2020 External Quality Review

EASTPOINTE

Submitted: April 9, 2021

Prepared on behalf of the
North Carolina Medicaid

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EXECUTIVE SUMMARY

The *Balanced Budget Act of 1997* requires State Medicaid Agencies that contract with Prepaid Inpatient Health Plans (PIHPs) to evaluate their compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358 (42 CFR § 438.358)*. This review determines the level of performance demonstrated by Eastpointe. This report contains a description of the process and the results of the 2020 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the North Carolina Medicaid (NC Medicaid).

Goals of the review are to:

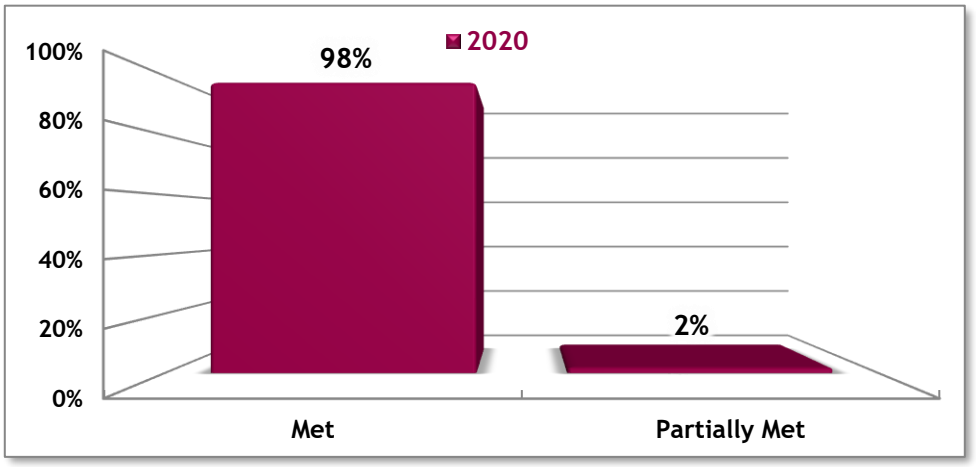
- Determine if the PIHP complies with service delivery as mandated by their *NC Medicaid Contract*
- Provide feedback for potential areas of further improvement
- Verify the delivery and determine the quality of contracted health care services

The process used for the EQR was based on the Centers for Medicare & Medicaid Services (CMS) protocols for EQR of Medicaid Managed Care Organizations (MCOs) and PIHPs. The review includes a Desk Review of documents, an Onsite visit, compliance review, validation of Performance Improvement Projects, validation of Performance Measures, validation of encounter data, an Information System Capabilities Assessment Audit, and Medicaid Program Integrity review of the PIHP. Due to COVID-19 pandemic, all 2020 EQRs was delayed and CCME implemented a focused review.

A. Overall Score

The 2020 Annual EQR reflects that Eastpointe achieved a "Met" score for 98% of the standards reviewed. As Figure 1 indicates, 2% of the standards were scored as "Partially Met". No EQR standards were scored as "Not Met".

Figure 1: 2020 EQR Results



B. Overall Findings

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

Administration

In the 2019 EQR, Eastpointe met 100% of the Administrative standards, which included the 2019 ISCA review. All standards in the 2020 ISCA review were scored as "Met". One Recommendation was issued in the 2020 EQR which aimed to reduce the number of duplicate denied encounters submitted to NCTracks.

Provider Services

In Eastpointe's 2019 EQR, there were three items requiring Corrective Action and three Recommendations in the Credentialing/Recredentialing section of Provider Services. Eastpointe addressed two of the Corrective Action items and all three Recommendations. The Corrective Action item regarding recredentialing within three years still needs to be more fully addressed, and continues as a Recommendation in the current EQR. In every EQR since 2017, Eastpointe has received Corrective Action or a Recommendation regarding recredentialing within three years. During the Onsite review, Eastpointe staff reported a number of actions they have taken to address this issue. In the current EQR, Eastpointe met 100% of the Credentialing/Recredentialing standards of Provider Services.

Quality Improvement

The Quality Improvement section included validation of Performance Measures (PMs) and Performance Improvement Projects (PIPs). The Performance Measure Query was accurate for (b) Waiver Measures. Six (b) Waiver Measures had a substantial rate decline from last year, and two measures had substantial rate increases. All (c) Waiver Performance Measures were above benchmark rates. The seven validated PIPs all scored in the High Confidence range, although three PIPs have Recommendations for improvement. That is an improvement over the 2019 EQR where six PIPs scored High Confidence and one PIP scored in the Confidence range. In this 2020 EQR, 100% of the QI standards were met.

Utilization Management

Eastpointe met 96% of the Utilization Management (UM) standards in the 2019 EQR. CCME issued two Corrective Actions and four Recommendations. Both Corrective Action items and one Recommendation aimed at developing a comprehensive monitoring plan that would review of all Intellectual/Developmental Disabilities (I/DD), Mental Health/Substance Use Disorders (MH/SUD), and Transition to Community Living Initiative

(TCLI) Care Coordination documentation. It was recommended in Care Coordination and TCLI to enhance the current clinical staffing processes to ensure staff provide more proactive and needed interventions. The final Recommendation was to update Policy C-3.4.12 MHSU Care Coordination Intensity of Need and Discharge Criteria. Eastpointe implemented all Recommendations and one Corrective Action.

In the 2020 EQR, Eastpointe met 96% of UM standards. CCME issued one Corrective Action and three Recommendations. The review of Care Coordination enrollee files found incomplete I/DD progress notes, inaccurate Monitoring Checklist and monthly monitoring that did not comply with *NC Medicaid Contract, Amendment 9, section 9*. Additionally, Individual Support Plans (ISP) goals did not replicate needs identified through I/DD assessments, and ISP crisis plans provided minimal supporting information to staff during periods of escalation. A Corrective Action was issued to revise the current monitoring plan to include a more comprehensive quality review of all I/DD progress notes and documentation.

The review of the Care Coordination program resulted in three Recommendations. Recommendations aimed at ensuring exemptions for waiver cost limits were identified and clarifying information regarding the qualifications for Children with complex needs.

Grievances and Appeals

Eastpointe met 75% of the Grievance and Appeal standards in the 2019 EQR and 12 Corrective Actions and 11 Recommendations were issued to address concerns primarily noted within the Grievance and Appeal policies, the *Provider Operations Manual*, the *Enrollee/Member and Family Handbook*, and the Grievance and Appeal files. Eastpointe attempted to address all Grievances and Appeals Corrective Actions and Recommendations from the 2019 EQR, but missed adding some required information into the Grievance policy and some recommended language to the *Provider Operations Manual*.

In the 2020 EQR. Eastpointe met 90% of the Appeal and Grievance standards. CCME issued two Corrective Actions in Grievances and one Recommendation in Appeals. The Corrective Actions required revision of the Grievance policy to include the requirement of notifying enrollees of their right to file a Grievance when Eastpointe extends the Grievance resolution timeframe. The other Corrective Action addressed the finding that four of the ten Grievance files reviewed showed Eastpointe did not resolve nor provide notice of Grievance resolution well outside of the 90 days required by *42 CFR § 438.408 (b)1*. These Grievances were also not resolved withing the 30 days required by Eastpointe's Grievance policy. The Recommendation issued in Appeals targeted the *Provider Operations Manual* and the requirement of Eastpointe to notify enrollees of their right to file a Grievance if Eastpointe extends the Appeal resolution timeframe.

Program Integrity

In the 2019 EQR, Eastpointe met all of the Program Integrity (PI) standards and received had one Recommendation. This Recommendation related to developing a policy specific to enrollee fraud, waste, and abuse. Eastpointe addressed this Recommendation and submitted a new enrollee fraud, waste, and abuse policy as part of the 2020 EQR Desk Materials.

In the 2020 EQR, Eastpointe again met 100% of the Program Integrity (PI) standards. As evidenced by the 2020 PI file review, Eastpointe makes use of data mining and collaborates with IBM to detect and investigate potential cases of fraud, waste, and abuse. Eastpointe's PI Department continued to work throughout the COVID-19 to resolve PI issues and further investigations as much as they could. Additionally, Eastpointe continues to foster relationships with other MCOs/PIHPs and collaborate and develop strategies to prevent fraud, waste, and abuse.

Encounter Data Validation

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

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

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

METHODOLOGY

The process used for the EQR was based on the CMS protocols for EQR of MCOs and PIHPs. This review focused on the three federally mandated EQR activities: compliance determination, validation of Performance Measures, validation of Performance Improvement Projects, as well as optional activity in the area of Encounter Data Validation, conducted by CCME's subcontractor HMS. Additionally, as required by CCME's contract with NC Medicaid, an ISCA Audit and Medicaid Program Integrity (PI) review of the Eastpointe was conducted by CCME's subcontractor, IPRO.

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

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

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

The review consisted of two segments. The first was a Desk Review of materials and documents received on November 23, 2020 and reviewed by CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. The Desk Review included a review of Credentialing, Grievance, Program Integrity, Care Coordination, and Appeal files.

The second segment of the EQR is typically a two-day, Onsite review conducted at the PIHP's offices. However, due to COVID-19, this Onsite was conducted through a teleconference platform on March 8, 2021. This Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's Onsite activities included:

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

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

FINDINGS

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

A. Information Systems Capabilities Assessment (ISCA)

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

Eastpointe, like many other PIHPs in North Carolina, uses the AlphaMCS transactional, a hosted system environment produced by WellSky. The AlphaMCS system is used to process member enrollment, claims, submit encounters and generate reports. WellSky modifies the user interface and conducts backend programming updates to the system.

The ISCA tool and supporting documentation for enrollment systems loading processes clearly define the process for enrollment data updates in the AlphaMCS enrollment system. During the ISCA Onsite, Eastpointe provided a demonstration of the AlphaMCS enrollment system, which maintains a member's enrollment history. The Global Eligibility File (GEF) file is imported daily into the AlphaMCS by WellSky.

During the ISCA Onsite, Eastpointe stated they also load the GEF files to a local SQL database that is used to compare the records with AlphaMCS. Eastpointe confirmed they rarely encounter errors while comparing the local database with AlphaMCS.

Eastpointe stores the Medicaid identification number received on the GEF. During the Onsite, Eastpointe indicated that they rarely see members with multiple IDs but are able to research and merge the information into one Member ID. The historical claims and authorizations for the member are also merged into one Member ID, the new Member ID.

During the Onsite system demonstration, staff displayed the enrollment information that is viewable and captured within AlphaMCS. This system is able to capture demographic data including race, ethnicity and language, and coordination of benefit (COB) information.

Eastpointe has experienced a small decrease in year-end enrollment numbers over the past three years. During the Onsite, Eastpointe stated that the decrease in enrollment has been due to having lost enrollment in two counties, Columbus, and Nash.

Table 1: Enrollment Counts

2017	2018	2019
170,303	155,365	149,586

Eastpointe's claims and authorizations 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. A demonstration of Eastpointe's AlphaMCS claims processing system was performed during the Onsite. Eastpointe receives claims from three methods: 837 electronic file, provider web portal, and paper claims. During the Onsite, Eastpointe stated that they receive claims from out-of-state providers on paper. Table 2 details the percentage of 2019 claims received via the three methods.

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

Source	HIPAA File	Paper	Provider Web Portal
Institutional	15%	.5%	1%
Professional	52%	.5%	31%

During the Onsite, Eastpointe indicated that they auto-adjudicated 98.2% of Institutional claims and 99.5% of Professional claims received in 2019. Eastpointe claims are approved, pended, or denied within 18 days of receipt and paid within 30 days of approval. If a required field is missing from a claim, provider 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 HIPAA 999 response file advising the provider of the claim submission failure. If the claim is submitted, Eastpointe claims processors do not change any information on the claims. Eastpointe conducts monthly and quarterly audits of claims processed, with the goal to audit 3% of all claims monthly.

All Eastpointe claims are processed through AlphaMCS' claims adjudication procedure, without pending. Although, Emergency Department claims and claims with amounts greater than $5,000 are pended for manual review.

For Professional claims, Eastpointe has the ability to receive and store up to 12 ICD-10 Diagnosis codes on both the provider web portal and via HIPAA files. For Institutional claims, Eastpointe has the ability to capture up to 25 ICD-10 Diagnosis codes, ICD-10 Procedure codes, and Diagnosis Related Groups (DRGs), if they are submitted on the claim on both provider web portal and via HIPAA files. Eight years of enrollment and claims history are maintained in the AlphaMCS' data warehouse and reporting system, with ability to recover older historical enrollment and claims data. During the Onsite discussion, Eastpointe indicated the reporting database is backed up on a nightly basis.

Eastpointe has a defined process in place for their encounter data submission for approved claims, with 837 files submitted to NC Medicaid, and 999 and 835 response files received back from NC Medicaid through the NCTracks system with the assistance of its vendor WellSky. Eastpointe has the ability to track claims from the adjudication process to their encounter submissions status. The 835 file from NCTracks is used to review denials. The extraction, submission, and reconciliation of encounter data are fully automated but the correcting of denials and fixing the issues related to incorrect provider information or member eligibility information is conducted manually.

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

Table 3: Volume of 2018 and 2019 Submitted Encounter Data

2019	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	79,387	21,867	3,259	104,513
Professional	1,130,320	36,043	6,292	1,172,655
2018	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	89,048	18,099	4,620	111,767
Professional	1,065,364	85,531	70,625	1,221,520

Eastpointe has an approximate 95% acceptance rate for both Professional and Institutional encounters with dates of service in 2019. During the Onsite, Eastpointe shared the three top denial reason codes for encounters in 2019:

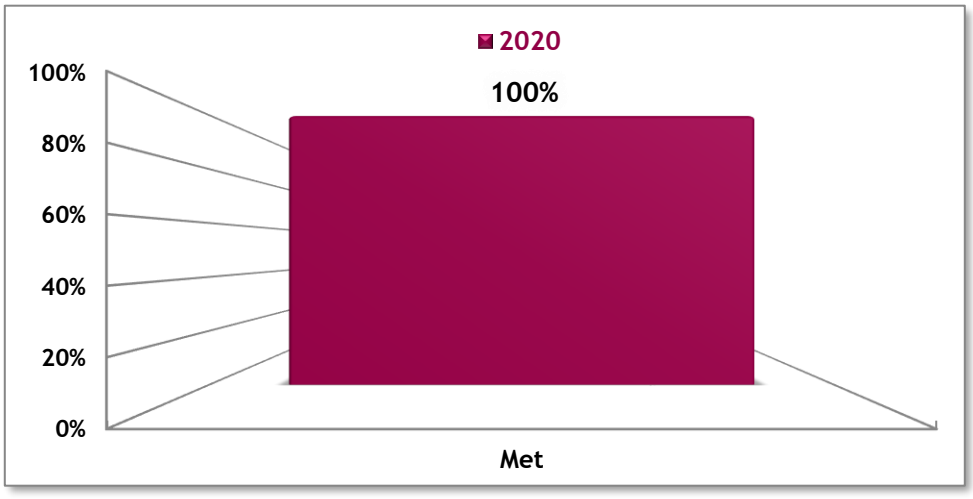
- Duplicate service or procedure
- Taxonomy code for attending or rendering provider missing or invalid
- Less severe duplicate

On average, Eastpointe submits an encounter within an average of five business days from the time of adjudication to NCTracks. It takes Eastpointe approximately 15 business days to correct and resubmit a denied encounter to NCTracks. Eastpointe uses the Adam Holtzman's Encounter Summary by MCO Checkwrite and an encounter denial detail report to identify encounters that were denied. Eastpointe's Claims Department is responsible for reviewing all denied encounters, correcting and resubmitting to NCTracks in a timely matter. Enrollment and eligibility issues are assigned over to Eastpointe's Medical Records Department and Provider related issues are assigned to a full-time dedicated staff in Eastpointe's Contracts Department. Once issues have been updated, the Claims Department's dedicated staff member rebills the claims to NCTRACKs for processing.

Eastpointe advised the number of ICD-10 Diagnosis codes submitted on Institutional and Professional encounters to NC Medicaid. Eastpointe is submitting up to 12 ICD-10 Diagnosis codes for Professional and 24 ICD-10 Diagnosis codes for Institutional encounters. Eastpointe submits any DRG and ICD-10 Procedure codes received from the provider on Institutional encounters to NCTracks.

Figure 2 demonstrates that Eastpointe met all of the standards in the 2020 ISCA EQR.

Figure 2: 2020 ISCA Findings



Strengths

- Eastpointe can capture of up to 25 Diagnosis codes on Institutional claims and 12 Diagnosis codes on Professional claims.
- Eastpointe can capture the DRG and ICD-10 Procedure codes on Institutional claims on the Provider Web Portal and via HIPAA files.
- Eastpointe has the ability to submit all ICD-10 Diagnosis codes, ICD-10 Procedure codes and DRG codes submitted by the provider on the encounter data extracts to NCTracks.
- Eastpointe's current NCTracks encounter data acceptance rate is approximately 95% for the combined Professional and Institutional extracts.

Weaknesses

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

Recommendations

- Continue to work with providers and the State to reduce the number denied duplicate encounters from NCTracks, review the process of submitting the adjusted and voided encounters separately.

B. Provider Services

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

In Eastpointe's 2019 EQR of Credentialing/Recredentialing, there were three items requiring Corrective Action and three Recommendations. Eastpointe addressed two of the Corrective Action items and all three of the Recommendations. The Corrective Action item regarding recredentialing every three years still needs to be more fully addressed, and continues as a Recommendation for the current EQR. During Onsite discussion, Eastpointe staff reported a number of actions they have taken to address the issue of recredentialing outside the three year timeframe required by Eastpointe's *Provider Credentialing Operations Manual/Plan (Credentialing Manual).*

The *Credentialing Manual*, the *Credentialing Committee By-Laws,* and several policies guide the credentialing and recredentialing processes. CCME's review of the credentialing and recredentialing files showed they were organized and contained appropriate information. Some of the language in the *Credentialing Manual* regarding processes appears to be conflicting (e.g., applications go to CAQH and are sent to Medversant , versus applications submitted to the MCO, etc.). Identified issues are detailed in the "Weaknesses" section and the Tabular Spreadsheet of this report.

There is conflicting language in the *Credentialing By-Laws* and the *Credentialing Manual* about the composition of the Credentialing Committee. Both documents list five voting members, but the specific provider representative composition is slightly different between the documents. There are also language differences between the *Credentialing Committee By-Laws* and the *Credentialing Manual* in the position titles of non-voting members. For example, the *Credentialing Committee By-Laws* list the Director of Provider Monitoring and that position is not included on the non-voting member list in the *Credentialing Manual*.

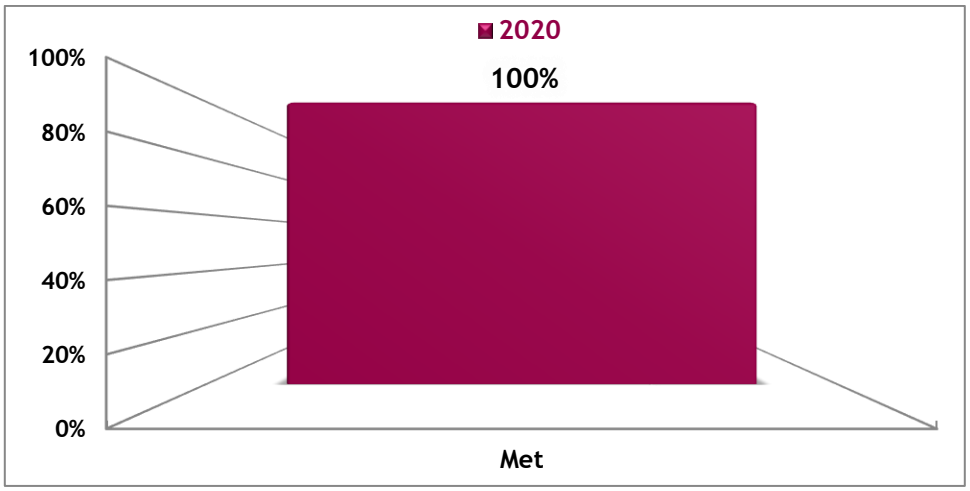
Dr. Venkata Doniparthi, Associate Medical Director (AMD) and a board-certified psychiatrist, chairs the Credentialing Committee. The *Credentialing Manual* states, "The meeting will not occur if the Associate Medical Director is not present at the meeting." During Onsite discussion, Dr. Doniparthi confirmed this is the case, and some committee meetings have had to be rescheduled during the pandemic. The sample of Credentialing Committee meeting minutes reviewed for this EQR indicated a quorum was present. In the event of a tie vote, Dr. Doniparthi breaks the tie.

Orientation materials, including a Provider Orientation Training Webinar, other trainings and events, provider manuals, forms, and other documents are posted on the Eastpointe website. New providers receive a "Welcome" letter, directing them to the materials.

Under the COVID-19 flexibilities as outlined in *NC Medicaid Contract Amendment #9*, the annual *Network Adequacy and Accessibility Analysis* (Gaps Analysis) will be submitted "no later than ninety (90) calendar days after termination of the Amendment." The 2019 Gaps Analysis indicated Eastpointe met all choice and location standards, and no *Exception Requests* were filed. During the Onsite review for this EQR, Eastpointe staff reported they have "submitted some *Exception Requests* around some of the newer requirements regarding MST, Ambulatory Detox, and Facility-Based Crisis Service for Children and Adolescents." Eastpointe increased rates for residential services, enhanced services, and crisis services because of the pandemic.

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

Figure 3: Provider Services Findings



Strengths

- Eastpointe provides a Network Operations Call Center with a dedicated toll-free number to assist providers. Network Operations also has a designated email address.
- Providers have an assigned Network Operations Provider Relations Account Representative, a back-up Account Representative, and a specific assigned Claims staff member. The Utilization Management (UM) Department has staff that answer UM-specific questions.
- Network Operations uses a two-tiered review process in which a Provider Relations Account Representative completes the *Credentialing Checklist* for the application, followed by a review by the Provider Relations Supervisor.

Weaknesses

- An agency was recredentialed after the three years specified in the Eastpointe Credentialing Manual. The agency credentialing expired in December 2018. In July 2020, the Eastpointe AMD granted provisional recredentialing retroactive to December 2018. In November 2020, the Eastpointe AMD approved recredentialing with "effective dates" from July 13, 2020 (the end of provisional recredentialing approved in July 2020) to December 5, 2021, though the Quality Monitoring Review Tool reports a "pending" quality of care concern (monitoring is paused due to COVID-19). None of this was discussed with the Credentialing Committee, despite requirements outlined in the Credentialing Manual.
- There is conflicting language within the Credentialing Manual about process (e.g., applications go to CAQH and are sent to Medversant, versus applications are submitted to the MCO, etc.).

- There is conflicting language between the Credentialing By-Laws and the Credentialing Manual about the composition of the Credentialing Committee, both regarding the position titles of the non-voting members and the specific provider representative composition.

Recommendations

- In order to comply with the Eastpointe *Credentialing Manual*, ensure: providers are recredentialed within three years of the initial credentialing or the most recent recredentialing; the Credentialing Committee is notified when the AMD approves provisional credentialing/recredentialing; and quality of care issues are discussed with the Credentialing Committee.

- Reconcile the language within the *Credentialing Manual* about the process (applications go to CAQH and are sent to Medversant, versus applications are submitted to the MCO, etc.).

- Revise the Credentialing By-Laws, the Credentialing Manual, and any other documents that reference the composition of the Credentialing Committee, to consistently reflect the composition of the Credentialing Committee, reconciling both the composition of the provider representative members and the position titles of the non-voting members.

C. Quality Improvement

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

In the 2019 EQR, there was one PIP that had a Corrective Action and four PIPs that had Recommendations which were addressed in the 2019 Corrective Action Plan (CAP) process. The 2019 EQR validation scores for (b) Waiver and (c) Waiver Performance Measures were fully compliant with an average validation score of 100%.

For the 2020 EQR, nine PIPs were submitted and seven were validated according to the CMS Protocol. During the Onsite, there were two PIPs discussed that are resistant to interventions even with extensive efforts to improve rates. It was recommended to reduce the number of concurrent active PIPs to allow more focused improvement efforts on each individual PIP. All seven PIPs scored in the High Confidence range. The 2020 EQR has no PIP Corrective Action items, although three PIPs have recommendations for improvement.

For the 2020 EQR, Performance Measure Query was accurate for (b) Waiver Measures and all measures were validated at 100%, "Fully Compliant". There was a substantial decline from the last EQR in six (b) Waiver Measures, and two (b) Waiver Measures showed significant improvement over the past EQR. Those measures with improvement and decline were discussed during the Onsite interview. The five (c) Waiver Performance Measures were above benchmark rates and did not require further Onsite discussion. All (c) Waiver Measures were validated at 100% and "Fully Compliant" for this 2020 EQR.

Performance Measure Validation

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

Table 4: (b) Waiver Measures

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

Table 5: (c) Waiver Measures

(c) WAIVER MEASURES
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.
Proportion of beneficiaries reporting they have a choice between providers.

Percentage of level 2 and 3 incidents reported within required timeframes.
Percentage of beneficiaries who received appropriate medication.
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.

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

- Performance measure documentation
- Denominator data quality
- Validity of denominator calculation
- Data collection policies and 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

The measures rates as reported by Eastpointe are included in the tables that follow. The current rate in comparison to the rate at the previous EQR is presented in Tables 6 through 15.

The Follow-up After Hospitalization for Mental Illness showed a substantial improvement for Facility Based Crisis (FBC) population for 7-day and 30-day Follow-up. The rate improved 26.3% for 7-day and 29.2% for 30-day follow-up. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measure showed very steep declines for

2020 when compared to 2018, as 2019 was not submitted due to lag in EQR. The sub-group for this measure, Percent With a 2nd Service or Visit Within 14 Days, has a rate for specific age groups. All age groups showed substantial (>10%) declines. For Ages 13-17, there was a 34% decline; ages 18-20, a 41.2% decline; ages 21-34, a 43.5% decline; ages 35-64, 49.2% decline; ages 65+, a 62.8% decline. The total for all ages 13+ shows a 46.9% decline.

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

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

Note: Decrease in rate is improvement for readmission rates.

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

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

Note: Decrease in rate is improvement for readmission rates.

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

Follow-up after Hospitalization for Mental Illness	2018	2020	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	37.7%	38.6%	0.90%
Percent Received Outpatient Visit Within 30 Days	54.1%	54.6%	0.50%
Facility Based Crisis			

Percent Received Outpatient Visit Within 7 Days	20.0%	46.3%	26.30%
Percent Received Outpatient Visit Within 30 Days	40.0%	69.2%	29.20%
PRTF			
Percent Received Outpatient Visit Within 7 Days	29.3%	22.5%	-6.80%
Percent Received Outpatient Visit Within 30 Days	53.7%	47.5%	-6.20%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	37.4%	38.3%	0.90%
Percent Received Outpatient Visit Within 30 Days	54.0%	54.5%	0.50%

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

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

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2018	2020	Change
Ages 13-17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	53.9%	19.9%	-34.00%

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

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

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

Table 12: D.2. Mental Health Utilization -% of Members that Received at Least 1 Mental Health Service in the Category Indicated during the Measurement Period

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

	Total	18.39%	18.74%	0.35%	1.79%	0.03%	-1.76%	0.02%	0.00%	-0.02%	18.19%	18.74%	0.55%
35-64	Male	19.15%	19.13%	-0.02%	2.06%	0.04%	-2.02%	0.02%	0.00%	-0.02%	18.96%	19.13%	0.17%
	Female	22.50%	21.93%	-0.57%	1.58%	0.03%	-1.55%	0.03%	0.00%	-0.03%	22.07%	21.93%	-0.14%
	Total	21.21%	20.84%	-0.37%	1.77%	0.03%	-1.74%	0.02%	0.00%	-0.02%	20.88%	20.84%	-0.04%
65+	Male	6.33%	5.38%	-0.95%	0.56%	0.00%	-0.56%	0.00%	0.00%	0.00%	6.08%	5.38%	-0.70%
	Female	5.88%	4.97%	-0.91%	0.26%	0.00%	-0.26%	0.01%	0.00%	-0.01%	5.78%	4.97%	-0.81%
	Total	6.02%	5.10%	-0.92%	0.35%	0.00%	-0.35%	0.01%	0.00%	-0.01%	5.88%	5.10%	-0.78%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**Male**	**14.12%**	**13.12%**	**-1.00%**	**1.02%**	**0.05%**	**-0.97%**	**0.32%**	**0.33%**	**0.01%**	**13.92%**	**13.03%**	**-0.89%**
	Female	**13.66%**	**13.07%**	**-0.59%**	**0.87%**	**0.03%**	**-0.84%**	**0.07%**	**0.07%**	**0.00%**	**13.49%**	**13.05%**	**-0.44%**
	Total	**13.86%**	**13.09%**	**-0.77%**	**0.93%**	**0.04%**	**-0.89%**	**0.18%**	**0.18%**	**0.00%**	**13.67%**	**13.04%**	**-0.63%**

Table 13: D.3. Identification of Alcohol and Other Drug Services

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

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

Table 14: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2018	2020	Change	2018	2020	Change	2018	2020	Change	2018	2020	Change
	3-12			13-17			18-20			21-34		
Bladen	0.00%	0.00%	0.00%	0.87%	0.40%	-0.47%	2.37%	1.52%	-0.85%	5.21%	5.87%	0.66%
Columbus	0.02%	0.00%	-0.02%	0.85%	0.30%	-0.55%	1.41%	1.50%	0.09%	5.15%	3.43%	-1.72%
Duplin	0.00%	0.00%	0.00%	0.35%	0.67%	0.32%	0.64%	1.74%	1.10%	2.71%	4.91%	2.20%
Edgecombe	0.02%	0.00%	-0.02%	0.59%	0.47%	-0.12%	1.04%	1.17%	0.13%	4.27%	4.58%	0.31%
Greene	0.00%	0.02%	0.02%	0.23%	0.90%	0.67%	2.08%	2.91%	0.83%	4.67%	6.61%	1.94%
Lenoir	0.05%	0.05%	0.00%	1.43%	1.90%	0.47%	3.36%	4.54%	1.18%	7.76%	12.72%	4.96%
Robeson	0.03%	0.00%	-0.03%	3.30%	0.23%	-3.07%	5.02%	1.15%	-3.87%	11.90%	3.46%	-8.44%
Sampson	0.02%	0.03%	0.01%	0.33%	0.45%	0.12%	0.89%	3.59%	2.70%	2.51%	7.26%	4.75%
Scotland	0.02%	0.03%	0.01%	2.34%	0.83%	-1.51%	3.61%	1.74%	-1.87%	9.45%	4.73%	-4.72%
Wayne	0.01%	0.00%	-0.01%	0.77%	0.69%	-0.08%	2.23%	1.99%	-0.24%	5.00%	6.10%	1.10%
Wilson	0.00%	0.00%	0.00%	1.02%	0.40%	-0.62%	2.52%	1.52%	-1.00%	5.73%	5.87%	0.14%

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		
	2018	2020	Change	2018	2020	Change	2018	2020	Change	2018	2020	Change
	35-64			65+			Unknown			Total		
Bladen	4.16%	4.96%	0.80%	0.50%	0.88%	0.38%	0.00%	0.00%	0.00%	2.02%	2.20%	0.18%
Columbus	3.84%	3.68%	-0.16%	0.63%	0.46%	-0.17%	0.00%	0.00%	0.00%	1.89%	1.21%	-0.68%
Duplin	4.23%	7.36%	3.13%	0.54%	1.80%	1.26%	0.00%	0.00%	0.00%	1.15%	2.79%	1.64%
Edgecombe	5.68%	5.71%	0.03%	1.20%	0.67%	-0.53%	0.00%	0.00%	0.00%	2.17%	1.79%	-0.38%
Greene	5.99%	10.26%	4.27%	0.66%	2.36%	1.70%	0.00%	0.00%	0.00%	1.86%	3.71%	1.85%
Lenoir	9.62%	10.58%	0.96%	1.76%	2.00%	0.24%	0.00%	0.00%	0.00%	3.79%	4.88%	1.09%
Robeson	8.43%	3.10%	-5.33%	1.20%	0.33%	-0.87%	0.00%	0.00%	0.00%	4.52%	1.12%	-3.40%
Sampson	2.44%	6.39%	3.95%	0.32%	0.52%	0.20%	0.00%	0.00%	0.00%	0.89%	2.89%	2.00%
Scotland	6.75%	7.44%	0.69%	1.47%	1.52%	0.05%	0.00%	0.00%	0.00%	3.72%	2.36%	-1.36%
Wayne	7.05%	10.02%	2.97%	0.65%	3.02%	2.37%	0.00%	0.00%	0.00%	2.36%	3.33%	0.97%
Wilson	9.22%	4.96%	-4.26%	2.01%	0.88%	-1.13%	0.00%	0.00%	0.00%	3.14%	2.20%	-0.94%

Table 15: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2018	2020	Change	2018	2020	Change	2018	2020	Change	2018	2020	Change
	3-12			13-17			18-20			21-34		
Bladen	9.08%	6.42%	-2.66%	11.80%	11.62%	-0.18%	8.89%	5.46%	-3.43%	11.02%	12.54%	1.52%
Columbus	11.03%	7.90%	-3.13%	12.34%	12.38%	0.04%	7.46%	9.45%	1.99%	9.75%	13.28%	3.53%
Duplin	7.66%	5.98%	-1.68%	12.07%	11.31%	-0.76%	9.74%	6.33%	-3.41%	14.05%	9.55%	-4.50%
Edgecombe	6.19%	6.29%	0.10%	10.15%	11.60%	1.45%	5.45%	8.50%	3.05%	7.74%	11.76%	4.02%
Greene	6.93%	9.21%	2.28%	13.45%	15.88%	2.43%	6.49%	11.31%	4.82%	11.11%	14.52%	3.41%
Lenoir	12.07%	8.79%	-3.28%	17.65%	12.40%	-5.25%	10.34%	8.77%	-1.57%	14.88%	13.10%	-1.78%
Robeson	9.90%	7.36%	-2.54%	12.55%	10.50%	-2.05%	8.58%	6.88%	-1.70%	13.51%	9.05%	-4.46%
Sampson	7.32%	9.76%	2.44%	10.50%	16.73%	6.23%	7.81%	10.27%	2.46%	10.27%	12.82%	2.55%
Scotland	11.53%	7.18%	-4.35%	15.41%	15.74%	0.33%	7.88%	9.66%	1.78%	12.68%	14.54%	1.86%
Wayne	8.35%	10.79%	2.44%	17.22%	15.47%	-1.75%	9.92%	9.20%	-0.72%	15.01%	14.21%	-0.80%
Wilson	10.19%	6.42%	-3.77%	13.95%	11.62%	-2.33%	8.57%	5.46%	-3.11%	13.15%	12.54%	-0.61%

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		
	2018	2020	Change	2018	2020	Change	2018	2020	Change	2018	2020	Change
	3-12			13-17			18-20			21-34		
	35-64			65+			Unknown			Total		
Bladen	14.34%	14.63%	0.29%	3.39%	5.07%	1.68%	0.00%	0.00%	0.00%	10.27%	9.62%	-0.65%
Columbus	12.44%	19.51%	7.07%	4.89%	7.80%	2.91%	0.00%	0.00%	0.00%	10.35%	11.23%	0.88%
Duplin	21.93%	13.09%	-8.84%	9.38%	4.75%	-4.63%	0.00%	0.00%	0.00%	11.69%	8.74%	-2.95%
Edgecombe	12.37%	16.12%	3.75%	6.66%	6.90%	0.24%	0.00%	0.00%	0.00%	8.29%	9.83%	1.54%
Greene	17.72%	19.82%	2.10%	5.24%	6.33%	1.09%	0.00%	0.00%	0.00%	10.22%	13.00%	2.78%
Lenoir	20.88%	17.21%	-3.67%	6.45%	4.40%	-2.05%	0.00%	0.00%	0.00%	14.43%	11.26%	-3.17%
Robeson	17.29%	11.14%	-6.15%	4.36%	2.96%	-1.40%	0.00%	0.00%	0.00%	11.73%	8.26%	-3.47%
Sampson	12.26%	15.53%	3.27%	5.63%	7.64%	2.01%	0.00%	0.00%	0.00%	8.91%	12.25%	3.34%
Scotland	15.73%	23.14%	7.41%	8.52%	7.85%	-0.67%	0.00%	0.00%	0.00%	12.57%	12.63%	0.06%
Wayne	22.83%	22.45%	-0.38%	11.14%	7.20%	-3.94%	0.00%	0.00%	0.00%	13.64%	13.74%	0.10%
Wilson	19.36%	14.63%	-4.73%	9.65%	5.07%	-4.58%	0.00%	0.00%	0.00%	12.77%	9.62%	-3.15%

(b) Waiver Validation Results

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

Table 16: (b) Waiver Performance Measure Validation Scores

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

(c) Waiver Measures Reported Results

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

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

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	1080/1081 = 99.91%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	1079/1081 = 99.81%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	33/34 = 97.06%	85%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	245/245 = 100%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	8/8 = 100%	85%

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

(c) Waiver Validation

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

Table 18: C Waiver Performance Measures Validation Scores

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

Performance Improvement Project (PIP) Validation

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

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

PIP Validation Results

Eastpointe submitted nine projects for this 2020 EQR. The seven projects in *Table 19, PIP Summary of Validation Scores*, were validated. This table provides an overview and comparison of the 2019 and 2020 EQR validation scores.

Table 19: PIP Summary of Validation Scores

Project Type	Project	2019 Validation Score	2020 Validation Score
Clinical	Increase number of individuals in the priority population served by a fidelity provider to 50% monthly	95/95 = 100% High Confidence in Reported Results	Not validated
	Increase percentage of members who received a face-to-face service within 48 hours to 70%	83/85 = 98% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
	Decrease state psychiatric hospital 30-day readmissions for high-risk members	84/85 = 99% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
	Increase the percentage of individuals who receive a 2nd service within or less than 14 days	85/90 = 94% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results
	Decrease Emergency Department admissions for active members to 20%	90/91 = 99% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results
	Decrease percentage of members who separate from transition to community living housing to 20% or less annually	42/47 = 89% Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results
Non-Clinical	Increase approval rate of Medicaid Encounter Claims to 95%	95/95 = 100% High Confidence in Reported Results	84/84 = 100% High Confidence in Reported Results
	Increase Follow up after discharge appointments to 40%	Not submitted or validated	79/79 = 100% High Confidence in Reported Results

All 2020 EQR validated PIPs received a validation score within the High Confidence range and met the validation requirements. Six of the seven PIPs validated for the 2020 EQR were also validated in the 2019 EQR. Six out of seven PIPs scored in the High Confidence range and one PIP scored in the Confidence scoring range in the 2019 EQR. A Corrective Action was issued for that PIP regarding the benchmark rate, and it was resolved during the CAP process after the 2019 review. The ISP Supported Employment PIP was validated in 2019, but was not validated this year.

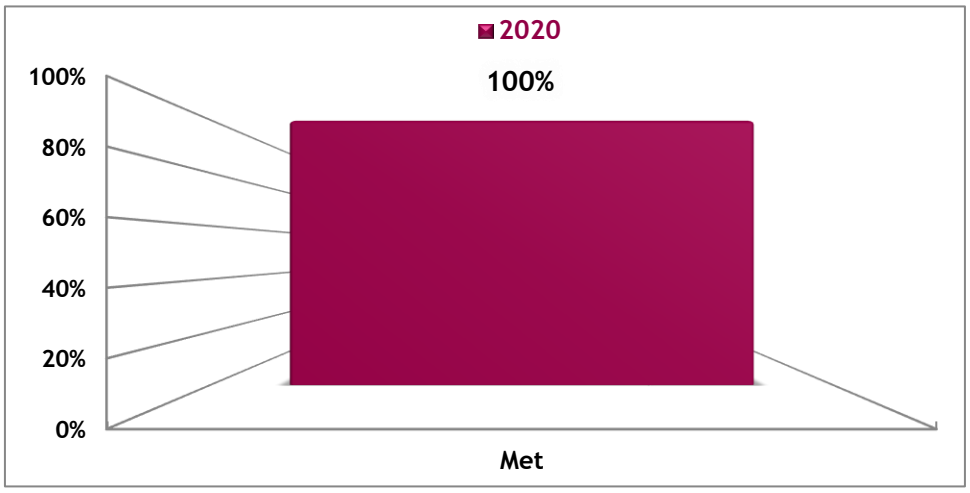
There were no Corrective Actions for the 2020 PIPs. There are three PIPs with one Recommendation each. These Recommendations are displayed in *Table 20: Performance Improvement Project Recommendations*.

Table 20: Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Increase the percentage of individuals who receive a 2nd service within or less than 14 days-Clinical	Was there any documented, quantitative improvement in processes or outcomes of care?	Rates have decreased over the past 3 months. Q1 had a rate of 25.4%. Rate most recently decreased slightly from 24.6% to 23.6%.	The PIP workgroup on November 12, 2020 noted that they are going to focus on education to providers on initiation of services. Continue the initial interventions and the most recent interventions and monitor for improvement.
Decrease Emergency Department admissions for active members to 20%-Clinical	Was there any documented, quantitative improvement in processes or outcomes of care?	Rate most recently increased, which is not improvement. Rate went from 30% in May 2020 to 31% in June 2020.	March 2020 PIP workgroup meeting focused on implementation of self-study tool and workflow; as well as care specialist; d/c team; and care specialists. Continue these interventions to determine if they reduce ED admissions.
Decrease percentage of members who separate from transition to community living housing to 20% or less annually-Clinical/TCLI	Was there any documented, quantitative improvement in processes or outcomes of care?	Rate most recently increased from 29% in FY2018 to 63% in FY2019. This is not improvement, as the goal is to decrease the rate.	Determine if Freedom Funds can help keep rate decreasing; work on increasing compliance of members and providing consistent information, as documented.

Details of the validation activities for the PMs and PIPs and specific outcomes related to each activity may be found in *Attachment 3, CCME EQR Validation Worksheets*. For this 2020 EQR, all standards in the Quality Improvement section received a "Met" score.

Figure 4: Quality Improvement Findings



Strengths

- All PIPs validated scored in the High Confidence range.
- Validation scores for (b) Waiver and (c) Waiver Performance Measures were fully compliant, with an average validation score of 100%.

Weaknesses

- A total of nine PIPs were submitted and seven were validated according to the CMS Protocol. During the Onsite, there were two PIPs discussed that are resistant to interventions even with extensive efforts to improve rates.
- The past three remeasurements show rate decreases for the Increase the Percentage of Individuals Who Receive a 2nd Service Within or Less Than 14 Days PIP. Q1 had a rate of 25.4%. This rate most recently decreased slightly from 24.6% to 23.6%.
- The rate most recently increased for the Decrease Emergency Department Admissions for Active Members to 20% PIP. This is not improvement. The rate went from 30% in May 2020 to 31% in June 2020.
- For the Decrease Percentage of Members Who Separate From Transition to Community Living Housing to 20% or Less Annually PIP, the rate most recently increased from 29% in FY2018 to 63% in FY2019. This is not improvement, as the goal is to decrease the rate.

Recommendations

- Reduce the number of concurrent active PIPs to allow more focused improvement efforts on each individual PIP.
- The PIP workgroup on November 12, 2020 noted that they are going to focus on education to providers on initiation of services. Continue the initial interventions and the most recent interventions and monitor for improvement for the Increase the Percentage of Individuals Who Receive a 2nd Service Within or Less Than 14 Days PIP.
- The March 2020 PIP workgroup meeting focused on implementation of self-study tool and workflow, care specialists, and d/c team. Continue these interventions to determine if they reduce ED admissions for the Decrease Emergency Department Admissions for Active Members to 20% PIP.
- Determine if Freedom Funds can help keep the rate decreasing for the Decrease Percentage of Members Who Separate From Transition to Community Living Housing to 20% or Less Annually PIP. Work on increasing compliance of members and providing consistent information, as documented.

D. Utilization Management

The EQR of Utilization Management (UM) included a review of the Care Coordination and Transition to Community Living (TCLI) programs. CCME reviewed relevant policies, Organizational Chart, *Enrollee/Member and Family Handbook* and 11 files of enrollees participating in mental health/substance use disorder (MH/SUD), Intellectual/Developmental Disability (I/DD), and TCLI Care Coordination.

In the 2019 EQR, Eastpointe met 96% of UM standards. CCME issued four Recommendations and two Corrective Actions. The 2019 review of I/DD and MH/SUD Care Coordination files showed a pattern of poor and late documentation when compared to the requirements outlined in Eastpointe's policies. Progress notes also showed a lack of proactive measures that could have been used to address barriers to services and client crises. A Corrective Action was issued to ensure improved quality and compliance of Care Coordination documentation through a comprehensive quality monitoring process. The monitoring process would routinely review all Care Coordination documentation (e.g., cases targeted for discharge, progress notes, follow up activities, Home and Community Based Services Monitoring Checklists, etc.), and the frequency and the scope of monitoring. CCME also recommended in the 2019 EQR that Eastpointe enhance its current clinical staffing process to proactively identify interventions that could address enrollee's needs. In the 2020 EQR, it was evident the Corrective Action and Recommendation from the 2019 EQR were implemented by Eastpointe.

The 2020 EQR of Care Coordination files showed more proactive engagement and activities by Care Coordination staff with Eastpointe members, as well as an overall

increase in the frequency of contacts with providers. However, compliance issues were again found in I/DD Care Coordination documentation.

The 2020 review of I/DD files found that 20% of progress notes are either blank or have 'NA' in the intervention. Additionally, the I/DD Monitoring Checklists were incomplete or did not correspond with the Observation narrative. Additionally, the review of ISPs found a lack of information in the Crisis Plans for individuals who were dually diagnosed, and goals do not reflect the needs identified through I/DD Assessments.

NC Medicaid Contract Amendment 9, Section 9, granted PIHPs permission to conduct monthly monitoring using two-way real time video and/or audio conferencing with the enrollee versus face-to-face contact with the enrollee, as required by the *NC Medicaid Contract*. This permission was issued by the State due to the State-wide Covid-19 Stay Home Order. However, the 2020 EQR of the Care Coordination files found that monthly contacts between the Care Coordinator and the enrollee did not routinely occur. As an example, one I/DD file showed monthly teleconferencing occurred for 9 months between the Care Coordinator and the service provider representative, instead of with the enrollee or legal responsible person (LRP). During the Onsite, Eastpointe acknowledged the Care Coordinators' misinterpretation of the amendment and reported they have put strategies in place to ensure ongoing monthly review occurs with the enrollee or LRP.

The review of Eastpointe policies and *Enrollee/Member and Family Handbook* found information that does not align with the *NC Medicaid Contract* and *NC Medicaid Joint Communication Bulletins*. Eastpointe's Policy C-3.3.22 Resource Allocation and Individual Budgets, does not include the three exemptions that would allow an enrollee to exceed the Innovations Waiver cost limits listed in *Joint Communication Bulletin J362*. Additionally, Eastpointe's Policy C-3.4.16 Complex Care Management, lists the age requirement for Children with Complex Needs as 3 to 18 years. However, *NC Medicaid Contract section 6.11.3.(c), section g,* lists the age as 5 to 21. Likewise, the information on page 40 in the *Enrollee/Member and Family Handbook* lists the age requirement as 3 to 21 years. In this 2020 EQR, CCME recommends Eastpointe update their policies and the *Enrollee/Member and Family Handbook* to reflect these *NC Medicaid Contract* and *NC Joint Communication Bulletin* requirements.

Figure 5 shows 96% of the Utilization Management standards were scored as "Met" and 4% were scored as "Partially Met". No standards were scored as "Not Met".

Figure 5: Utilization Management Comparative Findings

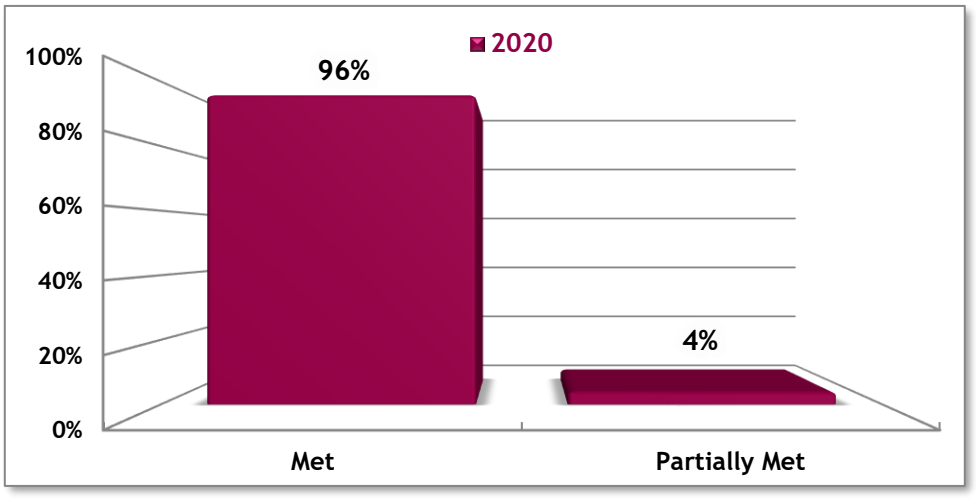


Table 21: Utilization Management

Section	Standard	2020 Review
Care Coordination	The PIHP applies the Care Coordination policies and procedures as formulated.	**Partially Met**

Strengths

- In this year's EQR it was noted Care Coordination progress notes now show proactive engagement with Eastpointe members and an increase in the frequency of contacts with providers.
- Eastpointe launched a new case management platform, Altruista, in October 2020.

Weaknesses

- Policy C-3.4.16 Complex Case Management, and Eastpointe's *Enrollee/Member and Family Handbook* contains conflicting information regarding the age of Medicaid enrollees that should be assessed and identified as having special health care needs.
- Eastpointe Policy C-3.3.22 Resource Allocation and Individual Budgets, does not reflect the exclusions listed in *NC Joint Communications Bulletin J362*.
- Eastpointe's current monitoring of Care Coordination documentation is not adequately addressing quality and compliance issues within I/DD Care Coordination files. 20% of

I/DD progress notes are either blank or have 'NA' in the intervention. Additionally, the I/DD Monitoring Checklists were incomplete or did not correspond with the Observation narrative. Lastly, the review of ISPs found a lack of information in the Crisis Plans for individuals who were dually diagnosed, and goals do not reflect the needs identified through I/DD Assessments.

Corrective Action

- Develop and document an enhanced quality monitoring process that routinely reviews I/DD Care Coordination documentation. This quality monitoring process should review I/DD progress notes and I/DD Monitoring Checklists for completeness, accuracy and compliance with Eastpointe policies and the *NC Medicaid Contract,* and *NC Medicaid Contract Amendment 9, Section 9*. The quality monitoring process should also include routine review of ISPs to ensure they are person-centered and reflect the needs identified in assessments and other support tools.

Recommendations

- Update Policy C-3.4.16 Complex Case Management, and the *Enrollee/Member and Family Handbook* to reflect the criteria listed in *NC Medicaid Contract, Section 6.11.3.(c), Section g, for Children with Complex Needs.*

- Update Policy C-3.3.22 Resource Allocation and Individual Budgets, to include the exclusion to waiver cost limits as listed in *NC Joint Communication Bulletin J362*.

E. Grievances and Appeals

The 2020 Grievances and Appeals EQR for Eastpointe included a Desk Review of policies, 10 Grievance and 10 Appeal files, the Grievances and Appeals Logs, the *Provider Operations Manual*, the *Enrollee/Member and Family Handbook*, the *Utilization Management Plan*, and information about Grievances and Appeals available on the Eastpointe website. An Onsite discussion with Grievance and Appeal staff occurred to further clarify Eastpointe's documentation and processes.

Eastpointe met 75% of the Grievance and Appeal standards in the 2019 EQR and 12 Corrective Actions and 11 Recommendations were issued to address concerns primarily noted within the Grievance and Appeal policies, the *Provider Operations Manual*, the *Enrollee/Member and Family Handbook*, and the Grievance and Appeal files. It should be noted that Eastpointe attempted to address all Grievances and Appeals Corrective Actions and Recommendations from the previous year but missed adding some required information into the Grievance policy and some recommended language to the *Provider Operations Manual*.

Grievances

In the 2019 EQR of Grievances, three Corrective Actions and five Recommendations were provided by CCME and all have been implemented and maintained by Eastpoint with one exception. One Corrective Action was issued in the 2019 EQR to address language missing from Policy Q-6.4.4 Member/Enrollee and Stake Holder Complaint/Grievance, regarding extensions to the Grievance resolution timeframe. Eastpointe implemented this Corrective Action but did not include a portion of the federal requirements in the policy. *NC Medicaid Contract, Attachment M.6* and *42 CFR § 438.408 (c)ii* require the PIHP to "inform the enrollee of their right to file a grievance" if they disagree with the extension. The language Eastpointe added to their policy stated the enrollee has a right to "appeal", if the enrollee disagrees with Eastpointe's decision to extend the Grievance resolution timeframe. CCME has issued a Corrective Action in this 2020 EQR to bring Eastpointe's Grievance policy into compliance with *NC Medicaid Contract* and federal regulation regarding Grievances.

In the 2019 EQR of Grievances, the Grievance file review showed there was no evidence of consultations with the Medical Director or other subject matter experts regarding Grievances with quality of care issues. CCME recommended Eastpointe ensure the attendance by the Medical Director and other subject matter experts is documented in the Quality of Care minutes where these Grievances are staffed. This Recommendation was addressed by Eastpointe, and there was evidence in the 2020 EQR Grievance file review of subject matter expert consultation.

Also, in the 2019 EQR file review, two of files reviewed showed Grievance notifications were either not issued or issued outside of the required timeframes. CCME recommended Eastpointe enhance the monitoring of Grievances to ensure notifications are issued in compliance with Eastpointe policies, *NC Medicaid Contract*, and federal regulations.

In the 2020 EQR, the Grievance file review showed four of the 10 files reviewed were not resolved, and notification was not provided within the required timeframe. *NC Medicaid Contract, Attachment M, Section C* and *42 CFR § 438.408 (b)1* require Grievances to be resolved within 90 days and Eastpointe's Grievance policy require Grievances to be resolved and notification provided within 30 days. All four of these files showed referrals were made to Eastpointe's Provider Monitoring Department, but placed "on hold" by that department. Notifications were sent by the Grievance Department to Grievants within 30 days, but these notifications did not provide resolution. Instead, these notifications informed the Grievant that "Due to the Coronavirus (COVID-19), most of our employees are working from home and unable to complete some monitoring functions. Therefore, there may be a delay in resolving your complaint. I will mail you a written letter when the investigation is completed." Eastpointe staff reported they considered these Grievances "resolved" based on this notification. Eastpointe cited a letter sent by the State to all PIHPs on March 20, 2020 outlining "emergency flexibilities" of PIHP

functioning during the COVID-10 pandemic. This letter stated PIHPs implement actions to "pause, to the greatest extent possible, all settlement and other oversight functions, save those necessary to ensure consumer health and safety." There was no evidence provided by Eastpointe that these Grievances were assessed for potential enrollee health and safety prior to placing them on hold. During the Onsite discussion, staff confirmed no alternative plan had been developed by Eastpointe for resolving provider Grievances within the required timeframes. Further, the March 20, 2020 letter did not preclude Eastpointe from resolving Grievances outside of the federal regulation, *42 CFR § 438.408 (b)1*, nor did Eastpointe consult with the State regarding their interpretation of the March 20, 2020 letter from the State.

These four Grievances contained concerns about access to Community Support Teams services, HIPAA violations, provider fraud, and a four-month gap in the provision of Developmental Therapy and Personal Assistance for two Intellectual/Developmental Disabled children. There were multiple opportunities, outside of Provider site visits and monitoring, for potential Grievance resolution steps by Eastpointe. For example, in the Grievances related to access to services issues, Eastpointe could have engaged the help of Care Coordination to assist the enrollees with accessing services.

Eastpointe did eventually provide resolution for these four Grievances, however, the resolution and the Grievance resolution notifications occurred five to eight months after receipt of the Grievance. During the Onsite, staff stated they did reach out to the Grievants by phone, but there was no evidence of this within the Grievance file.

During the Onsite, staff stated they were monitoring these "pended" Grievances through their weekly staff meeting. However, they were unable to identify how many of these provider Grievances were "pended" during this past year. There was also no indication of which Grievances were pended on the Grievance Log submitted to CCME with the EQR Desk Materials. CCME has issued a Corrective Action requiring Eastpointe to closely monitor Grievances for compliance with required notification timeframes. Additionally, Eastpointe must establish a deadline for ensuring any of the Grievances placed "on hold" by the Provider Monitoring Department are resolved.

Appeals

In the 2019 EQR of Appeals, Eastpointe received nine Corrective Actions and six Recommendations. Four Corrective Actions required revision of language within Policy C-3.2.6 Appeal of UM Adverse Benefit Determination, which was out of compliance with federal regulations and the *NC Medicaid Contract*. For similar reasons, four Corrective Actions required revision of the language within the *Provider Operations Manual* and/or *Enrollee/Member and Family Handbook*. The ninth Corrective Action addressed concerns noted in the Appeal files where it was unclear the steps Eastpointe staff followed when releasing the Appeal record. Recommendations from the 2019 EQR centered upon

opportunities to clarify language within the Appeal policy to better guide staff through Appeal resolution process. One Recommendation encouraged Eastpointe to ensure any required revisions to Appeal templates are completed and implemented in a timely manner.

Eastpointe implemented all Corrective Actions and Recommendations from the 2019 EQR, with one exception. Part of a 2019 Corrective Action required revision of *Provider Operations Manual* to accurately reflect the required notifications when Eastpointe extends the Appeal resolution timeframe. While Eastpointe did revise the manual, they omitted the requirement of Eastpointe to "inform the enrollee of the right to file a Grievance if he or she disagrees with that decision." Notification of this right is required by *42 CFR § 438.408 (2)(c)ii*.

For this year's Appeals EQR, Eastpointe submitted the Appeals log that captures all Appeals processed between October 2019 through September 2020. The log showed Eastpointe resolved 46 Appeals during this timeframe, which included four expedited Appeal, 13 invalid Appeals, and 30 standard Appeals. From that log, 10 Appeal files were selected; seven standard Appeals and three expedited Appeals. Review of one standard file showed the Appeal was resolved in 31 days. However, this file was deemed invalid as the Appellant had appealed the wrong service. Outside of that anomaly, all documentation within the files and Appeal Log reviewed showed Eastpointe acknowledged and resolved all Appeals within the requirements outlined in *NC Medicaid Contract, Attachment M*.

Figure 6, Grievances and Appeals Findings indicates the scoring for Grievances and Appeals for the 2020 EQR of Eastpointe.

Figure 6: Grievances and Appeals Findings

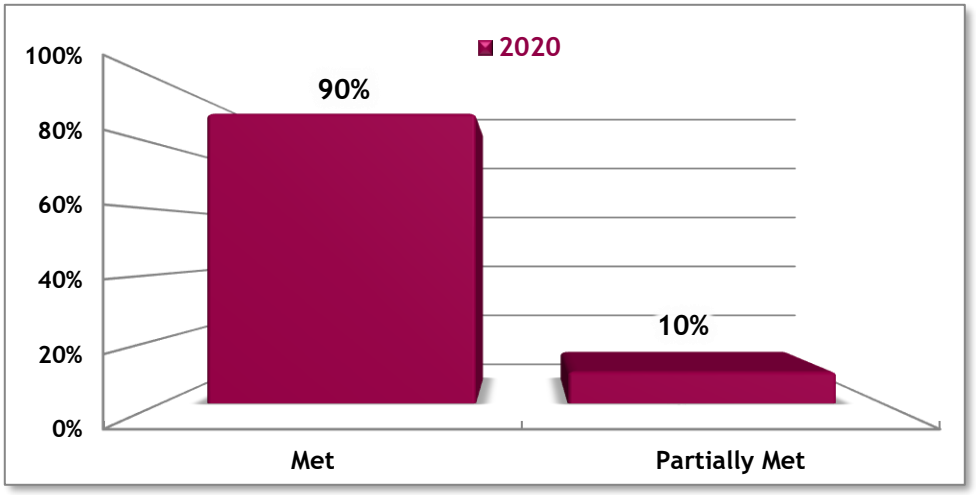


Table 22: Grievances and Appeals

Section	Standard	2020 Review
Grievances	Timeliness guidelines for resolution of the Grievance as specified in the contract;	**Partially Met**
Appeals	The PIHP applies the Grievance policy and procedure as formulated.	**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.
- Eastpointe implemented the majority of the 2019 EQR Corrective Actions and Recommendations for Grievances and Appeals.

Weaknesses

- Policy Q-6.4.4 does not note Eastpointe's requirement to notify the enrollee of their right to file a Grievance if Eastpointe extends the Grievance resolution timeframe.
- Four of the 10 Grievance files reviewed in this year's EQR showed Eastpointe did not resolve and provide written notification of Grievances within the timeframes required by Eastpointe's policy into compliance with *NC Medicaid Contract, Attachment M.6* and *42 CFR § 438.408 (c)ii*. Provider Grievances were referred to Eastpointe's Provider Monitoring Department and then placed "on hold" by that department. No additional efforts to resolve these Grievances or assess for potential health and safety issues were evident in the files reviewed or provided by Eastpointe staff during the Onsite.
- The *Provider Operations Manual* does not explain the requirement of PIHPs to notify enrollees of their right to file a Grievance when the PIHP extends the Appeal resolution timeframe. This notification is required by *42 CFR § 438.408 (2)(c)ii*.

Corrective Action

- Add language to Policy Q-6.4.4 that Eastpointe will notify enrollees of their right to file a Grievance if the enrollee disagrees with Eastpointe's decision to extend the Grievance resolution timeframe. This will bring the Eastpointe's policy into compliance with *NC Medicaid Contract, Attachment M.6* and *42 CFR § 438.408 (c)ii*.

- Develop, document, and implement a monitoring plan to increase compliance with required Grievance notifications. This monitoring plan should include the timeline for implementation, frequency of monitoring, staff that will implement the monitoring, compliance benchmarks, and how and when outcomes of monitoring are captured, reviewed, and reported. Monitoring should ensure Grievance notifications are compliant with Eastpointe's Grievance policies, *NC Medicaid Contract*, *Attachment M* and *42 CFR § 438.408 (b)2*. Include in this monitoring plan the timeframe by which Eastpointe will resolve any provider Grievances placed on hold by Provider Monitoring Department.

Recommendations

- Add to the *Provider Operations Manual* that Eastpointe will notify the enrollee of their right to file a Grievance if Eastpointe extends the Appeal resolution timeframe.

F. Program Integrity

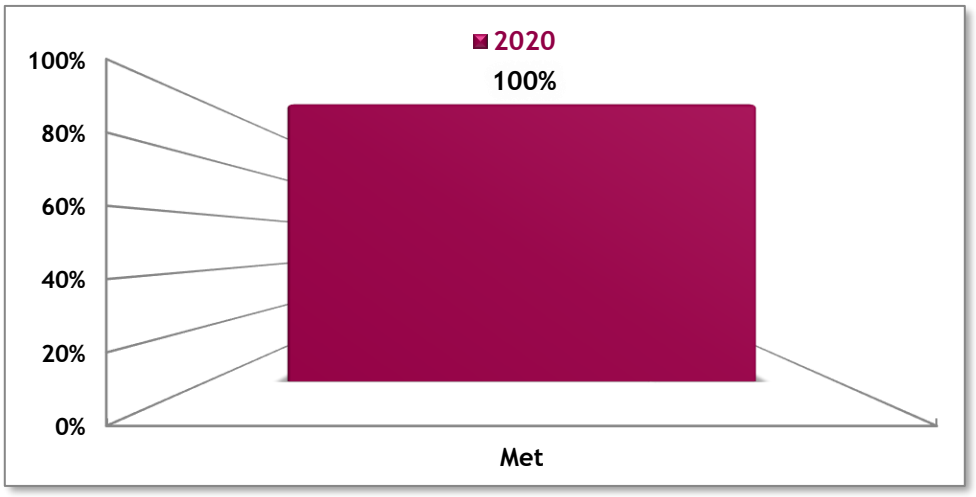
The EQR of Program Integrity (PI) includes review of each PIHP's policies, training materials, Organizational charts, job descriptions, committee meeting minutes and reports, provider agreements, enrollment application, workflows, *Provider Operations Manual*, *Enrollee/Member and Family Handbook*, provider newsletters, conflict of interest forms, fifteen PI files and the PIHP's *Corporate Compliance Plan*. Findings within the Desk Materials and PI files were discussed with Eastpointe staff during the Onsite.

Fifteen PI files were selected from a list of Eastpointe's case files active from October 2019 through September 2020. The file review showed that all fifteen files contained the information required by Eastpointe's contract with NC Medicaid. During the Onsite interview, staff stated that while PIHPs were allowed to pause provider monitoring activities during the COVID-19 pandemic, Eastpointe continued preliminary investigations and claims monitoring so they could resume operations and resolve PI cases, when appropriate. Additionally, it was discussed that the PIHP has continued to work with IBM on data mining, which was cited as the referral source in five of the 15 files reviewed.

A Desk Review of Eastpointe's documentation was conducted to assess their compliance with federal and state regulations and the PIHP's contract with NC Medicaid. The Desk Review of Eastpointe's policies showed most contractually-required areas to be addressed. During the Onsite interview, a discussion took place to clarify Eastpointe's process for tracking overpayments. The PIHP stated they still use Smartsheet to track overpayments and described the workflow that is followed to ensure that issues related to overpayments are addressed in a timely manner.

Figure 7 demonstrates that Eastpointe met 100% of the Program Integrity EQR standards.

Figure 7: Program Integrity Findings



Strengths

- Eastpointe continued to work throughout the COVID-19 pause to resolve PI issues as much as they could internally so that when the pause ended, they could resume operations and resolve/close PI cases as soon as possible.
- Eastpointe makes use of data mining and collaborates with their IBM partners to detect and investigate potential cases of fraud, waste, and abuse.
- 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.

G. 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 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 2019 through December 2019. 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 consistently populated on Professional claims. This issue was present in the 2017 review. The Professional claims contained up to 12 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: EQR Validation Worksheets
- Attachment 3: Tabular Spreadsheet
- Attachment 4: 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

November 2, 2020

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 2020 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 one-day, virtual Onsite that will address contractually required services.

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

The CMS EQR protocols can be found at:

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

Due to COVID-19 and the issuance of the contractual flexibilities issued by the State outlined in Contract Amendment #9, the 2020 EQR will be a focused review. The focus of this review will be on the Corrective Actions from the previous EQR and Eastpointe functions that impact enrollee health and safety. Similarly, for the 2020 EQR, the two day Onsite previously performed at PIHP offices will conducted during a one day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **March 11, 2021**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

In preparation for the Desk Review, the items on the enclosed **Desk Materials List** are to be submitted electronically. **Please note that, to facilitate a timely review, there are three lists on the Desk Materials List (items 9, 10, and 19.a) that should be submitted by no later than November 6, 2020.** The remaining items are due by no later than **November 23, 2020**. Also, as indicated in item 20 of the Desk Materials List, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted with the other Desk Materials on **November 23, 2020**.

Further, as indicated on item 21 of the Desk Materials List, Encounter Data Validation (EDV) will also be part of this review. Our subcontractor, Health Management Systems (HMS) will be evaluating this component. Please read the documentation requirements for this section carefully and make note of the submission instructions, as they differ from the other requested materials.

All other materials should be submitted to CCME electronically through our secure file transfer website. The location for the file transfer site is: https://eqro.thecarolinascenter.org

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 5

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

EASTPOINTE

Focused External Quality Review 2020

MATERIALS REQUESTED FOR DESK REVIEW

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

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

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

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

16. Information regarding the following selected Performance Measures:

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

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

Required information includes the following for each measure:

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

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

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

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

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

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

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

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

A. Insurance:

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

B. Other:

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

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

    b. Program Integrity Plan and/or Compliance Plan.

    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.

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

    e. All ‘Attachment Y’ reports collected during the review period.

    f. All ‘Attachment Z’ reports collected during the review period.

    g. Provider Manual and Provider Application.

    h. Enrollee Handbook

    i. Subcontractor Agreement/Contract Template.

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

k. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse.

l. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors, and employees.

m. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other State or Federal agency.

n. Code of Ethics and Business Conduct.

o. Internal and/or external monitoring and auditing materials.

p. Materials pertaining to how the PIHP captures and tracks complaints.

q. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting

    i. NC Medicaid approved reporting templates.

r. Sample Data Mining Reports.

s. NC Medicaid Monthly Meeting Minutes for entire review period, including agendas and attendance lists.

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

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

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

w. Policies/Procedures for:

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

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

a. A completed ISCA.

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

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

c. A copy of the IT Disaster Recovery Plan.

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

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

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

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

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

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

B. Attachment 2: EQR Validation Worksheets

- MH/SUD (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 beneficiaries reporting their Care Coordinator helps them to know what waiver services are available
  - Proportion of beneficiaries reporting they have a choice between providers
  - Percentage of Level 2 and 3 incidents reported within required timeframes
  - Percentage of beneficiaries who received appropriate medication
  - Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required
- Performance Improvement Project Validation Worksheet
  - 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 housing to 20% or less annually
  - Increase approval rate of Medicaid Encounter Claims to 95%
  - Increase Follow up after discharge appointments to 40%

CCME EQR MH/SUD PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR MH/SUD PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR MH/SUD PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR MH/SUD PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR MH/SUD PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR MH/SUD PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR MH/SUD PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR MH/SUD PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR MH/SUD PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR MH/SUD PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	Proportion of beneficiaries reporting they have a choice between providers. IW D10
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	**Percentage of level 2 and 3 incidents reported within required timeframes. IW G2**
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	Percentage of beneficiaries who received appropriate medication. IW G5
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PM:	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PIP:	**INCREASE PERCENTAGE OF MEMBERS WHO RECEIVED A FACE TO FACE SERVICE WTIHIN 48 HOURS TO 70%**
Reporting Year:	2019-2020
Review Performed:	03/2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed and reported quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	QIP workgroup collects and monitors data.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters and interpretation of rate and lowest rate for the measure.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate most recently improved from 36% to 40%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be a result of interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge; target rate not yet met.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	79
Project Possible Score	79
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PIP:	**DECREASE STATE PSYCHIATRIC HOSPITAL 30-DAY READMISSIONS FOR HIGH-RISK MEMBERS TO 6% OR LESS**
Reporting Year:	2019-2020
Review Performed:	03/2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using claims/encounter coding.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed and reported quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	QIP workgroup collects and monitors data.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters and interpretation of rate and lowest rate for the measure.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions (care coordination, tracking system) and barriers (lack of beds) are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate most recently improved (decreased) from 11.8% (July to Sept 2019) to 7.6% (Oct-Dec 2019). Meeting occurred on 7/15/2020 for QIP workgroup.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be a result of interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge- target rate not yet met.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	79
Project Possible Score	79
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PIP:	**INCREASE THE PERCENT OF INDIVIDUALS WHO RECEIVE A 2ND SERVICE WITHIN OR LESS THAN 14 DAYS TO 35%**
Reporting Year:	2019-2020
Review Performed:	03/2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed and reported quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	QIP workgroup collects and monitors data.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters and interpretation of rate.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported for each FY.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Rate most recently decreased slightly from 24.6% to 23.6%. Q1 had 25.4%, so it has declined the past 3 remeasurements. ***Recommendations: The workgroup on 11/12/20 noted that they are going to focus on education to providers on initiation of services. Continue the initial interventions and the most recent interventions and monitor for improvement.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement noted.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge- target rate not yet met.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	73
Project Possible Score	74
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PIP:	**DECREASE EMERGENCY DEPARTMENT ADMISSIONS FOR ACTIVE MEMBERS TO 20%**
Reporting Year:	2019-2020
Review Performed:	03/2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed and reported monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	QIP workgroup collects and monitors data.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Monthly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several months and interpretation of rate and lowest rate for the measure.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Rate most recently increased, which is not improvement, from 30% in May 2020 to 31% in June 2020. ***Recommendation: March 2020 workgroup meeting focused on implementation of self-study tool and workflow; as well as care specialist; d/c team; and care specialists. Continue these interventions to determine if they reduce ED admissions.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement occurred.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge- target rate not yet met.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PIP:	**DECREASE PERCENTAGE OF MEMBERS WHO SEPARATE FROM TCLI HOUSING TO 20% OR LESS ANNUALLY**
Reporting Year:	2019-2020
Review Performed:	03/2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed and reported monthly and annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	QIP workgroup collects and monitors data.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Annual rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and for rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation for FY2018 and FY2019.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Rate most recently increased, from 29% in FY2018 to 63% in FY2019. This is not improvement, as the goal is to decrease the rate. ***Recommendations: Determine if Freedom Funds can help keep rate decreasing; work on increasing compliance of members and providing consistent information, as documented.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement in rate.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	73
Project Possible Score	74
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PIP:	**INCREASE APPROVAL RATE OF MEDICAID ENCOUNTER CLAIMS TO 95%**
Reporting Year:	2019-2020
Review Performed:	03/2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed and reported monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	QIP workgroup collects and monitors data.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Monthly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several months.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate most recently increased, from 96% in May 2020 to 100% in June 2020.
9.2 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Rate improved as a result of interventions and no barriers were identified in latest meeting June 18, 2020.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**MET**	Rate has been sustained for three consecutive measurement periods.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Eastpointe**
Name of PIP:	**INCREASE FOLLOW UP AFTER DISCHARGE APPOINTMENTS TO 40%**
Reporting Year:	2019-2020
Review Performed:	03/2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed and reported monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	QIP workgroup collects and monitors data.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Monthly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using line charts and tables for rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation through March 2020.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate most recently increased, from 18.2% to 29.4% for mental health follow up and from 11.5% to 18.6% for SU follow up within 7 days.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be a result of compliance monitoring, MH/SUD transportation, and walk in crisis clinics.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge. 40% goal not yet met.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	79
Project Possible Score	79
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

C. Attachment 3: Tabular Spreadsheet

CCME PIHP Data Collection Tool

PIHP Name:	Eastpointe
Collection Date:	2021

I. Information Systems Capabilities Assessment (ISCA)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I A. Management Information Systems						
1. Enrollment Systems						
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Eastpointe has standard processes in place for enrollment data updates. WellSky uploads the daily and quarterly GEF files to the AlphaMCS enrollment system and the monthly 834 files. Eastpointe uses the monthly 820 capitation file to reconcile the payment received every month to determine the categories of aid for which payments were received. Demographic data is captured in the AlphaMCS system, and patients IDs are unique to members. Historical enrollment information is captured and maintained for all members.
1.2 The MCO is able to identify and review any errors identified during, or as a result, of the State enrollment file load process.	X					Eastpointe produces an enrollment exception report to verify the completeness of the GEF load.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.	X					During the Onsite discussion, Eastpointe demonstrated the AlphaMCS enrollment screens and their capability to store the demographic information. All historical data for members is stored and merged under one member ID.
2. Claims System						
2.1 The MCO processes provider claims in an accurate and timely fashion.	X					For 2019, approximately 98.21% of the Institutional and 98.55% of Professional claims are auto-adjudicated. Eastpointe claims are approved, pended, or denied within 18 days of receipt and paid within 30 days of approval. If a required field is missing from a claim, provider 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 HIPAA 999 response file advising the provider of the claim submission failure. Eastpointe claims processors do not change any information on the claims. All Eastpointe claims are processed through AlphaMCS' claims adjudication procedure, without pending, except for Emergency Department claims and claims with amounts greater than $5,000 are pended for manual review.
2.2 The MCO has processes and procedures in place to monitor review and audit claims staff.	X					Eastpointe conducts monthly and quarterly audits of claims processed. Eastpointe staffs' goal is to audit 3% of all claims monthly.
2.3 The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted	X					Eastpointe indicated in their ISCA response that 24 Institutional ICD-10 diagnosis codes and 12 ICD-10 Diagnosis codes are captured for Professional on the provider web portal.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.						ICD-10 procedure codes and DRG codes received from the provider are captured.
2.4 The MCO's claim system screens store and track claim information and claim adjudication/payment information.	X					Onsite review of the claims system screens identified the capture of adjudication/payment information for the claims.
3. Reporting						
3.1 The MCO's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Eastpointe captures all necessary data elements required for enrollment and claims reporting. Eight years of enrollment history and behavioral health claims data is stored in the reporting system.
3.2 The MCO has processes in place to back up the enrollment and claims data repositories.	X					WellSky is responsible for the backup and archive of data in the cloud environment. Eastpointe receives a local copy of the database nightly, and that data is also backed up and stored according to Eastpointe's backup policy.
4. Encounter Data Submission						
4.1 The MCO has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	X					Eastpointe's encounter data submission process allows for up to 24 ICD-10 Diagnosis codes for Institutional and 12 ICD-10 Diagnosis codes for Professional to be submitted to NC Tracks. Eastpointe's encounter data submission process allows for the ICD-10 Procedure codes received on an Institutional claim to be submitted to NCTracks.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2 The MCO has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					Eastpointe's vendor WellSky updates and maintains details on encounters that are submitted for encounter data submission on the 837 files and also the details on the 999 and 835 response files.
4.3 MCO has policies and procedures in place to reconcile and resubmit encounter data denied by NC Medicaid.	X					Eastpointe's claims department works encounter denials received. When an error is identified it is assigned out to an appropriate staff to review and resolved the issue based on the denial error code received. Enrollment and eligibility issues are assigned over to Eastpointe's Medical Records department. Provider related issues are assigned to a full-time dedicated staff in Eastpointe's Contracts Department. Once issues have been updated, the Claims dedicated staff person rebills the claims to NCTRACKs for processing. It is Eastpointe's Claims Department's responsibility to make sure all denied encounters are worked timely and resubmitted to NCTracks. On average, Eastpointe submits an encounter within an average of five business days from the time of adjudication to NCTracks. It takes Eastpointe approximately 15 business days to correct and resubmit a denied encounter to NCTracks.
4.4 The MCO has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to NC Medicaid	X					Communications have been established between the various departments to address the encounter denials, correct the issues, and resubmit the encounter to NCTracks. ***Recommendation: Continue to work with providers and the State to reduce the number denied duplicate encounters from NCTracks, possibly review the process of submitting the adjusted and voided encounters separately.***

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). "Medversant conducts the pre-screens, criminal records check, and all PSVs" (Primary Source Verifications). There is some conflicting language within the *Credentialing Manual* about the credentialing/recredentialing process (e.g., applications go to CAQH and are sent to Medversant, versus applications are submitted to the MCO, etc.). ***Recommendation*: Reconcile the language within the Eastpointe Credentialing Manual about the process (applications go to CAQH and are sent to Medversant, versus applications are submitted to the MCO, etc.).**
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	X					The *Credentialing Manual* states, "The Associate Medical Director chairs the Credentialing Committee, reviews and approves practitioners' credentialing files that meet criteria for participation (e.g., "clean applications"), provides input to policy changes and/or revision of policies and procedures, and follows up with practitioners as needed." The Credentialing Committee Minutes indicate which members are "voting" members, which members are present, which member(s) made specific motions, and the outcome of votes cast. The meeting notes contain evidence of the committee discussion and decision-making.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						There is conflicting language in the *Credentialing By-Laws* and the *Credentialing Manual* about the composition of the Credentialing Committee. Both documents list five voting members, but the specific provider representative composition is slightly different between the documents. Further, there is conflicting language between the *Credentialing By-Laws* and the *Credentialing Manual* in the position titles of nonvoting members. ***Recommendation: Revise the Credentialing By-Laws, the Credentialing Manual, and any other documents that reference the composition of the Credentialing Committee, to consistently reflect the composition of the Credentialing Committee.***
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Credentialing files reviewed for the EQR were organized and contained appropriate information.
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
3.1.3 Valid DEA certificate; and/or CDS certificate	X					
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					
3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.8 Query of the National Practitioner Data Bank (NPDB) ;	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); and query of the State Exclusion List;	X					
3.1.10 Query for the System for Awards Management (SAM);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	X					
3.1.14 Names of hospitals at which the physician has admitting privileges, if any	X					
3.1.15 Ownership Disclosure is addressed.	X					
3.1.16 Criminal background Check	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files reviewed for the EQR were organized and contained appropriate information. CCME identified the following issues in the file review:
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." The April 23, 2020 Provider Meeting PowerPoint notes that, in response to COVID-19, Eastpointe increased "the period for organizations to complete participating provider

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						recredentialing by an additional 90 days to thirty nine (39) months (from thirty six (36) months)." In each EQR beginning with 2017, Eastpointe received Corrective Action or a Recommendation regarding this standard. Items of note in files submitted for this EQR: • Two practitioners were recredentialed within the three year timeframe. • Licensed Practitioner (LP) at a contracted agency: Initial credentialing was for one year only. Recredentialing was approved about three weeks after the end of the one year credentialing expired, retroactive to date on the attestation, so the effective date was within the one year of the initial credentialing. • Agency: Credentialing lapsed on December 6, 2018; ○ a contract renewal effective July 1, 2020 was fully executed on June 11, 2020, despite the fact that the agency's credentialing lapsed in December 2018; ○ an Attestation for recredentialing was signed/dated by the agency Authorized Representative on July 2, 2020; ○ on July 14, 2020, the Associate Medical Director approved provisional recredentialing for this agency retroactive to December 16, 2018 (a year and 7 months earlier), due to "internal delays and Medversant errors;" ○ the *Quality Monitoring Review Tool* dated September 15, 2020 references two quality of care issues, one of which is pending due to provider monitoring being paused due to COVID-19 restrictions; ○ on November 6, 2020, the Associate Medical Director approved recredentialing with "effective dates" from July 13, 2020 (the end date of the provisional recredentialing approved in July 2020) – December 5, 2021.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The *Credentialing Manual* states, "In the event there are clinical reasons which present a compelling reason to grant 'provisional approval' to a provider, Eastpointe's Associate Medical Director may grant such approval. Generally, such situations present themselves in connection to a need to provide continuity of care to an enrollee and/or ensure a continuum of services is available across the MCO coverage area." The *Credentialing Manual* goes on to state, "The Credentialing Committee will be notified of any providers being given 'provisional approval' for Re-Credentialing." During the Onsite discussion, Dr. Doniparthi confirmed quality of care concerns are taken to/reviewed by the Credentialing Committee. CCME requested that Eastpointe submit any Credentialing Committee meeting minutes that document the committee discussed the quality of care issue for the agency whose recredentialing file was reviewed for this EQR. Minutes documenting this were not submitted. On the *Missing Desk Materials* list and during the Onsite discussion, CCME requested the relevant Credentialing Committee meeting minutes, if the provisional credentialing was discussed in the Credentialing Committee. Eastpointe did not submit minutes documenting discussion of this granting of provisional recredentialing on July 14, 2020 retroactive to December 16, 2018, nor of recredentialing approved by Dr. Doniparthi on November 6, 2020, with "effective dates" of July 13, 2020 - December 5, 2021. ***Recommendation: In order to comply with the Eastpointe Credentialing Manual, ensure: providers are recredentialed within three years of the initial credentialing or the most recent recredentialing; the Credentialing Committee is notified when the AMD approves provisional credentialing/recredentialing; quality of care issues are discussed with the Credentialing Committee.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
4.2.3 Valid DEA certificate; and/or CDS certificate	X					
4.2.4 Board certification if claimed by the applicant;	X					
4.2.5 Malpractice claims since the previous credentialing event;	X					
4.2.6 Practitioner attestation statement;	X					
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event; and query of the State Exclusion List;	X					
4.2.9 Requery of the SAM.	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (OIG LEIE);	X					
4.2.11 Requery of the Social Security Administration's Death Master File	X					
4.2.12 Requery of the NPPES;	X					
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					
4.2.14 Ownership Disclosure is addressed.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.3 Site reassessment if the provider has had quality issues.	X					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 various Eastpointe departments, including Program Integrity, Provider Monitoring, Grievance and Appeals and other departments. The Credentialing Committee Meeting Notes reflect consideration of quality of care concerns and other items for recredentialing candidates.
5. The PIHP formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the PIHP for serious quality of care or service issues.	X					Policy E-4.4.24, Provider Termination, Suspension and/or Sanctioning, outlines the termination and suspension decision process, including when providers have serious quality of care concerns. The *MCO Provider Sanctions Grid* is posted in the Manuals and Information section of the Provider section of the Eastpointe website. The *MCO Provider Sanctions Grid* is "Version date 5-17-17". During Onsite discussion, Eastpointe staff reported the sanctions grid is reviewed every year and Eastpointe is currently in the process of updating and revising the sanctions grid.
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					The *Credentialing Manual* states, "Eastpointe monitors Accreditation for required providers at least on a quarterly basis and verifies at the time of re-credentialing as part of the application process."

III. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III Quality Improvement						
III A. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					
III B. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					A total of nine PIPs were submitted and seven were validated according to the CMS Protocol. During the Onsite, there were two PIPs discussed that are resistant to interventions even with extensive efforts to improve rates. ***Recommendation: Reduce the number of concurrent active PIPs to allow more focused improvement efforts on each individual PIP.***
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					The seven validated PIPs scored in the High Confidence range, although three PIPs had errors and CCME provided recommendations for improvement. The errors and recommendations included: The past 3 remeasurements show rate decreases for the Increase the Percentage of Individuals Who Receive a 2nd Service Within or Less Than 14 Days PIP. Q1 had a rate of 25.4%. Rate most recently decreased slightly from 24.6% to 23.6%.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: The PIP workgroup on November 12, 2020 noted that they are going to focus on education to providers on initiation of services. Continue the initial interventions and the most recent interventions and monitor for improvement for the Increase the Percentage of Individuals Who Receive a 2nd Service Within or Less Than 14 Days PIP. The rate most recently increased for the Decrease Emergency Department Admissions for Active Members to 20% PIP. This is not improvement. The rate went from 30% in May 2020 to 31% in June 2020. ***Recommendation: The March 2020 PIP workgroup meeting focused on implementation of self-study tool and workflow, care specialists, and d/c team. Continue these interventions to determine if they reduce ED admissions for the Decrease Emergency Department Admissions for Active Members to 20% PIP.*** For the Decrease Percentage of Members Who Separate From Transition to Community Living Housing to 20% or Less Annually PIP, the rate most recently increased from 29% in FY2018 to 63% in FY2019. This is not improvement, as the goal is to decrease the rate. ***Recommendation: Determine if Freedom Funds can help keep the rate decreasing for the Decrease Percentage of Members Who Separate From Transition to Community Living Housing to 20% or Less Annually PIP. Work on increasing compliance of members and providing consistent information, as documented.***

IV. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV A. Care Coordination						
1. The PIHP utilizes care coordination techniques to ensure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					
2. The case coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					Policy C-3.4.16 Complex Case Management, lists three criteria that must be met by the enrollee to participate in the program, which includes an age limit of 3-18 years. Also, page 40 of the *Enrollee/Member and Family Handbook* lists the age for Children with Complex Needs as 3 to 21 years. This is in conflict with *NC Medicaid Contract section 6.11.3.(c), Section g,* which lists the age for Children with Complex Needs as 5 to 21 years. ***Recommendation: Update Policy C-3.4.16 Complex Case Management, and the Enrollee/Member and Family Handbook to reflect the criteria listed in NC Medicaid Contract section 6.11.3.(c), section g, for Children with Complex Needs.***

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					Eastpointe has Policy C-3.3.22 Resource Allocation and Individual Budgets, in place that discuss the cost limits of the Innovations Waiver. The policy states that "Combined, these services [referring to Base Budget services and Non-base budget services] may not total more than the $135,000 cost limit within the waiver." On April 29, 2020, NC Medicaid issued *Joint Communication Bulletin J362*, extending the waiver limits to exceed $135,000 cost limits when: • The individual lives independently • The individual receives Supported Living Level III, and • The individual requires 24-hour support. ***Recommendation: Update Policy C-3.3.22 Resource Allocation and Individual Budgets, to include the exclusion to waiver cost limits as listed in NC Joint Communication Bulletin J362.***
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					During the last EQR, CCME issued a Recommendation that Eastpointe update Policy C-3.4.12, MHSUD Care Coordination Intensity of Need and Discharge Criteria, to include the requirement that cases must be staffed with supervisor prior to discharge. This Recommendation was implemented.
2.10 Ensure privacy for each Enrollee is protected.	X					
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					
3. The PIHP applies the Care Coordination policies and procedures as formulated.		X				In the 2019 EQR, Eastpointe met 96% of UM standards. CCME issued four Recommendations and two Corrective Actions. The 2019 review of I/DD and MH/SUD Care Coordination files showed a pattern of poor and late documentation when compared to the requirements outlined in Eastpointe's policies. Progress notes also showed a lack of proactive measures that could have been used to address barriers to services and client crises. A Corrective Action was issued to ensure improved quality and compliance of Care Coordination documentation through a comprehensive quality monitoring process. The monitoring process would routinely review all Care Coordination

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	documentation (e.g., cases targeted for discharge, progress notes, follow up activities, Home and Community Based Services Monitoring Checklists, etc.), and the frequency and the scope of monitoring. CCME also recommended in the 2019 EQR that Eastpointe enhance its current clinical staffing process to proactively identify interventions that could address enrollee's needs. In the 2020 EQR, it was evident the Corrective Action and Recommendation from the 2019 EQR were implemented by Eastpointe. The 2020 EQR of Care Coordination files showed more proactive engagement and activities by Care Coordination staff with Eastpointe members, as well as an overall increase in the frequency of contacts with providers. However, compliance issues were again found in I/DD Care Coordination documentation. The 2020 review of I/DD files found that 20% of progress notes are either blank or have 'NA' in the intervention. Additionally, the I/DD Monitoring Checklists were incomplete or did not correspond with the Observation narrative. Additionally, the review of Individual Support Plans (ISPs) found a lack of information in the Crisis Plans for individuals who were dually diagnosed, and goals do not reflect the needs identified through I/DD Assessments. *NC Medicaid Contract Amendment 9, Section 9*, granted PIHPs permission to conduct monthly monitoring using two-way real time video and/or audio conferencing with the enrollee versus face-to-face contact with the enrollee, as required by the *NC Medicaid Contract*. This permission was issued by the State due to the State-wide Covid-19 Stay Home Order. However, the 2020 EQR of the Care Coordination files found that monthly contacts between the Care Coordinator and the enrollee did not routinely occur. As an example, one I/DD file showed monthly teleconferencing occurred for 9 months between the Care Coordinator and the service provider representative, instead of with the enrollee or legal responsible person (LRP). During the Onsite, Eastpointe acknowledged the Care Coordinators' misinterpretation of the amendment and reported they

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						have put strategies in place to ensure ongoing monthly review occurs with the enrollee or LRP. ***Corrective Action: Develop and document an enhanced quality monitoring process that routinely reviews I/DD Care Coordination documentation. This quality monitoring process should review I/DD progress notes and I/DD Monitoring Checklists for completeness, accuracy and compliance with Eastpointe policies and the NC Medicaid Contract and NC Medicaid Contract Amendment 9, Section 9. The quality monitoring process should also include routine review of ISPs to ensure they are person-centered and reflect the needs identified in assessments and other support tools.***
IV B. Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					
2.1 Care Coordination activities occur, as required.	X					
2.2 Person Centered Plans are developed as required.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.3 Assertive Community Treatment, Peer Support, Supported Employment, Community Support Team, Psychosocial Rehabilitation, and other services as set forth in the DOJ Settlement are included in the individual's transition, if applicable.	X					
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					
2.5 QOL Surveys are administered timely.	X					The review of the 2019 EQR found that several 11-month QOL surveys were either missing or not completed in the required timeframe. CCME issued a Recommendation that Eastpointe monitor the timeliness and completion of QOL Surveys and ensure that documentation standards aligned with Eastpointe policy and *NC Medicaid Contract*. This Recommendation was implemented. The review of TCLI files for this EQR found all QOL surveys and In-Reach tools were completed timely.
3. Transition, diversion and discharge processes are in place for TCLI members as outlined in the DOJ Settlement and *DHHS Contract*.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.	X					
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					
6. A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	X					During the 2019 EQR review of TCLI files, a pattern of poor follow-up activities was identified. Progress notes showed a lack of proactive intervention that could have been used to address care coordination activities such as barriers to service and or client crises. CCME recommended that Eastpoint enhance its current clinical staffing process to ensure TCLI staff provide proactive and needed interventions. This recommendation was implemented. Eastpointe was also issued a Corrective Action to develop a comprehensive monitoring plan that would include a review of all TCLI Care Coordination documentation (In-Reach Tools, progress notes, follow up activities, etc.). The monitoring plan would include the frequency and the scope (i.e., timeliness of documentation, completeness, quality, etc.) of monitoring activities. The Corrective Action was implemented. The review of TCLI files for this EQR showed more engagement with enrollees and a more direct approach to addressing needs. The files showed that Eastpointe TCLI policies are being followed.

V. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee Grievances in a manner consistent with contract requirements, including, but not limited to:	x					Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaint/Grievance, is the primary policy governing Eastpointe's Grievance process.
1.1 Definition of a Grievance and who may file a Grievance;	X					In the 2019 EQR, CCME issued a Corrective Action requiring revision of Policy Q-6.4.4 to clarify who can file a Grievance. It was also recommended that Eastpointe revise the *Provider Operations Manual* provide a clear definition of a Grievance. In the 2020 EQR, it was evident that Eastpointe revised the Grievance policy and *Provider Operations Manual* to address these 2019 findings.
1.2 The procedure for filing and handling a Grievance;	X					
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract;		X				A Corrective Action was issued in the 2019 EQR to address language missing from Policy Q-6.4.4 regarding extensions to the Grievance resolution timeframe. Eastpointe implemented this Corrective Action but did not include a portion of the federal requirements in the policy. *NC Medicaid Contract, Attachment M.6* and *42 CFR § 438.408 (c)ii* require the PIHP to "inform the enrollee of their right to file a grievance" if they disagree with Eastpointe's extension. The language Eastpointe added to their policy stated the enrollee has a right to "appeal" if the enrollee disagrees with Eastpointe's decision to extend the Grievance resolution timeframe.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Corrective Action: Add language to Policy Q-6.4.4 that Eastpointe will notify enrollees of their right to file a Grievance if the enrollee disagrees with Eastpointe's decision to extend the Grievance resolution timeframe. This will bring the Eastpointe's policy into compliance with NC Medicaid Contract, Attachment M.6 and 42 CFR § 438.408 (c)ii.
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					In the 2019 EQR, CCME recommended that Eastpointe describe in the Grievance policy the internal steps staff take to refer quality of care Grievances to the Quality of Care Committee. Eastpointe revised this policy and these steps are now captured in Policy Q-6.4.4, Member/Enrollee and Stake Holder Complaint/Grievance.
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					It was recommended in the 2019 EQR that Eastpointe add to the Grievance policy the time frame PIHPs are contractually required to maintain Grievance files. In the 2020 EQR, this timeframe was evident in the Grievance policy.
2. The PIHP applies the Grievance policy and procedure as formulated.		X				In the 2020 EQR, the Grievance file review showed four of the ten files reviewed were not resolved and notification was not provided within the required timeframe. *NC Medicaid Contract, Attachment M, Section C and 42 CFR § 438.408 (b)1* require Grievances to be resolved within 90 days and Eastpointe's Grievance policy require Grievances to be resolved and notification provided within 30 days. All four of these files showed referrals were made to Eastpointe's Provider Monitoring Department, but placed "on hold" by that department. Notifications were sent by the Grievance Department to Grievants within 30 days, but these notifications did not provide resolution. Instead, these notifications informed the Grievant that "Due to the Coronavirus (COVID-19), most of our employees are working from home and unable to complete some monitoring functions. Therefore, there may be a delay in resolving your complaint. I will mail you a written letter when the investigation is completed." Eastpointe staff reported they considered these

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Grievances "resolved" based on this notification. Eastpointe cited a letter sent by the State to all PIHPs on March 20, 2020 outlining "emergency flexibilities" of PIHP functioning during the COVID-10 pandemic. This letter stated PIHPs implement actions to "pause, to the greatest extent possible, all settlement and other oversight functions, save those necessary to ensure consumer health and safety." There was no evidence provided by Eastpointe that these Grievances were assessed for potential enrollee health and safety prior to placing them on hold. During the Onsite discussion, staff confirmed no alternative plan had been developed by Eastpointe for resolving provider Grievances within the required timeframes. Further, the March 20, 2020 letter did not preclude Eastpointe from resolving Grievances outside of the federal regulation, *42 CFR §438.408 (b)1*, nor did Eastpointe consult with the State regarding their interpretation of the March 20, 2020 letter from the State. These four Grievances contained concerns about access to Community Support Teams services, HIPAA violations, provider fraud, and a four-month gap in the provision of Developmental Therapy and Personal Assistance for two Intellectual/Developmental Disabled children. There were multiple opportunities, outside of Provider site visits and monitoring, for potential Grievance resolution steps by Eastpointe. For example, in the Grievances related to access to services issues, Eastpointe could have engaged the help of Care Coordination to assist the enrollees with accessing services. Eastpointe did eventually provide resolution for these four Grievances, however, the resolution and the Grievance resolution notifications occurred five to eight months after receipt of the Grievance. During the Onsite, staff stated they did reach out to the Grievants by phone, but there was no evidence of this within the Grievance file. During the Onsite, staff stated they were monitoring these "pended" Grievances through their weekly staff meeting.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						However, they were unable to identify how many of these provider Grievances were "pended" during this past year. There was also no indication of which Grievances were pended on the Grievance Log submitted to CCME with the EQR Desk Materials. CCME has issued a Corrective Action requiring Eastpointe to closely monitor Grievances for compliance with required notification timeframes. Additionally, Eastpointe must establish a deadline for ensuring any of the Grievances placed "on hold" by the Provider Monitoring Department are resolved. ***Corrective Action: Develop, document, and implement a monitoring plan to increase compliance with required Grievance notifications. This monitoring plan should include the timeline for implementation, frequency of monitoring, staff that will implement the monitoring, compliance benchmarks, and how and when outcomes of monitoring are captured, reviewed, and reported. Monitoring should ensure Grievance notifications are incompliance with Eastpointe's Grievance policies, NC Medicaid Contract, Attachment M and 42 CFR § 438.408 (b)2. Include in this monitoring plan the timeframe by which Eastpointe will resolve any provider Grievances placed on hold by the Provider Monitoring Department.***
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider Appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					In the 2019 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*. Eastpointe addressed these Corrective Actions and Recommendations from the 2019 EQR.
1.1 The definitions an Appeal and who may file an Appeal;	X					
1.2 The procedure for filing an Appeal;	X					
1.3 Review of any Appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					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					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 is documented in *Policy* C-3.2.6 Appeal of UM Adverse Benefit Determination.
1.5 Timeliness guidelines for resolution of the Appeal as specified in the contract;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.6 Written notice of the Appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					Eastpointe implemented all Corrective Actions and Recommendations from the 2019 EQR, with one exception. Part of a 2019 Corrective Action required revision of *Provider Operations Manual* to accurately reflect the required notifications when Eastpointe extends the Appeal resolution timeframe. While Eastpointe did revise the manual, they overlooked the requirement that PIHPs are required to "inform the enrollee of the right to file a Grievance if he or she disagrees with that decision." This notification is required by *42 CFR § 438.408(2)(c)ii*. ***Recommendation: Add to the Provider Operations Manual that Eastpointe will notify the enrollee of their right to file a Grievance if Eastpointe extends the Appeal resolution timeframe.***
2. The PIHP applies the Appeal policies and procedures as formulated.	X					
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					

VI. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI A. General Requirements						
1. PIHP shall be familiar and comply with Section 1902(a)(68) of the Social Security Act, 42 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					
4. PIHP shall investigate all Grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with 42 C.F.R. 438.608 that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the *NC Medicaid Contract* Administrator on an annual basis.	X					
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of 42 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					

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					
4. PIHP shall participate in quarterly Program Integrity meetings with NC Medicaid Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. PIHP shall send staff to participate in monthly meetings with Division Program Integrity staff, either telephonically or in person at PIHP's discretion, to review and 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					
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:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(66) of the Social Security Act;	X					
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing and development of corrective action initiatives;	X					
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					
8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including NC Medicaid or MFCU/MID, and including promptly supplying all data in a uniform format provided by NC Medicaid and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by 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 § 438.608 (a) vii*, PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under *NC Medicaid Contract*, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under *NC Medicaid Contract*; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month. PIHP shall be penalized One Hundred Dollars ($100) for each overpayment that is not specified in an Attachment Y Report within the applicable month. In addition, PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.1 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 permitted to retain some or all of the recoveries of overpayments. This provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.	X					This requirement is addressed in the Complaints Tracking Workflow, which provides the process for how incoming complaints are tracked and processed. This is also addressed in 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 FWA.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.3 In accordance with Attachment Y – Audits/Self-Audits/Investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an· overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					This requirement is addressed in the 2020 *Provider Operations Manual* on pages 142-143.
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					This requirement is addressed in Policy CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA). During the Onsite, staff explained they use Smartsheet to track overpayments. Additionally, the workflow for processing and tracking overpayments was discussed.
10.5 Process for handling self-audits and challenge audits;	X					This requirement is addressed in the Policy CC-3.3 Voluntary Provider Self Audit and Policy CC-1.17 Internal Compliance Auditing and Monitoring.
10.6 Process for using data mining to determine leads;	X					This requirement is addressed in page 5 of Policy CC-3.5, Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA).
10.7 Process for informing PIHP employees, subcontractors and providers regarding the False Claims Act;						This requirement is addressed in the *PI Training Manual*, in the Provider Meeting slides, and provider sign-in sheets.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.8 If PIHP makes or receives annual payments of at least $5,000,000, PIHP shall establish and maintain written policies for all employees, contractors or agents that detail information about the False Claims Act and other Federal and State laws as described in the Social Security Act 1902(a)(66), including information about rights of employees to be protected as whistleblowers.	X					
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					This requirement is addressed in Policy E-4.2.1, Local Monitoring, which describes the process by which the PIHP will verify services billed by provided were rendered.
10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available database or other search mechanism.	X					
11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					
13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations or policies violated; and dates of suspected intentional misconduct;	X					
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					
13.6 All communications between PIHP and the Provider concerning the conduct at 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					
13.8.1 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					
13.8.2 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.8.3 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					
13.8.4 Information on Biller/Owner;	X					
13.8.5 Additional Provider Locations that are related to the allegations;	X					
13.8.6 Legal and Administrative Status of Case.	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 enrollee fraud files were reviewed for the 2020 EQR. However, a thorough review of Eastpointe's enrollee FWA policies and tools occurred.
14.1 The Enrollee's name, birth date, and Medicaid number;	X					
14.2 The source of the allegation;	X					
14.3 The nature of the allegation, including the timeframe of the allegation in question;	X					
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	x					This requirement is addressed on page 2 in Policy CC-3.4, Beneficiary Fraud and Abuse.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
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					This requirement is addressed on page 12 in Policy CC-3.5, Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA).
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	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
changing roles within the organization or termination of employment.						
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	X					This requirement is addressed on pages 5 and 6 in the Policy CC-3.5, Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA).

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
prosecuting authorities determine that there is insufficient evidence of fraud by the Provider; or Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.						
1.1 In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.	X					This requirement is addressed in the CC-3.5 Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA) policy, page 14.
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					This requirement is addressed on page 14 in Policy CC-3.5, Preventing, Detecting, Investigating Potential Fraud, Waste and Abuse (FWA).
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.	X					This requirement is addressed on page 4 in the Policy B-2.7.24, Provider Paybacks (Fund Recovery).

D. Attachment 4: Encounter Data Validation Report

Eastpointe

Encounter Data Validation Report

performed on behalf of

North Carolina Medicaid

March 24, 2021

Prepared By:

hms

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

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Background

Health Management Systems (HMS) has completed a review of the encounter data submitted by Eastpointe to North Carolina Medicaid (NC Medicaid). CCME contracts 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 CMS Encounter Data Validation Protocol, focused on measuring the data quality and completeness of claims paid and submitted to NC Medicaid by Eastpointe for the period of January 2019 through December 2019. All claims paid by Eastpointe are expected to be submitted and accepted as valid encounters by 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 converted 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 Electronic Data Interchange (EDI) validator to check for errors and produce a 999 response to confirm receipt and any compliance errors. The behavioral health encounter claims are then validated by applying a list of edits provided by the state (See Appendix 1) and adjudicated accordingly by Medicaid Management Information System (MMIS). Using existing Medicaid pricing methodology and the billing or rendering provider accordingly, the appropriate Medicaid allowed amount is calculated for each encounter claim in order to shadow price what was paid by the 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 2019, Eastpointe submitted 1,367,707 unique encounters to the State. To date, 3% of all 2019 encounters submitted have not been corrected and accepted by NC Medicaid. This figure represents an improvement in comparison to 15% denial rate in 2018.

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 make consistent progress in their encounter data reporting, increasing the acceptance rate and quality of encounter data year over year. The table below shows the actual acceptance rates between 2016 and 2019 and large fluctuation in those rates during that time.

Year of Service	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
2016	987,620	653,787	63,805	270,028	27%
2017	2,004,846	1,657,212	179,219	168,415	8%
2018	2,238,435	1,720,265	191,894	326,276	15%
2019	1,367,707	1,271,765	51,674	44,268	3%

Eastpointe experienced a sizeable decrease in encounter denials in 2019 compared to 2018 but the denial rate continues to be higher than expected. Furthermore, denial rates have seen dramatic fluctuations over the past four (4) years. The types of denials seen in 2019 appear to mirror those seen in 2018, suggesting that majority of 2019 denials resulted from same root cause issues. First, a large number of duplicate records were submitted and denied in January of 2019. As encounter data had already been submitted, these duplicate submissions resulted in an abnormally high number of denials. In total, 27,964 denials resulted from multiple transmissions of the same encounter record. A second potential issue involves submission of 837 transactions to void or adjust previous encounter submissions were denied due to lack of history records. This may be a result of a timing issue where the voids and adjustments were created before all the 835 return files from NCTracks from previous encounter submissions had been posted in Eastpointe's system.

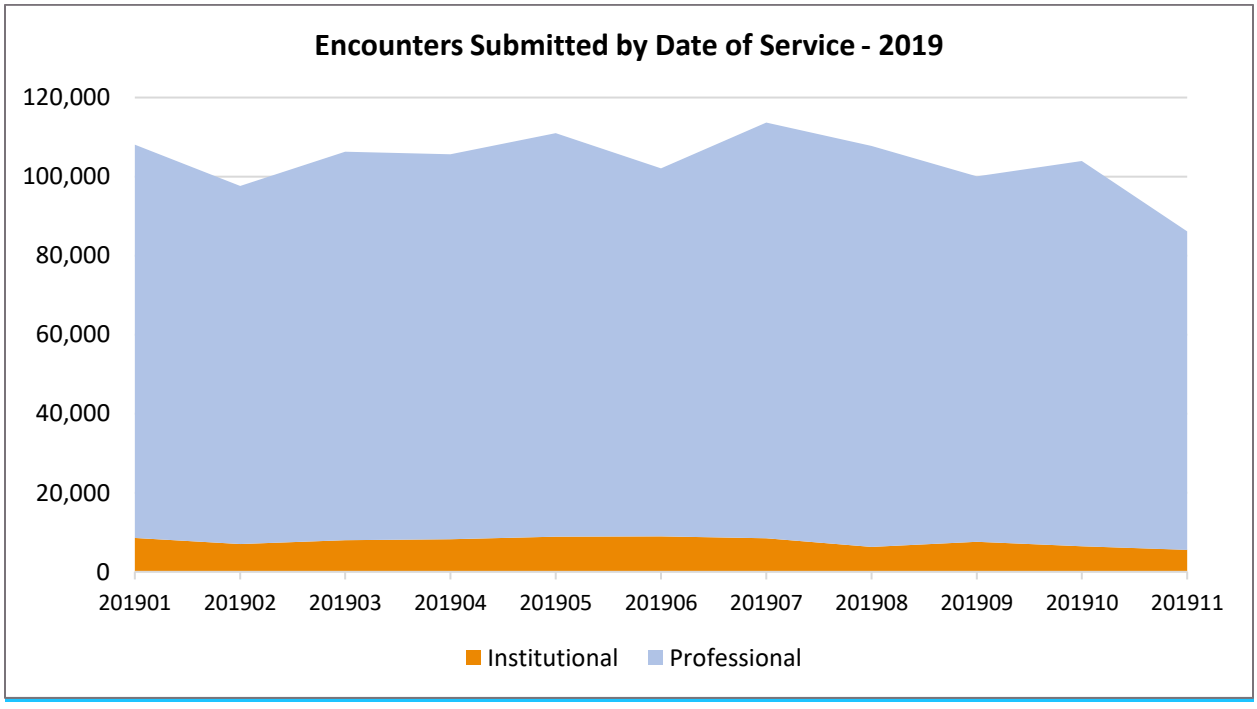
Eastpointe took Corrective Actions in the latter part of 2018 to address these issues. The low denial rates seen during the second half of 2018 seemed to suggest that the new protocols Eastpointe implemented have been effective in eliminating erroneous submissions. However, the uptick in early 2019 suggests that these issues require consistent monitoring to eliminate the duplicate denials.

Eastpointe's Claims Department is responsible for investigating all denied encounters. In 2017, Eastpointe has identified all interventions and barriers that are associated with encounter reporting. The following year, Eastpointe took corrective actions to minimize duplicate submissions. While improvements were noted in 2019, Eastpointe's work to improve encounter data reporting is ongoing. Eastpointe's overall approach includes using the "Encounter Summary by MCO Checkwrite" and other reports issued by NC Medicaid, with a particular emphasis on reviewing the denials. In addition, Eastpointe's Claims Department team reviews 835 responses and identifies denials that need to be resolved. All encounter claims receive one denial code but the remark codes have to be used to narrow down to the true denial reason. Eastpointe has a detailed reconciliation and correction process in place to ensure that all denials are reviewed, corrected, and resubmitted to NC Medicaid.

When an error is identified it is assigned 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

Our analysis of encounter data evaluated whether Eastpointe submitted complete, accurate, and valid data to v for all claims paid between January 1, 2019 and December 31, 2019. Eastpointe extracted all claims adjudicated and submitted to NC Medicaid during 2019 and submitted these to a secure file transfer portal. This included 1,102,036 Professional and 85,712 Institutional claim lines. These figures also included dates of service prior to 2019, resubmissions of previously denied encounters, and voids and adjustments.



Eastpointe provided copies of original 837 transactions submitted to NC Medicaid during calendar year 2019. Other PIHPs typically convert their 837 files to a pipe- or comma-delimited file using an EDI translator, but Eastpointe does not have a tool to perform this data conversion. Instead, HMS consolidated the 837 batch files and then converted the data into a delimited using an EDI translator. Once the data onboarding was completed, HMS applied proprietary, internally designed data analysis logic within SAS to review each data element, focusing on the data elements defined as required. 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 were then 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 the complete data set was reviewed and all data values validated, 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	1,305,988	100.00%	1,305,981	100.00%	1,305,981	100.00%	1,305,981	100.00%
Recipient Name	1,305,988	100.00%	1,305,988	100.00%	1,305,988	100.00%	1,305,988	100.00%
Recipient Date of Birth	1,305,988	100.00%	1,305,988	100.00%	1,305,988	100.00%	1,305,988	100.00%
MCO/PIHP ID	1,305,988	100.00%	1,305,988	100.00%	1,305,988	100.00%	1,305,988	100.00%
Provider ID	1,305,988	100.00%	1,305,871	99.99%	1,305,871	99.99%	1,305,871	99.99%
Attending/Rendering Provider ID	1,305,988	100.00%	1,305,926	100.00%	1,305,926	100.00%	1,305,926	100.00%
Provider Location	1,305,988	100.00%	1,305,988	100.00%	1,305,988	100.00%	1,305,988	100.00%
Place of Service	1,305,988	100.00%	1,305,988	100.00%	1,305,988	100.00%	1,305,988	100.00%
Specialty Code / Taxonomy - Billing	1,305,987	100.00%	1,305,985	100.00%	1,305,985	100.00%	1,305,985	100.00%
Specialty Code / Taxonomy - Rendering / Attending	1,305,988	100.00%	1,305,975	100.00%	1,305,975	100.00%	1,305,975	100.00%
Principal Diagnosis	1,305,988	100.00%	1,305,988	100.00%	1,305,988	100.00%	1,305,988	100.00%
Other Diagnosis	280,031	21.44%	280,031	21.44%	280,031	21.44%	280,031	21.44%
Dates of Service	1,305,988	100.00%	1,305,988	100.00%	1,305,988	100.00%	1,305,988	100.00%
Unit of Service (Quantity)	1,305,969	100.00%	1,305,923	100.00%	1,305,923	100.00%	1,305,923	100.00%
Procedure Code	1,280,578	98.05%	1,280,578	98.05%	1,280,578	98.05%	1,280,578	98.05%
Procedure Code Modifier	415,894	31.85%	415,894	31.85%	415,894	31.85%	415,894	31.85%
Patient Discharge Status Code Inpatient	101,940	100.00%	101,940	100.00%	101,940	100.00%	101,940	100.00%
Revenue Code	101,940	100.00%	101,940	100.00%	101,940	100.00%	101,940	100.00%

Overall, few inconsistencies were found in the data other than the denial issues highlighted in Eastpointe's ISCA response and NC Medicaid's encounter acceptance report. Institutional claims contained complete and valid data in 17 of the 18 key fields (94%) that met or exceeded CMS's Data Quality Standards. Of note, it was found that 21.44% of all claim lines contained Other Diagnosis codes. This is a decrease from 24.66% in 2018 and is well below CMS guidelines.

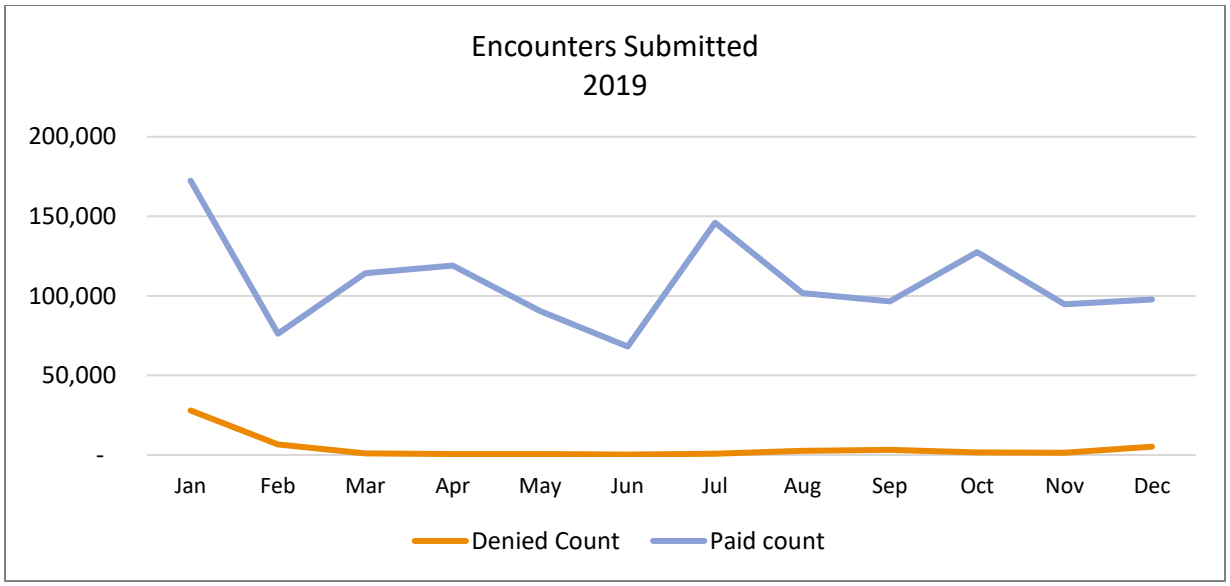
Separately, a small issue was identified with the Procedure codes. Some Institutional claims are missing Procedure codes when one is needed to clearly identify the service described by the Revenue code. Missing Procedure codes did not affect the payments as the providers were paid per diem. However, Procedure codes are necessary to identify the actual service that was rendered when the Revenue code itself cannot fully describe the service. Eastpointe did make improvement in this area when compared to 2018.

Professional encounter claims submitted contained complete and valid data in 14 of the 15 key Professional fields (93%). The primary issue identified also involved Other Diagnosis codes being populated infrequently. The Principal Diagnosis code was populated 100% of the time, but there was very little consistency in Other Diagnosis codes being present. One correction from our review in 2018 that was noted is that Eastpointe is submitting up to 12 Diagnosis codes for Professional claims and continued to be case in 2019. In the previous reviews, the PIHP was only submitting a Principal and Secondary Diagnosis code when one was available.

Encounter Acceptance Report

In addition to performing evaluation of the encounter data submitted, the Encounter Acceptance Report maintained weekly by NC Medicaid was reviewed. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write and excludes duplicates or resubmission which made it difficult to tie back to the ISCA response and converted encounter files. Data provided by Eastpointe for this review includes all submission and resubmissions during 2019 which may include older dates of service.

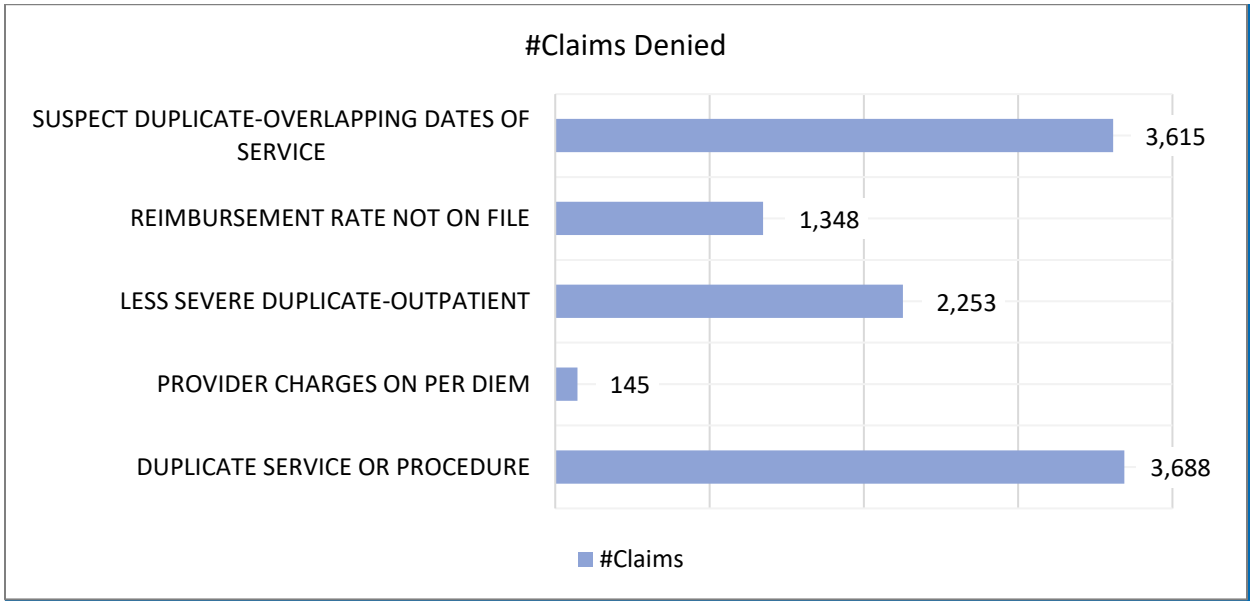
During the 2019 weekly check write schedule, Eastpointe submitted a total of 1,367,707 encounters to NC Medicaid. On average, 7% of all encounters submitted were initially denied, which is down from 19% for 2018 submissions. The decrease was primarily a result of reduction in duplicate records being submitted to NCTracks.



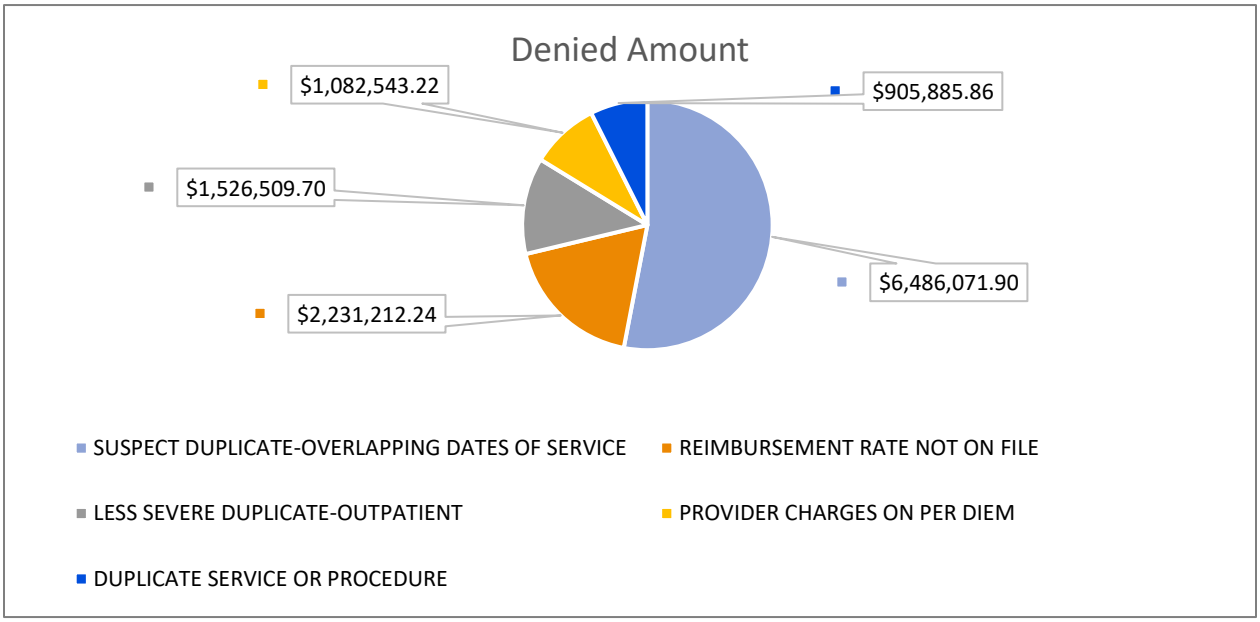
Evaluation of the top denials for Eastpointe encounters correlates with the data deficiencies identified in the Key Field analysis an ISCA review above. Encounters were denied primarily for:

- Suspect duplicate-overlapping dates of service
- Reimbursement rate not on file
- Less severe duplicate – outpatient
- Provider charges on per diem
- Duplicate service or procedure

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: Other Diagnosis

Principal and Admitting Diagnosis code was populated consistently where appropriate. However, Other Diagnosis codes were often missing, especially on Professional claims. This issue has been present since the 2017 review when it was noted that only the Principal and Secondary Diagnosis codes were being submitted. In general, claims from certain providers are missing the Other Diagnosis code at an extremely high rate, including instances where they are missing on 100% of the claims. In the meantime, claims from other providers frequently show Other Diagnosis codes. This suggests that some providers are simply not coding Other Diagnosis codes or failing to map them onto the claims.

Resolution:

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

Issue: Submission of Duplicate Records or Incorrect Voids and Adjustments

Similar to 2018, the majority of the denials in 2019 resulted from their being suspected duplicates. While the overall denial rate has dropped significantly, it remains relatively high due to a large number of suspected duplicate denials.

Resolution:

Eastpointe should review the processes for selecting and submitting encounter records. This review should encompass the following areas:

- Identification and routing out claims based on program (Medicaid vs State-funded)
- Selection of new encounters to report
- Mechanisms for tracking encounter records that have been submitted
- Posting 835 response files from NCTracks
- Correcting and re-submitting previously denied encounters
- Mechanism for tracking re-submissions
- Submission of voids and adjustments

By analyzing the denials, Eastpointe should be able to determine which area is creating the highest number of denials. In the case of suspected duplicates, it is likely caused by resubmitting the same encounter records more than once or the timing of when void and adjustment to previous encounter are submitted. This is an avoidable issue and improvements in tracking of encounter submissions should drastically eliminate the suspected duplicate denials.

Conclusion

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

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

For the next review period, it is recommended that the encounter data from NCTracks be reviewed to review 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