes to Eastpointe's contract with NC Medicaid were effective in August of 2018 and included the requirement of reporting to Division Program Integrity "additional provider locations that are related to the allegations." This reporting requirement also relates to Beneficiary fraud and abuse but was not added to *Eastpointe's Policy CC-3.4 Beneficiary Fraud and Abuse*. ***Recommendation: Add to a fraud, waste or abuse policy the requirement of Eastpointe to report to Division Program Integrity "additional provider locations that are related to the allegations." See Amendment 4, Attachment B-Scope of Work (SOW), Section 14.2.9 Provider Information to Division Program Integrity for the full list of requirements.***
14.13 Legal and Administrative Status of Case.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
15. PIHP and NC Medicaid shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of State and Federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.	X					*Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)*, indicates Eastpointe's use of PI tools furnished by the state.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
18. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month or the next business day if the 10th day is a non-business day (i.e. weekend or State or PIHP holiday). Section 9.8 Fraud and Abuse Reports. In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to NC Medicaid Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to NC Medicaid Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.	X					*Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)* and the X, Y, and X reports demonstrate Eastpointe's compliance regarding monthly reporting to NC Medicaid.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII C. Provider Payment Suspensions and Overpayments						
1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, NC Medicaid Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If NC Medicaid determines that a full investigation is warranted, NC Medicaid shall make a referral within five (5) business days of such determination to the MFCU/ MID and will suspend payments in accordance with 42 CFR § 455.23. At least monthly, NC Medicaid shall provide written notification to PIHP of the status of each such referral. If MFCU/ MID indicates that suspension will not impact their investigation, NC Medicaid may send a payment suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates that payment suspension will impact the investigation, NC Medicaid shall temporarily withhold the suspension notice and notify PIHP. Suspension of payment actions under this Section 14.3 shall be temporary and shall not continue if either of the following occur: PIHP or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider; or Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.						*Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA)* contained information addressing the EQR standards related to provider payment suspensions and overpayments.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.	X					
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					
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	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
investigation being conducted by NC Medicaid, MFCU/MID or other oversight agency.						
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.	X					*Policy B-2.7.24 Provider Paybacks (Fund Recovery)*, contained information that addressed this standard relating to the detailed steps required by Eastpointe in handling provider payments to NC Medicaid.
7. Recovery Audit Contactors (RACs) for the Medicaid program may audit Providers in the PIHP Network and may work collaboratively with PIHP on identification of overpayments. NC Medicaid shall require RACs to give PIHP prior written notice of such audits and the results of any audits as permitted by law.						

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

IX. FINANCIAL SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IX. Financial						
1. The PIHP has policies and systems in place for submitting and reporting financial data.	X					Eastpointe's *Policy B-2.2.24, Finance Committee*, states the Finance Committee shall review monthly all financial reports required by the *NC Medicaid Contract*. Also, *Policy B-2.2.27, Financial Report Certification,* states the monthly financial reports are prepared by the Director of Budget and Finance.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP has and adheres to a cost allocation plan that meets the requirements of *42 CFR § 433.34*.	X					Eastpointe's *Policy B-2.2.26,* refers to the method of allocating administrative expenses by funding source according to the cost allocation plan. The *DMA Monthly Cost Report* segregates Medicaid funds from state, federal, and local funds. The administrative costs are segregated by general ledger account when incurred and allocated between funding sources on the monthly *DMA Monthly Cost Report*. Eastpointe is still using the same rate as last FY, 88%. ***Recommendation: Update the cost allocation plan calculation on an annual basis and submit to State Medicaid.***
3. PIHP maintains detailed records of the administrative costs and expenses incurred as required by the *NC Medicaid Contract*.	X					The administrative costs are captured by the general ledger in Great Plains and allocated to Medicaid via the monthly *DMA Monthly Cost Report*.
4. Maintains an accounting system in accordance with *42 CFR § 433.32 (a).*	X					Eastpointe uses Great Plains, version 2018, for its accounting system, and AlphaMCS for claims processing.
5. The PIHP follows a record retention policy of retaining records for ten years. (*NC Medicaid Contract, Section 8.3.2* and *Amendment 4, Section 31).*	X					Eastpointe's *Policy B-2.2.26, Accounting by Funding Source*, states that Eastpointe shall follow all record retention requirements, in accordance with *42 CFR § 433.32 (b)(c)(d)*, and *Policy B-2.2.28, Medical Claims Liability,* states that all documentation should be retained for 10 years.
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution in accordance with *NC Medicaid Contract*.	X					Eastpointe's *Policy B-2.2.25, Risk Reserve,* states, "A restricted risk reserve account is established and maintained with a federally guaranteed financial institution licensed to do business in the state of North Carolina." Eastpointe's account is held with PNC Bank.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
7. The required minimum balance of the Risk Reserve Account meets the requirements of the *NC Medicaid Contract*.	X					Eastpointe's *Policy B-2.2.25, Risk Reserve,* states the procedures that Eastpointe follows regarding the Restricted Risk Reserve payment, transfer, reconciliation, interest, possible withdrawals, and property at the end of contract. All staff roles are adequately explained in the policy, and contract and EQR requirements are referenced. CCME recommended last year for Eastpointe to add language to this policy stating the 5-business day requirement after receipt of capitation payment. *Policy B-2.2.25, Risk Reserve,* was revised to accommodate this additional information.
8. All funds received by PIHP are accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as required by the *NC Medicaid Contract*.	X					The general ledger structure of the Great Plains chart of accounts provides adequate separation of Medicaid expenditures from other funding. This is reiterated in *Policy B-2.2.26, Accounting by Funding Source*.
9. The Medical Loss Ratio (MLR) meets the requirements of *42 CFR § 438.8* and the *NC Medicaid Contract*.	X					The MLR calculation process is detailed in *Policy B-2.2.28, Medical Claims Liability*, and referenced in *Policy B-2.2.26, Accounting by Funding Source*.

E. Attachment 5: Encounter Data Validation Report

Eastpointe

Encounter Data Validation Report

performed on behalf of

North Carolina Medicaid

December 11, 2019

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 contracted with HMS to perform encounter data validation for each PIHP. North Carolina Senate Bill 371 requires that each PIHP submit encounter data "for payments made to providers for Medicaid and State-funded mental health, intellectual and developmental disabilities, and substance abuse disorder services. NC Medicaid may use encounter data for purposes including, but not limited to, setting PIHP capitation rates, measuring the quality of services managed by PIHPs, assuring compliance with State and federal regulations, and for oversight and audit functions."

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

Overview

The scope of our review, guided by the Centers for Medicare & Medicaid Services (CMS) Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid and submitted to NC Medicaid by Eastpointe for the period of January 2018 through December 2018. All claims paid by Eastpointe should be submitted and accepted as a valid encounters to NC Medicaid. Our approach to the review included:

- A review of Eastpointe's response to the Information Systems Capability Assessment (ISCA)
- Analysis of Eastpointe's 2018 encounter data provided as a data extract
- Analysis of Eastpointe's 837 encounter files
- A review of NC Medicaid's encounter data acceptance report

Review of Eastpointe's ISCA response

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

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

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

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

Looking at claims with dates of service in 2018, Eastpointe submitted 2,238,435 unique encounters to the State. To date, 15% of all 2018 encounters submitted have not been corrected and accepted by NC Medicaid which is almost double the denial rate from 2017.

2018	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
Institutional	190,071	146,460	25,459	18,152	10%
Professional	2,048,364	1,573,805	166,435	308,124	15%
Total	2,238,435	1,720,265	191,894	326,276	15%

Eastpointe should be making improvements to their encounter submission process, increasing their acceptance rate and quality of encounter data year over year. The table below reflects the increase in acceptance rate from 2016 to 2017, but then a significant decline in 2018.

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%
2017	2,004,846	1,657,212	179,219	168,415	8%
2018	2,238,435	1,720,265	191,894	326,276	15%

Eastpointe experienced a sizeable increase in encounter denials in 2018 compared to 2017. Upon a close examination of the denials during the Onsite audit, it was discovered that the increase in denials was due to errors in file submissions. More specifically, there were two types of submission errors. First, a large number of duplicate records were submitted in February, March and July of 2018. As encounter data had already been submitted, these duplicate submissions resulted in a significant number of denials. In total, 211,388 denials resulted from multiple transmissions of the same encounter record.

The second type of submission error occurred in August 2018. A total of 49,224 records intended to void and adjust previous encounter submissions were denied due to lack of history records. This submission appears to have been caused by a timing issue where the voids and adjustments were created before all the 835 return files from NCTracks for previous encounter submissions had been posted in Eastpointe's system.
Eastpointe ultimately recognized both issues and took actions in the latter part of 2018 to address them. The low denial rates seen during the last several months of 2018 seem to suggest that the new protocols Eastpointe implemented have been effective in eliminating erroneous submissions.

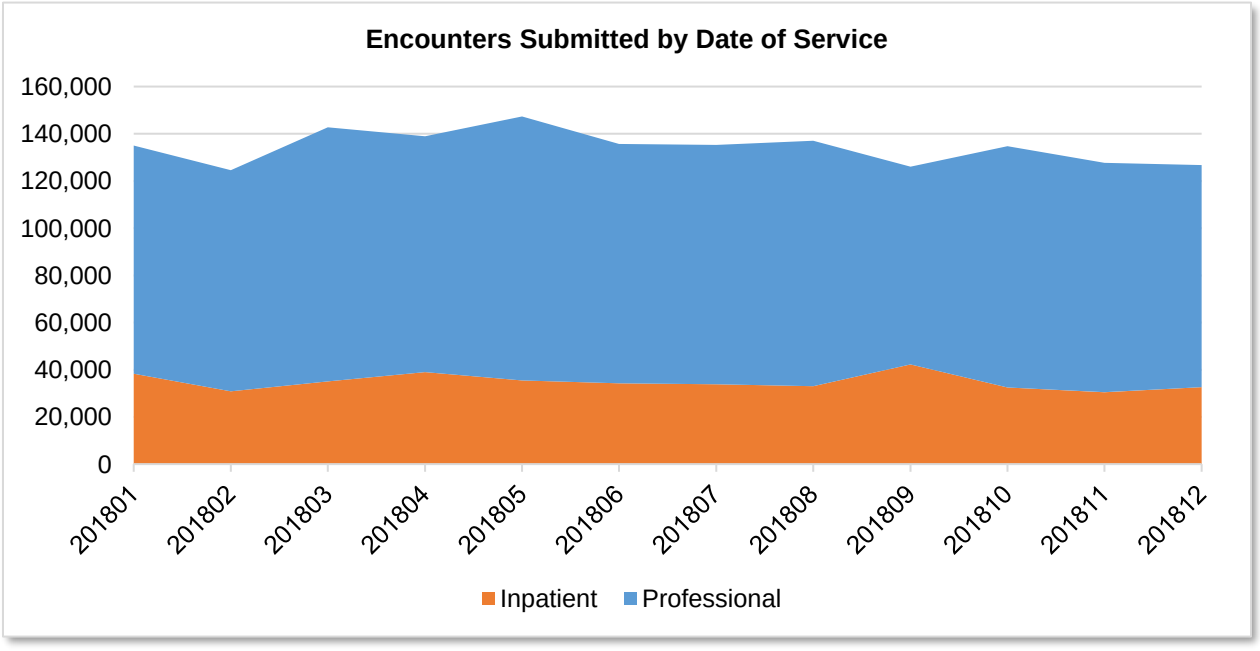
Once we normalized the data to account for the denials related to the issues cited above, we have found that the overall denial rate for the remaining population was 7%, which represents a slight improvement over the previous year.

Eastpointe's Claims Department is responsible for investigating all denied encounters. Thanks to a quality improvement project in 2017, Eastpointe has identified all interventions and barriers that are associated with encounter reporting. The Claims Department utilizes the Encounter Summary by MCO Check write and an encounter denial detail report issued by the State, as well as numerous other parameters for all encounters that are denied. All encounter claims receive one denial code; however, the remark codes have to be used to narrow down to the true denial reason. The PIHP 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 out to appropriate staff to fix the issues based on the denial error that occurs. Enrollment issues or eligibility issues are assigned over to the Medical Records Department. Provider related issues are assigned to a full-time FTE in the Contracts Department that was hired for this responsibility. Once issues have been updated the Claims FTE 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, 2018 and December 31, 2018. Eastpointe pulled all claims adjudicated and submitted to NC Medicaid during 2018 and sent to HMS via Secure File Transfer Protocol (SFTP). This included more than one million Professional claims and just over four hundred thousand Institutional claims. Some may have been resubmissions for denials or adjustments, however, there was not an easy way to identify a subsequent adjustment looking at the data elements provided.



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

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

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

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	Expectation	Validity Criteria
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% non-missing and valid on physician or other applicable provider type claims (e.g., other practitioners)
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid codes (using International Statistical Classifications of Diseases, Ninth Revision, Clinical Modification [ICD-9-CM] lookup tables) for practitioner providers (not including transportation, lab, and other ancillary providers)
Other Diagnosis	This is not expected to be coded on all claims even with applicable provider types, but should be coded with a fairly high frequency.	90% valid when present
Dates of Service	Dates should be evenly distributed across time.	If looking at a full year of data, 5%–7% of the records should be distributed across each month.
Unit of Service (Quantity)	The number should be routinely coded.	98% nonzero <70% should have one if Current Procedural Terminology (CPT) code is in 99200–99215 or 99241–99291 range.
Procedure Code	Critical Data Element	99% present (not zero, blank, or 8- or 9-filled). 100% should be valid, State-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.
Procedure Code Modifier	Important to separate out surgical procedures/ anesthesia/assistant surgeon, not applicable for all procedure codes.	> 20% non-missing. Expect a variety of modifiers both numeric (CPT) and Alpha (Healthcare Common Procedure Coding System [HCPCS]).
Patient Discharge Status Code (Hospital)	Should be valid codes for inpatient claims, with the most common code being “Discharged to Home.” For outpatient claims, the code can be “not applicable.”	For inpatient claims, expect >90% “Discharged to Home.” Expect 1%–5% for all other values (except “not applicable” or “unknown”).
Revenue Code	If the facility uses a UB04 claim form, this should always be present	100% valid

Encounter Accuracy and Completeness

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

Table: Evaluation of Key Fields

Required Field	Information Present?		Correct type of information?		Correct size of information?		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%
Recipient Name	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%
Recipient Date of Birth	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%
MCO/PIHP ID	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%
Provider ID	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%
Attending/Rendering Provider ID	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%
Provider Location	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%
Place of Service	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%
Specialty Code / Taxonomy - Billing	1,611,741	99.99%	1,611,741	99.99%	1,611,741	99.99%	1,611,741	99.99%
Specialty Code / Taxonomy - Rendering / Attending	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%
Principal Diagnosis	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%
Other Diagnosis	397,535	24.66%	397,535	24.66%	397,535	24.66%	397,535	24.66%
Dates of Service	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%
Unit of Service (Quantity)	1,611,878	100.00%	1,611,878	100.00%	1,611,878	100.00%	1,611,515	99.98%

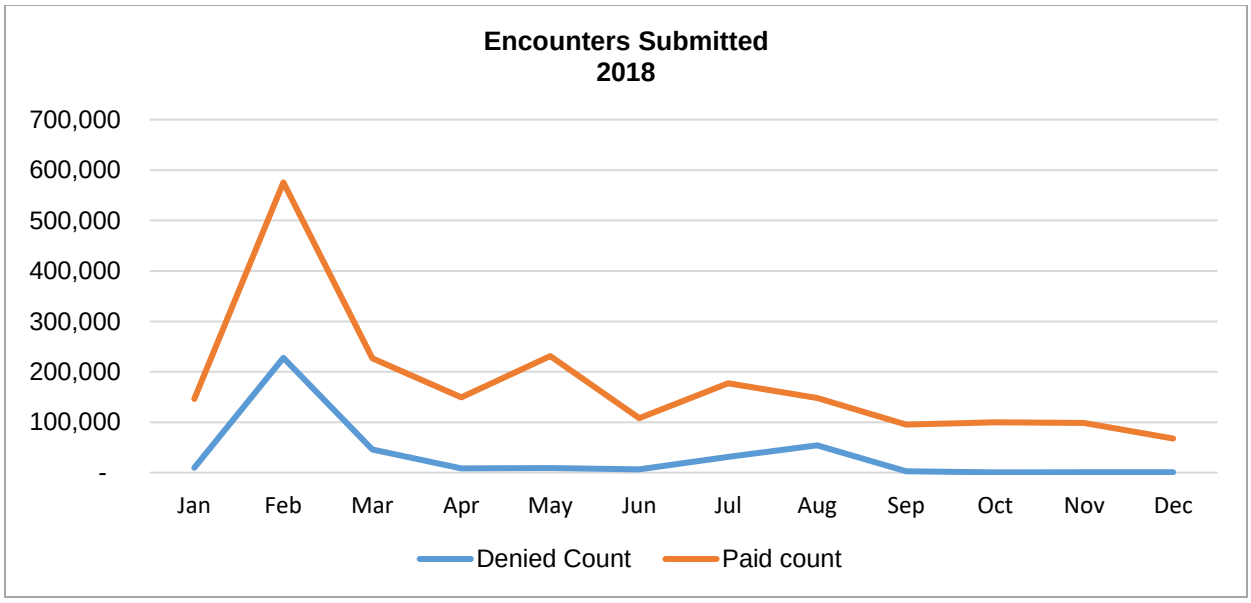
Procedure Code	1,611,878	100.00%	1,611,878	100.00%	1,355,873	84.12%	1,355,873	84.12%
Procedure Code Modifier	453,576	28.14%	453,576	28.14%	453,576	28.14%	453,576	28.14%
Patient Discharge Status Code Inpatient	415,881	99.54%	415,881	99.54%	415,881	99.54%	412,892	98.83%
Revenue Code	417,793	100.00%	417,793	100.00%	417,793	100.00%	417,793	100.00%

Overall, there were very few 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%) with issues identified with procedure code. Eastpointe is allowing and reporting claims without a valid procedure code. A small issue was identified with the discharge status codes submitted. Providers and/or the PIHP are using non-standard values; however, the issue does not exceed the error threshold, so it is not reported as an error in the summary below. Eastpointe did correct the number of diagnosis codes submitted to NC Medicaid and the consistency of the secondary diagnosis. Last year, Eastpointe did not provide any secondary diagnosis code values. 2018 claims included up to 12 diagnosis codes and the secondary diagnosis was populated over 58% of the time.

Professional encounter claims submitted contained complete and valid data in 14 of the 15 key Professional fields (93%). The primary issue is the consistency of other diagnosis codes provided. The principal diagnosis code was populated 100% of the time, however, there was very little consistency in additional diagnosis codes being present. Other Diagnosis codes should be populated more than 10% of the time. One correction from our review in 2018 that was noted is that Eastpointe is submitting up to 12 diagnosis codes for Professional claims. In the previous reviews, the PIHP was only submitting a principal and secondary diagnosis.

Encounter Acceptance Report

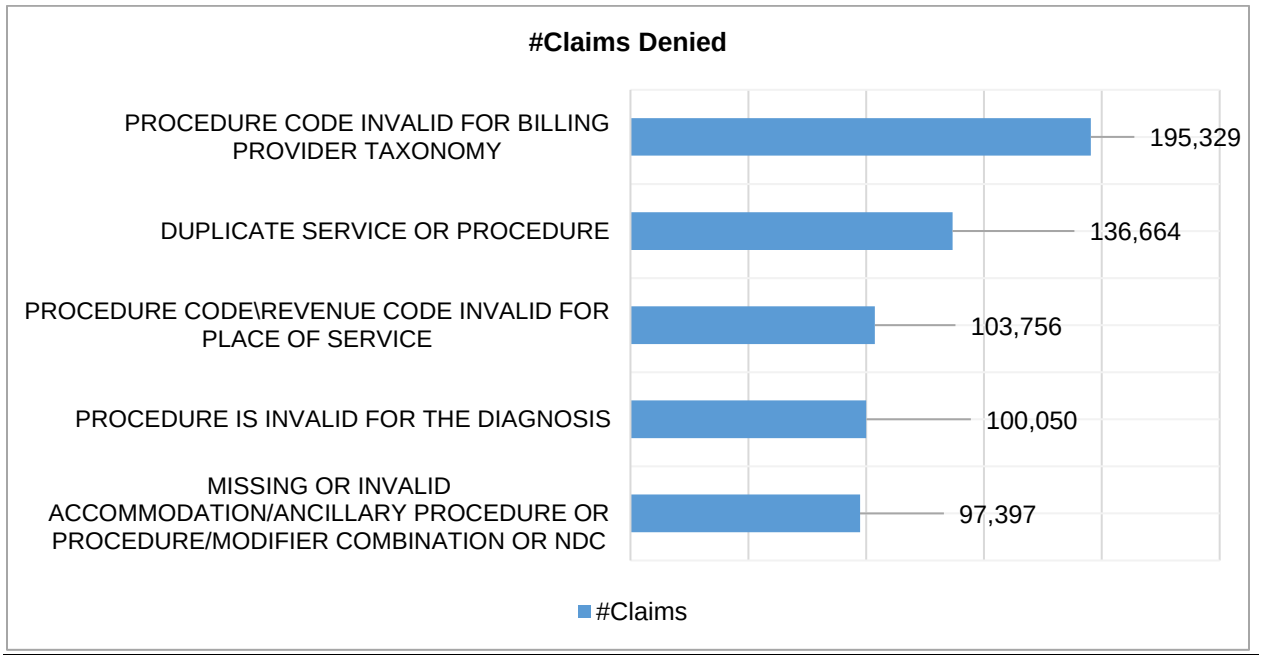
In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write and excludes duplicates or resubmission which made it difficult to tie back to the ISCA response and converted encounter files. Data provided by PIHP's reports for our review includes all submission and resubmissions during 2018 which may include older dates of service. During the 2018 weekly check write schedule, Eastpointe submitted a total of 2,123,434 encounters to NC Medicaid. On average, 19% of all encounters submitted were initially denied, which is up from 11% for 2017 submissions. The increase was a result of duplicate file submissions described in the ISCA section above.



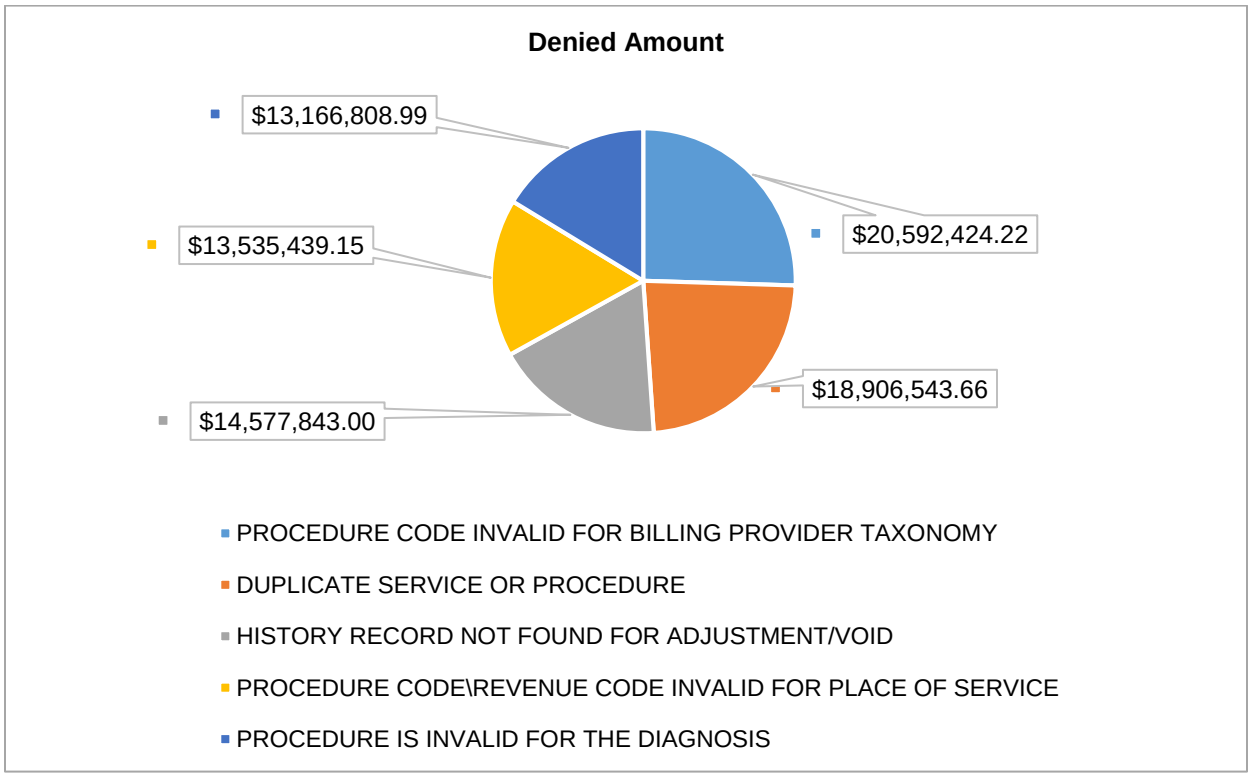
Evaluation of the top denials for Eastpointe encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis an ISCA review above. Encounters were denied primarily for:

- Procedure code invalid for billing provider taxonomy
- Duplicate service or procedure
- Procedure Code/Revenue Code invalid for Place of Service
- Procedure is invalid for the diagnosis
- Missing or invalid accommodation/ancillary procedure or procedure/modifier

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



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



Results and Recommendations

Issue: Procedure Code

The procedure code for Institutional claims should be populated 99% of the time. In the encounter data provided, 61% of the claims were populated with a revenue code instead of a valid procedure code. 6% of the Institutional claims missing a valid procedure code, require one based on the revenue code provided on the claim.

Resolution:

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

Issue: Other Diagnosis

Principal and admitting diagnosis was populated consistently where appropriate, however, additional diagnosis codes were not populated consistently Professional claims. This issue was present in the 2017 review. The Professional claims contained up to twelve diagnosis codes which is an improvement from the 2017 review in which only the principal and secondary diagnosis was provided. However, additional diagnosis codes were only populated 10% of the time, which is considerably low, especially in comparison to the consistency of the data in the Institutional claims which was 58%.

Resolution:

Eastpointe should educate providers and validate their 837 encounter mapping to ensure that providers are reporting all applicable diagnosis codes and the PIHP is reporting them.

Conclusion

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

One issue noted related to the consistency of diagnosis codes being reported to NC Medicaid for Professional claims. Although the additional diagnosis codes do not impact adjudication, the codes are key for reporting, evaluating member health, and factors that will be used in a value based payment model. Eastpointe should review and revise their 837 mapping immediately. Eastpointe should also take action to ensure they are capturing and reporting valid procedure codes for Institutional claims when required for the reported revenue code.

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

Appendix 1

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
00001	HDR BEG DOS INVLD/ > TCN DATE	DENY
00002	ADMISSION DATE INVALID	DENY
00003	HDR END DOS INVLD/ > TCN DATE	DENY
00006	DISCHARGE DATE INVALID	PAY AND REPORT
00007	TOT DAYS CLM GTR THAN BILL PER	PAY AND REPORT
00023	SICK VISIT BILLED ON HC CLAIM	IGNORE
00030	ADMIT SRC CD INVALID	PAY AND REPORT
00031	VALUE CODE/AMT MISS OR INVLD	PAY AND REPORT
00036	HEALTH CHECK IMMUNIZATION EDIT	IGNORE
00038	MULTI DOS ON HEALTH CHECK CLM	IGNORE
00040	TO DOS INVALID	DENY
00041	INVALID FIRST TREATMENT DATE	IGNORE
00044	REQ DIAG FOR VITROCERT	IGNORE
00051	PATIENT STATUS CODE INVALID	PAY AND REPORT
00055	TOTAL BILLED INVALID	PAY AND REPORT
00062	REVIEW LAB PATHOLOGY	IGNORE
00073	PROC CODE/MOD END-DTE ON FILE	PAY AND REPORT
00076	OCC DTE INVLD FOR SUB OCC CODE	PAY AND REPORT
00097	INCARCERATED - INPAT SVCS ONLY	DENY
00100	LINE FDOS/HDR FDOS INVALID	DENY
00101	LN TDOS BEFORE FDOS	IGNORE
00105	INVLD TOOTH SURF ON RSTR PROC	IGNORE
00106	UNABLE TO DETERMINE MEDICARE	PAY AND REPORT
00117	ONLY ONE DOS ALLOWED/LINE	PAY AND REPORT
00126	TOOTH SURFACE MISSING/INVALID	IGNORE

00127	QUAD CODE MISSING/INVALID	IGNORE
00128	PROC CDE DOESNT MATCH TOOTH #	IGNORE
00132	HCPCS CODE REQ FOR REV CODE	IGNORE
00133	HCPCS CODE REQ BILLING RC 0636	IGNORE
00135	INVL POS INDEP MENT HLTH PROV	PAY AND REPORT
00136	INVLD POS FOR IDTF PROV	PAY AND REPORT
00140	BILL TYPE/ADMIT DATE/FDOS	DENY
00141	MEDICAID DAYS CONFLICT	IGNORE
00142	UNITS NOT EQUAL TO DOS	PAY AND REPORT
00143	REVIEW FOR MEDICAL NECESSITY	IGNORE
00144	FDOS AND TDOS MUST BE THE SAME	IGNORE
00146	PROC INVLD - BILL PROV TAXON	PAY AND REPORT
00148	PROC\REV CODE INVLD FOR POS	PAY AND REPORT
00149	PROC\REV CD INVLD FOR AGE	IGNORE
00150	PROC CODE INVLD FOR RECIP SEX	IGNORE
00151	PROC CD/RATE INVALID FOR DOS	PAY AND REPORT
00152	M/I ACC/ANC PROC CD	PAY AND REPORT
00153	PROC INVLD FOR DIAG	PAY AND REPORT
00154	REIMB RATE NOT ON FILE	PAY AND REPORT
00157	VIS FLD EXAM REQ MED JUST	IGNORE
00158	CPT LAB CODE REQ FOR REV CD	IGNORE
00164	IMMUNIZATION REVIEW	IGNORE
00166	INVALID VISUAL PROC CODE	IGNORE
00174	VACCINE FOR AGE 00-18	IGNORE
00175	CPT CODE REQUIRED FOR RC 0391	IGNORE
00176	MULT LINES SAME PROC, SAME TCN	IGNORE
00177	HCPCS CODE REQ W/ RC 0250	IGNORE

00179	MULT LINES SAME PROC, SAME TCN	IGNORE
00180	INVALID DIAGNOSIS FOR LAB CODE	IGNORE
00184	REV CODE NOT ALLOW OUTPAT CLM	IGNORE
00190	DIAGNOSIS NOT VALID	DENY
00192	DIAG INVALID RECIP AGE	IGNORE
00194	DIAG INVLD FOR RECIP SEX	IGNORE
00202	HEALTH CHECK SHADOW BILLING	IGNORE
00205	SPECIAL ANESTHESIA SERVICE	IGNORE
00217	ADMISSION TYPE CODE INVALID	PAY AND REPORT
00250	RECIP NOT ON ELIG DATABASE	DENY
00252	RECIPIENT NAME/NUMBER MISMATCH	PAY AND REPORT
00253	RECIP DECEASED BEFORE HDR TDOS	DENY
00254	PART ELIG FOR HEADER DOS	PAY AND REPORT
00259	TPL SUSPECT	PAY AND REPORT
00260	M/I RECIPIENT ID NUMBER	DENY
00261	RECIP DECEASED BEFORE TDOS	DENY
00262	RECIP NOT ELIG ON DOS	DENY
00263	PART ELIG FOR LINE DOS	PAY AND REPORT
00267	DOS PRIOR TO RECIP BIRTH	DENY
00295	ENC PRV NOT ENRL TAX	IGNORE
00296	ENC PRV INV FOR DOS	IGNORE
00297	ENC PRV NOT ON FILE	IGNORE
00298	RECIP NOT ENRL W/ THIS ENC PRV	IGNORE
00299	ENCOUNTER HMO ENROLLMENT CHECK	PAY AND REPORT
00300	BILL PROV INVALID/ NOT ON FILE	DENY
00301	ATTEND PROV M/I	PAY AND REPORT
00308	BILLING PROV INVALID FOR DOS	DENY

00313	M/I TYPE BILL	PAY AND REPORT
00320	VENT CARE NO PAY TO PRV TAXON	IGNORE
00322	REND PROV NUM CHECK	IGNORE
00326	REND PROV NUM CHECK	PAY AND REPORT
00328	PEND PER 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