CCME

2018 External Quality Review

TRILLIUM HEALTH RESOURCES

Submitted: June 29, 2018

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

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EXECUTIVE SUMMARY

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

EQR goals include the following:

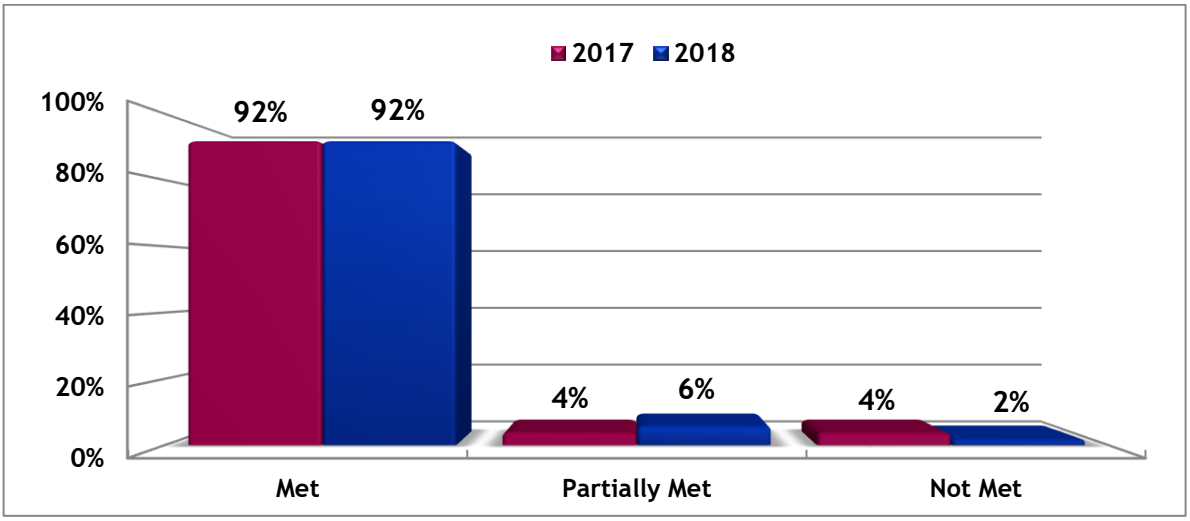
- Determine if Trillium followed service delivery requirements in the PIHP contract with DMA.
- Evaluate the status of deficiencies identified during the 2017 Annual Review and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Assure that contracted health care services are actually being delivered and are of good quality.

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

A. Overall Findings

The 2018 annual EQR shows that Trillium achieved a "Met" score for 92% of the standards reviewed. As the following chart indicates, 4% of the standards were scored as "Partially Met," and 4% of the standards scored as "Not Met." The chart that follows provides a comparison of Trillium's current review results to the 2017 review results.

Figure 1: Annual EQR Comparative Results



B. Overall Recommendations

This EQR report provides detailed recommendations that address each review finding under their respectively labeled section of this report. CCME identified global recommendations for improvement and recommend that Trillium implement our global recommendations, in conjunction with the detailed recommendations in each section.

An overview of the findings for each section follows. Details of the review, as well as specific strengths, weaknesses, any applicable quality improvement items, and recommendations can be found further in the narrative of this report.

Administration

No concerns were noted about Trillium's policies and procedures, organizational staffing, or confidentiality practices. Since Trillium intends to parcel out the Chief Medical Officer (CMO) and Medical Director responsibilities following the retirement of the current CMO, clear delineation of any organizational changes in Trillium's medical oversight in the organizational chart is needed as those changes occur.
During the Onsite, Trillium demonstrated its CIE system's enrollment and claim screens, and provider Web portal. Trillium has comprehensive processes and reporting systems for enrollment, claims reporting, encounter data submission, and reporting and claim functions.

Trillium works with DMA and its providers to address encounter data denials related to missing and invalid provider taxonomy codes. Since December 2017, Trillium improved to a 1% denial rate for encounters submitted to NCTracks. However, Trillium still needs to

submit about 418,439 denied historical encounters to NCTracks for reconciliation, correction and resubmission.

Trillium's CIE claim system and encounter data submission process handles up to 12 ICD-10 diagnosis codes for professional claims and up to 14 ICD-10 diagnosis codes for Institutional claims. Twenty-five ICD-10 diagnosis codes is the maximum number of diagnosis codes that can be submitted on an 837I and the maximum number that is captured by NCTracks. Trillium's CIE claim system and encounter data submission process cannot accept and report all Institutional secondary diagnosis codes submitted on an 837I. This limitation deprives DMA of secondary diagnosis codes available for reporting purposes and submission to NCTracks.

Provider Services

The Provider Services review includes Network Adequacy and Credentialing and Recredentialing. Some issues identified at the last EQR remain unchanged. As indicated in the Network Adequacy EQR last year, Trillium still does not meet some choice and access standards. Also, as at the EQR last year, Trillium submitted, and DMA approved, nine exception requests. Trillium improved regarding several standards in the Credentialing and Recredentialing portion of the review. Opportunities to improve exist regarding several standards, some of which were also issues at the last EQR (e.g., completing required site visits and having the reports in the files, as well as ensuring admitting privileges information and provider profiling information is in the files).

Enrollee Services

The Enrollee Services review focuses on enrollee rights and responsibilities, enrollee PIHP program education, behavioral health and chronic disease management education, and the Call Center. The review revealed standards in the Enrollee PIPH Program Education section that need improvement. Specifically, Trillium needs to include non-English Languages, if any, spoken by each Network Provider in *the Network Provider Directory*.

They need to expand on the extent to which, and how, after-hours and emergency coverage is provided for Post Stabilization Services. Trillium also needs to consistently provide timely written notification to enrollees of a provider's termination from Trillium's provider network.

Quality Improvement

Trillium implemented all PIPs and PM-related recommendations, and corrective actions from the last EQR. In this EQR all items in this section scored "Met." We recommend improvement in the next version of the *Annual Quality Management Program Evaluation)*.

More detail of the year's work for each item along with analysis of outcome data for each section would add value to the document.

Utilization Management

Trillium's utilization management (UM) EQR resulted in three recommendations for the Utilization Management Department and three "partially met" standards in Transition to Community Living (TCLI). Language in the UM procedures did not clearly explain the "expedited" processing of service authorization requests. There was also no detail around the *DMA Contract* requirement that all authorization requests should be processed as "expeditiously as the member's health condition requires." Trillium monitors overutilization of services by enrollees, but not underutilization. This does not provide a comprehensive view of strengths and liabilities within their service array. TCLI procedures need to include Peer Support Specialist credentialing requirements, and the processes around utilizing one-time transitional support services for enrollees involved with TCLI. The TCLI Communication Plan was not included in the *Provider Manual* as indicated in the Trillium Corrective Action Plan response from the previous year's EQR.

Grievances and Appeals

During the past year, Trillium moved the Grievance process from the Program Integrity Department to the Call Center/Connections Department. Staff practices show overall confusion and inconsistencies with the terms "grievance" and "complaint", which impacts the due process rights related to grievances. This may also be impacting data reported to Trillium committees and DMA.

There are three corrective actions and one recommendation related to missing or incorrect language in *the Medicaid Clinical Reconsideration Process* procedure, some of which were noted in last year's EQR. Staff practices are also not consistent with general appeal statutes, the *DMA Contract*, and Trillium procedures when processing an oral, expedited appeal. While new *DMA Contract* and appeal related general statutes went into effect on July 1, 2017, the *Medicaid Clinical Reconsideration Process* procedure and notifications to enrollees about appeals were not in compliance with these changes until late August of 2017.

Delegation

Trillium uses six delegated entities. All delegate files include current contracts/Letters of Agreement, Business Associate Agreements for delegates who have access to Protected Health Information, and evidence of the required annual monitoring. Trillium completed a pre-delegation audit when one delegate was acquired by another business. Trillium ended their only delegated credentialing agreement when the delegate failed to comply with a Plan of Correction. To comply with *DMA Contract, Section 7.6.4 Exclusions*,

Trillium should revise the Delegation procedure and the Delegation Assessment Tool-Credentialing to include the query of the *State Exclusion List*.

Program Integrity

During the 2018 review, Trillium updated and provided all documentation including policies and procedures that meet contractual requirements. CCME recommends Trillium enhance their data mining systems by establishing a strong process to collect and identify potential cases of member fraud, waste, or abuse. Trillium can do this by working directly with the North Carolina Department of Social Services to determine if the State, through reports it receives, is made aware of potential member fraud or abuse before Trillium.

Financial Services

Trillium meets all the Financial Services EQR standards with one exception: Trillium needs to document their retention of financial records procedure as required by *DMA Contract, Section 8.3.2*.

Encounter Data Validation

Based on the analysis of Trillium's encounter data, the EQR concluded that the data submitted to DMA is not complete or accurate as defined by DMA standards.

Trillium should take corrective action to resolve the issues identified specifically with taxonomy denials and procedure codes for institutional claims. As indicated in Trillium's ISCA response, they have already defined a strategy to address issues with invalid or missing taxonomy codes, as well as a reconciliation process to address all DMA denials noted in the report above. Compared to claims reviewed from 2016, Trillium's denial rate has dropped from 29% to 9%.

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 Trillium. The goal is to ensure that Trillium is reporting all paid claims as encounters to DMA.

METHODOLOGY

The process used for the EQR was based on the CMS protocols for EQR of MCOs and PIHPs. This review focused on the three federally mandated EQR activities: compliance determination, validation of PMs, and validation of PIPs, as well as optional activity in the area of Encounter Data Validation, conducted by CCME's subcontractor, HMS. Additionally, as required by the CCME contract with NC DHHS, an ISCA Audit and Medicaid program integrity review of the health plan was conducted by CCME's subcontractor, IPRO. On April 11, 2018, CCME sent notification to Trillium that the annual EQR was being initiated (see *Attachment 1*). This notification included:

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

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

The review consisted of two segments. The first was a Desk Review of materials and documents received from Trillium on May 2, 2018 and reviewed in the offices of CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. Also included in the Desk Review was a review of credentialing, grievance, utilization, care coordination, case management, and appeal files.

The second segment was a two-day, Onsite review conducted on May 30, 2018 and May 31, 2018, at Trillium corporate office in Greenville, North Carolina. CCME's Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's Onsite activities included:

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

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

FINDINGS

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

A. Administration

The EQR of the Administration section includes a review of policies, procedures, staffing levels, information systems, and the health plan's handling of confidential health information.

Policies & Procedures

Trillium's policies and procedures are comprehensive, well written and organized in a consistent manner. In addition, Trillium's process for maintaining all policies and procedures are outlined in *Procedure Development* policy, *Policy Development* policy, *and Policy and Procedure Management* procedure. These policies and procedures mandate at least annual reviews of all policies and procedures with revisions as needed. In addition, Trillium sends staff notifications of revised policies and procedures through email. Trillium policies and procedures each have a master list that identifies the document name, original effective date, approval authority, and the annual review and revision dates. Staff can access all policies and procedures and both master lists using the SharePoint electronic platform.

For this year's EQR, Trillium submitted 100 policies and 170 procedures to CCME. It was determined that this was an accurate accounting of their complete set of policies and procedures by comparing the submittal to their master policy and procedures lists and the previous year's Desk Material submissions. The only exception was one procedure that was missed in the uploading of the EQR documentation.

Staff in the Quality Management Department manually track the policy and procedure annual reviews, revisions, and retirement through the *Master Policy List* and the *Master Procedure List*. Since this is a manual process, there were minor, human errors noted in these master lists. For example, CCME noted that the *Human Rights* policy has a revision date of 8/24/17 within its header, but the *Master Policy List* shows the most recent revision was in 10/22/2015. Similarly, the *Clinical Reconsideration Process* procedure shows it was revised on 4/16/18 and 6/28/17. However, the *Master Procedure List* gives the most recent revisions as 3/20/18 and 7/18/17. To correct these minor errors, CCME

recommends Trillium conduct an annual quality check process where staff reconcile all policies and procedures to their corresponding master lists, not just those recently revised.

Organizational Staffing/ Management

Chief Executive Officer (CEO) Leza Wainwright heads up Trillium's executive leadership team. Dr. Burt Johnson, Chief Medical Officer (CMO) and Dr. Michael Smith, Medical Director provide support and oversight to Trillium's medical and clinical areas. Both doctors, along with a Staff Psychologist and an Integrated Care Nurse comprise the Medical Affairs Department. Our review of Trillium's organizational chart, CMO and Medical Director job descriptions, and committee meeting minutes demonstrate that these doctors provide significant oversight and support of the Care Coordination, Transition to Community Living Initiative (TCLI), Quality Management (QM), Utilization Management (UM), Call Center, Appeals, Program Integrity, and Network Development Departments. Committee minutes show involvement by one or both doctors in the UM, Compliance, Credentialing, Clinical Advisory, Global Quality Improvement (QI), Human Rights, Quality Improvement Committee (QIC), Data Cross Functional Team, and Sentinel Events Review Committees.

CCME's review shows both Dr. Smith and Dr. Johnson participate in the development and monitoring of the *QM Work Plan*, including support and review of projects targeting improved UM and care coordination functions, and Clinical Practice Guidelines (CPGs) development.

During the Onsite discussion, Trillium notified CCME of Dr. Johnson's imminent retirement, and that they are implementing a transition plan to orient Dr. Smith to the CMO position. It was unclear whether Trillium will fill the Medical Director position once Dr. Smith vacates it.

Staffing within Trillium appears sufficient to adequately manage the PIHP functions and responsibilities. During the Desk Review, CCME noted that three Trillium departments had 33% or more of their positions vacant. This was discussed during the Onsite visit. Staff explained that additional positions were recently added to the Information Technology (IT) Department to better support current and upcoming system improvements. Per staff, vacancies within the Human Resources (HR) and Call Center have either been filled since the Desk Materials were uploaded or were recently created to prepare for the addition of Columbus County.

Overall, the organizational chart demonstrated staffing patterns, lines of responsibilities, and department oversight. However, job functions around the Network Director position were unclear. Given the upcoming transition of CMO and Medical Director duties, and

Trillium's recent departmental reorganization, it is recommended that Trillium conduct a thorough review and update to the organizational chart to ensure it reflects changes in departmental oversight.

Confidentiality

CCME reviewed Trillium's policies and procedures on the management and protection of consumer confidentiality. Trillium's strong complement of policies and procedures fully address both state and federal requirements for preserving enrollee confidentiality and protecting health information.

Information Systems Capabilities Assessment

The EQR of Trillium's information system capabilities used the Information Systems Capabilities Assessment (ISCA) Audit, as specified in the Centers for Medicare & Medicaid Services (CMS) protocol.

Using Trillium's completed ISCA tool and supporting documentation, IPRO reviewed the responses and followed up on areas requiring clarification via interviews and a system walk through at the Trillium office located in Greenville, North Carolina, on May 31, 2018. This review was part of the annual compliance audit CCME conducted on May 30th and May 31st, 2018.

Enrollment Systems

Trillium experienced stable enrollment growth during the 2015-2017 period. Comparative end of year enrollment totals are as follows:

Table 1: Enrollment

Year	Enrollment Numbers
2015	190,783
2016	192,046
2017	207,479

In October 2018, Columbus County will move from Eastpointe to Trillium. Trillium will include these members in its system as new enrollees.

During the ISCA Onsite review, Trillium demonstrated its CIE system's enrollment module. The system maintains member enrollment history and imports Global Eligibility Files (GEF) daily. The system compares the daily eligibility file to the system's existing eligibility records. Trillium adds new recipients to the CIE system with their

accompanying eligibility information. For existing recipients, Trillium modifies base information. Eligibility is compared between the CIE system and the daily GEF file. If an 'add' record is contiguous to existing eligibility, the system extends the end date to match the GEF record. If the add record is not contiguous, the system creates a new eligibility record. If a change or delete record overlaps with an existing eligibility record, the system extends the member's end date to match the GEF.

Trillium stores the Medicaid identification number received on the GEF. Trillium's eligibility system can merge multiple member records and link the patient's historical claims.

Trillium's provider Web portal (Provider Direct) allows Trillium providers to confirm a member's eligibility and provide Trillium with third-party liability (TPL) information.

Monthly, Trillium generates a GEF exception report. Enrollment and Eligibility staff review and determine if any consumer information or eligibility changes/corrections exist and need to be addressed.

Trillium reconciles CIE system's enrollment records with the monthly 820 Capitation file.

Claims Systems

Trillium's claims and encounters are processed in the CIE system. The EQR process required review of Trillium's processes for collecting, adjudicating and reporting claims using information contained in Trillium's ISCA response and supporting documentation. A demonstration was given of Trillium's Provider Direct claims entry portal and the CIE system during the Onsite review.

Trillium receives claims from the following three methods:

Table 2: Claim Method Percentages

Source	HIPAA File	Paper	Provider Web Portal
Institutional	4.67 %	.09 %	.78 %
Professional	78.61 %	.22 %	15.63 %

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

If a required field is missing from the claim, Trillium's Provider Direct will not allow the claim to be submitted to Trillium. If the claim is submitted electronically via an electronic 837 file and fields are missing, Provider Direct returns a 999 and an 824 HIPAA

response file to the provider, advising the provider of the claim failure. Trillium claim processors do not add or change any information on the claims. Claims are processed during the nightly adjudication and assigned a CIE claim number.

Trillium adjudicates claims nightly. Trillium auto-adjudicates 98.65% of Institutional claims and 99.80% of professional claims.

Trillium processes claims within 18 days of receipt. Trillium pays approved claims within 30 calendar days after receipt. On average Trillium paid clean claims within 7.23 days of claim receipt during 2017.

Trillium accepts ICD-10 procedure codes and DRG codes if the provider includes the values on an 837I. DRG codes are available for reporting purposes, but the DRGs are not used for payment.

Trillium followed up after the ISCA Onsite and advised that the CIE system captures up to 12 ICD-10 diagnosis codes for professional claims and up to 14 ICD-10 diagnosis codes for Institutional claims. The maximum number of diagnosis codes that can be submitted on an 837I and the maximum number that is captured by NCTracks is 25 ICD-10 diagnosis codes. Trillium does not have the capability to store all possible secondary diagnosis codes submitted on an 837I file.

Trillium staff audits at least 3% of all claims and all claims over $5,000, with a date of service after a date of death or date of service on a holiday.

Reporting

Trillium's data repository captures all the enrollment and claims information in the CIE system. Trillium uses a relational database to create reports and data extracts. Historical data for CoastalCare is available in the AlphaMCS database. The current data warehouse is updated nightly. Since the historical databases are static, they do not require additional updates.

Trillium is planning to perform an in-house migration of the CIE system. Trillium will assume responsibility for all CIE system updates, maintenance, and reporting. For report development, Trillium uses MS SQL (SQL Server Management Studio) and Visual Studio. Trillium has nine developers using SQL Server Reporting Services (SSRS) to produce reports. There are currently 11 vacant report developer positions available.

Currently, Trillium outsources 95% (all except for internal SSRS report development and ad hoc reporting) of programming. Trillium Programmers and Developers will handle the programming for the system migration.

Encounter Data Submissions

Trillium submits encounter data to DMA using a fully automated process its IT Department developed.

Weekly, Trillium submits claims to NCTracks using the 837I and 837P file formats. A total of 46,723 institutional and 827,711 professional encounters were submitted to NCTracks for 2017 dates of service. Trillium identified 362 Institutional and 68,133 professional encounters that were denied and not yet accepted with 2017 dates of service. Trillium is also working on the resubmission of the historical 837I/837P encounters to DMA, including the following:

- 715 Institutional encounters with 2016 dates of service
- 146,244 professional encounters with 2016 dates of service
- 554.960 encounters for CoastalCare
- 40,900 encounters for East Carolina Behavioral Health (ECBH)

Trillium has shown an improvement since the last ISCA audit, in regard to encounter data submissions and the reduction of provider taxonomy related denials. Since December 2018, Trillium achieved a 99% claims acceptance rate. On average, it takes Trillium 39 days to correct and resubmit an encounter to NCTracks. As of March 2018, the three top denial reason codes are as follows:

1. Diagnosis non-specific
2. Billing provider must be enrolled for billing taxonomy code
3. Duplicate service for procedure

Trillium maintains its encounter data submission and reconciliation information in an SQL database. As of December 2017, per State guidelines, Trillium made changes to the outgoing 837 files. Trillium now submits claims at the header level with the detail lines (Detail ID). When a claim denial is returned to Trillium from NCTracks via the incoming 835 file, the claim record is matched in the SQL database (Tracking Log) using the Detail ID. Denials are then categorized by denial code and sent by IT to the appropriate functional area in a tracking sheet for correction and resubmission.

After the ISCA Onsite, Trillium confirmed that it will submit any physical health secondary diagnosis codes and ICD-10 procedure codes to NCTracks.

Trillium followed up after the ISCA Onsite and advised that up to 12 ICD-10 diagnosis codes for professional claims and up to 14 ICD-10 diagnosis codes for Institutional claims can be submitted to NCTracks. Twenty-five ICD-10 diagnosis codes is the maximum

number of diagnosis codes that may be submitted on an 837I and the maximum number that is captured by NCTracks. Trillium does not have the capability to submit to NCTracks all the possible 837I secondary diagnosis codes.

The chart that follows provides a comparison of Trillium's current Administrative Review results to the 2017 review results

Figure 2: Administration Comparative Findings

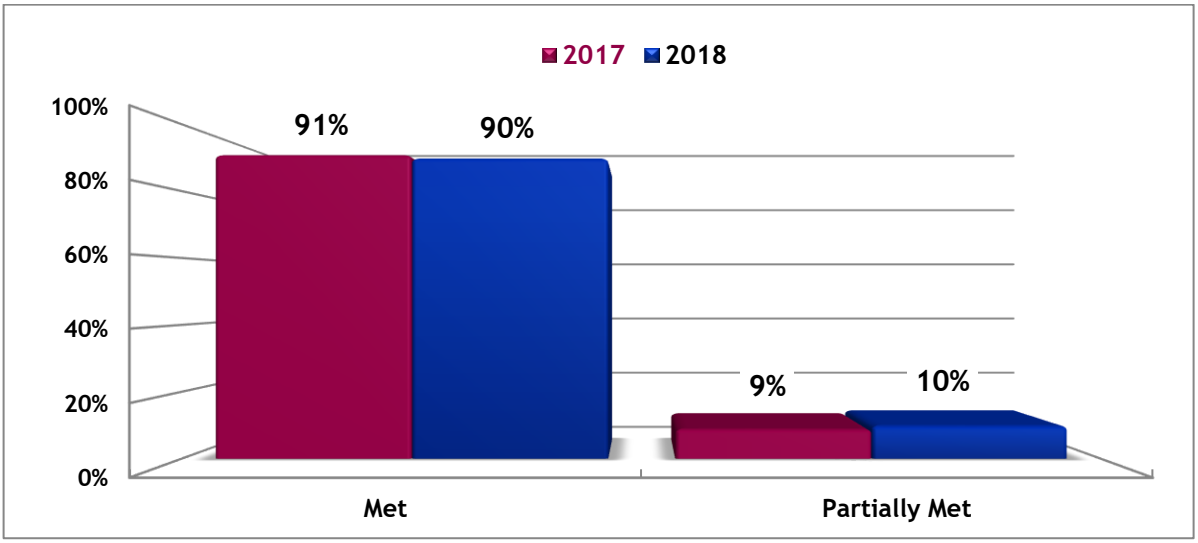


Table 3: Administration

Section	Standard	2018 Review
Management Information Systems	The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 diagnosis codes received on an 837 Institutional and 837 professional file, capabilities of receiving and storing ICD-10 procedure codes on an 837 Institutional file.	Partially Met
	The MCO has the capabilities in place to submit the State required data elements to DMA on the encounter data.	Partially Met

Strengths

- Trillium demonstrated adequate management, annual review and active revisions of their policies and procedures.

- Trillium's current staffing patterns show adequate management and oversight of PIHP functions.
- Trillium has comprehensive enrollment and claim processing transaction and reporting systems.
- Trillium can merge multiple member records and link the member's historical claims data to the merged member record.
- Trillium reconciles the CIE enrollment records with the monthly 820 Capitation file, which serves as an additional level of reconciliation.
- Nightly, Trillium auto-adjudicates clean claims; 98.65% of Institutional claims and 99.80% of professional claims.
- Trillium's current NCTracks encounter acceptance rate is at 99% since December 2017.
- Well-informed staff are dedicated to improving encounter data submissions and reducing the number of denials.

Weaknesses

- Trillium has errors on their organizational chart regarding the Network Director position and could not report a plan to distribute the Medical Director functions and oversight in preparation for the retirement of their Chief Medical Officer.
- As of April 19th, 2018, Trillium had about 418,439 encounters that were not corrected, resubmitted and accepted by NCTracks.
- Trillium cannot receive, store and report all the ICD-10 secondary diagnosis codes for the Institutional encounters. Trillium's CIE system can only store up to 18 ICD-10 diagnosis codes for an Institutional encounter.
- Trillium cannot receive, store, report and submit to NCTracks all the ICD-10 secondary diagnosis codes. Trillium can only submit to NCTracks up to 18 ICD-10 diagnosis codes on an 837I file.

Corrective Actions

- Update the CIE system and Provider Direct so that all ICD-10 CM diagnosis codes can be submitted on an Institutional 837 HIPAA file and be stored in the CIE system. Trillium does not capture all the secondary ICD-10 CM diagnosis codes populated on an incoming 837 Institutional file and the Provider Direct. Only a maximum of 14 diagnosis codes are captured. Update the CIE system so that it accepts all secondary ICD-10 diagnosis codes for an 837I.

- Update the encounter data submission process so that all ICD-10 CM diagnosis codes submitted on an Institutional 837 HIPAA file can be submitted to NCTracks. Twenty-five ICD-10 diagnosis codes is the maximum number of diagnosis codes that can be submitted on an 837I and the maximum number that is captured by NCTracks. Trillium submits a maximum of 14 diagnosis codes on an 837I file. Update the encounter data submission process so that it can submit all secondary ICD-10 diagnosis codes present on an 837I.

Recommendations

- Update the current organizational chart to reflect the recent changes in the Network Development Department staffing.
- Given the CMO's upcoming retirement, document the potential plan to ensure the responsibilities and oversight of Medical Director functions are covered as specified in *DMA Contract, Sections 6.7.6* and *7.1.3*.
- Trillium has a 1% encounter denial rate, but there are approximately 418,439 encounters that have not yet been submitted to NCTracks. Work with DMA on developing a plan to resubmit the denied historical encounters.

B. Provider Services

The Provider Services External Quality Review (EQR) is comprised of Credentialing and Recredentialing, and Network Adequacy (which includes Provider Accessibility, Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, and Practitioner Medical Records). The EQR of Provider Services included relevant policies and procedures, the *Provider Manual*, the *Credentialing Program Description*, the *Credentialing Committee By-Laws*, Credentialing Committee minutes, provider network information, credentialing/ recredentialing files, practice guidelines, provider training materials, the *Trillium Health Resources Needs Assessment for the NC DMHDDSA and DMA June 1, 2017* ("*Gaps Analysis*"), and the Trillium website.

The Network Adequacy section of the Onsite visit included a presentation by Cindy Ehlers, LPC, Vice President Clinical Operations, and an interview with Trillium staff, including:

- Amy Bryant, Network Director
- Julie Brinson, Network Auditing Manager
- Khristine Brewington, LPC, LCAS, CCS, CCJP, Network Service Manager
- Christie Edwards, LPC, LCAS, Senior Director of Trillium Connections
- Luz Terry, Contracts and Training Director

- Rebbecca Basden, Contracts Manager
- Miriam Godwin, Provider Training Manager

The Credentialing/Recredentialing section of the Onsite visit included a presentation by Ms. Brewington and an interview with Ms. Ehlers, Ms. Brewington, Dr. Burt Johnson, Chief Medical Officer (CMO), Dr. Michael Smith, Medical Director, and other Trillium staff.

The Trillium Network area experienced significant change within the past year, including a number of key personnel changes. Susan Hanson, the former Operations Vice President, is no longer with Trillium. The departments that previously reported to Ms. Hanson were redistributed among other Executive Team members, with Network Auditing, Network Services (which includes Network Development), and the Network Contract area now reporting to Ms. Ehlers. After the most recent Network Director left in February 2018, Ms. Ehlers served as "Network Operations Director-Interim" until Amy Bryant, who was an Intellectual and Developmental Disabilities (I/DD) Child Unit Manager, became the Network Director on May 1. Khristine Brewington, LPC, LCAS, CCS, CCJP, who had been an Adult Team Clinician in the Mental Health Substance Use Care Coordination area, started as the Network Service Manager in March 2018.

Dr. Burt Johnson, CMO and a board-certified psychiatrist, chairs the Credentialing Committee. Dr. Michael Smith, Trillium Medical Director and a board-certified psychiatrist, is a voting member of the Credentialing Committee. Additional Credentialing Committee members include seven network providers representing several licensure categories and specialty areas. Various Trillium staff members serve as voting members of the committee.

The *Credentialing Program Description* and several procedures, including the *Credentialing and Re-Credentialing Process* procedure, address the credentialing process. There is conflicting language in the *Credentialing Committee By-Laws* and the *Credentialing Program Description* about the frequency of Credentialing Committee meetings, with some statements indicating the committee meets monthly and one statement that it meets "at least quarterly".

There is a discrepancy between the *Credentialing Program Description* and the *Credentialing Committee By-Laws* regarding the definition of a quorum. The *Credentialing Program Description* definition includes the Committee Chair and the Credentialing Specialist, neither of whom is a voting member of the committee (the CMO is the Committee Chair and only votes in the event of a tie).

The committee met monthly between May 2017 and April 2018. A quorum of voting members was present for 11 of the committee's 12 meetings. There was no quorum of

voting members present at the November 15, 2017 meeting. Electronic votes were cast for business items that would have been conducted at that meeting.

Over the course of the 12 meetings from May 2017 to April 2018, 16 different people are listed as voting members, with seven different Trillium employees listed as voting members for six or fewer of the 12 meetings. The committee meeting attendance of the Trillium employees who are voting members ranged from 33% to 100% meeting attendance where they were members of the committee. At the Onsite, Trillium staff explained that the erratic attendance by Trillium staff members was due to the changes in the Network Department. The attendance of the seven non-Trillium employees ranged from one member who attended 17% of the meetings to two members who each attended 83% of the meetings. Dr. Johnson and Dr. Smith were the only two committee members who attended all 12 meetings. Two Trillium employees were included in the "Voting Members" of the Credentialing Committee meeting minutes for the February 21, 2018 meeting, but were listed as "visitors". Visitors are not voting members of a committee.

The credentialing and recredentialing file review showed the files were organized and contained appropriate information; however, several items were not located during the Desk Review. Most items were located and provided either in response to the Onsite Documents Request, or during the Onsite visit. Details regarding these items are contained in the Tabular Spreadsheet. For future reviews, ensure all requested items are included in the files uploaded for Desk Review.

CCME could not find evidence of a *State Exclusion List* query in any credentialing or recredentialing files submitted for review. During the Onsite visit, Trillium staff reported this query is conducted by the Program Integrity Department. A screen shot of a spreadsheet including a column labeled "Other Findings (*i.e.* NC DMA Excluded Provider List, Sec. of State, etc.)" was uploaded during the Onsite visit. The date of the queries listed on the spreadsheet ranged from May 4, 2018 to May 29, 2018. CCME requested that Trillium staff submit evidence documenting these queries were conducted during the credentialing and recredentialing process for the files submitted for review, but the information was not received. The *Credentialing Program Description* and the *Credentialing and Re-Credentialing Process* procedure do not include any reference to a query of the *State Exclusion List*.

The *Trillium Health Resources Needs Assessment for the NC DMHDDSA and DMA June 1, 2017* ("Gaps Analysis") lists nine Medicaid-funded services for which Trillium did not meet choice/access standards. Exception Requests for those services were submitted to and approved by DMA. Trillium staff attributed several gaps to the rural, sparsely populated nature of much of its catchment area, and reported numerous unsuccessful efforts, including Requests for Proposals (RFPs) and direct targeting of providers, to add providers for services for which access standards are not being met. Ms. Wainwright, the Trillium

Chief Executive Officer, noted special challenges with locating providers for bundled services such as ACT, as it is not financially viable for providers in rural areas. Trillium "unbundles" services when they are unsuccessful in locating a provider for bundled services, and also uses Client Specific Agreements to secure services. For the *Gaps Analysis*, Trillium undertook a number of efforts to increase survey responses from consumers and family members, which resulted in a 35% increase in surveys collected. Efforts to increase stakeholder participation resulted in 23% more completed surveys than the previous year.

Trillium reported a smooth transition for the addition of Nash County last July. Columbus County will be added in July 2018. Several RFPs are posted in an effort to provide additional services in Columbus County, and Trillium will add providers who are currently contracted with the other Prepaid Inpatient Health Plan (PIHP) (from which Columbus County is transitioning) to its network. To prepare Columbus County for inclusion within the Trillium PIHP, a series of "Columbus Realignment – Listening Sessions" is offered throughout Columbus County from June 4-18, 2018 to educate that community on services Trillium offers.

The following chart shows that 87% of the standards in the Provider Services section were scored as "Met." The "Partially Met" and "Not Met" scores are related to items missing in the credentialing/recredentialing process, inaccurate information regarding situations requiring immediate care, and failure to include enrollee rights in the *Provider Manual*. Trillium reports it plans to include enrollee rights in an updated *Provider Manual* to be issued in July 2018.

Figure 3 provides a comparison of the 2017 scores versus the 2018 scores.

Figure 3: Provider Services Findings

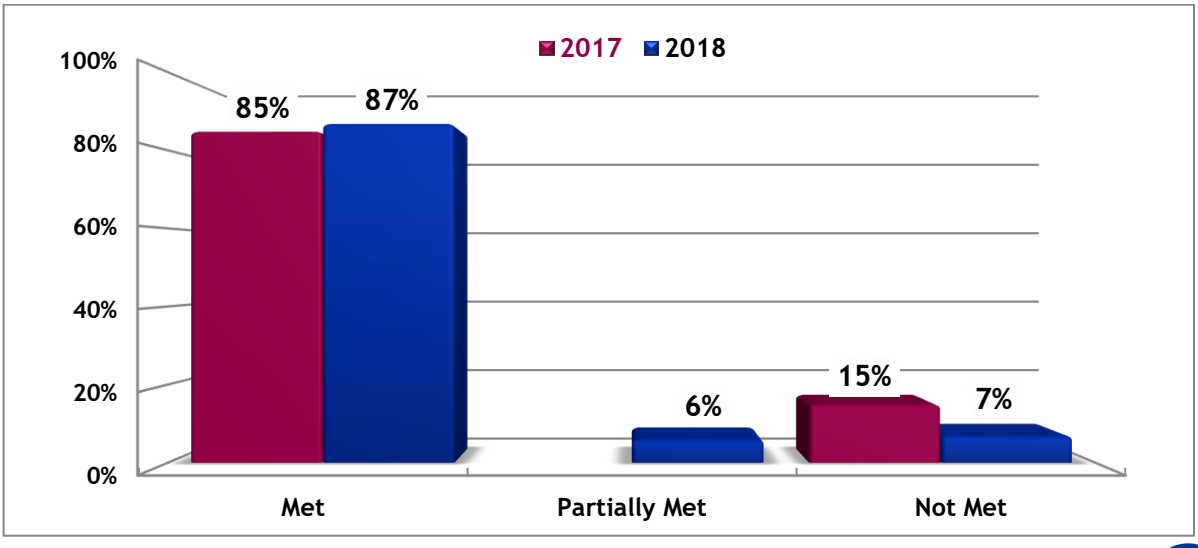


Table 4: Provider Services

Section	Standard	2018 Review
Credentialing and Recredentialing	Credentialing: Verification of information on the applicant, including: Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	Partially Met
	Site assessments	Not Met
	Recredentialing every three years	Not Met
	Recredentialing: Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat enrollees;	Partially Met
	Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event;	Partially Met
	In good standing at the hospital designated by the provider	Not Met
	Review of provider profiling activities	Not Met
Provider Accessibility	The PIHP formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	Partially Met
Provider Education	Enrollee rights and responsibilities	Not Met

Strengths

- Trillium's strategies to increase consumer responses for the *Gaps Analysis* resulted in a 35% increase in surveys over the previous year.

- The *Gaps Analysis* process used with stakeholders resulted in 23% more completed surveys than the previous year.
- There is a separate toll-free number for administrative and business matters.
- Trillium reports they have instituted a variety of changes they believe will eliminate some of the issues that have occurred in the credentialing and recredentialing processes.
- In September 2017, Trillium implemented a ticket system for Site/Service Requests or Network Application Requests, to standardize processes and track workflow and productivity.
- Trillium has a Learning Portal with training/education materials that is accessible to providers on demand.

Weaknesses

- Credentialing and recredentialing files uploaded for Desk Review were missing items, including, for example:
  - Primary Source Verification (PSV) of some clinical licenses, particularly when the provider has two licenses;
  - Supervision contracts for providers with an "associate" license such as LCSW-A, LCAS-A;
  - Ownership Disclosure information for persons with an "ownership or control interest in the provider, and agents and managing employees of the provider".

  Trillium presented the preceding and other items when CCME requested them during the Onsite review.
- Inconsistent and conflicting language exists in the *Credentialing Program Description* and the *Credentialing Committee By-Laws* about the Credentialing Committee meeting frequency and about what constitutes a quorum. Though a quorum of voting members attended most Credentialing Committee meetings from May 2017 through April 2018, employee representation and committee meeting attendance by all committee members was inconsistent except for the CMO and the Medical Director.
- The submitted credentialing file for one physician contained no PSV of the physician's education, including no PSV of Educational Commission for Foreign Medical Graduates (ECFMG) certification, and it was not located by Trillium staff at the Onsite.
- No evidence of a query of the *State Exclusion List* was found in the submitted credentialing or recredentialing files. During the Onsite visit, Trillium staff indicated these checks are conducted by the Program Integrity Department. Trillium submitted a screenshot of a spreadsheet of checks the Program Integrity Department conducted

in May 2018. CCME asked Trillium staff to submit evidence of the *State Exclusion List* queries conducted during the credentialing and recredentialing processes for the credentialing and recredentialing files that were submitted for review. This evidence was not received. The *Credentialing Program Description* and the *Credentialing and Re-Credentialing Process* procedure do not reference a query of state sanctions, including no reference to a query of the *State Exclusion List*.

- Physician admitting privileges:
  - An initial credentialing file for a physician applying to be added to a practice in Concord, NC lists the secondary practice address as an address in New Jersey and includes a current certificate of insurance for the New Jersey address. The physician listed admitting privileges at a hospital in Berea, Kentucky. There was no inquiry from Trillium regarding this information.
  - Two recredentialing files were submitted for physicians. Neither file included hospital admitting privileges, and Trillium did not locate the information during the Onsite. This was also an issue at the 2016 and 2017 EQRs. As noted at the last EQR, the Recredentialing Application does not include a question regarding hospital admitting privileges, and it does not appear on the Trillium *Supplemental & LIP Credentialing Checklist*.
- Site visits did not occur in four of the twelve initial credentialing files and, in two additional cases, the site visit occurred after credentialing was approved. This was also an issue in the 2017 EQR.
- Seven of the 12 providers were not re-credentialed within three years, with recredentialing ranging from a day to about 8 weeks late. In some files, it appeared that Trillium was counting the time since credentialing or the prior recredentialing based on the date the approval letter was sent, versus the date of the actual approval. At the Onsite, Trillium staff acknowledged this was a problem that is now resolved.
- Supervision contracts were not located in the recredentialing files for two Licensed Psychological Associates (LPAs). This was also an issue at the 2017 EQR.
- Complete practitioner profiling information was not found in any of the recredentialing files or in the Credentialing Committee meeting minutes, and Trillium did not locate them at the Onsite. This was also an issue at the 2017 EQR.
- The *Clinical Screening and Triage* procedure includes a table that has columns labeled "Urgency of the Triage" ("Routine", "Urgent" or "Emergent"), "Definition", and "Timeframe to be Seen". The "Definition" for rows labeled "Emergent" lists

situations (such as "an imminent risk of harm to self or others") that would warrant being seen immediately, rather than "Within 2 hours" as indicated in the procedure.

- The Trillium *Provider Manual* includes a link to the Clinical Practice Guidelines on the Trillium website; however, the link goes to "Page not found". It appears there may be a typographical error in the link, as the final word is "Guidlines" (instead of "Guidelines").
- As indicated at the last EQR, the *Trillium Call Center Training for New Providers* has correct timeframes for Access Standards but does not contain any information regarding appointment wait times.
- The current *Provider Manual* does not list enrollee rights. Trillium indicated the *Provider Manual* to be revised in July 2018 will include the enrollee rights. This was also an issue at the last EQR.

Corrective Actions

- Ensure all credentialing and recredentialing files include evidence of the query of the *State Exclusion List*, as required by *DMA Contract, Section 1.14.4*. Revise the *Credentialing Program Description*, the *Credentialing and Re-Credentialing Process* procedure, and any other relevant documents to include the query of state sanctions, including the *State Exclusion List*.
- Verify the provider's site visit documentation is included in each credentialing file. If the site visit was done in the past, include proof of the site visit in the individual practitioner credentialing file for the EQR. If the practitioner is joining an agency that is a licensed facility, include the current PSV of the facility license in the credentialing file. See *DMA Contract, Section 7.9*, *42 CFR § 455.432*, and Trillium's *Network Monitoring* procedure.
- Per Trillium's *Credentialing Program Description*, ensure providers are recredentialed within three years of the date of the approval of initial credentialing or the most recent recredentialing. This is not the date on the letter conveying approval, but the date of approval by the Chief Medical Officer (CMO) for "clean" files or the Credentialing Committee for "red-flagged" files.
- Ensure the required supervision contracts are in the files for practitioners for whom it is required, including LPA practitioners.
- Confirm all physician files include the names of hospitals at which the practitioner currently has admitting privileges. See DMA Contract, Attachment O, #9 ii.
- As indicated in the Corrective Action for the last EQR: To comply with Trillium's *Credentialing and Recredentialing Process* procedure and *DMA Contract, Section 7.6*, ensure provider performance is taken into consideration at recredentialing. If Trillium

is using the *Verification of Provider Standing* (*VPS*) forms for this process, confirm all completed *VPS* forms have been received prior to submitting the recredentialing application packet for approval by the CMO or the Credentialing Committee.

- Revise the *Clinical Screening and Triage* procedure to clearly indicate care is to be provided immediately in life-threatening situations, as indicated in *DMA Contract, Attachment S*.
- Revise the *Provider Manual* to include the list of enrollee rights, as required by *DMA Contract, Section 7.11.1 m*, and as recommended at the last EQR. Additionally, if Trillium includes in any printed materials links to the Trillium website, ensure the links are checked periodically, to confirm they work.

Recommendations

- Ensure credentialing and recredentialing files contain all items (*e.g.*, PSV of clinical licenses, particularly when the provider has two licenses; supervision contracts for providers with an "associate" license such as LCSW-A, LCAS-A; Ownership Disclosure information for persons with an "ownership or control interest in the provider, and agents and managing employees of the provider". If items are maintained elsewhere at the PIHP, include a copy in the credentialing/recredentialing files submitted for review.
- Within and across documents related to the Credentialing Committee, reconcile language regarding frequency of meetings and what constitutes a quorum. Consider ways to stabilize committee meeting attendance.
- Conduct PSV for ECFMG certification for physicians educated outside the United States, as this serves as PSV of education. For physicians who are not board certified, but for whom ECFMG is not relevant, conduct PSV of education.
- When an application includes practice information or hospital privilege information for locations that are not near the location for which the provider/practitioner is applying, follow up to clarify the information and verify the location at which the provider is practicing.
- Correct the link in the *Provider Manual* to the Clinical Practice Guidelines. Have a staff member periodically check links to ensure they work.
- Include appointment wait times in the *Trillium Call Center Training for New Providers*.

C. Enrollee Services

The review of Enrollee Services included policies and procedures, the *Member & Family Handbook*, the submitted enrollee educational materials, the Call Center training materials, and a variety of items on the Trillium Health Resources (Trillium) website.

Cindy Ehlers is the Vice President (VP) of Clinical Operations and oversees the Connections Department. The Connections Department includes the Call Center and Customer Service Departments. Christie Edwards is the Connections Senior Director. the Communications and Marketing Department led by Jennifer MacKethan maintains and updates all enrollee education materials, including the *Member & Family Handbook*.

Within 14 days of enrollment, Trillium sends the *New Enrollee Form Letter* notifying enrollees of information available on the Trillium website, including the *Member & Family Handbook*. The Access to Care toll-free phone number is provided in the letter, which informs enrollees that they may request a copy of the *Member & Family Handbook* or other information via a phone call. The *Network Provider Directory* is located on the Trillium website via the "Find a Provider" button and has a helpful search feature. The written *Network Provider Directory* provides minimal information when compared to the online version. The online and written *Network Provider Directory* is missing a field for non-English language spoken by the provider. Trillium has not developed large print enrollee materials, but said they would develop, print, and send enrollee materials to an enrollee if requested.

Trillium offers several enrollee education options. To prepare Columbus County for inclusion within the Trillium Prepaid Inpatient Health Plan (PIHP), Trillium is offering a series of "Columbus Realignment – Listening Sessions" throughout Columbus County from June 4-18, 2018 to educate that community on services Trillium offers. During the past year, Trillium has offered a program for *Mental Health and Youth Mental Health First Aid* and recorded attendance. Trillium will deploy a "New Member Orientation" Power Point presentation this year. Trillium also offers a "Community Education Training Needs" assessment on the website for enrollees to fill out on demand.

Trillium maintains a toll-free 24/7/365 Crisis Call and Service Enrollment line and a separate toll-free line for administrative matters. The Trillium Call Center is in Greenville. Although the organization chart lists 7.5 open positions in the Call Center, Onsite discussion confirms they fill those positions with temporary staff. Response times remain good, with Trillium using increased temporary staff members when call volume increases.

There is no contracted vendor for overflow or after-hours calls. Several staff members are cross-trained to answer calls when needed and are contracted to answer calls after-hours. Trillium verified during the Onsite interview there are always a minimum of two clinicians available for referrals, assessments, and crisis care.

Trillium acknowledged that enrollees leave a message if their call comes in when all lines are busy. Trillium staff is required to return the call within one hour. Trillium does not collect data about how often this happens. They indicated it does not happen often and

that they return calls within one hour, which is consistent with the *DMA Contract* requirement.

The "Individuals & Families" section of the Trillium website provides information and resources for enrollees and family members, including information on Crisis Services, and specific information for Mental Health Substance Abuse (MHSA), Intellectual and Developmental Disabilities (I/DD), Innovations, and Traumatic Brain Injury resources.

In the following chart, 94% of the standards received a "Met" score and 6% received a "Partially Met" score. No standard was scored "Not Met."

Figure 4 compares 2017 EQR scores to 2018 EQR scores.

Figure 4: Enrollee Services Comparative Findings

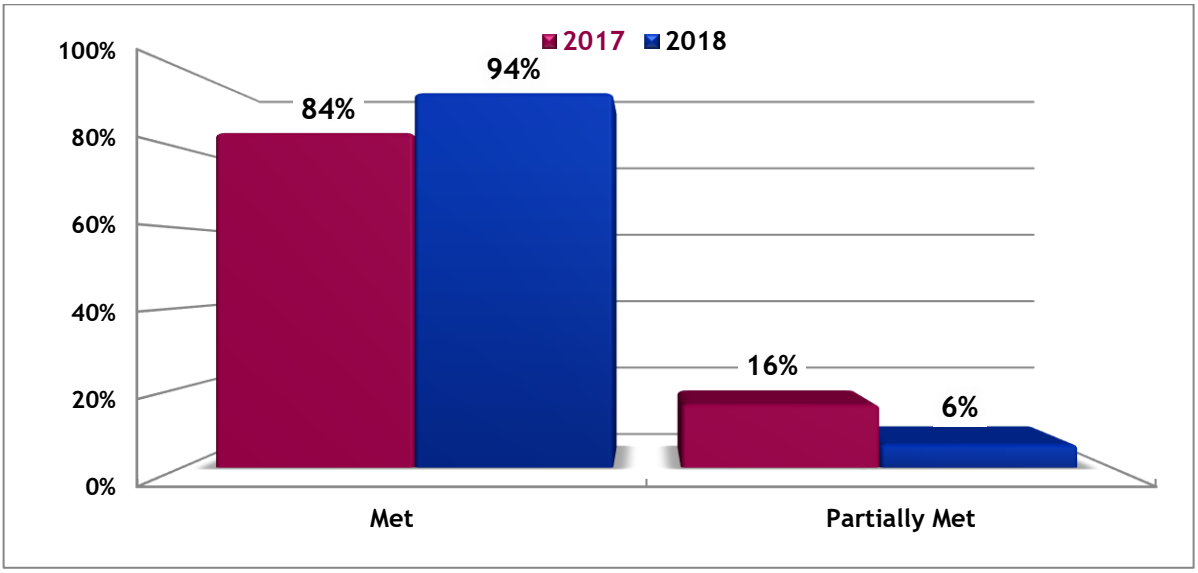


Table 5: Enrollee Services

Section	Standard	2018 Review
Enrollee PIHP Program Education	Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid Waiver managed care program which they are contractually entitled, including: • The non-English languages, if any, spoken by each Network Provider; • The extent to which, and how, after-hours and emergency coverage are provided, including: What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services in accordance with 42 CFR§ 438.114 and EMTALA; The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract	Partially Met
	Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in CFR 438.10 (f) (61) and 438.10 (g) at least 30 days before calendar days before the intended effective date of the change; and (2). termination of their provider within fifteen (15) calendar days after PIHP receives notice that DMA or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider	Partially Met

Strengths

- Call Center meets all metrics with no delegated entity.
- Trillium offers several for enrollee education options. Trillium will conduct extensive member outreach and training in June 2018 for Columbus County joining the catchment area. Other member-focused trainings are outlined in the stakeholder newsletters.
- The Trillium website provides enrollees with valuable information about Trillium, obtaining services, crisis intervention, and educational/training opportunities.
- The "Contact Us" link at the top of each page of the Trillium website goes to an overview page full of information, including information about TTY, information for

non-English speakers, a list of Trillium holidays, and links to submit concerns, complaints, compliments, or questions.

Weaknesses

- The on-line and written *Network Provider Directory* do not contain information about provider spoken language.
- Post Stabilization Services are not explained in the *Member & Family Handbook*.
- Locations for Post Stabilization Services are not outlined in the *Member & Family Handbook*.
- *DMA Contract, Section 6.10*, requires the PIHP to make "good faith effort" to give notice within fifteen calendar days after the PIHP receives notice that DMA or the provider has terminated the Provider Agreement or within fifteen calendar days after the PIHP terminates the written agreement. All files reviewed contained letters that were sent after the 15-day notification requirement.
- Trillium does not currently have enrollee materials created or printed in large front (18 point or greater) for visually impaired members. Neither the website nor the *Member and Family Handbook* contains a notice in large font (18 point or greater) that these materials are available to enrollees.

Corrective Actions

- Add a field to the on-line and written *Network Provider Directory* for non-English languages spoken by network providers. This corrective action was required during last year's EQR and was not implemented.
- In the *Member & Family Handbook*, add an explanation of Post Stabilization Services or continued care after an emergent situation.
- Confirm written notice of provider termination is given to all enrollees in compliance with *DMA Contract, Section 6.10*. Follow the process outlined in the *Continuity of Care-Provider's Termination* procedure. This corrective action was required during last year's EQR and was not implemented.

Recommendations

- In the *Member & Family Handbook*, add language for where members can receive Post Stabilization Services or continued care after an emergent situation.
- Create enrollee materials in large font and have a plan to print enrollee material in large font when requested. See *DMA Contract, Section 6.9.2* and *CFR 438.10 (d)*. Add a notice to the website and in the *Member & Family Handbook,* in 18-point font or

greater, that states all enrollee materials can be printed in large print and mailed if needed. Include a contact for that request in all notices.

D. Quality Improvement

Trillium Health Resource's (Trillium's) *2017-2018 Quality Management Plan* (QM Plan) outlines its program for measuring and improving the care and services enrollees and providers receive. The Governing Board is ultimately responsible for oversight of the Quality Management (QM) Program and annual approval of the written QM Plan. The Senior Director of QM, Kim Keehn, is responsible for the QM Program. Dr. Burt Johnson serves as the Chief Medical Officer and provides support for the QM Department. Dr. Michael Smith, Medical Director, reports to Dr. Johnson. Both physicians are members of the Quality Improvement Committee (QIC). Ms. Keehn and Dr. Johnson co-chair the QIC.

QIC responsibilities are listed in the QM Plan and all responsibilities are "Met" as evidenced by the QIC meeting minutes and *QM Work Plan* updates. The QIC has 14 voting members, all internal to Trillium. Over the past year, most members attended more than 75% of meetings. No attendee fell below 50% attendance. Global Quality Improvement Committee (GQIC) consists of 12 voting members, all outside the Trillium organization. GQIC has four non-voting members within Trillium. GQIC updates were reported in the QIC meetings. A quorum was always present at QIC and GQIC.

The *QM Work Plan* is up-to-date and tracks projects the QM team is following. The work plan document consists of activity/goal/tasks, start date, completion date, assigned to, percent complete, and status fields. Items are highlighted when completed. It's clear and easy to follow.

Trillium implemented a project to monitor provider adherence to Clinical Practice Guidelines (CPGs) for two specific areas: rating scales for depression and metabolic monitoring of patients taking antipsychotics. Dr. Johnson oversees the rating scale for depression monitoring. Of three pilot sites, two sites reported data consistently. Trillium analyzed the data. Dr. Smith oversees the metabolic monitoring of patients taking antipsychotics. There was an issue in capturing this data by a third-party vendor over the past year. As a result, Trillium is moving data-capturing activities in-house and plans to have data for analysis going forward. The summary of these two CPG monitoring projects were explained well at the Onsite interview, but results were not detailed in the *Annual Quality Management Program Evaluation Fiscal Year 2016-2017*. More detail is needed in this program evaluation to explain how Trillium monitors CPGs and what results were produced throughout the year.

Trillium is monitoring and analyzing results for all provider and enrollee surveys with a written document for each survey. A plan is in place to implement improvements on

lower-scoring survey items. Follow through on that plan is not evident in the reports Trillium prepared or in the *Annual Quality Management Program Evaluation Fiscal Year 2016-2017*. More detail is needed in this program evaluation to explain how Trillium addresses and follows lower scoring measures from the surveys. Trillium also places survey results on its website for enrollees and providers to view.

The *Annual Quality Management Program Evaluation Fiscal Year 2016-2017* consists of an executive summary, 2016-2017 highlights, activities and accomplishments, and a summary at the end of the report. The activities and accomplishments section describe each quality management objective, the 2016-2017 activities for that objective with next steps, and if the objective was met or not met. This document is objective and gives a summary of the year's activities. It could be improved by adding more detail about the year's work for each item along with analysis of outcome data for each section. For example, the CPGs lack outcomes achieved from the year's work on both CPGs that were monitored.

Performance Measure Validation

As part of the EQR, CCME conducted the independent validation of Division of Medical Assistance (DMA)-selected *B* and *C Waiver* performance measures.

Table 6: *B Waiver* Measures

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

Table 7: *C Waiver* Measures

C WAIVER MEASURES	
Number and percentage of new waiver enrollees who have a LOC prior to receipt of services	Proportion of PCPs that are completed in accordance with DMA requirements

C WAIVER MEASURES	
Proportion of providers that meet licensure, certification, and/or other standards prior to their furnishing waiver services	Proportion of records that contain a signed Freedom of Choice Statement
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Proportion of participants reporting their Care Coordinator helps them understand which waiver services are available to them
Proportion of providers reviewed according to PIHP monitoring schedule to determine continuing compliance with licensing, certification, and contract and waiver standards	Proportion of participants reporting they have a choice between providers
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	Proportion of claims paid by the PIHP for Innovations waiver services that have been authorized in the service plan

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

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

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

The reported results for these measures are included in the following tables for 2016 and 2017. The percentage rate covers a time of July 1, 2016 through June 30, 2017.

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

30-day Readmission Rates for Mental Health	2016	2017	Change
Inpatient (Community Hospital Only)	14.3%	15.6%	1.3%
Inpatient (State Hospital Only)	16.2%	6.1%	-10.1%
Inpatient (Community and State Hospital Combined)	14.3%	15.4%	1.1%

30-day Readmission Rates for Mental Health	2016	2017	Change
Facility Based Crisis	22.4%	15.9%	-6.5%
Psychiatric Residential Treatment Facility (PRTF)	5.1%	5.7%	0.6%
Combined (includes cross-overs between services)	14.0%	15.0%	1.0%

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

30-day Readmission Rates for Substance Abuse	2016	2017	Change
Inpatient (Community Hospital Only)	18.0%	7.0%	-11.0%
Inpatient (State Hospital Only)	0.0%	0.0%	0.0%
Inpatient (Community and State Hospital Combined)	17.9%	7.0%	-10.9%
Detox/Facility Based Crisis	14.2%	7.2%	-7.0%
Combined (includes cross-overs between services)	15.0%	7.1%	-7.9%

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

Follow-up after Hospitalization for Mental Illness	2016	2017	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	43.1%	40.8%	-2.3%
Percent Received Outpatient Visit Within 30 Days	64.8%	62.5%	-2.3%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	28.9%	39.4%	10.5%
Percent Received Outpatient Visit Within 30 Days	71.1%	60.6%	-10.5%
PRTF			
Percent Received Outpatient Visit Within 7 Days	19.2%	19.2%	0.0%
Percent Received Outpatient Visit Within 30 Days	47.7%	51.7%	4.0%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	41.7%	39.7%	-2.0%
Percent Received Outpatient Visit Within 30 Days	64.0%	62.0%	-2.0%

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

Follow-up after Hospitalization for Substance Abuse	2016	2017	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	16.3%	15.6%	-0.7%
Percent Received Outpatient Visit Within 30 Days	34.1%	28.4%	-5.7%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	31.6%	43.1%	11.5%
Percent Received Outpatient Visit Within 7 Days	37.3%	51.5%	14.2%
Percent Received Outpatient Visit Within 30 Days	51.8%	59.8%	8.0%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	32.9%	43.5%	10.6%
Percent Received Outpatient Visit Within 30 Days	47.9%	52.5%	4.6%

**NR = Denominator is equal to zero.*

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2016	2017	Change
Ages 13-17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	39.4%	36.2%	-3.2%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	18.3%	14.0%	-4.3%
Ages 18-20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	45.7%	38.8%	-6.9%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	25.8%	25.2%	-0.6%
Ages 21-34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	49.2%	43.5%	-5.7%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	31.6%	27.2%	-4.4%
Ages 35-64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	41.7%	38.5%	-3.2%

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2016	2017	Change
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	24.8%	22.7%	-2.1%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	35.0%	37.2%	2.2%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	27.5%	23.1%	-4.4%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	44.3%	40.0%	-4.3%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	26.8%	23.8%	-3.0%

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

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		2016	2017	Change	2016	2017	Change
3–12	Male	0.3	0.4	0.1	17.7	6.0	-11.7
	Female	0.2	0.2	0	14.9	2.4	-12.5
	Total	0.2	0.3	0.1	16.7	4.3	-12.4
13–17	Male	1.4	1.2	-0.2	13.9	21.2	7.3
	Female	2.0	1.6	-0.4	12.6	22.0	9.4
	Total	1.7	1.4	-0.3	13.1	21.6	8.5
18–20	Male	1.8	1.5	-0.3	7.8	15.7	7.9
	Female	1.8	1.6	-0.2	8.5	12.4	3.9
	Total	1.8	1.6	-0.2	8.2	13.9	5.7
21–34	Male	4.0	4.1	0.1	8.5	35.9	27.4
	Female	1.4	1.4	0	7.9	12.4	4.5
	Total	2.0	2.0	0	8.2	17.8	9.6
35–64	Male	2.2	2.8	0.6	9.3	24.7	15.4
	Female	2.2	2.2	0	8.6	19.7	11.1
	Total	2.2	2.4	0.2	8.9	21.6	12.7

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		2016	2017	Change	2016	2017	Change
65+	Male	0.2	0.4	0.2	12.2	5.1	-7.1
	Female	0.3	0.4	0.1	9.8	5.9	-3.9
	Total	0.3	0.4	0.1	10.4	5.6	-4.8
Unknown	Male	0.0	0.0	0	0.0	0.0	0.0
	Female	0.0	0.0	0	0.0	0.0	0.0
	Total	0.0	0.0	0	0.0	0.0	0.0
Total	**Male**	**1.2**	**1.4**	**0.2**	**10.8**	**15.2**	**4.4**
	Female	**1.2**	**1.1**	**-0.1**	**9.6**	**11.7**	**2.1**
	Total	**1.2**	**1.2**	**0**	**10.1**	**13.2**	**3.1**

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

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
3-12	Male	15.88%	17.76%	1.88%	0.30%	0.36%	0.06%	0.42%	0.42%	0.00%	15.84%	17.70%	1.86%
	Female	10.45%	11.63%	1.18%	0.17%	0.18%	0.01%	0.10%	0.11%	0.01%	10.43%	11.62%	1.19%
	Total	13.23%	14.77%	1.54%	0.24%	0.27%	0.03%	0.26%	0.27%	0.01%	13.20%	14.73%	1.53%
13-17	Male	18.39%	18.44%	0.05%	1.41%	1.22%	-0.19%	0.66%	0.58%	-0.08%	18.28%	18.37%	0.09%
	Female	20.18%	20.23%	0.05%	1.98%	1.73%	-0.25%	0.25%	0.24%	-0.01%	20.05%	20.13%	0.08%
	Total	19.28%	19.32%	0.04%	1.69%	1.47%	-0.22%	0.46%	0.41%	-0.05%	19.16%	19.24%	0.08%
18-20	Male	13.36%	10.18%	-3.18%	1.70%	1.51%	-0.19%	0.17%	0.12%	-0.05%	13.13%	10.11%	-3.02%
	Female	14.03%	13.20%	-0.83%	1.71%	1.48%	-0.23%	0.19%	0.11%	-0.08%	13.79%	13.10%	-0.69%
	Total	13.73%	11.76%	-1.97%	1.70%	1.50%	-0.20%	0.18%	0.12%	-0.06%	13.50%	11.67%	-1.83%
21-34	Male	26.01%	24.02%	-1.99%	3.64%	3.20%	-0.44%	0.32%	0.22%	-0.10%	25.55%	23.89%	-1.66%
	Female	19.87%	19.45%	-0.42%	1.35%	1.42%	0.07%	0.52%	0.19%	-0.33%	19.73%	19.37%	-0.36%
	Total	21.24%	20.51%	-0.73%	1.86%	1.83%	-0.03%	0.48%	0.20%	-0.28%	21.03%	20.42%	-0.61%
35-64	Male	20.69%	21.03%	0.34%	2.13%	2.56%	0.43%	0.29%	0.20%	-0.09%	20.42%	20.89%	0.47%
	Female	25.67%	25.40%	-0.27%	2.02%	2.03%	0.01%	0.30%	0.26%	-0.04%	25.51%	25.31%	-0.20%
	Total	23.78%	23.76%	-0.02%	2.06%	2.23%	0.17%	0.30%	0.24%	-0.06%	23.58%	23.65%	0.07%
65+	Male	6.19%	6.47%	0.28%	0.26%	0.44%	0.18%	0.02%	0.02%	0.00%	6.12%	6.42%	0.30%
	Female	6.61%	7.29%	0.68%	0.38%	0.41%	0.03%	0.01%	0.02%	0.01%	6.51%	7.25%	0.74%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	Total	6.49%	7.05%	0.56%	0.35%	0.42%	0.07%	0.01%	0.02%	0.01%	6.40%	7.00%	0.60%
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**	**17.26%**	**17.66%**	**0.40%**	**1.16%**	**1.24%**	**0.08%**	**0.39%**	**0.35%**	**-0.04%**	**17.12%**	**17.57%**	**0.45%**
	Female	**16.54%**	**16.92%**	**0.38%**	**1.13%**	**1.13%**	**0.00%**	**0.24%**	**0.17%**	**-0.07%**	**16.43%**	**16.86%**	**0.43%**
	Total	**16.84%**	**17.23%**	**0.39%**	**1.14%**	**1.18%**	**0.04%**	**0.30%**	**0.24%**	**-0.06%**	**16.72%**	**17.16%**	**0.44%**

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

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
3–12	Male	0.01%	0.03%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.03%	0.02%
	Female	0.02%	0.01%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
	Total	0.02%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.02%	0.01%
13–17	Male	1.83%	1.58%	-0.25%	0.10%	0.14%	0.04%	0.16%	0.13%	-0.03%	1.79%	1.50%	-0.29%
	Female	1.09%	0.89%	-0.20%	0.08%	0.15%	0.07%	0.10%	0.04%	-0.06%	1.03%	0.82%	-0.21%
	Total	1.46%	1.24%	-0.22%	0.09%	0.14%	0.05%	0.13%	0.09%	-0.04%	1.41%	1.16%	-0.25%
18–20	Male	4.40%	2.93%	-1.47%	0.42%	0.52%	0.10%	0.57%	0.59%	0.02%	4.10%	2.63%	-1.47%
	Female	3.32%	2.80%	-0.52%	0.43%	0.25%	-0.18%	0.62%	0.52%	-0.10%	3.08%	2.67%	-0.41%
	Total	3.80%	2.86%	-0.94%	0.42%	0.38%	-0.04%	0.59%	0.55%	-0.04%	3.54%	2.65%	-0.89%
21–34	Male	9.78%	8.81%	-0.97%	1.00%	0.90%	-0.10%	1.91%	1.61%	-0.30%	9.12%	8.42%	-0.70%
	Female	7.72%	7.57%	-0.15%	0.38%	0.42%	0.04%	1.76%	1.80%	0.04%	7.54%	7.39%	-0.15%
	Total	8.18%	7.86%	-0.32%	0.52%	0.53%	0.01%	1.79%	1.76%	-0.03%	7.90%	7.63%	-0.27%
35–64	Male	8.70%	8.70%	0.00%	0.75%	0.88%	0.13%	1.57%	1.53%	-0.04%	8.32%	8.37%	0.05%

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Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	Female	5.89%	5.94%	0.05%	0.35%	0.47%	0.12%	0.97%	0.99%	0.02%	5.71%	5.74%	0.03%
	Total	6.96%	6.97%	0.01%	0.50%	0.62%	0.12%	1.20%	1.19%	-0.01%	6.70%	6.73%	0.03%
65+	Male	1.32%	1.14%	-0.18%	0.02%	0.10%	0.08%	0.26%	0.34%	0.08%	1.18%	0.97%	-0.21%
	Female	0.38%	0.49%	0.11%	0.03%	0.04%	0.01%	0.06%	0.06%	0.00%	0.35%	0.44%	0.09%
	Total	0.64%	0.68%	0.04%	0.03%	0.06%	0.03%	0.12%	0.14%	0.02%	0.58%	0.60%	0.02%
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**	**3.00%**	**2.90%**	**-0.10%**	**0.26%**	**0.30%**	**0.04%**	**0.51%**	**0.50%**	**-0.01%**	**2.85%**	**2.76%**	**-0.09%**
	Female	**3.08%**	**3.10%**	**0.02%**	**0.18%**	**0.22%**	**0.04%**	**0.59%**	**0.60%**	**0.01%**	**2.99%**	**3.00%**	**0.01%**
	Total	**3.05%**	**3.02%**	**-0.03%**	**0.22%**	**0.26%**	**0.04%**	**0.56%**	**0.56%**	**0.00%**	**2.93%**	**2.90%**	**-0.03%**

Table 16: D.5. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Beaufort	0.02%	0.02%	0.00%	2.34%	2.04%	-0.30%	5.52%	4.86%	-0.66%	9.07%	9.13%	0.06%
Bertie	0.11%	0.00%	-0.11%	0.44%	0.75%	0.31%	2.39%	2.87%	0.48%	3.61%	5.11%	1.50%
Brunswick	0.01%	0.00%	-0.01%	1.73%	1.34%	-0.39%	1.85%	3.73%	1.88%	6.57%	7.90%	1.33%
Camden	0.00%	0.00%	0.00%	0.56%	0.61%	0.05%	2.82%	1.45%	-1.37%	4.81%	5.65%	0.84%
Carteret	0.00%	0.00%	0.00%	1.57%	1.42%	-0.15%	5.45%	4.57%	-0.88%	8.16%	9.49%	1.33%
Chowan	0.00%	0.00%	0.00%	2.24%	1.77%	-0.47%	8.33%	8.90%	0.57%	5.96%	5.23%	-0.73%
Craven	0.03%	0.01%	-0.02%	1.37%	0.93%	-0.44%	2.78%	3.64%	0.86%	8.31%	8.71%	0.40%
Currituck	0.00%	0.00%	0.00%	1.31%	0.69%	-0.62%	2.67%	1.96%	-0.71%	6.58%	6.83%	0.25%
Dare	0.00%	0.05%	0.05%	0.97%	1.11%	0.14%	4.94%	3.05%	-1.89%	8.31%	7.99%	-0.32%
Gates	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.88%	2.94%	-0.94%	5.82%	2.04%	-3.78%
Hertford	0.00%	0.00%	0.00%	1.21%	1.08%	-0.13%	3.05%	2.97%	-0.08%	4.13%	3.71%	-0.42%
Hyde	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.33%	0.00%	-1.33%	6.11%	6.88%	0.77%
Jones	0.00%	0.13%	0.13%	0.35%	0.35%	0.00%	0.00%	1.72%	1.72%	4.02%	5.47%	1.45%
Martin	0.05%	0.00%	-0.05%	0.75%	0.79%	0.04%	3.17%	3.11%	-0.06%	6.81%	6.67%	-0.14%
New Hanover	0.00%	0.02%	0.02%	1.82%	2.03%	0.21%	3.65%	3.66%	0.01%	6.37%	6.99%	0.62%
Northampton	0.00%	0.00%	0.00%	1.09%	0.59%	-0.50%	2.13%	1.91%	-0.22%	4.40%	3.61%	-0.79%
Onslow	0.02%	0.00%	-0.02%	0.54%	0.63%	0.09%	2.60%	1.70%	-0.90%	4.30%	4.81%	0.51%
Pamlico	0.00%	0.00%	0.00%	1.90%	1.71%	-0.19%	5.59%	3.57%	-2.02%	11.24%	12.65%	1.41%
Pasquotank	0.00%	0.03%	0.03%	0.81%	0.70%	-0.11%	2.07%	1.61%	-0.46%	4.24%	4.15%	-0.09%
Pender	0.00%	0.02%	0.02%	0.84%	0.90%	0.06%	2.45%	1.66%	-0.79%	4.62%	5.30%	0.68%

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County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Perquimans	0.00%	0.00%	0.00%	1.63%	0.28%	-1.35%	2.80%	3.41%	0.61%	4.77%	3.09%	-1.68%
Pitt	0.01%	0.03%	0.02%	1.62%	1.48%	-0.14%	3.17%	2.67%	-0.50%	6.22%	5.89%	-0.33%
Tyrrell	0.00%	0.00%	0.00%	0.93%	0.95%	0.02%	6.25%	5.88%	-0.37%	5.26%	6.10%	0.84%
Washington	0.08%	0.08%	0.00%	0.86%	0.86%	0.00%	3.21%	3.69%	0.48%	8.50%	5.16%	-3.34%
Total	**0.01%**	**0.02%**	**0.01%**	**1.34%**	**1.23%**	**-0.11%**	**3.21%**	**3.06%**	**-0.15%**	**6.11%**	**6.37%**	**0.26%**
	35-64			65+			Unknown			Total		
Beaufort	8.43%	7.32%	-1.11%	0.93%	0.95%	0.02%	0.00%	0.00%	0.00%	3.76%	3.50%	-0.26%
Bertie	4.39%	4.87%	0.48%	0.54%	0.55%	0.01%	0.00%	0.00%	0.00%	1.82%	2.17%	0.35%
Brunswick	5.20%	5.73%	0.53%	0.57%	0.77%	0.20%	0.00%	0.00%	0.00%	2.46%	2.84%	0.38%
Camden	8.97%	7.24%	-1.73%	1.08%	1.14%	0.06%	0.00%	0.00%	0.00%	2.84%	2.65%	-0.19%
Carteret	5.86%	8.09%	2.23%	0.11%	0.77%	0.66%	0.00%	0.00%	0.00%	3.10%	3.70%	0.60%
Chowan	9.60%	7.84%	-1.76%	1.52%	1.69%	0.17%	0.00%	0.00%	0.00%	3.86%	3.33%	-0.53%
Craven	6.06%	5.74%	-0.32%	0.22%	0.37%	0.15%	0.00%	0.00%	0.00%	2.90%	2.87%	-0.03%
Currituck	5.87%	4.59%	-1.28%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.53%	2.13%	-0.40%
Dare	7.41%	7.84%	0.43%	1.10%	1.09%	-0.01%	0.00%	0.00%	0.00%	2.91%	2.86%	-0.05%
Gates	3.53%	3.62%	0.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.76%	1.20%	-0.56%
Hertford	5.66%	5.62%	-0.04%	1.00%	0.77%	-0.23%	0.00%	0.00%	0.00%	2.24%	2.14%	-0.10%
Hyde	2.42%	5.65%	3.23%	0.53%	0.00%	-0.53%	0.00%	0.00%	0.00%	1.38%	2.08%	0.70%
Jones	4.80%	3.62%	-1.18%	0.00%	0.63%	0.63%	0.00%	0.00%	0.00%	1.61%	1.82%	0.21%
Martin	4.81%	4.86%	0.05%	0.57%	0.42%	-0.15%	0.00%	0.00%	0.00%	2.35%	2.32%	-0.03%

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	35-64			65+			Unknown			Total		
New Hanover	6.63%	7.52%	0.89%	0.83%	1.27%	0.44%	0.00%	0.00%	0.00%	2.87%	3.21%	0.34%
Northampton	5.02%	4.15%	-0.87%	0.93%	0.67%	-0.26%	0.00%	0.00%	0.00%	2.17%	1.78%	-0.39%
Onslow	3.94%	4.66%	0.72%	0.47%	0.75%	0.28%	0.00%	0.00%	0.00%	1.78%	1.96%	0.18%
Pamlico	7.74%	8.46%	0.72%	0.38%	0.38%	0.00%	0.00%	0.00%	0.00%	3.80%	4.03%	0.23%
Pasquotank	5.42%	5.54%	0.12%	0.15%	0.29%	0.14%	0.00%	0.00%	0.00%	1.98%	1.96%	-0.02%
Pender	4.46%	5.06%	0.60%	0.35%	0.23%	-0.12%	0.00%	0.00%	0.00%	1.89%	2.06%	0.17%
Perquimans	5.94%	5.19%	-0.75%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.31%	1.80%	-0.51%
Pitt	7.38%	7.71%	0.33%	0.92%	0.89%	-0.03%	0.00%	0.00%	0.00%	2.83%	2.81%	-0.02%
Tyrrell	4.17%	3.64%	-0.53%	0.71%	2.16%	1.45%	0.00%	0.00%	0.00%	1.86%	2.07%	0.21%
Washington	9.00%	7.25%	-1.75%	1.65%	1.90%	0.25%	0.00%	0.00%	0.00%	3.81%	2.96%	-0.85%
Total	**5.99%**	**6.28%**	**0.29%**	**0.64%**	**0.78%**	**0.14%**	**0.00%**	**0.00%**	**0.00%**	**2.58%**	**2.67%**	**0.09%**

Table 17: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Beaufort	11.84%	12.50%	0.66%	16.52%	16.79%	0.27%	13.14%	13.95%	0.81%	20.16%	20.93%	0.77%
Bertie	8.85%	8.27%	-0.58%	17.03%	17.34%	0.31%	9.14%	8.28%	-0.86%	13.25%	12.77%	-0.48%

2018 External Quality Review

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Brunswick	10.11%	10.50%	0.39%	17.28%	18.07%	0.79%	9.58%	10.65%	1.07%	14.82%	15.76%	0.94%
Camden	13.17%	10.34%	-2.83%	14.29%	20.25%	5.96%	8.33%	10.14%	1.81%	16.58%	11.86%	-4.72%
Carteret	15.67%	16.97%	1.30%	22.07%	24.95%	2.88%	12.48%	16.48%	4.00%	19.73%	21.68%	1.95%
Chowan	9.53%	10.04%	0.51%	13.23%	13.94%	0.71%	8.72%	9.42%	0.70%	11.78%	11.16%	-0.62%
Craven	10.24%	10.35%	0.11%	17.11%	16.25%	-0.86%	12.28%	10.52%	-1.76%	17.43%	17.70%	0.27%
Currituck	9.75%	9.97%	0.22%	16.70%	15.51%	-1.19%	14.56%	11.11%	-3.45%	15.84%	13.88%	-1.96%
Dare	8.86%	8.79%	-0.07%	17.73%	17.43%	-0.30%	10.94%	12.60%	1.66%	14.31%	13.48%	-0.83%
Gates	6.96%	5.76%	-1.20%	7.84%	10.53%	2.69%	9.71%	9.80%	0.09%	14.24%	10.54%	-3.70%
Hertford	6.94%	5.47%	-1.47%	11.39%	9.38%	-2.01%	6.65%	7.84%	1.19%	10.83%	10.35%	-0.48%
Hyde	7.94%	8.64%	0.70%	13.16%	14.60%	1.44%	5.33%	3.80%	-1.53%	10.73%	14.38%	3.65%
Jones	10.59%	13.19%	2.60%	16.43%	19.86%	3.43%	16.22%	12.93%	-3.29%	18.32%	17.93%	-0.39%
Martin	10.70%	11.74%	1.04%	17.98%	18.18%	0.20%	10.79%	12.71%	1.92%	16.36%	13.57%	-2.79%
New Hanover	13.27%	13.92%	0.65%	20.94%	21.28%	0.34%	13.44%	14.09%	0.65%	16.06%	16.51%	0.45%
Northampton	9.37%	10.06%	0.69%	17.03%	17.98%	0.95%	10.21%	9.84%	-0.37%	12.30%	12.06%	-0.24%
Onslow	10.11%	11.22%	1.11%	17.36%	18.99%	1.63%	13.51%	14.33%	0.82%	17.46%	18.42%	0.96%
Pamlico	16.06%	17.56%	1.50%	21.86%	26.78%	4.92%	13.58%	13.10%	-0.48%	20.00%	23.19%	3.19%
Pasquotank	10.20%	10.54%	0.34%	15.52%	15.66%	0.14%	11.07%	10.04%	-1.03%	12.87%	13.21%	0.34%

2018 External Quality Review

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Pender	9.28%	10.31%	1.03%	15.54%	16.34%	0.80%	8.61%	7.63%	-0.98%	13.86%	14.90%	1.04%
Perquimans	9.45%	9.51%	0.06%	16.26%	13.64%	-2.62%	12.24%	11.36%	-0.88%	12.28%	13.14%	0.86%
Pitt	10.67%	12.46%	1.79%	16.19%	18.39%	2.20%	10.64%	10.62%	-0.02%	14.88%	15.84%	0.96%
Tyrrell	9.81%	8.42%	-1.39%	12.04%	13.33%	1.29%	12.50%	11.76%	-0.74%	12.77%	13.41%	0.64%
Washington	7.32%	5.96%	-1.36%	12.04%	10.49%	-1.55%	10.05%	7.83%	-2.22%	12.75%	12.05%	-0.70%
Total	**10.80%**	**11.53%**	**0.73%**	**17.27%**	**18.15%**	**0.88%**	**11.44%**	**11.75%**	**0.31%**	**15.78%**	**16.28%**	**0.50%**
	35-64			65+			Unknown			Total		
Beaufort	22.81%	22.92%	0.11%	6.48%	7.38%	0.90%	0.00%	0.00%	0.00%	15.54%	16.14%	0.60%
Bertie	14.94%	16.06%	1.12%	4.70%	6.22%	1.52%	0.00%	0.00%	0.00%	11.34%	11.58%	0.24%
Brunswick	17.11%	18.80%	1.69%	6.61%	6.10%	-0.51%	0.00%	0.00%	0.00%	13.05%	13.83%	0.78%
Camden	19.37%	18.10%	-1.27%	6.45%	6.82%	0.37%	0.00%	0.00%	0.00%	14.24%	13.33%	-0.91%
Carteret	20.35%	22.82%	2.47%	4.41%	6.26%	1.85%	0.00%	0.00%	0.00%	17.12%	19.13%	2.01%
Chowan	19.86%	16.81%	-3.05%	4.30%	5.08%	0.78%	0.00%	0.00%	0.00%	11.86%	11.52%	-0.34%
Craven	22.81%	21.52%	-1.29%	6.28%	7.70%	1.42%	0.00%	0.00%	0.00%	14.66%	14.36%	-0.30%
Currituck	17.07%	18.37%	1.30%	2.75%	3.65%	0.90%	0.00%	0.00%	0.00%	13.02%	12.64%	-0.38%
Dare	17.71%	17.88%	0.17%	7.75%	5.80%	-1.95%	0.00%	0.00%	0.00%	12.53%	12.39%	-0.14%
Gates	14.07%	14.73%	0.66%	2.59%	3.48%	0.89%	0.00%	0.00%	0.00%	9.30%	8.92%	-0.38%

2018 External Quality Review

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	35-64			65+			Unknown			Total		
Hertford	15.89%	15.61%	-0.28%	5.27%	7.06%	1.79%	0.00%	0.00%	0.00%	9.74%	9.19%	-0.55%
Hyde	18.25%	19.57%	1.32%	8.47%	7.83%	-0.64%	0.00%	0.00%	0.00%	10.84%	11.87%	1.03%
Jones	19.62%	19.72%	0.10%	4.95%	5.06%	0.11%	0.00%	0.00%	0.00%	13.80%	14.98%	1.18%
Martin	18.94%	20.14%	1.20%	5.97%	7.49%	1.52%	0.00%	0.00%	0.00%	13.68%	14.15%	0.47%
New Hanover	23.23%	24.27%	1.04%	13.41%	13.83%	0.42%	0.00%	0.00%	0.00%	16.85%	17.49%	0.64%
Northampton	15.78%	14.95%	-0.83%	4.66%	4.18%	-0.48%	0.00%	0.00%	0.00%	11.65%	11.66%	0.01%
Onslow	22.87%	23.91%	1.04%	9.67%	10.52%	0.85%	0.00%	0.00%	0.00%	14.93%	16.01%	1.08%
Pamlico	20.04%	23.16%	3.12%	3.42%	15.41%	11.99%	0.00%	0.00%	0.00%	16.80%	20.29%	3.49%
Pasquotank	20.94%	21.40%	0.46%	4.06%	5.34%	1.28%	0.00%	0.00%	0.00%	12.95%	13.30%	0.35%
Pender	18.82%	18.53%	-0.29%	10.53%	11.14%	0.61%	0.00%	0.00%	0.00%	12.87%	13.41%	0.54%
Perquimans	17.59%	18.89%	1.30%	4.43%	4.81%	0.38%	0.00%	0.00%	0.00%	12.14%	12.19%	0.05%
Pitt	20.07%	21.31%	1.24%	5.77%	6.95%	1.18%	0.00%	0.00%	0.00%	13.53%	14.97%	1.44%
Tyrrell	13.69%	11.52%	-2.17%	5.71%	6.47%	0.76%	0.00%	0.00%	0.00%	10.61%	9.98%	-0.63%
Washington	18.80%	18.72%	-0.08%	4.68%	7.61%	2.93%	0.00%	0.00%	0.00%	11.23%	10.63%	-0.60%
Total	**20.30%**	**21.01%**	**0.71%**	**7.01%**	**8.06%**	**1.05%**	**0.00%**	**0.00%**	**0.00%**	**14.13%**	**14.83%**	**0.70%**

B Waiver Validation Results

The overall validation score was in the Fully Compliant range, with an average validation score of 100% across the ten measures. The following tables display the validation scores for each of Trillium's ten measures, as well as the combined the final validation for the ten measures to present an overall validation score for Trillium (see Performance Measure Validation Worksheets for details).

Table 18: *B Waiver* Performance Measure Validation Scores 2017

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

Changes made to the measures were validated for review of 2016-2017 *C Waiver* measures. Eight new measures were selected and retained two previously-validated measures. Trillium included documentation for all ten *C Waiver* measures. Trillium's reported rates are displayed in the following table.

Table 19: *C Waiver* Measures Validation Rates 2016-2017

Performance Measure	Data Collection	July 1 2016 - June 30, 2017*
Proportion of Level of Care evaluations completed at least annually for enrolled participants	Semi Annually	99.86%
Proportion of Level of Care evaluations completed using approved processes and instrument	Semi Annually	99.72%

Performance Measure	Data Collection	July 1 2016 - June 30, 2017*
Proportion of New Level of Care evaluations completed using approved processes and instrument	Semi Annually	100%
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Annually	100%
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	Annually	100%
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	Annually	99.54%
Proportion of Individual Support Plans that address identified health and safety risk factors	Semi Annually	99.91%
Percentage of participants reporting that their Individual Support Plan has the services that they need	Annually	99.93%
Proportion of individuals for whom an annual ISP and/or needed updates took place	Annually	100%
Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval	Quarterly	96%

*NR = Denominator is equal to zero.

C Waiver Validation Results

Validation scores are fully compliant with an average validation score of 100% across the 10 measures. The validation scores are shown in table 20, *C Waiver Performance Measure Validation Scores 2017*. Documentation on data sources, data validation, source code, and calculated rate for the ten *C Waiver* measures was provided. The validation worksheets offer detailed information on point deduction when validating each *C Waiver* measure.

Table 20: *C Waiver* Performance Measure Validation Scores 2017

Measure	Percentages Reported
Proportion of Level of Care evaluations completed at least annually for enrolled participants	100%
Proportion of Level of Care evaluations completed using approved processes and instruments	100%

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

Performance Improvement Project Validation

CCME conducted PIP validations in accordance with the CMS-developed protocol titled, EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012. The protocol validates project components and its documentation to provide an assessment of the overall study design and project 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 procedures
- Improvement strategies

In 2017 (last year), Trillium submitted three projects that CCME validated. Two of the three scored in the high confidence range. In 2018, Trillium submitted five projects. Only the PIP, *Increasing the use of Admission, Discharge and Transfer Data (ADT)*, was validated in 2017. The *Therapeutic Foster Care (TFC) Services* and *Provider Directory* PIPs were closed after last year's review. For the 2018 review, three of the five submitted PIPs were validated: *ADT*, *Transition to Community Living (TCLI)*, and

Supermeasures-Mental Health (MH). Trillium implemented the recommendations from last year's review into this year's PIP reports. Scores for the previous review year and current review year are shown in Table 21.

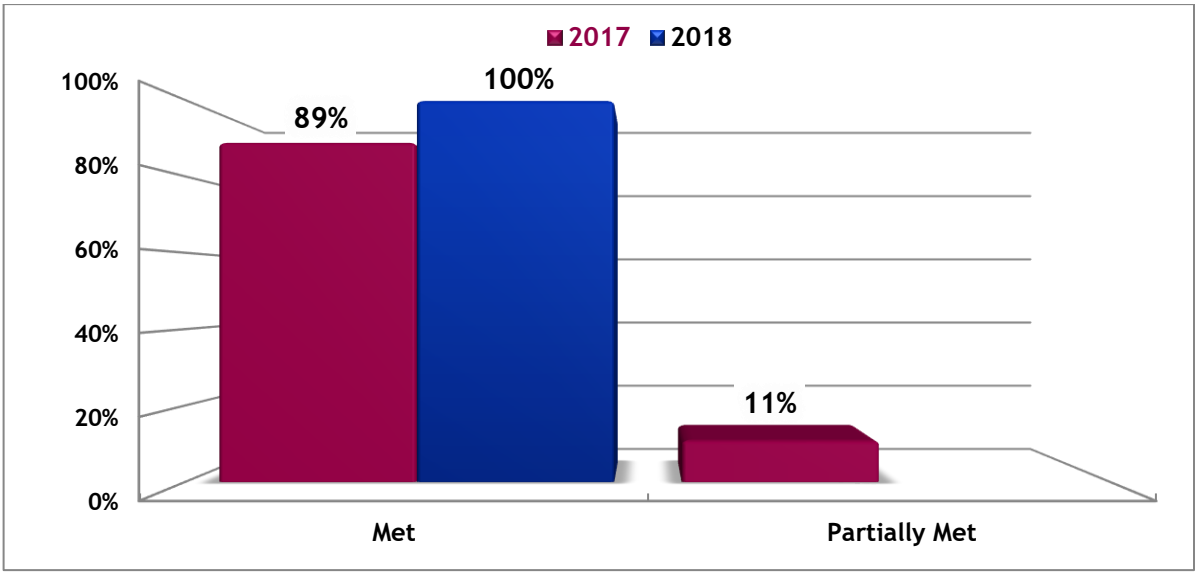
Table 21: Performance Improvement Project Validation Scores

Project Type	Project	2017 Validation Score	2018 Validation Score
Clinical	Increasing Outpatient Therapy in children receiving Therapeutic Foster Care (TFC) services	99% High Confidence in Reported Results	Closed
	Increasing the use of Admission, Discharge and Transfer (ADT) data	85% Confidence in reported results	100% High Confidence in Reported Results
	Supermeasures-Mental Health (MH)	Not validated	100% High Confidence in Reported Results
Non-Clinical	A Complete Trillium Health Resources Provider Directory	100% High Confidence in Reported Results	Closed
	Transition to Community Living Initiative (TCLI)	Not Validated	100% High Confidence in Reported Results

There were no specific errors by project and no corrections recommended.

The chart that follows provides a comparison of Trillium's current review results to the 2017 review results.

Figure 5: Quality Improvement Comparative Findings



Strengths

- *B* and *C Waiver* measures included all necessary documentation and Trillium reported measures according to specifications.
- All three validated PIPs were in High Confidence range. The PIPs needed no corrections.
- Trillium makes Clinical Practice Guidelines (CPG) projects a priority. Dr. Smith and Dr. Johnson support CPG projects along with Clinical Advisory Committee input.
- Consumer Surveys (ECHO child, ECHO adult, and Perception of Care) have been analyzed in detail by Trillium with a report summarizing each of these survey results created by Trillium.
- The *QM Work Plan* is up to date and used to track all projects the for which the Quality Management Department is responsible.

Weaknesses

- Trillium implemented a project to monitor provider adherence to CPGs for two specific areas: rating scales for depression and metabolic monitoring of patients taking antipsychotics. But, results were not detailed in the *Annual Quality Management Program Evaluation Fiscal Year 2016-2017*.

- Trillium is monitoring and analyzing results for all enrollee surveys with a written document for each survey. A plan is in place to implement improvements on lower-scoring survey items. Follow through to evaluate improvement on that plan is not evident in the prepared reports or in the *Annual Quality Management Program Evaluation Fiscal Year 2016-2017*.
- The *Annual Quality Management Program Evaluation Fiscal Year 2016-2017* consists of an executive summary, 2016-2017 highlights, activities and accomplishments, and a summary at the end of the report. It could be improved by adding more detail about the year's work for each item along with analysis of outcome data for each section. For example, the CPGs lack outcomes achieved from the year's work on both CPGs that were monitored.

Recommendations

- The summary of the two CPG monitoring projects was explained well at the Onsite interview, but results were not detailed in the *Annual Quality Management Program Evaluation Fiscal Year 2016-2017*. More detail is needed in this program evaluation to explain how the CPGs were monitored and what results were produced throughout the year.
- Add more detail to the *Annual Quality Management Program Evaluation* that explains how Trillium addresses and follows up on improvement of lower scoring measures from the enrollee surveys.
- In the next version of the *Annual Quality Management Program Evaluation*, add more detail of the year's work for each item along with analysis of outcome data for each section.

E. Utilization Management

The EQR review of the Trillium's utilization management (UM) functions included a file review consisting of; 25 approval files, 25 denial files, 5 State Fair Hearing files, 25 Care Coordination files and 15 Transition to Community Living (TCLI) files. Also reviewed were the *Utilization Management Plan*, the *Care Coordination Program Description*, and all UM, Care Coordination and TCLI procedures. Lastly, Onsite discussion provided further clarity of staff and departmental processes.

The Trillium Utilization Management (UM) Program is overseen by Cindy Ehlers, Clinical Operations Vice President (VP), Cham Trowell, UM Director. Dr. Burt Johnson, Chief Medical Officer and Dr. Michael Smith, Medical Director, provide clinical oversight and consultation formally and informally to the UM Department.

File review demonstrated that all UM decisions were rendered in a timely manner. There was adequate medical oversight of both the UM staff, as well as, the delegated peer

reviewer, BHM. Decisions were well documented and referenced the appropriate service definitions. It was evident that Trillium would frequently offer partial authorizations to allow time for additional documentation and/or provider consideration.

Trilliums' *Utilization Management Plan* defines the UM scope of services and provides clarification regarding staff roles and qualifications. The UM Department procedures provide details regarding Initial Clinical review. The procedures speak to the use of Urgent Care being provided in 72 hours, however there is no language that indicates the definition of an expedited service authorization request as is required per processing of service authorizations as indicated in the *DMA Contract, Sections 7.4 and 7.4.14*. Similarly, there is no procedural language that explains the requirement that all requests (i.e., expedited or standard) are, per *DMA Contract, Sections 7.4 and 7.4.13,* processed as "expeditiously as the member's health condition requires".

There are mechanisms for monitoring overutilization and outliers of service use through data reports and regular case review meetings. The Onsite discussion indicated that much focus was placed on overutilization and that monitoring of underutilization of services through data analysis was limited. There is a need to define a process to regularly monitor low utilization to ensure the full picture of service utilization is monitored and analyzed.

Over the past year, Trillium implemented the Incedo platform in the Care Coordination Program. This data platform supports and guides the care coordinating staff to complete tasks and collect required data in a predictable process.

The *Care Coordination Program Description* provides an overview of the Care Coordination Program. The report provided Care Coordination project measures that had been monitored over the past year including the DMA Super Measures which Trillium Care Coordination exceeded the benchmark goals. The Care Coordination Department consists of the Intellectual and Developmental Disability (I/DD) Department and Care Coordination- Mental Health/ Substance Use (MH/SU) and TCLI. There was limited information regarding TCLI separate from care coordination within the *Care Coordination Program Description*.

Care Coordination Case Loads per Care Coordinator:

- Intellectual Developmental Disability Disorder (I/DD): 20-25 cases
- MH/SU: 40-50 cases
- SED Child: 35-40 cases

TCLI is housed within the Care Coordination Program. The TCLI procedures include In-Reach services, but do not include the in-reach the role and responsibilities of a Peer

Support Specialist, or the educational and certification requirements of the position, as indicated in *the DMA Contract, Section 15*. While the In-Reach services are delegated to in-reach to Recovery Innovations (RI) and there is a three (3) year delegate contract in place that may define the staffing requirements, specification of the educational and certification requirements of TCLI staff is needed.

There is no mention of one-time transitional funds in the TCLI procedures, nor do the procedures define how they can be accessed, as indicated in the *DMA Contract, Section 15*.

Trilliums CAP response from last year indicated a communication plan was designed to bolster information on the website, the *Member & Family Handbook* and the *Provider Manual*. Specific to the *Provider Manual*, Trillium stated, "Additions will include information regarding what the settlement is, how a member qualifies, once a member qualifies what services and supports they can access. Information will also be included regarding the PASRR process and how a PASRR can be completed (Process can potentially change discussion are under way with DHHS)." This information was not added and so remains an issue for this year's EQR.

The following graph provides the scores for the 2018 EQR of the UM Department compared to the 2017 EQR of the UM Department.

Figure 6: Utilization Management Comparative Findings

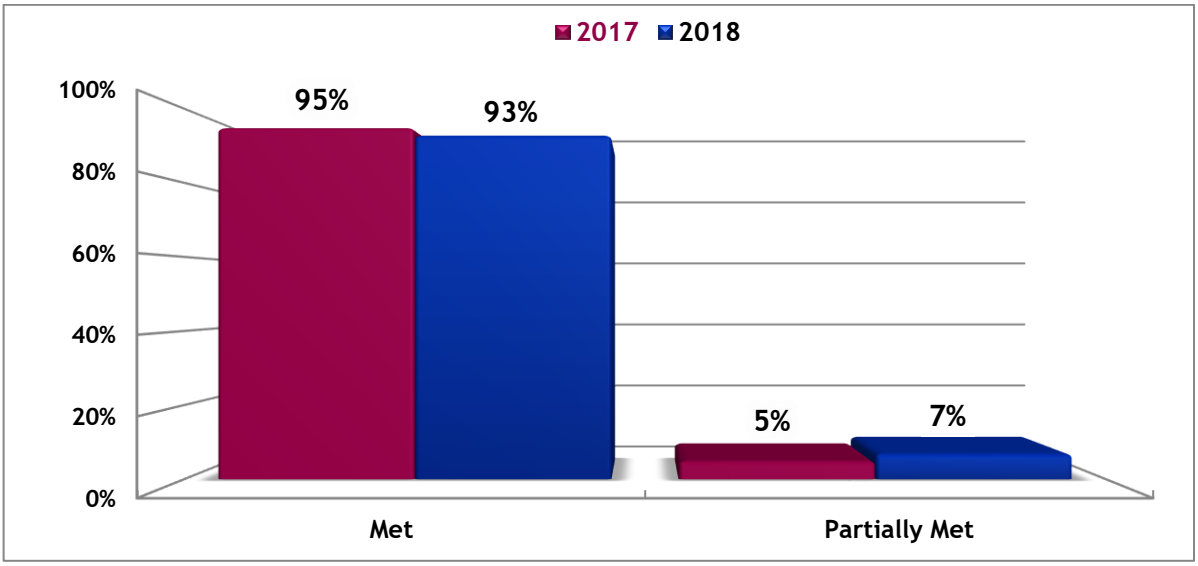


Table 22: Utilization Management

Section	Standard	2018 Review
Transition to Community Living Initiative	Transition to Community Living functions are performed by appropriately licensed, or certified, and trained staff	Partially Met
	A mechanism is in place to provide one-time transitional supports, if applicable	Partially Met
	The PIHP will develop a TCLI communication plan that includes materials and training about crisis hotline, services for enrollees with limited English proficiency and also to for external and internal stakeholders providing information on the TCL initiative, resources, and system navigation tools, etc.	Partially Met

Strengths

- *The Care Coordination Program* description provides an overview of the Care Coordination Program.
- Chief Medical Officer and Medical Director are involved in daily activities and regularly attend committee meetings.
- Trillium over the past year has implemented the Incedo software platform for Care Coordination. This platform supports the identification needs through the assessment process that provides feedback to Care Coordinators re member health care needs.
- Referrals and linkages were present and identified in the files reviewed.
- A review of the TCLI files indicated that documentation was provided for in-reach activities every 90 days, Person Centered Plans (PCP) and Individual Service Plans (ISP) were present in documentation.

Weaknesses

- There is no language that indicates the definition of an expedited service authorization request as is required per processing of service authorizations as indicated in the *DMA Contract, Sections 7.4 and 7.4.14.* Similarly, there is no procedural language that explains the requirement that all requests (i.e., expedited or standard) are, per *DMA Contract, Sections 7.4* and *7.4.13* processed as "expeditiously as the member's health condition requires".

- There are mechanisms in place to monitor and detect overutilization; however, there does not appear to be a mechanism in place regarding the monitoring of underutilization.
- The educational and certification requirements are not indicated in the TCLI procedures, as specified in *DMA Contract, Section 15.9*.
- The TCLI procedures do not describe the availability of one-time transitional supports, the process for accessing those supports, or how these one-time funds are tracked and/or monitored by the PIHP.
- Trilliums CAP response from last year indicated a communication plan was designed to bolster information on the website, the *Member & Family Handbook* and the *Provider Manual*. Specific to the *Provider Manual*, Trillium stated, "Additions will include information regarding what the settlement is, how a member qualifies, once a member qualifies what services and supports they can access. Information will also be included regarding the PASRR process and how a PASRR can be completed (Process can potentially change discussion are under way with DHHS)." This information was not added and so remains an issue for this year's EQR.

Corrective Actions

- Revise the TCLI procedure to include the certification requirements of Peer Support Specialists.
- Include in a TCLI procedure the definition and availability of TCLI One-Time Transitional supports and how these supports and/or funds are monitored. (See *DMA Contract, Section 15.9)*.
- As was agreed to in last year's EQR, add the additional information to the *Provider Manual*. Information should include what the settlement is, how a member qualifies, and once a member qualifies what services and supports they can access.

Recommendations

- Add language to UM procedures that indicates the definition of an expedited service authorization request as indicated in the *DMA Contract, Sections 7.4 and 7.4.14*.
- Add language to UM procedures that clarifies that all requests (i.e., expedited or standard) are, per *DMA Contract, Sections 7.4 and 7.4.13* processed as "expeditiously as the member's health condition requires".
- Describe in the UM Plan and UM procedures the mechanism of monitoring underutilization of services.

F. Grievances and Appeals

Grievances

The EQR of Trillium's grievance and appeals included a thorough review of the Grievance and Appeals procedures, the *Complaint Appeal Process* procedure, 25 grievance files, 25 appeals files, and information presented during the Onsite interview.

During the past year, Trillium implemented a departmental reorganization that moved the grievance functions from the Program Integrity Department to the Call Center/Connections Department. During the Onsite interview, Trillium staff explained that this reorganization was intended to decrease the number of Trillium staff and the time required to resolve a grievance. While grievances are now processed within the Call Center/Connections Department, agency wide there is "No Wrong Door" for enrollees to file a grievance. Trillium asserts all staff are trained in the identification, documentation and process for handling or routing grievances.

Despite this assertion and Trillium procedures that clearly define the difference between a "grievance" and "complaint," our file review indicated that staff do not use consistent practices when identifying grievances and complaints.

First, the logs submitted for this EQR were supposed to be grievances and complaints. Trillium submitted an Excel workbook that was a mix of grievances and complaints with no information given to discern a grievance from a complaint. The cases listed on the grievance tab of the submitted Excel workbook duplicated all the complaints listed on the complaints tab.

Second, the documents uploaded for this EQR were labelled erroneously, which shows that staff used the term "complaint" and "grievance" interchangeably. The only way to distinguish the which files were grievances, was to read the narratives within the files.

Third, documentation within the files showed the terms "grievance" and "complaint" were used interchangeably. For example, when an acknowledgement letter for a grievance was mailed, the resolution narrative within the file would indicate complaint, which generated a complaint resolution notification. These inconsistencies were noted to be in six of the 25, or 24%, of the files reviewed. To further confuse this matter, the link to file a grievance via Trillium's website is titled "Concern, Complaint, Compliment, Question." Trillium procedures for both complaints and grievances are clearly written and all grievances were processed within the required timeframes. During the Onsite discussion, staff advocated that enrollees, guardians, stakeholders, and the public at large need not understand the difference between all these terms. However, Trillium needs to take steps to untangle these two terms in multiple areas of their operations to

prevent further confusion, and to be compliant with their procedures, definitions, and practices around grievances and complaints.

Appeals

Mr. Richard Leissner, Chief Compliance Officer (CCO) and General Counsel and Ms. Fonda Gonzales, who is the Appeals Manager oversee appeals. The Chief Medical Officer and the Medical Director are actively involved in the Appeals Process through participation in various committee meetings and availability for appeal case review.

The *Medicaid Clinical Reconsideration Process* procedure guides the Appeals process and provides good overall detail in explaining the complicated process around appeals. However, there are some errors within this procedure, some of which were identified in last year's EQR and not corrected.

The *Medicaid Clinical Reconsideration Process* states that the appeal process is, "available to all member and providers and/or facilities rendering services." This is an incorrect definition of who can file an appeal. Specifically, and per *DMA Contract, Attachment M.G.1*, "a Provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent can file a PIHP internal appeal." As in last year's EQR, it was recommended that Trillium correct this definition. Trillium did not address this recommendation.

As part of the EQR process in the previous year, Trillium agreed to add the following statement to their appeal procedure: "Trillium must ensure that punitive action is not taken against the authorized representative who either request an expedited or support an enrollee appeal." his CAP response was accepted by CCME last year, but this was never added to the procedure.

Another correction needed in the *Medicaid Clinical Reconsideration Process* procedure is the timeframe by which an expedited appeal is required to be resolved. The procedure states this resolution timeframe is "3 calendar days" when, contractually, the timeframe is 72 hours.

Similarly, this procedure does not note that requirement that all appeals, both standard and expedited, be, per *DMA Contract, Attachment M.4*, resolved "as expeditiously as the Enrollee's health condition requires." This means that staff review each appeal and take into consideration the enrollee's current health condition to determine, outside of the standard and expedited timeframe requirements, how quickly to resolve the appeal. This consideration by staff needs to be captured procedurally, including how staff evaluate and document their decision on how quickly an appeal should be resolved.

Lastly, CCME also recommended in last year's EQR that providers are informed via the *Provider Manual* that Trillium acknowledges the receipt of an appeal in writing. Trillium neither followed nor addressed this recommendation in this past year. The written acknowledgement alerts the appellant that an appeal is underway. The acknowledgement also alerts providers, who may be providing unpaid services or waiting to coordinate referrals during the pendency of the appeal that, in fact, the appeal is underway. It also lets the provider know that the enrollee has been informed it is underway. This missing information in the *Provider Manual* remains a concern in this year's EQR.

New federal regulations (42 CFR 438.402) and DMA contractual requirements went into effect on July 1, 2017 that impacted the timeframe in which an appeal can be filed. Appeal procedure and file review showed that Trillium struggled to accurately inform enrollees of this timeframe through their Notices of Action UM staff generated. The Notices of Action have since been moved to oversight by the Appeals Department. Enrollees are now consistently informed about the timeframe to appeal.

While the *Medicaid Clinical Reconsideration Process* procedure clearly states, "D. A request made orally must be followed with a signed, written request within thirty (30) calendar days, unless it is a request for an expedited appeal." File review showed that staff continued to require appellants to submit a written request after an oral expedited appeal request was submitted. *DMA Contract, Attachment M.H.3*, provides further clarification in that "3. The Enrollee may file an expedited appeal either orally or in writing. No additional Enrollee follow-up is required." Whether the PIHP accepts or denies the request for expedited appeal is irrelevant. Appeal staff need to be aware of this contractual language by adding it to the *Medicaid Clinical Reconsideration Process* procedure. The *Provider Manual* also needs to be corrected to reflect that no additional Enrollee follow-up is required if an oral, expedited appeal is submitted.

While trends in number of appeals are reviewed in committee, little analysis of other appeal trends is evident. A deeper analysis into trends by outcomes, service, UM staff, UM Peer reviewers would provide a deeper understanding of potential areas where quality could be improved (e.g., IRR of UM Peer Reviewers) and liabilities minimized (e.g., decreasing the number of State fair hearings).

Figure 7 indicates the scoring for Grievances and Appeals for 2018 compared to the scores received in the 2017 EQR.

Figure 7: Grievances and Appeals Comparative Findings

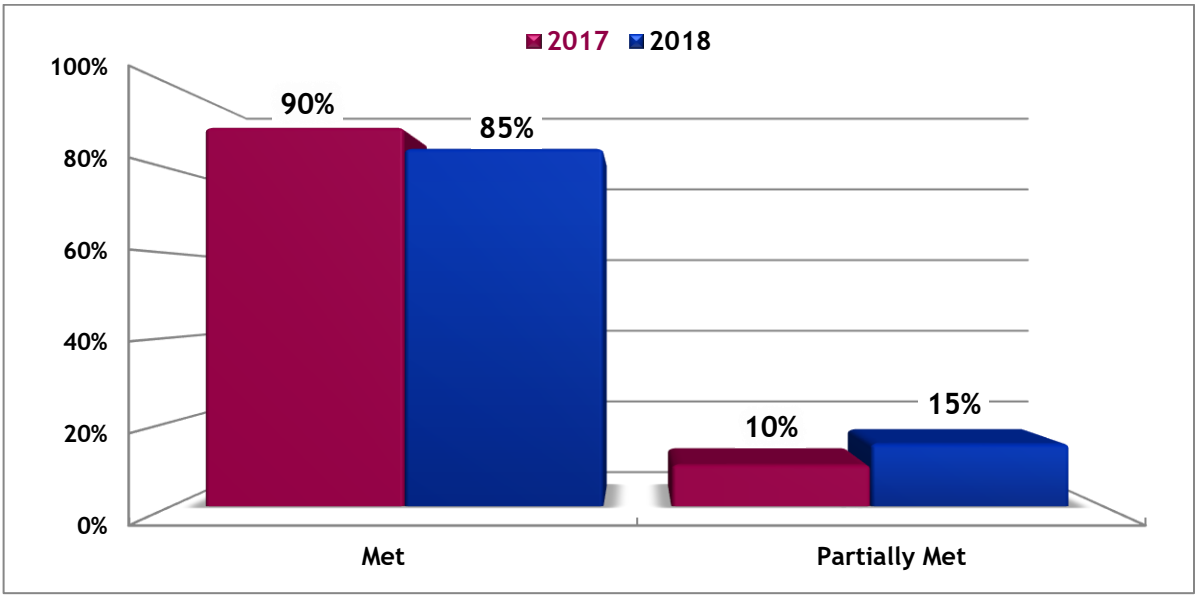


Table 23: Grievances and Appeals

Section	Standard	2018 Review
Grievances	The PIHP applies the grievance policy and procedure as formulated	Partially Met
Appeals	The definitions of an action and an appeal and who may file an appeal	Partially Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met
	Other requirements as specified in the contract	Partially Met
	The PIHP applies the appeal policies and procedures as formulated	Partially Met

Strengths

- The Chief Medical Officer and Medical Director are involved in the Grievance and Appeals process.
- Moving the Grievance process to the Call Center is intended decrease the number of staff involved in the resolution of a grievance.

- Clear procedures define the difference between a grievance and complaint.
- Standard and expedited appeals were processed within the required timeframes.

Weaknesses

- Outside of the grievance and complaint procedures, staff use the terms grievance and complaint interchangeably. Documentation shows a lack of clarity between the two terms, their related processes and, potentially, data collection and due process rights related to grievances.
- The link to file a grievance via Trillium's website, leads to an electronic form titled "Concern, Complaint, Compliment, Question." This further confuses the categorization of grievances.
- The *Medicaid Clinical Reconsideration Process* procedure states that the appeal process is, "available to all member and providers and/or facilities rendering services." This is incorrect language regarding who can file an appeal. Specifically, and per *DMA Contract, Attachment M. G.1*, "a Provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent can file a PIHP internal appeal."
- As part of the EQR process in the previous year, Trillium agreed to add the following statement to their appeal procedure: "Trillium must ensure that punitive action is not taken against the authorized representative who either request an expedited or support an enrollee appeal." CCME accepted this CAP response last year, but Trillium never added it to the procedure.
- The *Medicaid Clinical Reconsideration Process* procedure erroneously states the resolution timeframe for an expedited appeal is "3 calendar days" when, contractually, the timeframe is 72 hours.
- The *Medicaid Clinical Reconsideration Process* procedure does not note that all appeals, both standard and expedited, should be, per *DMA Contract, Attachment M.4,* resolved "as expeditiously as the Enrollee's health condition requires."
- The *Provider Manual* does not inform providers that Trillium acknowledges the receipt of an appeal in writing.
- File review showed that appeals staff require appellants to submit a written request after an oral, expedited appeal request is submitted. *DMA Contract, Attachment M.H.3,* as well as Trillium's *Medicaid Clinical Reconsideration Process* procedure, clearly state that a written request is not required in this circumstance, regardless of whether the PIHP agrees that the request meets criteria for an expedited appeal. This information is incorrect on page 64 of the *Provider Manual*.

Corrective Actions

- Provide training to all staff regarding the differences between documenting, labelling and logging grievances as defined in Trillium procedures.
- Correct the *Medicaid Clinical Reconsideration Process* procedure to consistently reflect that "a Provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent can file a PIHP internal appeal."
- Add to the *Medicaid Clinical Reconsideration Process* procedure the statement "Trillium must ensure that punitive action is not taken against the authorized representative who either requests an expedited or support an enrollee appeal."
- Correct the *Medicaid Clinical Reconsideration Process* procedure to state the resolution timeframe for an expedited appeal is 72 hours.
- Train appeal staff on the requirements within Trillium procedures and *DMA Contract, Attachment M.H.3,* that once an oral, expedited appeal is filed by an appellant, no written request is then required.
- Correct page 64 of the *Provider Manual* to clarify no additional follow up is needed by an enrollee when an oral, expedited appeal is filed.

Recommendations

- Add the term "grievance" to the link labelled "concern, complaint, compliment, question" where enrollees can electronically file grievances.
- Develop and implement a monitoring plan that reviews the grievance log to ensure that grievances are logged correctly and not duplicated.
- Include in the *Medicaid Clinical Reconsideration Process* procedure that all appeals, both standard and expedited, per *DMA Contract, Attachment M.G.4,* are resolved "as expeditiously as the Enrollee's health condition requires."
- Include in the *Provider Manual* that Trillium acknowledges in writing the receipt of an appeal.

G. Delegation

CCME's EQR of the Delegation section included a review of the relevant policies and procedures, the Delegate List, the Delegation Contracts/Letters of Agreement, and the Delegation Monitoring Tools. The Onsite visit included a Quality Management Department presentation, and an interview with Trillium staff, including Luz Tracy, Contracts and Training Department Director, Julie Quisenberry, Contract Manager, Krissy Vestal,

Performance Improvement Manager, and Kim Keehn, LPC, Quality Management Senior Director.

Trillium has six delegated entities, as evidenced in Table 24. At the last External Quality Review (EQR), Trillium had a contract with Confidential Records Management, Inc. (CRMI) for record management and shredding. CRMI was acquired by Iron Mountain. Trillium completed a pre-delegation review, and subsequently executed a contract with Iron Mountain.

Trillium resolved all corrective action items from the last EQR. Trillium added dates to signature lines on the Letters of Agreement (LOA), and updated the LOAs. Trillium staff added items that were missing from the *Credentialing Delegation Oversight Monitoring Tool* at the last EQR. At the last EQR, the contract with CRMI included services that were not being contracted. The contract with Iron Mountain is limited to contracted services. Trillium conducted the required annual monitoring for all delegates.

At the last EQR, Trillium had a delegation to East Carolina University (ECU) Physicians for credentialing of their providers. When the results of the annual monitoring showed there were requirements from the Delegation that were not met, it was brought to the Quality Improvement Committee (QIC). Trillium implemented a Plan of Correction (POC), but ECU physicians did not comply with the POC. After multiple failed attempts to help ECU Physicians comply, Trillium terminated the delegation contract. Providers with ECU Physicians now must go through the re-credentialing process and new providers must go through Trillium's credentialing process.

Trillium does not currently have any delegated credentialing. The Credentialing Delegation section of the current *Delegation* procedure and the *Delegation Assessment Tool-Credentialing* do not include information about a search of the *State Exclusion List*. As discussed in the Credentialing/Re-Credentialing Onsite session, this element needs to be included in the Primary Source verifications, to comply with *DMA Contract, Section 7.6.4, Exclusions*.

Table 24 lists the current delegated services.

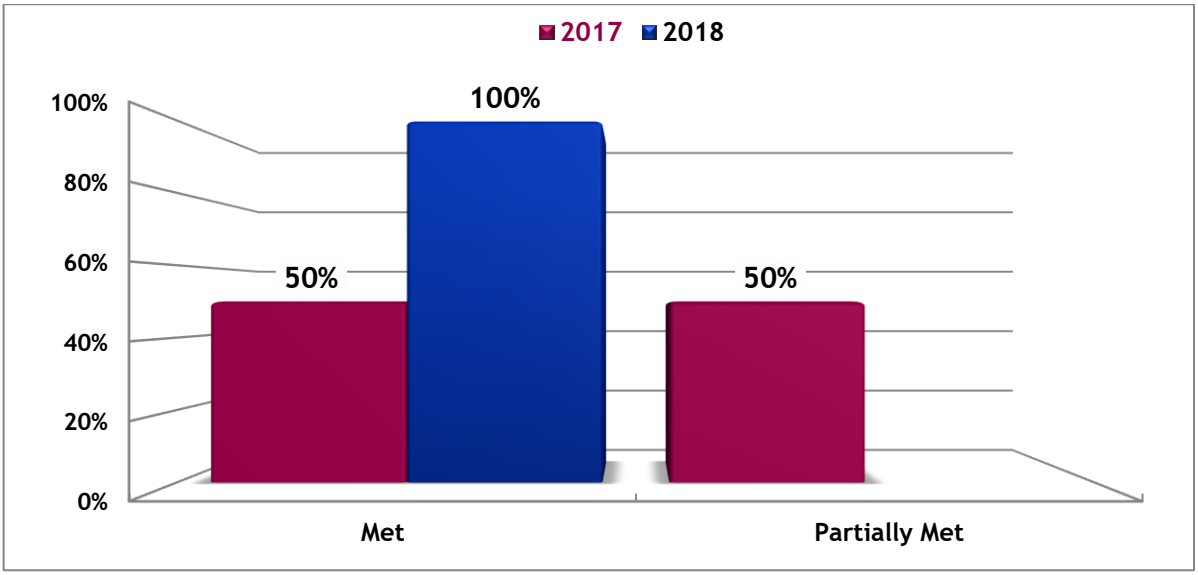
Table 24: Delegated Entities

Delegated Entity	Delegated Activity	Month of Annual Review
Iron Mountain (CRMI was acquired by Iron Mountain)	Record Management and Shredding	June
Clear Messaging	Interpretation	June

Delegated Entity	Delegated Activity	Month of Annual Review
BHM	Peer and Appeal Review	July
RI International	TCLI In-Reach	August
Shred It/Cintas	Record Management and Shredding	December
Fluent/Language Line	Interpretation	December

Figure 8 provides a comparison of the 2017 scores versus the 2018 scores.

Figure 8: Delegation Comparative Findings



Strengths

- Trillium has an executed contract with each delegate, including Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreements with those delegates that have access to Protected Health Information (PHI).
- Trillium conducted the required annual monitoring for each delegate. When one delegate was acquired by another business, Trillium conducted the required pre-delegation audit before executing the contract.

- Trillium ended the delegated credentialing contract when the delegate failed to comply with changes required by a POC.

Weakness

- The Delegation procedure and the *Delegation Assessment Tool-Credentialing* do not include information about a search of the *State Exclusion List*.

Recommendation

- Revise the *Delegation* procedure and the *Delegation Assessment Tool-Credentialing* to include a search of the *State Exclusion List*, as required by *DMA Contract, Section 7.6.4, Exclusions*.

H. Program Integrity

The EQR of Trillium Program Integrity (PI) began in the beginning of May 2018 with an offsite review of Trillium's PI files and documentation. IPRO analyzed the files and documentation and conducted Onsite reviews with the Chief Compliance Officer (CCO) and PI staff to review the offsite documentation and file review findings on May 31st, 2018.

FILE REVIEW:
IPRO requested the universe of PI files from Trillium for the 2017-2018 review period and selected a random sample of 15 files with a two (2) file oversample for a total of 17 files.

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

Findings: -Fifteen (15) of fifteen (15) files reviewed were compliant with this requirement.

Contract Requirement: in each case where the PIHP investigates a credible allegation of fraud, the PIHP shall provide DMA Program Integrity with the following information on a DMA approved template:

- Subject (name, Medicaid provider ID, address, provider type)
- Source/origin of complaint
- Date reported to the PIHP or, if developed by the PIHP, the date the PIHP initiated the investigation

- Description of the suspected intentional misconduct, with specific details including: the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated, and dates of suspected misconduct
- Amount paid to the provider for the last three years or during the period of the alleged misconduct, whichever is greater
- All communications between the PIHP and the provider concerning the conduct at issue, when available
- Contact information for PIHP staff persons with practical knowledge of the workings of the relevant programs
- Sample/exposed dollar amount, when available

Findings: - Fifteen (15) of fifteen (15) files reviewed were compliant with this requirement.

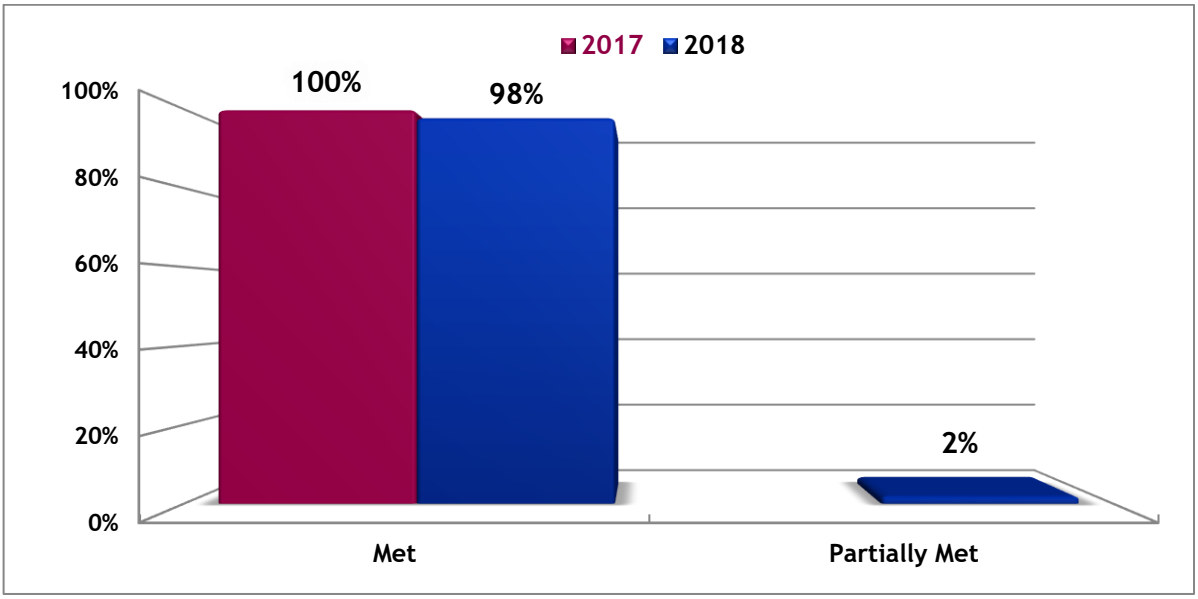
Contract Requirement: in each case of suspected enrollee fraud, the PIHP shall provide DMA Program Integrity with:

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

Findings: -No cases under review involved suspected enrollee fraud.

Figure 9 indicates the Program Integrity scoring for 2018 compared to the scores received in the 2017 EQR.

Figure 9: Program Integrity Findings



Strengths

- Trillium's PI Unit is well versed in the contractual language that governs their work. The implementation of the contractual requirements is found in the Unit's practices.
- The PI files were all well organized, thorough and contained all contractual requirements.

Weakness

- Moving forward, there is opportunity for Trillium to further capture enrollee fraud, waste, and abuse through data mining systems.

Recommendation

- Enhance data mining systems to establish a comprehensive process to collect and identify potential cases of member fraud, waste or abuse. Trillium can do this by working directly with the North Carolina Department of Social Services to determine if the State, through reports it receives, is made aware of potential member fraud or abuse before the PIHP.

I. Financial Services

CCME reviewed the following Trillium Health Resources (Trillium) Desk Review materials prior to the Onsite visit:

- Financial policies and procedures
- Audited financial statements and footnotes dated June 30, 2017
- Balance sheet and income statements dated February 28, 2018 and March 31, 2018
- Medicaid monthly financial reports for February and March 2018
- Claims processing aging reports for February and March, as well as claims processing policies
- Accounting Department staffing structure
- Fiscal year budget for 2017-2018
- Budget to actual expenses report for Medicaid for February and March 2018
- Executive Leadership Team dashboard for March 2018

After reviewing Trillium's Desk Review materials, an Onsite interview with Trillium staff occurred on May 31, 2018. In reviewing Trillium's financial operations, CCME used the *2018 NC EQR Standards* for Finance to guide the Desk Review and Onsite discussion. CCME also reviewed deficiencies from prior EQRs to determine if they were addressed. In addition to the standardized Desk Review Materials, CCME asked additional interview questions in the following areas:

- Policies and procedures
- Staffing changes in finance
- Accounting system
- Claims adjudication and re-adjudication
- Budget variances and development
- Internal audit function
- Board of Directors oversight
- Trillium's reinvestment plan

Although Trillium demonstrates ongoing financial stability, they are currently operating at a net loss for both Medicaid and non-Medicaid services. This loss is due to funding decreases by the NC General Assembly. The Medicaid loss has caused a decrease in funding for reinvestment projects since the prior fiscal year.

Trillium's audit report for June 30, 2017 had no deficiencies reported for their compliance with federal programs. The audit opinion was unqualified.

Trillium exceeded the contract benchmarks for current ratio, defensive ratio, and medical loss ratio. Trillium's Medicaid current ratio was 1.88 total with a total current ratio of 1.94 in February 2018. The Medicaid current ratio was 1.88 total with a total current ratio of 1.79 for March 2018 (benchmark is 1.00). Trillium's defensive interval was 49.5 days in February 2018 and 47.9 days in March 2018 (benchmark is 30 days). Trillium's year-to-date medical loss ratio was 93.5% on March 31, 2018 (benchmark is 85%). Trillium's Medicaid total assets on March 31, 2018 were $103,852,536. Trillium's net assets position as of June 30, 2017 was $101,225,109.

Trillium meets standard *42 CFR § 433.32 (a)* for maintaining an appropriate accounting system (Great Plains). Trillium uses the following Great Plains modules: general ledger, accounts payable, and purchasing. Trillium uses ADP for payroll and has used Great Plains since 2012. Trillium is using the CIE system for claims processing.

Trillium "Partially Met" the financial records retention requirement of ten years, as required by *DMA Contract, Section 8.3.2.* Trillium stated at the Onsite interview that they are following the state guidelines, and keeping paper records an average of five to seven years. Within Great Plains and Trillium's CIE system, records are not purged and remain accessible. They keep records longer if there are any unresolved audit findings. Trillium's *Record Retention* policy addresses compliance with *DMA Contract* requirements for record retention for enrollee medical records but does not specifically mention financial records. It is recommended that Trillium develop a procedure that documents the procedures for financial records retention.

Trillium management annually reviews its procedures. All finance policies CCME reviewed reflected an annual review date within 2018. Procedure changes are initiated by the procedure owner and are reviewed and housed by the Quality Improvement Division. Procedure updates are communicated via email to all staff and in monthly meetings. Further training takes place, if needed, and staff signs off on their review. All Medicaid reports were filed timely with DMA and include documented standard operating procedures on completing the DMA reports.

Trillium's cost allocation plan meets the requirements for allocating the administrative costs between federal, state, and local based on revenue as required by *42 CFR § 433.34.* There were no costs disallowed per the audit report and Onsite interview. Annually, Trillium submits a cost allocation plan to DMA to determine the percentage of Medicaid's share of administrative costs. Currently this percentage is 85%. The administrative expenses are recorded by expense type in the general ledger, and then allocated to the different funding sources based on a percentage of total revenues received (except county funding). Trillium's Medicaid funds are properly segregated through the chart of accounts in the general ledger in Great Plains.

Trillium's Medicaid Risk Reserve account meets the minimum requirement of 2% of the capitation payment per month required by *DMA Contract, Section 1.9*. Trillium currently has reached 9.7% of their required percentage of annualized capitation maximum (15%), with a balance of $37,689,098. Once the capitation payment is received from DMA, the Senior Accountant reconciles the payments and the Accounting Manager pays the risk reserve contribution electronically to the risk reserve account at Southern Bank. All deposits were made timely and there were no unauthorized withdrawals. Trillium provided CCME with bank statements demonstrating the risk reserve deposit and balance.

The prior EQR recommended that Trillium develop a formal procedure documenting retention of financial records. This recommendation was not implemented. Also, CCME recommended that Trillium add a procedure documenting the cost allocation plan. This was added to the Expenditures and Purchasing procedure. Another recommendation was to develop a strategic staffing plan to properly align staff with organizational needs and determine if there are staff redundancies after the merger. Trillium did not do a companywide assessment, but used a consultant to conduct an administrative workforce assessment.

All but one of the EQR standards received a "Met" score in the Financial Services section. Figure 8 provides a comparison of the 2017 scores versus the 2018 scores.

Figure 10: Financial Services Comparative Findings

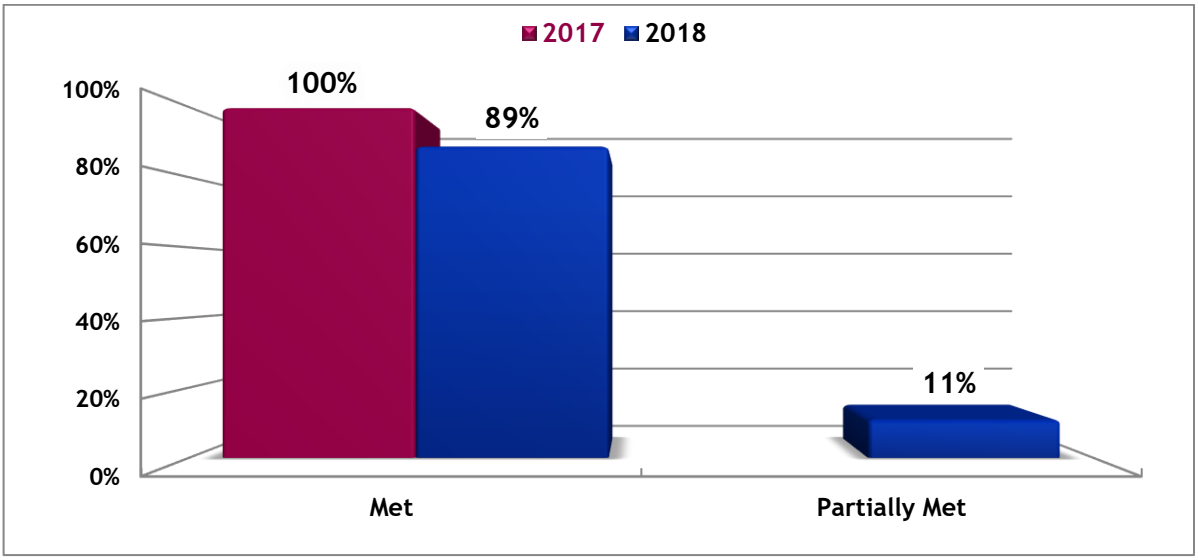


Table 25: Financial Services

Section	Standard	2018 Review
Financial Records Retention	The PIHP follows a record retention policy of retaining records for ten years, as required by DMA contract section 8.3.2	Partially Met

Strengths

- Trillium has submitted all DMA reports on time and has procedures documenting DMA reporting.
- Trillium is using an appropriate accounting system, and their general ledger structure segregates Medicaid costs.
- Trillium's risk reserve is meeting the requirements of the *DMA Contract*, and is being handled appropriately. The balances were confirmed with the bank statements.

Weaknesses

- Trillium does not document in a formal procedure the requirement of record retention of financial records.
- Financial records should be retained for ten years per the *DMA Contract, Section 8.3.2*.

Corrective Action

- Retain financial records for ten years per the *DMA Contract, Section 8.3.2*.

Recommendation

- Document financial record retention with a formal policy and/or procedure.

J. Encounter Data Validation

HMS has completed a review of the encounter data submitted by Trillium to DMA, as specified in the CCME agreement with DMA.

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

- A review of Trillium's response to ISCA.
- Analysis of Trillium's converted 837 encounter files.
- A review of DMA's encounter data acceptance report.

Results and Recommendations

Issue: Taxonomy code for Billing and Rendering providers

Taxonomy values were consistently populated for institutional claims; however, both the Rendering/Attending Provider Id and Specialty were missing for 61% of the claims. This is the primary denial for all Trillium encounters submitted. This information is key for passing the front end edits put in place by the State and to effectively price the claim. NCTracks is expecting the correct combination of NPI, taxonomy and procedure code. The taxonomy code did not always match up with the Taxonomy values enrolled in NCTracks for the Billing and/or Rendering Provider. These errors result in denials by the DMA that must be corrected and resubmitted.

Resolution:

As outlined in their ISCA response, Trillium has a process in place to review denials and correctly resubmit encounters to the State that were denied due to invalid or missing taxonomy. Trillium should continue to follow their current process and HMS will continue to monitor to ensure that the issue improves.

Issue: Procedure Code

The Procedure Code should be populated 99% of the time. In the encounter files provided, HMS found that the procedure code was populated more than 85% of the time with invalid values for institutional claims. The professional claims were accurate for 100% of the claims received. For institutional claims, the procedure code was populated with a mix of valid procedure codes and revenue codes. Revenue codes should never be received or populated in the Procedure Code field.

Resolution:

Procedure codes are a required field in order to pay the claim appropriately. Trillium should check their claims processing system and data warehouse to ensure the field is required and being captured appropriately. Trillium should also ensure that the appropriate data validation checks are in place in their provider portal to prevent revenue codes being submitted in the procedure code fields. If captured correctly, Trillium should double check their 837 encounter creation process and EDI translator to ensure the data was not lost during transformation.

Conclusion

Based on the analysis of Trillium's encounter data, we have concluded that the data submitted to DMA is not complete or accurate as defined by DMA standards.

Trillium should take corrective action to resolve the issues identified specifically with taxonomy denials and procedure codes for institutional claims. As indicated in Trillium's ISCA response, they have already defined a strategy to address issues with invalid or missing taxonomy codes, as well as a reconciliation process to address all DMA denials noted in the report above. Compared to claims reviewed from 2016, Trillium's denial rate has dropped from 29% to 9%.

For the next review period, HMS is recommending that the encounter data from NCTracks be reviewed to look at encounters that pass front end edits and are adjudicated to either a paid or denied status. It is difficult to reconcile the various tracking reports with the data submitted by the LME/MCO. 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 Trillium. The goal is to ensure that Trillium is reporting all paid claims as encounters to DMA.

ATTACHMENTS

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

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

April 12, 2018

Ms. Leza Wainwright
Chief Executive Officer
Trillium Health Resources
1708 E. Arlington Blvd.
Greenville, NC 27858-5872

Dear Ms. Wainwright,

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

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

The CMS EQR protocols can be found at:

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

The CCME EQR review team plans to conduct the onsite visit at Trillium on **May 30, 2018** through **May 31, 2018**. For your convenience, a tentative agenda for the two-day review is enclosed.

In preparation for the desk review, the items on the enclosed **Materials Requested for Desk Review** list are to be submitted electronically, and are due no later than **May 2, 2018**. As indicated in item 42 of the review list, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted by the aforementioned deadline.

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

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

The location for the file transfer site is:

https://eqro.thecarolinascenter.org

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

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

An opportunity for a pre-onsite conference call with your management staff, in conjunction with the DMA, 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: Kimberly Huneycutt, Trillium Contract Manager
Tasha Griffin, DMA Contract Manager
Renee Rader, DMA EQRO Contract Manager
Deb Goda, DMA Behavioral Health Unit Manager

External Quality Review 2018

MATERIALS REQUESTED FOR DESK REVIEW

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

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

3. Current Medical Director, medical staff job descriptions.

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

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

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

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

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

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

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

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

12. A current provider manual and provider directory.

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

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

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

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

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

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

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

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

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

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

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

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

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

25. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.
26. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal PIHP compliance with these standards.
27. Practice guidelines developed for use by practitioners, including references used in their development, when they were last updated and how they are disseminated. Also, policies and procedures for researching, selecting, adopting, reviewing, updating, and disseminating practice guidelines.
28. All information supplied as orientation to new providers, including a copy of the provider handbook or manual.
29. A copy of the provider contract/application.
30. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the PIHP, and any reports of activities submitted by the subcontractor to the PIHP. Also, completed evaluations of entities conducted before delegation is granted.
31. Contracts for all delegated entities.
32. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used. Include annual evaluation, if applicable.
33. Please provide an excel spreadsheet with a list of enrollees that have been placed in care coordination since April 2015. Please indicate the disability type (MH/SA, I/DD).
34. Please provide an excel spreadsheet with a list of enrollees that have been place in the TCLI program since April 2015. Please include the following: number of individuals transitioned to the community, number of individuals currently receiving Care Coordination, number of individuals connected to services and list of services receiving, number of individuals choosing to remain in ACH connected to services and list of services receiving.
35. Information regarding the following selected Performance Measures:

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

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

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.

3. 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.)

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

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

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

The credentialing files should include all of the following:

Proof of original credentialing date and all recredentialing dates, including the current recredentialing	Site visit/assessment reports, if the provider has had a quality issue or a change of address.
Proof of all insurance coverages. For practitioners who are employed at already-contracted agencies, include copies of the insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.	Ownership disclosure information/form

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

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

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

8. Provide the following for Program Integrity:
   a. File Review: Please produce a listing of all active files during the review period (April 2017 – March 2018) including:
      i. Date case opened
      ii. Source of referral
      iii. Category of case (enrollee, provider, subcontractor)
      iv. Current status of the case (opened, closed)
   b. Program Integrity Plan and/or Compliance Plan.
   c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
   d. Workflow of process of taking complaint from inception through closure.
   e. All 'Attachment Y' reports collected during the review period.
   f. Provider Manual and Provider Application.
   g. Enrollee Handbook.
   h. Subcontractor Agreement/Contract Template.

i. Training and educational materials for the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
j. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse.
k. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees.
l. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to DMA or any other State or Federal agency.
m. Code of Ethics and Business Conduct.
n. Internal and/or external monitoring and auditing materials.
o. Materials pertaining to how the PIHP captures and tracks complaints.
p. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
    i. DMA approved reporting templates.
q. Sample Data Mining Reports.
r. DMA Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
s. Monthly reports of NCID holders/FAMS-users in PIHP.
t. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
u. Corrective action plans including any relevant follow-up documentation.
v. Policies/Procedures for:

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

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

Section	Question Number	Attachment
Enrollment Systems	1b	Enrollment system loading process
Enrollment Systems	1e	Enrollment loading error process

Enrollment Systems	1f	Enrollment loading completeness reports
Enrollment Systems	2c	Enrollment reporting system load process
Enrollment Systems	2e	Enrollment reporting system completeness reports
Claims Systems	2	Claim process flowchart
Claims Systems	2t	Claim exception report.
Claims Systems	3e	Claim reporting system completeness process / reports.
Claims Systems	3h	Physician and institutional lag triangles.
Reporting	1a	Overview of information systems
DMA Submissions	1d	Workflow for DMA submissions
DMA Submissions	2b	Workflow for DMA denials
DMA Submissions	2e	DMA outstanding claims report

c. A copy of the IT Disaster Recovery Plan.
d. A copy of the most recent disaster recovery or business continuity plan test results.
e. An organizational chart for the IT/IS staff and a corporate organizational chart that shows the location of the IT organization within the corporation.

10. Provide the following for Financial Reporting:
    a. Most recent annual audited financial statements.
    b. Most recent annual compliance report
    c. Most recent two months' State-required DMA financial reports.
    d. Most recent two months' balance sheets and income statements including associated balance sheet and income statement reconciliations.
    e. Most recent months' capitation/revenue reconciliations.
    f. Most recent reconciliation of claims processing system, general ledger, and the reports data warehouse. Provide full year reconciliation if completed.
    g. Most recent incurred but not reported claims medical expense and liability estimation. Include the process, work papers, and any supporting schedules.
    h. Any other most recent month-end financial/operational management reports used by PIHP to monitor its business. Most recent two months' claims aging reports.
    i. Most recent two months' receivable/payable balances by provider. Include a detailed list of all receivables/payables that ties to the two monthly balance sheets.
    j. Any P&Ps for finance that were changed during the review period.
    k. PIHP approved annual budget for fiscal year in review.
    l. P&Ps regarding program integrity (fraud, waste, and abuse) including a copy of PIHP's compliance plan and work plan for the last twelve months.

m. Copy of the last two program integrity reports sent to DMA's Program Integrity Department.
n. An Excel spreadsheet listing all of the internal and external fraud, waste, and abuse referrals, referral agent, case activity, case status, case outcome (such as provider education, termination, recoupment and recoupment amount, recoupment reason) for the last twelve months.
o. A copy of PIHP's Special Investigation Unit or Program Integrity Unit Organization chart, each staff member's role, and each staff member's credentials.
p. List of the internal and external program integrity trainings delivered by PIHP in the past year.
q. Description and procedures used to allocate direct and overhead expenses to Medicaid and State funded programs, if changed during the review period.
r. Claims still pending after 30 days.
s. Bank statements for the restricted reserve account for the most recent two months.
t. A copy of the most recent cost allocation plan.
u. A copy of the PIHP's accounting manual.
v. A copy of the PIHP's general ledger chart of accounts.
w. Any finance Corrective Action Plan
x. Detailed medical loss ratio calculation, including the following requirements under CFR § 438.8:
    i. Total incurred claims
    ii. Expenditures on quality improvement activities
    iii. Expenditures related to PI requirements under §438.608
    iv. Non-claims costs
    v. Premium revenue
    vi. Federal, state and local taxes, and licensing and regulatory fees
    vii. Methodology for allocation of expenditures
    viii. Any credibility adjustment applied
    ix. The calculated MLR
    x. Any remittance owed to State, if applicable
    xi. A comparison of the information reported with the audited financial report required under §438.3 (m)
    xii. The number of member months

11. Provide the following for Encounter Data Validation (EDV):
    a. Include all adjudicated claims (paid and denied) from January 1, 2017 – December 31, 2017. Follow the format used to submit encounter data to DMA (i.e., 837I and 837P). If you archive your outbound files to DMA, you can forward those to HMS for the specified time period. In addition, please convert each 837I and 837P to a pipe delimited text file or excel sheet using an EDI translator. If your EDI translator does not support this functionality, please reach out immediately to HMS.

b. Provide a report of all paid claims by service type from January 1, 2017 – December 31, 2017. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

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

B. Attachment 2: Materials Requested for Onsite Review

Trillium

External Quality Review 2018

MATERIALS REQUESTED FOR ONSITE REVIEW- REVISED

1. Copies of all committee minutes for committees that have met since the desk materials were uploaded.
2. List of staff licensures as requested in #2 on the Desk Materials Request List.
3. Please provide a list of Peer Support Specialist within the TCLI program and which ones are Peer Support certified.
4. In Folder 10, there is a document named "Voluntary Terminations April 2017-March 2018". That document lists 8 providers. Please submit 2-3 Notifications from any of the eight providers to Trillium notifying Trillium of the termination. Please submit 3 termination notifications from Trillium to enrollees (for each provider) that were currently receiving care from these 2-3 providers.
5. Communications to, and electronic votes submitted by, Credentialing Committee members related to the November 2017 Credentialing Committee meeting.
6. Credentialing Committee meeting minutes of 12/20/17 state "12/10/17 minutes reviewed". Please submit the referenced minutes (12/10/17 Credentialing Committee meeting).
7. As requested in item #40 b on the Desk Materials List, please provide proof of the original credentialing date and all recredentialing dates, including the current recredentialing for the files listed below, for which we could not locate some or all of this information. (Proof of date of credentialing would typically be a copy of the letter to the provider, or the minutes from the Credentialing Committee, or a form signed by the Medical Director.)
   - Proof of date of original credentialing, and any subsequent recredentialing (not current recredentialing):
   - Proof of recredentialing in 2015:
     - for Rickie Ellis (initial credentialing date was 11/27/12, per letter in file); provider was recredentialed in 02/18.
     - for Robeson Health Care Corporation (initial credentialing date was in 2012); provider was recredentialed in 03/18.
8. Primary Source Verification for designated license (some providers have more than one license):
9. Supervision contract:
   - For these providers with LCAS-A
   - For these providers with LPA:
10. Current Network Development Plan (as required by *DMA Contract 6.4.4*).
11. TCLI Dashboard Report

All items can be uploaded on the CCME File Transfer Site (folder 49, Other Info):

https://eqro.thecarolinascenter.org

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

Plan Name:	**TRILLIUM**
Name of PIP:	**Improving the percentage of timely contacts with members in In-reach status TCLI Project**
Reporting Year:	**2017**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Trillium is not attaining the 95% rate (monthly target rate).
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Question was clearly stated on page 1.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is defined in Baseline Measurement section.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not done for this study.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not done for this study.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not done for this study.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Source section.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method is systematic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources will be pulled monthly.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis plan was documented as monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in Data Audit/Validation plan.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions were noted and linked to barriers.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analysis was conducted monthly.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	No statistical significance tests were conducted due to non-sampling methodology.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Discussion was noted in barriers sections regarding data accuracy.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Same methodology at baseline and remeasurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Rate improved over time.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement appears to be related to interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No statistical analyses were conducted due to non sampling.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**Met**	Improvement was demonstrated and sustained over several months.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	95
Project Possible Score	95
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**TRILLIUM**
Name of PIP:	**Increasing access to adequate admission, discharge and transfer data from hospitals in the Trillium catchment area**
Reporting Year:	**2017**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Trillium currently has access to 47% of adequate Admission, Discharge and Transfer (ADT) data from hospitals within the catchment area and receives this data from just eight of the 17 hospital EDs in the catchment area.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Question was clearly stated on page 1.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is defined in Baseline Measurement section.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not done for this study.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not done for this study.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not done for this study.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data (ADT database) were clearly specified in Data Source section.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method is systematic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources will be pulled quarterly.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis plan was documented on page 3.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in Data Audit/Validation plan.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions were noted and linked to barriers.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses were conducted quarterly.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly in Table.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	No statistical significance tests were conducted due to non-sampling methodology.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Discussion was noted in analysis sections below each measurement period.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	There was improvement in the rate.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement appears to be related to interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No statistical analyses were conducted because of non-sampling.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**Met**	Rate has been increasing and has been above 80% and sustained for two consecutive 2018 remeasurements.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	90
Project Possible Score	90
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**TRILLIUM**
Name of PIP:	**SUPERMEASURES (Mental Health)**
Reporting Year:	**2017**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not done for this study.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not done for this study.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not done for this study.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Source section.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method is systematic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources will be pulled monthly.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis plan was documented as monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in Data Audit/Validation plan.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions were noted and linked to barriers.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NA**	Too early to judge if data analysis plan was followed as there are baseline analysis only.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	No statistical significance tests were conducted due to non-sampling methodology and only baseline data.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NA**	Too early to judge impact of follow-up activities since baseline data is only timepoint recorded.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Baseline data only.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline data only.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Baseline data only.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Baseline data only.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Baseline data only.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	77
Project Possible Score	77
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**READMISSION RATES FOR MENTAL HEALTH**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**05/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**READMISSION RATES FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2016-6/30/2017
Review Performed:	05/18

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**05/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2016-6/30/2017
Review Performed:	05/18

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**05/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**MENTAL HEALTH UTILIZATION- INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**05/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**MENTAL HEALTH UTILIZATION**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**05/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**05/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**SUBSTANCE ABUSE PENETRATION RATE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**05/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**MENTAL HEALTH PENETRATION RATE**
Reporting Year:	7/1/2016-6/30/2017
Review Performed:	05/18

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	**Trillium**
Name of PM	**INNOVATIONS MEASURE: LEVEL OF CARE EVALUATION**
Reporting Year	**2018**
Review Performed	**05/18**

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	**Trillium**
Name of PM	**INNOVATIONS MEASURE: LEVEL OF CARE EVALUATIONS COMPLETED USING APPROVED PROCESSES AND INSTRUMENTS**
Reporting Year	**2017**
Review Performed	**05/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G2. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D3. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D4. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

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

VALIDATION SUMMARY

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

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

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	**Trillium**
Name of PM	**INNOVATIONS MEASURE: NEW LEVEL OF CARE EVALUATIONS COMPLETED USING APPROVED PROCESSES AND INSTRUMENTS**
Reporting Year	2017
Review Performed	05/18

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	**Trillium**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF PROVIDERS THAT IMPLEMENTED AN APPROVED CORRECTIVE ACTION PLAN**
Reporting Year	**2017**
Review Performed	**05/18**

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	**Trillium**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF PROVIDERS WHEREIN ALL STAFF COMPLETED MANDATED TRAINING**
Reporting Year	2017
Review Performed	05/18

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	**Trillium**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF ISPS IN WHICH SERVICES AND SUPPORTS REFLECT PARTICIPANT ASSESSED NEEDS AND LIFE GOALS**
Reporting Year	**2017**
Review Performed	**05/18**

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	**Trillium**
Name of PM	**INNOVATIONS MEASURE: ISPS ADDRESS IDENTIFIED HEALTH AND SAFETY RISK FACTORS**
Reporting Year	**2017**
Review Performed	**05/18**

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	**Trillium**
Name of PM	**INNOVATIONS MEASURE: PARTICIPANTS REPORTING THAT ISP HAS SERVICES THEY NEED**
Reporting Year	**2017**
Review Performed	**05/18**

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	**Trillium**
Name of PM	**INNOVATIONS MEASURE: INDIVIDUALS FOR WHOM AN ANNUAL ISP AND OR NEEDED UPDATES TOOK PLACE**
Reporting Year	**2017**
Review Performed	**05/18**

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	**Trillium**
Name of PM	**INNOVATIONS MEASURE: NEW WAIVER PARTICIPANTS ARE RECEIVING SERCICES ACCORDING TO ISP WITHIN 45 DAYS OF APPROVAL**
Reporting Year	**2017**
Review Performed	**05/18**

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

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

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

VALIDATION SUMMARY

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

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

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

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

AVERAGE VALIDATION PERCENTAGE & AUDIT DESIGNATION
100% FULLY COMPLIANT

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

D. Attachment 4: Tabular Spreadsheet

CCME PIHP Data Collection Tool

Plan Name:	**Trillium Health Resources**
Collection Date:	2018

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A. General Approach to Policies and Procedures						
1. The PIHP has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Trillium demonstrated adequate management, annual review and active revisions of their policies and procedures.
I. B. Organizational Chart / Staffing						
1. The PIHP's resources are sufficient to ensure that all health care products and services required by the State of North Carolina are provided to enrollees. At a minimum, this includes designated staff performing in the following roles:						
1.1 A full time administrator of day-to-day business activities;	X					Leza Wainwright continues in her role as CEO of Trillium.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities.	X					Trillium was able to demonstrate substantial Medical Director oversight of the medical aspects and quality assurance activities through the Chief Medical Officer (CMO) and Medical Director. However, distribution of these responsibilities could not be explained during the Onsite as it related to the upcoming retirement of the CMO. It was reported during the Onsite that a transition plan is in process to shift some or all responsibilities and oversight to Dr. Burt Johnson the current Medical Director, but explanation of the distribution of all duties could not be explained. ***Recommendation: Given the CMO's upcoming retirement, document the potential plan to ensure the responsibilities and oversight of Medical Director functions are covered as specified in DMA Contract, Sections 6.7.6 and 7.1.3.***
2. Operational relationships of PIHP staff are clearly delineated.	X					There was inconsistency around the Network Director position on the Organizational chart. ***Recommendation: Update the current organizational chart to reflect the recent changes in the Network Development Department staffing.***
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all PIHP staff positions, including those that are required by DMA contract.	X					
I. C. Confidentiality						
1. The PIHP formulates and acts within written confidentiality policies and procedures that are consistent with state	X					Trillium's complement of confidentiality procedures adequately addresses the protection of consumer privacy practices.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
and federal regulations regarding health information privacy.						
2. The PIHP provides HIPAA/confidentiality training to new employees and existing staff.	X					New hires are trained on Trillium's confidentiality practices prior to exposure to Protected Health Information (PHI).
I D. Management Information Systems						
1. Enrollment Systems						
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Global Eligibility Files (GEF) are imported daily into the CIE system. The daily eligibility file is compared to existing eligibility in the CIE system and add/changes/delete records are updated in the CIE system.
1.2 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					A new Medicaid ID# and a former Medicaid ID# is stored in the CIE enrollment module and Trillium can see the claims history for the prior member record since the data is merged.
1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.	X					Demographic information is stored in the CIE system. The system also captures historical member addresses and phone numbers.
2. Claims System						
2.1 The MCO processes provider claims in an accurate and timely fashion.	X					Claims are processed within 18 days after receipt and if approval, denial, or determination of need of additional information. If

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						approved, payment will be made within 30 calendar days after received. Trillium's ISCA response indicates on average Trillium has paid clean claims within 7.23 days of claim receipt during 2017. Trillium's ISCA response indicated Institutional at 98.65% and professional at 99.80% auto-adjudication.
2.2 The MCO has processes and procedures in place to monitor review and audit claims staff.	X					Trillium conducts audits of claims. Trillium audits any manual overrides and any manual reversals.
2.3 The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 procedure codes on an 837 Institutional file.		X				Trillium confirmed that it receives, makes available for reporting and submits to NCTracks any physical health secondary diagnosis code, DRG codes, and ICD-10 procedure codes. Trillium advised that up to 12 ICD-10 diagnosis codes for professional claims and up to 14 ICD-10 diagnosis codes for Institutional claims can be submitted to NCTracks. Twenty-five ICD-10 diagnosis codes is the maximum number of diagnosis codes that may be submitted on an 837I and the maximum number that is captured by NCTracks. ***Corrective Action: Trillium does not have the ability to receive, store, and report all the ICD-10 secondary diagnosis codes for the Institutional encounters. Twenty-five ICD-10 diagnosis codes is the maximum number of diagnosis codes that may be submitted on an 837I and the maximum number that is captured by NCTracks. Trillium does not have the capability to receive and store all the possible 837I secondary diagnosis codes.***
2.4 The MCO's claim system screens store and track claim information and claim adjudication/payment information.	X					During the Onsite, Trillium demonstrated the CIE claim screens (for institutional and professional) and the Provider Direct (provider web portal) claim entry interface.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Reporting						
3.1 The MCO's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					The enrollment DBMS is updated nightly. Trillium is in the process of a system migration; Trillium has purchased CIE and will be supporting all system upgrades, maintenance and reporting internally. Current relationship with Cardinal will terminate. Currently 9 internal developers and number will increase. Currently, 11 vacant positions and new positions to be developed. All information within CIE is readily available and reportable.
3.2 The MCO has processes in place to back up the enrollment and claims data repositories.	X					Trillium has processes in place that back up the CIE enrollment, claims and reporting systems on a nightly basis.
4. Encounter Data Submission						
4.1 The MCO has the capabilities in place to submit the State required data elements to DMA on the encounter data submission.		X				Trillium's submission process to DMA is fully automated by IT. On a weekly basis Trillium submits claims to NCTracks using the 837I and 837P file. Trillium does not have the ability to receive, store, report and submit to NCTracks all the ICD-10 secondary diagnosis codes for the Institutional encounters. Twenty-five ICD-10 diagnosis codes is the maximum number of diagnosis codes that may be submitted on an 837I and the maximum number that is captured by NCTracks. Trillium does not have the capability to submit to NCTracks all the possible 837I secondary diagnosis codes. ***Corrective Action: Update the encounter data submission process so that it can submit all secondary ICD-10 diagnosis codes present on an 837I.***

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 DMA.	X					Trillium has tracking and reconciliation reports to identify encounter status. Internally developed report that compares paid claims to encounters submitted to the State. Truven file used for reporting and identification of 1% denial rate. The 835 response file is used for reconciliation purposes, but not for the reporting and identification of the State denial rate (1%). As of March 2018, the top 3 reasons for encounter denials are: 1. Diagnosis non-specific 2. Billing provider must be enrolled for billing taxonomy code 3. Duplicate service for procedure
4.3 MCO has policies and procedures in place to reconcile and resubmit encounter data denied by DMA.	X					A total of 46,723 institutional and 827,711 professional encounters were submitted to NCTracks for 2017 dates of service. Trillium identified 362 institutional and 68,133 professional encounters that have been denied and not yet accepted with 2017 dates of service. Trillium is also working on the resubmission of the historical 837I/837P encounters to DMA; this includes CoastalCare and ECBH encounters. ***Recommendation: Currently, Trillium has a 1% encounter denial rate, but there are approximately 418,439 encounters that have not yet been submitted to NCTracks. Work with DMA on developing a plan to resubmit the denied historical encounters.***
4.4 The MCO has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to DMA	X					Staff is well informed, is dedicated to improving encounter data submissions and reducing the number of denials.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II. A. Credentialing and Recredentialing						
1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					The *Credentialing Program Description*, the *Credentialing Committee By-laws*, and policies and procedures, including the *Credentialing and Re-credentialing Process* procedure, guide the credentialing and recredentialing processes.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	X					The *Credentialing Committee Bylaws* define the responsibilities of the Credentialing Committee and delegate to the Chief Medical Officer the authority for approval of "clean" applications. The Credentialing Committee meetings are held in a variety of ways ("Face to Face; Webex, Telepresence"). The committee met monthly between May 2017 and April 2018, with a quorum present for 11 of the 12 meetings, and electronic votes taken after the meeting at which a quorum of voting members was not present. As discussed in this report and at the Onsite, there is inconsistent language regarding the frequency of meetings, and some inconsistency in the definition of a quorum. There is inconsistent employee representation and inconsistent committee meeting attendance by all committee members. ***Recommendation: Within and across documents, reconcile language regarding frequency of meetings and what constitutes a quorum. Consider ways to stabilize committee meeting attendance.***
3. The credentialing process includes all elements required by the contract and by	X					Initial credentialing files reviewed were organized and contained appropriate information. Issues regarding the initial credentialing process are discussed in the standards that follow.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
the PIHP's internal policies as applicable to type of provider.						
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					In response to a Corrective Action at the last EQR, Trillium instituted an Attestation form regarding insurance. The form provides options for each type of insurance (professional liability, general liability, automobile liability, and worker's comp/employer's liability) from which the provider can choose. For example, a provider can indicate they do not transport members (therefore, automobile liability insurance is not needed).
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					One initial credentialing file did not include Primary Source Verification (PSV) of one of the practitioner's two licenses. Additionally, no supervision contract for the "associate" (LCAS-A) license was located in that provider file. The PSV of the LPC license of another provider was not found in the file. All missing items were subsequently uploaded or were shown to the EQR reviewer at the Onsite. ***Recommendation: Ensure credentialing files include PSV of all clinical licenses listed by a practitioner, including all "associate" licenses. See DMA Contract, Attachment O.***
3.1.3 Valid DEA certificate; and/or CDS certificate	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					Professional education is Primary Source Verified by most licensing boards. As noted at the last EQR, the NC Medical Board has indicated they do not conduct PSV of education for physicians. If a physician is board certified, the PSV of board certification serves as PSV for education, as the board conducts PSV of education. If the physician graduated from an international medical school, the PSV of the Educational Commission for Foreign Medical Graduates (ECFMG) certification serves as PSV for education, as ECFMG conducts PSV of education. Two initial credentialing files were submitted for physicians. One of the physicians is board certified. The other physician is not board certified and received his education in Dominica. The file for that physician lacked PSV of the physician's education, including no PSV of ECFMG certification, and it was not located by Trillium staff at the Onsite. ***Recommendation: For physicians educated outside the United States, conduct PSV of ECFMG. If the physician was educated in the United States and is not board certified, ensure PSV of education is in the credentialing file.***
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.8 Query of the National Practitioner Data Bank (NPDB) ;	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);		X				No evidence of a query of the *State Exclusion List* was found in any submitted credentialing file. During the Onsite visit, Trillium staff reported this query is conducted by the Program Integrity Department. Trillium submitted a screenshot of a spreadsheet of checks the Program Integrity Department conducted in May 2018. CCME asked Trillium staff to submit evidence of the *State Exclusion List* checks conducted during the credentialing process for the credentialing files that were submitted for review. This evidence was not received. The *Credentialing and Re-Credentialing Process* procedure and the *Credentialing Program Description* do not include any reference to a query of the *State Exclusion List*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Corrective Action: Ensure all credentialing files include evidence of the query of the State Exclusion List, as required by DMA Contract, Sections 1.14.4 and 7.6.4. Revise the Credentialing and Re-Credentialing Process procedure and the Credentialing Program Description (and any other documents that list the documents to be queried in the credentialing process) to include the query of state sanctions, including the State Exclusion List.
3.1.10 Query for the System for Awards Management (SAM);	X					
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					Two physician credentialing files were submitted for review. Both files included admitting privileges information, though one physician (who was being credentialed to add to an agency in Concord, NC) listed admitting privileges in Kentucky, and listed his secondary practice address as a location in New Jersey. The Certificate of Insurance for his Professional Liability insurance lists the address in New Jersey.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Trillium staff indicated it is possible this physician is a tele-medicine provider, but the file had no confirmation of this. Though physicians use the Council for Affordable Quality Healthcare (CAQH) application for all of their practice locations, there was no documentation of any inquiry by credentialing staff regarding this situation. ***Recommendation: When an application includes practice information or hospital privilege information that are not near the location for which the application was received, follow up to clarify the information and verify the location at which the provider is practicing.***
3.1.15 Ownership Disclosure is addressed.	X					Missing ownership disclosure information was an issue requiring Corrective Action at the last EQR. Trillium's Corrective Action Plan response was to implement the use of an "*Ownership Disclosure Statement for all Supplemental Clinicians/Licensed Practitioners* joining agencies". With their Desk Materials, Trillium submitted initial credentialing files for six Licensed Independent Practitioners (LIPs) and for six Licensed Practitioners (LPs) who were joining agencies. The six LIP files contained the required ownership disclosure information. The six files for LPs joining agencies included the *Ownership Disclosure Statement for all Supplemental Clinicians/Licensed Practitioners,* but did not contain the Ownership Disclosure for persons with an "ownership or control interest in the provider, and agents and managing employees of the provider", as outlined in the *DMA Contract, Attachment O*. At the Onsite, Trillium staff was able to display the Ownership Disclosure information in the agency files.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Ensure credentialing files contain all items. If Trillium does not keep a copy of the relevant ownership disclosure information in the individual credentialing file, retrieve copies from the relevant file and upload as part of the credentialing files for the Desk Review.
3.1.16 Criminal background Check	X					
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.			X			Three of the initial credentialing files were for LPs who work for the same agency, but in different locations (one in Asheville, one in High Point, one in Concord). All three files included a site visit report completed for the agency location in New Bern. At the Onsite, Trillium staff pulled the files and located the PSV of the license issued by NC DHSR for the facility in Asheville and in Concord, so those two files would not require a site visit. A site visit would be required for the site in High Point, as it is not a licensed site. Three other initial credentialing files were for practitioners joining an agency at a Durham location. The site visit in their files was for the agency location in Wilson. At the Onsite visit, Trillium staff attempted to locate a site visit report for the Durham location, but were unsuccessful. The Durham location is not a licensed facility, so a site visit would be required. The "Site Visit" folder in two other submitted credentialing files had a sub-folder named "Requested TBA", but the files were empty. At the Onsite, the Trillium staff located these two site visit reports. For two other files, site visits occurred after the credentialing was approved and the approval letter was sent to the providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						In summary, site visits that were needed did not occur in four of the twelve initial credentialing files and, in two additional cases, the site visit occurred after credentialing was approved. This was also an issue in the 2016 and 2017 EQRs. ***Corrective Action: Verify the provider's site visit documentation is included in each credentialing file uploaded for Desk Review. If the site visit was done in the past, include proof of the site visit in the individual practitioner credentialing file for the EQR. If the practitioner is joining an agency that is a licensed facility, include the current PSV of the facility license in the credentialing file. See DMA Contract, Section 7.9, 42 CFR § 455.432, and Trillium's Network Monitoring procedure.***
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					One provider was credentialed in 01/18 and both Letters of Reference in the file were dated 04/17. The *Supplemental & LIP Credentialing Checklist* included this note: "eval forms dated 4/17 but will accept due to misunderstanding about contractual application category". The requirement for all elements being no older than 180 days applies in all instances, irrespective of any "misunderstanding".
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files reviewed were organized and contained appropriate information. Issues regarding the recredentialing process are discussed in the standards that follow.
4.1 Recredentialing every three years;			X			The *Credentialing Program Description* states "Trillium Health Resources re-credentials each participating provider and practitioner at least every three (3) years. This three-year timeframe is based on the date initial credentialing was granted, and re-credentialing must be completed before that 3-year anniversary date."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Seven of the twelve providers were not re-credentialed within three years, with recredentialing ranging from a day to about 8 weeks late. In some files, it appeared that Trillium was counting the time since credentialing or the prior recredentialing based on the date the approval letter was sent, versus the date of the prior approval. At the Onsite, Trillium staff acknowledged this was a problem in the past but reported it is now resolved. ***Corrective Action: Per Trillium's Credentialing Program Description, ensure providers are recredentialed within three years of the date of the approval of initial credentialing or the most recent recredentialing. (This is not the date on the letter conveying approval, but the date of approval by the Chief Medical Officer for "clean" files or the Credentialing Committee for "red-flagged" files.)***
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					In response to Corrective Action at the last EQR, Trillium instituted an Attestation form regarding insurance. The form provides options for each type of insurance (professional liability, general liability, automobile liability, and worker's comp/employer's liability) from which the provider can choose. For example, a provider can indicate they do not transport members (therefore, automobile liability insurance is not needed). No insurance information was received for one provider agency. Instead, Trillium submitted a shortcut to "Insurance" for that agency and CCME has no access to files on the Trillium system. The insurance information for that agency was viewed at the Onsite visit.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;		X				Copies of license verification are in files. The supervision contracts were not located in the recredentialing files of two providers with Licensed Clinical Addictions Specialist, Associate (LCAS-A). Trillium uploaded these in response to the Onsite Documents Request. Supervision contracts were also not located in the recredentialing files for two providers with LPAs and were not provided at the Onsite visit. This was also an issue at the 2017 EQR. As was discussed at the Onsite, the NC Psychology Board has verified that, "even if the LPA is verified via the Board website, there is no guarantee that their supervision contract on file is current and up to date." Therefore, the PIHP should obtain the current supervision contract as part of the credentialing and recredentialing process. ***Corrective action: Ensure the required supervision contracts are in the files for practitioners for whom it is required, including LPA practitioners, when files are uploaded for Desk Review.***
4.2.3 Valid DEA certificate; and/or CDS certificate	X					
4.2.4 Board certification if claimed by the applicant;	X					Two physician recredentialing files were submitted for review. PSV query of board certification (ABMS) was located in the physician recredentialing files. As noted at the last EQR, the recredentialing application does not ask if the provider is board certified. The Trillium *LIP & Supplemental Re-credentialing Evidence/Sanctions Check Sheet* includes "Board certification verified" in the "PSV & Sanctions Checks" section.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.5 Malpractice claims since the previous credentialing event;	X					
4.2.6 Practitioner attestation statement;	X					
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event;		X				No evidence of a query of the *State Exclusion List* was found in any of the submitted recredentialing files. During the Onsite visit, Trillium staff indicated these checks are conducted by the Program Integrity area. A screenshot of a spreadsheet of checks conducted by the Program Integrity Department in May 2018 was submitted. At the Onsite, Trillium staff was asked to submit evidence of the *State Exclusion List* checks conducted during the recredentialing process for the recredentialing files that were submitted for review. This evidence was not received. The *Credentialing and Re-Credentialing Process* procedure and the *Credentialing Program Description* do not reference a query of state sanctions, including no reference to a query of the *State Exclusion List*. ***Corrective Action: Ensure all recredentialing files include evidence of the query of the State Exclusion List, as required by DMA Contract, Sections 1.14.4 and 7.6.4. Revise the Credentialing and Re-Credentialing Process procedure, the Credentialing Program Description (and any other documents that reference the documents to be queried in the***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						recredentialing process) to include the query of state sanctions, including the State Exclusion List.
4.2.9 Requery of the SAM.	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event;	X					
4.2.11 Query of the Social Security Administration's Death Master File	X					
4.2.12 Query of the NPPES;	X					
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;			X			Trillium submitted two recredentialing files for physicians in the Desk Materials. Neither file contains information regarding admitting privileges for the physician, and Trillium did not locate the information at the Onsite. This was also an issue in the 2016 and 2017 EQRs. As noted in the 2017 EQR, the Recredentialing Application does not have a question about hospital admitting privileges. The Recredentialing Application contains a question about "Emergency Coverage". ***Corrective Action: Confirm all physician files include the names of hospitals at which the practitioner currently has admitting privileges. See DMA Contract, Attachment O, #9 ii.***
4.2.14 Ownership Disclosure is addressed.	X					Missing ownership disclosure information was an issue requiring Corrective Action at the last EQR. Trillium's Corrective Action Plan (CAP) response was to implement the use of an "*Ownership*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Disclosure Statement for all Supplemental Clinicians/Licensed Practitioners joining agencies". With their Desk Materials, Trillium submitted initial credentialing files for five Licensed Independent Practitioners (LIPs) and for seven Licensed Practitioners (LPs) who were joining agencies. The five LIP files contained the required ownership disclosure information. The seven files for LPs joining agencies included the *Ownership Disclosure Statement for all Supplemental Clinicians/Licensed Practitioners,* but did not contain the Ownership Disclosure for persons with an "ownership or control interest in the provider, and agents and managing employees of the provider", as outlined in the *DMA Contract, Attachment O.* At the Onsite, Trillium staff showed the Ownership Disclosure information in the agency files. ***Recommendation: Ensure credentialing files contain all items. If Trillium does not keep a copy of the relevant ownership disclosure information in the individual credentialing file, retrieve copies from the relevant file and upload as part of the credentialing files for the Desk Review.***
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.			X			The *Credentialing Program Description* states, "Trillium Health Resources considers any collected information regarding the participating provider's performance, including any information collected through the Provider Monitoring Program." At the Onsite, Trillium personnel confirmed this is done through the *Verification of Provider Standing (VPS)* forms sent to Program Integrity, Network, and Complaints/Grievances for completion.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Seven recredentialing files had a *VPS* form completed by Program Integrity, but none completed by Network or Complaints/ Grievances. Three files had a *VPS* form completed by Program Integrity and by Complaints/Grievances, but none by Network. One file had a *VPS* form completed by Complaints/Grievances, but none by Program Integrity or Network. No recredentialing file had *VPS* forms completed by all three sources (Program Integrity, Network, and Complaints/Grievances), and Trillium staff did not locate them at the Onsite. This was also an issue at the previous EQR. Trillium submitted a CAP which stated, "Trillium has updated our *Agency, and Supplemental & LIP Recredentialing Checklists* (attached) to specifically note that we have received *VPS* forms from Program Integrity, Network, and Compliance and that they have been placed in the practitioner's file." A spot check of the *Credentialing Checklists* revealed that the checklist for one file had no *VPS* forms checked, even though that included a completed *VPS* form from Program Integrity. The *Credentialing Checklist* for two other files included the *VPS* boxes with only the Program Integrity box checked, but the providers were recredentialed, anyway. ***Corrective Action: As indicated in the Corrective Action for the last EQR: To comply with Trillium's Credentialing and Recredentialing Process procedure and DMA Contract, Section 7.6, ensure provider performance is taken into consideration at recredentialing. If Trillium is using the Verification of Provider Standing (VPS) forms for this process, confirm all completed forms have been received prior to submitting the recredentialing application packet for approval by the Chief Medical Officer or the Credentialing Committee.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					The *Credentialing Program Description* addresses quality of care issues, including the responsibilities of the Credentialing Committee when quality of care issues are identified. The *Credentialing and Re-credentialing Process* procedure states "Practitioners or facilities may be provisionally credentialed when justified by continuity or quality of care issues." The *Provider Sanctions* procedure outlines the process of investigating violations or performance problems, including quality of care concerns, and imposing sanctions, up to and including, termination of contract(s).
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					
II B. Adequacy of the Provider Network						
1. The PIHP maintains a network of providers that is sufficient to meet the health care needs of enrollees and is consistent with contract requirements.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 Enrollees have a Provider location within a 30 – mile distance or 30 minutes' drive time of their residence. Rural areas are 45 miles and 45 minutes. Longer distances as approved by DMA are allowed for facility based or specialty providers.	X					The *Trillium Health Resources Provider Gaps Analysis and Needs Assessment for the NC DMHDDSA and DMA June 1, 2017* (*Gaps Analysis)* lists nine services that did not meet choice/access standards. Trillium submitted, and DMA approved, Exception Requests for those services.
1.2 Enrollees have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the enrollee may utilize an out-of-network specialist with no benefit penalty.	X					The *Out of Network Client Specific Agreements* procedure addresses the usage of out-of-network services, including as needed for specialty services.
1.3 The sufficiency of the provider network in meeting enrollee demand is formally assessed at least annually.	X					The most recent *Gaps Analysis* is dated June 2017. Surveys for members and families, and separate surveys for stakeholders, Trillium Staff and Board members are currently available on the Trillium website.
1.4 Providers are available who can serve enrollees with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					The *Cultural Competency Plan* was sent to the provider network in the *Network Communication Bulletin #022* on 02/22/18. A Cultural Competency Training was added to the Provider Learning Portal. Trillium has contracts with providers who use sign language, and with Fluent Language, which includes Braille.
1.5 The PIHP demonstrates significant efforts to increase the provider network when it is identified as not meeting enrollee demand.	X					Trillium uses Consumer Specific Agreements to obtain needed services when an in-network provider is not available. Trillium has issued Request for Proposals (RFPs) and used targeted provider recruitment to try to address gaps and needs. Challenges cited by Trillium include the large geographic area it serves, as well as the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						fact that much of the area is rural and sparsely populated, which often precludes financial viability for providers. When specific services (such as ACT) are not available, Trillium has sometimes met needs by offering "unbundled" services or "in lieu of" services. Trillium submitted their *Strategic Plan - ACTT PSR CADT SAIOP SACOT - April 2018* as their *Network Development Plan*. Trillium's presentation at the Onsite visit reported: • Increased access to Mobile Crisis Management across the catchment area including Nash County. • Continued development of a Network of Preferred Providers to increase same day access. • Added several Nash County providers and posted an RFP for a Comprehensive Outpatient Provider in Nash County. • Filled immediate need in the Network for a Day Treatment Provider in March 2018. Several RFPs are posted on the website and Trillium staff reported others will be posted soon. Columbus County is leaving another PIHP and joining Trillium effective July 1, 2018, and Trillium is specifically targeting providers in Columbus County.
2. Provider Accessibility						
2.1 The PIHP formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				*Section III. Clinical Screening and Triage* of the *Clinical Screening and Triage* procedure includes a table that has columns labeled "*Urgency of the Triage*" ("Routine", "Urgent" or "Emergent"), "*Definition*", and "*Timeframe to be Seen*". The "*Definition*" for rows labeled "Emergent" lists situations (copied and pasted below) that would warrant being seen

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						immediately, rather than "Within 2 hours" as indicated in the procedure. 1. "Member presents with severe risk in one (1) or more of the following: safety, cognition, physical or behavioral, or 2. Member has a moderate to severe risk related to safety, or 3. Member has a moderate to severe risk substance use withdrawal, or 4. Member presents with an imminent risk of harm to self or others." *DMA Contract, Attachment S* states, "Provider must provide face-to-face emergency care immediately for life threatening emergencies." The examples listed in the *Clinical Screening and Triage* procedure all reference "severe risk" or "imminent risk," which could be life-threatening, and, therefore, would require immediate care. ***Corrective Action: Revise the Clinical Screening and Triage procedure to clearly indicate care is to be provided immediately in life-threatening situations, as indicated in DMA Contract, Attachment S.***
II C. Provider Education						
1. The PIHP formulates and acts within policies and procedures related to initial education of providers.	X					The *Provider Network Training* procedure states "The Provider Network Training Unit is tasked with identifying the training needs of the Provider Network and responsible for the coordination of all Provider Network trainings through collaboration with various Trillium committees."
2. Initial provider education includes:						New providers are notified about orientation materials and requirements via a letter from the Contracts Department.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.1 PIHP purpose and mission;	X					
2.2 Clinical Practice Standards;	X					The Trillium *Provider Manual* includes a link to the Clinical Practice Guidelines on the Trillium website, however, the link goes to "Page not found". It appears there may be a typographical error in the link, as the final word is "Guidlines" (instead of "Guidelines"). ***Recommendation: Correct the link in the Provider Manual to the Clinical Practice Guidelines. Have a staff member periodically check links to ensure they work.***
2.3 Provider responsibilities;	X					
2.4 PIHP closed network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability.	X					
2.5 Access standards related to both appointments and wait times;	X					The *Provider* Manual provides the correct access standards for both appointments and wait times. As indicated at the last EQR, the *Trillium Call Center Training for New Providers* has correct timeframes for Access Standards, but does not contain any information regarding appointment wait times. ***Recommendation: Include appointment wait times in the Trillium Call Center Training for New Providers.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.6 Authorization, utilization review, and care management requirements;	X					
2.7 Care Coordination and discharge planning requirements;	X					
2.8 PIHP dispute resolution process;	X					
2.9 Complaint investigation and resolution procedures;	X					
2.10 Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements;	X					
2.11 Enrollee rights and responsibilities			X			As was the case at the last EQR, the current *Provider Manual* does not list the enrollee rights. The *Provider Manual* references "Member Rights & Empowerment" and provides a link to the *Member & Family Handbook* on the Trillium website. However, the link in the *Provider Manual* goes to "Page not found" on the Trillium website. It was a "Recommendation" at the last EQR that Trillium revise the *Provider Manual* to include the list of enrollee rights, since providers may not access the online information. Trillium did not make this revision in the *Provider Manual* revised 3/28/18. ***Corrective Action: Revise the Provider Manual to include enrollee rights, as required by DMA Contract, Section 7.11.1 m, and as recommended at the last EQR. Additionally, if Trillium***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						includes links to the Trillium website in any printed materials, ensure the links are checked periodically, to confirm they work.
2.12 Provider program integrity requirements that include how to report suspected fraud, waste and abuse, training requirements as outlined in the False Claims Act, and other State and Federal requirements.	X					
3. The PIHP provides ongoing education to providers regarding changes and/or additions to its programs, practices, enrollee benefits, standards, policies and procedures.	X					The Trillium website gives providers access to newsletters and notifies them about available training events. Trillium reports having a training plan and that they will update it once Columbus County is added. CCME requested the training plan during the Onsite, but it was not provided.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II D. Clinical Practice Guidelines for Behavioral Health Management						
1. The PIHP develops clinical practice guidelines for behavioral health management of its enrollees that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					
2. The PIHP communicates the clinical practice guidelines for behavioral health management and the expectation that they will be followed for PIHP enrollees to providers.	X					Clinical Practice Guidelines are posted on the Trillium website. Page 21 of the *Provider Manual* includes a link to the Clinical Practice Guidelines page on the Trillium website, but the link goes to "Page not found". Beginning on page 34 of the *Provider Manual* is a list with the heading, "Your responsibility as a Trillium contracted provider is to:…" This list includes, "Maintain services at an optimal level to meet member needs by providing services in accordance with Trillium Practice Guidelines."
II E. Continuity of Care						
1. The PIHP monitors continuity and coordination of care between providers.	X					During monitoring visits and via electronically submitted materials, Trillium staff review the policies and procedures of the providers and check the medical records for Consent to Release Information forms, as well as evidence of disclosure of information.
II F. Practitioner Medical Records						
1. The PIHP formulates policies and procedures outlining standards for	X					The *Medical Records Provider Requirements* procedure and the *Provider Manual* include regulations for medical records compliance, including references to *Administrative Procedural Service Manual*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
acceptable documentation in the Enrollee medical records maintained by providers.						(*APSM) 45-2*, *APSM 30-1*, and the *NCTracks Provider Claims and Billing Assistance Guide*.
2. The PIHP monitors compliance with medical record documentation standards through formal periodic medical record audit and addresses any deficiencies with the providers.	X					The *Adequacy of Treatment Record Keeping* section of the *Practitioner Office Site Quality* procedure includes information about documentation requirements. Medical record monitoring is conducted as a part of the NC DHHS provider monitoring program. Julie Brinson, Trillium Auditing Manger, reported Trillium staff review service notes from providers and check them against clinical coverage policies. Some of these reviews are done electronically, with providers submitting information via secure email, FAX, and some providers drop off hard copies.
3. The PIHP has a process for handling abandoned records, as required by the contract.	X					The "Abandoned Records" section of the *Management and Assumption of Medical Records* procedure includes all steps required by *DMA Contract 8.2, Clinical Records*.

III. ENROLLEE SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III A. Enrollee Rights and Responsibilities						
1. The PIHP formulates policies outlining enrollee rights and procedures for informing enrollees of these rights.	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III B. Enrollee PIHP Program Education						
1. Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid Waiver managed care program which they are contractually entitled, including:		X				*Enrollee Rights and Responsibilities* procedure indicates the Communications Department notifies new enrollees of the *Trillium Member & Family Handbook* within 14 days of enrollment. The *New Enrollee Form Letter* advises enrollees that the *Member & Family Handbook* and other information, including Rights & Responsibilities, is available on the Trillium website, or by calling the Access to Care toll-free number. Issues that resulted in this partially met standard are discussed in the standards that follow (1.10, and 1.11.1)
1.1 A description of the benefits and services provided by the PIHP and of any limitations or exclusions applicable to covered services. These descriptions must have sufficient detail to ensure the Enrollees understand the benefits to which they are entitled and may include a web link to the PIHP Benefit Plan. This includes a descriptions of all Innovations Waiver services and supports;						
1.2 Benefits include access to a 2nd opinion from a qualified health care professional within the network, or arranges for the enrollees to obtain one outside the network, at no cost to the enrollee;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Updates regarding program changes;						
1.4 A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;						
1.5 An explanation of the Enrollee's responsibilities and rights and protection;						
1.6 An explanation of the Enrollee's rights to select and change Network Providers						
1.7 The restrictions, if any, on the enrollee's right to select and change Network Providers						
1.8 The procedure for selecting and changing Network Providers						
1.9 Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request);						The on-line *Network Provider Directory* has all required fields in this standard and has an effective search feature. The written *Network Provider Directory* is not as extensive.
1.10 The non-English languages, if any, spoken by each Network Provider;						The on-line and written *Network Provider Directory* do not contain information about provider spoken language. ***Corrective Action: Add a field to the on-line and written Network Provider Directory for non-English languages spoken by network providers. This was a corrective action for the last EQR.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.11 The extent to which, and how, after-hours and emergency coverage are provided, including:						
1.11.1 What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services in accordance with 42 CFR§ 438.114 and EMTALA;						Post Stabilization Services are not explained in the *Member & Family Handbook*. Examples of emergent needs are listed. ***Corrective Action: In the Member & Family Handbook, add an explanation of Post Stabilization Services or continued care after an emergent situation.***
1.11.2 The fact that prior authorization is not required for emergency services;						
1.11.3 The process and procedures for obtaining Emergency Services, the use of 911 telephone services or the equivalent;						
1.11.4 The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract;						Locations for Post Stabilization Services are not outlined in the *Member & Family Handbook*. ***Recommendation: In the Member & Family Handbook, add language for where members can receive Post Stabilization Services or continued care after an emergent situation.***
1.11.5 A statement that, subject to the provisions of the DMA this contract, the Enrollee has a right to use any hospital or other setting for Emergency care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.12 The PIHP's policy on referrals for Specialty Care to include cost sharing, if any, and how to access Medicaid benefits that are not covered under this Contract;						
1.13 Any limitations that may apply to services obtained from Out-of Network Providers, including disclosures of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of Network Providers, and the procedures for obtaining authorization for such services.						
1.14 How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost-sharing;						
1.15 Procedures for obtaining out-of-area or out-of-state coverage of or services, if special procedures exist;						
1.16 Information about medically necessary transportation services by the department of Social Services in each country;						
1.17 Identification and explanation of State laws and rules Policies regarding the treatment of minors;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.18 The enrollee's right to recommend changes in the PIHP's policies and procedures						
1.19 The procedure for recommending changes in the PHIP's policies and procedures;						
1.20 The Enrollee's right to formulate Advance Directives;						
1.21 The Enrollee's right to file a grievance concerning non-actions, and the Enrollee's right to file an appeal if PIHP takes an action against an Enrollee;						
1.22 The accommodations made for non-English speakers, as specified in 42 CFR §438.10(c)(5);						Information regarding oral translation is found on pages 11 and 20 in the *Member & Family Handbook* and on the main *For Individuals & Families* page on the Trillium website.
1.23 Written information shall be made available in the non-English languages prevalent in the PIHP's services area.						
1.24 The availability of oral interpretation service for non-English languages and how to access the service;						
1.25 The availability of interpretation of written information in prevalent languages and how to access those services						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.26 Information on how to report fraud and abuse; and						
1.27 Upon an Enrollee's request, the PIHP shall provide information on the structure and operation of the agency and any physician incentive plans.						
1.28 Information on grievance, appeal and fair hearing procedures and information specified in CFR §438.10 (g) and CFR §438.10 (f) (6).						
2. Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.	X					
3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in CFR 438.10 (f) (61) and 438.10 (g) at least 30 days before calendar days before the intended effective date of the change; and (2) . termination of their provider within fifteen (15) calendar days after PIHP receives notice that DMA or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.		X				1. Trillium notifies members of any "significant change" 30 days before the effective date. This review period did not have any significant changes. 2. Files of five terminated providers were reviewed to determine if enrollees received appropriate notification. *DMA Contract, Section 6.10,* requires the PIHP to make a "good faith effort" to give notice within 15 calendar days after the PIHP receives notice that DMA or the provider has terminated the Provider Agreement or within 15 calendar days after the PIHP terminates the written agreement. All files reviewed contained letters that were sent after the 15-day notification requirement. ***Corrective Action: Confirm written notice of provider termination is given to all enrollees in compliance with DMA Contract, Section 6.10. Follow the process outlined in the Continuity of Care-***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Provider's Termination procedure. This corrective action was issued last EQR, too.
4. Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation of prevalent non-English languages as required by the contract.	X					Trillium does not currently have enrollee materials created or printed in large front (18 point or greater) for visually impaired members. Neither the website nor in the *Member & Family Handbook* has a notice in large font (18 point or greater) that these materials are available to enrollees. ***Recommendations: Create enrollee materials in large font and have a plan to print enrollee material in large font when requested. See DMA Contract, Section 6.9.2 and CFR 438.10 (d).*** ***Add a notice to the website and in the Member & Family Handbook, in 18 point font or greater, that states all enrollee materials can be printed in large print and mailed if needed. Include a contact for that request in all notices.***
5. The PIHP maintains and informs Enrollees of how to access a toll-free vehicle for 24-hours Enrollee access to coverage information from the PIHP, including the availability of free oral translation services for all languages and care management services such as crisis interventions.	X					
III C. Behavioral Health and Chronic Disease Management Education						
1. The PIHP enables each enrollee to choose a Provider upon enrollment and provides assistance as needed.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP informs enrollees about the behavioral health education services that are available to them and encourages them to utilize these benefits.	X					
3. The PIHP tracks the participation of enrollees in the behavioral health education services.	X					
III D. Call Center						
1. The PIHP provides customer services that are responsible to the needs of the Enrollees and their families. Services include:	X					The *Customer Service* procedure describes Call Center processes.
1.1 Respond appropriately to inquiries by enrollees and their family members (including those with limited English proficiency);	X					
1.2 Connect enrollees, family members and stakeholders to crisis services when clinically appropriate;	X					Call Center processes are outlined in the *Clinical Triage Process* procedure and in the *Customer Service* procedure. The Trillium website provides information on *Crisis Care & Service Enrollment*.
1.3 Provide information to enrollees and their family members on where and how to access behavioral health services;	X					
1.4 Train its staff to recognize third-party insurance issues, recipient appeals,	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
and grievances and to route these issues to the appropriate individual;						
1.5 Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;	X					
1.6 Process referrals twenty-four (24) hours per day, seven (7) days per week; 365 days per year; and	X					See *page 10 of the Member & Family Handbook*. The 24-Hour Crisis Care & Services Enrollment toll-free number is prominently displayed at the top of each webpage on the Trillium website. The *Clinical Triage* procedure states, "The call-center operates 24/7/365 from both a toll-free and a local telephone number." The *Teams & Functions* page on the Trillium website states Call Center staff, "are avilable 24 hours a day, seven days a week, 365 days a year."
1.7 Process Call Center linkage and referral requests for services twenty-four (24) hours per day, seven (7) days per week, 365 days per year.	X					During Onsite discussion, Trillium confirmed that there is no contract for overflow or after-hours coverage of phone calls, and that it is possible that an enrollee might end up leaving a voicemail message. Trillium was unable to quantify how often this might occur, but stated that it "it has not happened in the past year." All Call Center metrics are met or exceeded. The Trillium Call Center operation is compliant with the *DMA Contract*.

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV A. The Quality Improvement (QI) Program						
1. The PIHP formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to enrollees.	X					Trillium's *2017-2018 Quality Management Plan* outlines its Program for measuring and improving the care and services received by their enrollees and providers.
2. The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.	X					Trillium implemented a project to monitor provider adherence to Clinical Practice Guidelines (CPGs) for two specific areas: rating scales for depression and metabolic monitoring of patients taking antipsychotics. ***Recommendation: A summary of the two CPG monitoring projects was explained in the Onsite interview, but results were not detailed in the Annual Quality Management Program Evaluation. More detail is needed In the Annual Quality Management Program Evaluation to explain how the CPGs were monitored and what results were produced throughout the year.***
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					The *QM Work Plan* has an entry for retrospective analysis of claims data to identify enrollees that overutilize crisis services and underutilize more appropriate community-based services.
4. The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.	X					Trillium is monitoring and analyzing results for all provider and enrollee surveys with a written document for each survey. A plan is in place to implement improvements on lower-scoring survey items. Follow through to evaluate improvement on that plan is not evident in the prepared reports or in the *Annual Quality Management Program Evaluation*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: More detail is needed in the Annual Quality Management Program Evaluation to explain how lower scoring measures from the surveys are addressed and followed for improvement.
5. The PIHP reports the results of the enrollee satisfaction survey to providers.	X					Enrollee and provider surveys are posted on the Trillium website.
6. The PIHP reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					
7. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, time frame for implementation and completion, and the person(s) responsible for the project(s).	X					The *QM Work Plan* is up-to-date and tracks projects the QM Team is following.
IV B. Quality Improvement Committee						
1. The PIHP has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					QIC responsibilities are listed in the *Quality Management Plan* and all responsibilities are "Met" as evidenced by the QIC meeting minutes and *QM Work Plan* updates.
2. The composition of the QI Committee reflects the membership required by the contract.	X					
3. The QI Committee meets at regular intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					
IV E. Provider Participation in Quality Improvement Activities						
1. The PIHP requires its providers to actively participate in QI activities.	X					All providers implement three QIPs.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					The Quality Management Department monitors QIPs and offers feedback by email and phone calls, if needed. The Global Quality Improvement Committee (GQIC) and QM staff offer technical assistance. The QM team communicates Performance Measures results to providers quarterly.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					The *Annual Quality Management Program Evaluation Fiscal Year 2016-2017* consists of an executive summary, 2016-2017 highlights, activities and accomplishments, and a summary at the end of the report. It could be improved by adding more detail about the year's work for each item along with analysis of outcome data for each section. For example, The CPGs lack outcomes achieved from the year's work on both CPGs that were monitored. ***Recommendation: In the next version of the Annual Quality Management Program Evaluation, add more detail about the year's work for each item along with analysis of outcome data for each section.***
2. The annual report of the QI program is submitted to the QI Committee and to the PIHP Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. The Utilization Management (UM) Program						
1. The PIHP formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					Trillium has several procedures that address various elements of the utilization management program, including review and clinical review processes. Additional procedures include over and underutilization. All procedures have been implemented.
1.1 structure of the program;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					There is no language that indicates the definition of an expedited service authorization request as is required per processing of service authorizations as indicated in the *DMA Contract, Sections 7.4 and 7.4.14*. Similarly, there is no procedural language that explains the requirement that all requests (i.e., expedited or standard) are, per *DMA Contract, Sections 7.4* and *7.4.13* processed as "expeditiously as the member's health condition requires". ***Recommendations: Add language to UM procedures that indicates the definition of an expedited service authorization request as indicated in the DMA Contract, Sections 7.4 and 7.4.14.*** ***Add language to UM procedures that clarifies that all requests (i.e., expedited or standard) are, per DMA Contract, Sections 7.4 and 7.4.13 processed as "expeditiously as the member's health condition requires".***
1.5 consideration of new technology;	X					
1.6 the appeal process, including a mechanism for expedited appeal;	X					
1.7 the absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.8 mechanisms to detect underutilization and overutilization of services.	X					In the *Detecting Over and Under Utilization* procedure, there are mechanisms in place to monitor and detect over utilization, however there does not appear to be a mechanism in place regarding the monitoring of underutilization. ***Recommendation: Describe in the UM Plan and UM procedures the mechanism of monitoring underutilization of services.***
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Chief Medical Officer and Medical Director are involved in daily activities and regularly attend committee meetings.
3. The UM program design is reevaluated annually, including Provider input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM program is evaluated annually; the assessment was completed in May. The evaluation report is in DRAFT form and goes before the Board in July for approval.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					UM standards were indicated in all files reviewed.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Utilization management standards/criteria are consistently applied to all enrollees across all reviewers.	X					The Trillium Medical Director, Dr. Smith, has responsibility of the IRR review process. The average PIHP score for Inter- Rater Reliability (IRR) was 90%.
5. Emergency and post stabilization care are provided in a manner consistent with contract and federal regulations.	X					
6. Utilization management standards/criteria are available for Providers.	X					
7. Utilization management decisions are made by appropriately trained reviewers	X					
8. Initial utilization decisions are made promptly after all necessary information is received	X					
9. Denials						
9.1 A responsible effort that is not burdensome on the enrollee or the provider is made to obtain all pertinent information prior to making the decisions to deny services	X					The process is not burdensome. Trillium, as a practice, does not request additional information to finalize UM decisions.
9.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
9.3 Denial decisions are promptly communicated to the provider and enrollee and include the basis for the denials of service and the procedure for appeal	X					The UM files reviewed showed adverse benefit determination notifications to both the provider and enrollee were made timely.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V C. Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					
2. The 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					The *Coordination of Services Following Hospitalization* procedure provides information regarding linking members to provider/services following discharge.
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					Trillium over the past year, Trillium has implemented the Incedo software platform for Care Coordination. This platform supports the identification needs through the assessment process that provides feedback to Care Coordinators regarding member health care needs.
2.4 Develop treatment plans for enrollees that meet all requirements;	X					The *Person Centered Plan and Individual Support Plans* procedure provides clarification regarding the Care Coordinators role and responsibilities in the PCP and ISP development.
2.5 Quality monitoring and continuous quality improvement;	X					
2.6 Determine of which Behavioral Health Services are medically necessary;	X					Referrals and linkages were present and identified in the files reviewed.
2.7 Coordinate Behavioral Health, hospital and institutional admissions	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
and discharges, including discharge planning;						
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					
2.10 Ensure privacy for each Enrollee is protected.	X					
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					The file review indicated that procedures were followed.
V. D Transition to Community Living Initiative						
1. Transition to Community Living functions are performed by appropriately licensed, or certified, and trained staff.		X				While it is understood that TCLI In Reach activities are delegated, the educational and certification requirements are not indicated in the Transition to Community Living procedures, as specified in *DMA Contract, Section 15.9.* ***Corrective Action: Revise the Transition to Community Living procedure to include the certification requirements of Peer Support Specialists.***
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements includes all required elements.	X					The *Transition to Community Living* and *Transition to Community Living In-Reach* procedures include all required elements.
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 Services, and Supported Employment services are included in the individual's transition, if applicable.	X					
2.4 A mechanism is in place to provide one-time transitional supports, if applicable		X				The TCLI procedures do not adequately describe the availability of one-time transitional supports, the process for accessing those supports, or how these one-time funds are tracked and/or monitored by the PIHP. ***Corrective Action: Include in a Transition to Community Living procedure the definition and availability of TCLI One-Time Transitional supports and how these supports and/or funds are monitored. (See DMA Contract, Section 15.9, One Time Transitional Supports).***
2.5 QOL Surveys are administered timely.	X					
3. A diversion process is in place for individuals considering admissions into an Adult Care Home (ACH).	X					The *Transition to Community Living* procedure provides information regarding the diversion process.
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to DMA within the timeframes determined by DMA.	X					
5. The PIHP will develop a TCLI communication plan that includes materials and training about crisis hotline, services for enrollees with limited English proficiency and also to for external and internal stakeholders providing information		X				Trilliums CAP response from last year indicated a communication plan was designed to bolster information on the website, *the Member & Family Handbook* and the *Provider Manual*. Specific to the *Provider Manual*, Trillium stated, "Additions will include information regarding what the settlement is, how a member qualifies, once a member qualifies what services and supports they can access. Information will also be included regarding the PASRR process and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
on the TCL initiative, resources, and system navigation tools, etc.						how a PASRR can be completed (Process can potentially change discussion are under way with DHHS)." This information was not added and so remains an issue for this year's EQR. ***Corrective Action: As was agreed to in last year's EQR, add the additional information to the Provider Manual. Information should include what the settlement is, how a member qualifies, and once a member qualifies what services and supports they can access.***
6 A review of files demonstrates the PIHP is following appropriate TCL policies, procedures and processes, as required by NC DMA, and developed by the PIHP.	X					A review of the files indicated that documentation was provided for in-reach activities every 90 days, PCPs and ISPs were present and documentation to the Quality of Life (QOL) surveys in files that met the guideline requirements. The individual receiving in-reach activities were noted they wanted to remain in supported living environments.

VI. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					
1.1 Definition of a grievance and who may file a grievance;	X					
1.2 The procedure for filing and handling a grievance;	X					The link to file a grievance via Trillium's website leads to an electronic form titled "Concern, Complaint, Compliment, Question." This further confuses the term grievance and DMA contractual requirements around grievance processing and due process, which needs clarification. ***Recommendation: Add the term "grievance" to the link labelled "concern, complaint, compliment, question" where enrollees can electronically file grievances.***
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					
2. The PIHP applies the grievance policy and procedure as formulated.		X				Documentation within the files showed the terms “grievance” and “complaint” were used interchangeably. These inconsistencies were noted to be in six of the 25, or 24%, of the files reviewed. ***Corrective Action: Provide training to all staff regarding the differences between documenting, labelling and logging grievances as defined in Trillium procedures.***
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The grievance logs submitted for this year’s EQR had duplicate files listed as both grievances and complaints. ***Recommendation: Develop and implement a monitoring plan and that reviews the grievance log to ensure that grievances are logged correctly and not duplicated.***
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to enrollee and/or provider appeals of an action by the PIHP in a manner consistent with contract requirements, including:	X					
1.1 The definitions of an action and an appeal and who may file an appeal;		X				The *Medicaid Clinical Reconsideration Process* procedure states that the appeal process is, "available to all member and providers and/or facilities rendering services." This is incorrect language regarding who can file an appeal. Specifically, and per *DMA Contract, Attachment M.G.1*, "a Provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent can file a PIHP internal appeal." ***Corrective Action: Correct the Medicaid Clinical Reconsideration Process procedure to consistently reflect that "a Provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent can file a PIHP internal appeal."***
1.2 The procedure for filing an appeal;	X					The *Provider Manual* does not inform providers that Trillium acknowledges the receipt of an appeal in writing. This recommendation was included in last year's EQR and was not followed or addressed by Trillium in this past year. This lack of information in the *Provider Manual* remains a concern in this year's EQR. ***Recommendation: Include in the Provider Manual that Trillium acknowledges in writing the receipt of an appeal.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				The *Medicaid Clinical Reconsideration Process* procedure erroneously states the resolution timeframe for an expedited appeal is "3 calendar days" when, contractually, the timeframe is 72 hours. The *Medicaid Clinical Reconsideration Process* procedure does not note that all appeals, both standard and expedited, be, per *DMA Contract, Attachment M.4*, resolved "as expeditiously as the Enrollee's health condition requires." ***Corrective Action: Correct the Medicaid Clinical Reconsideration Process procedure to state the resolution timeframe for an expedited appeal is 72 hours.*** ***Recommendation: Include in the Medicaid Clinical Reconsideration Process procedure that all appeals, both standard and expedited, be, per DMA Contract, Attachment M.4, resolved "as expeditiously as the Enrollee's health condition requires.***
1.6 Written notice of the appeal resolution as required by the contract;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.7 Other requirements as specified in the contract.		X				As part of the EQR process in the previous year, Trillium agreed to add the following statement to their appeal procedure: "Trillium must ensure that punitive action is not taken against the authorized representative who either request an expedited or support an enrollee appeal." This CAP response last year, but Trillium never added it to the procedure. ***Corrective Action: Add to the Medicaid Clinical Reconsideration Process procedure the statement "Trillium must ensure that punitive action is not taken against the authorized representative who either requests an expedited or support an enrollee appeal."***
2. The PIHP applies the appeal policies and procedures as formulated.		X				*DMA Contract, Attachment M.H.3*, as well as Trillium's *Medicaid Clinical Reconsideration Process* procedure, clearly state that a written request is not required when an oral, expedited appeal has been filed, regardless of whether the PIHP agrees that the request meets criteria for an expedited appeal. ***Corrective Actions: Train appeal staff on the requirements within Trillium procedures and DMA Contract, Attachment M.H.3, that once an oral, expedited appeal is filed by an appellant, no written request is then required.*** ***Correct page 64 of the Provider Manual to reflect that no additional Enrollee follow-up is required if an oral, expedited appeal is submitted.***
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. Delegation						
1. The PIHP has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Trillium has written contracts and Letters of Agreement (LOAs) with its delegates. Delegates with access to Protected Health Information (PHI) also have executed Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreements.
2. The PIHP conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the PIHP if the PIHP were directly performing the delegated functions.	X					Corrective Action items from the previous review were addressed. The *Delegation* procedure and the *Delegation Assessment Tool-Credentialing* do not include information about a search of the *State Exclusion List*. Since Trillium does not have a credentialing delegation, this is not currently an issue; however, the documents need to be revised to include the search of the *State Exclusion List*, in case there is a future credentialing delegate, and to comply with the *DMA Contract*. ***Recommendation: Revise the Delegation procedure and the Delegation Assessment Tool-Credentialing to include a search of the State Exclusion List, as required by MA Contract 7.6.4, Exclusions.***

VIII. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII A. General Requirements						
1. PIHP shall be familiar and comply with Section 1902(a)(68) of the Social Security Act, 42 C.F.R. Parts 438,455 and 1000 through 1008, as applicable, including proper payments to Providers and methods for detection of fraud and abuse.	X					This requirement is addressed in Trillium's *Compliance Plan 2017-2018* in *Appendix C*.
2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents' and subcontractors,' compliance with the requirements of this Section 14.	X					This requirement is addressed in Trillium's *Compliance Plan 2017-2018*. The *Compliance Plan* denotes the policies and procedures that guide and require compliance with federal and state regulations.
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					The *Procurement Contract for Provision of Services* addresses this requirement. Trillium's provider application, as well as the *Provider Manual*, contain all program integrity requirements.
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					This requirement is addressed in the *Investigations of Suspected Fraud, Waste, and Abuse* procedure.
VIII B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with 42 C.F.R. 438.608 that is designed to guard against fraud and abuse. The Compliance Plan shall	X					This requirement is addressed on page 1 of the *Program Integrity Reporting* procedure.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
be submitted to the DMA Contract Administrator on an annual basis.						
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of 42 C.F.R. 438.608 and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under DMA Contract in accordance with 42 CFR 438.608(a)(1)(iv).	X					The roles of the Chief Compliance Officer (designated as the Director of Compliance) and Compliance Committee are addressed on page 11 of the *Compliance Plan 2017-2018*. The reporting structure is as follows: The Compliance Officer shall report to the Compliance Committee regarding day-to-day issues of significant importance. In addition, the Compliance Officer has access to the executive leadership. The Compliance Officer is the liaison between Trillium and the Governing Board and is required to report on compliance activities at least annually.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. PIHP shall establish and implement a special investigation or program integrity unit, however named, that is responsible for PIHP program integrity activities, including identification, detection, and prevention of fraud, waste and abuse in the PIHP Closed Provider Network. PIHP shall identify an appropriately qualified contact for Program Integrity and Regulatory Compliance issues as mutually agreed upon by PIHP and DMA. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator.	X					Page 6 of the *Investigations of Suspected Fraud Waste and Abuse* procedure states that all Program Integrity activities are reported to DMA each month and/or quarter. The *Program Integrity Reporting* procedure outlines that Program Integrity activities are reported to DMA monthly (submitted on or before the 5th of each month), quarterly (60 days after the quarter ends), and annually. Additionally, the PIHP identifies the Program Integrity Director, the DMA Security Administrator and Program Integrity Liaison as key qualified contacts for compliance communications.
4. PIHP shall participate in quarterly Program Integrity meetings with DMA Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').	X					Trillium submitted Program Integrity Committee meeting minutes as evidence of its quarterly program integrity meetings with DMA.
5. PIHP shall participate in monthly meetings with DMA Program Integrity, in the most productive setting, either telephonically or in person at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.	X					Trillium submitted Program Integrity Committee meeting minutes as evidence of its monthly program integrity meetings with DMA.
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					Trillium submitted Program Integrity Committee meeting minutes as evidence of appropriate qualified staff attending monthly meetings. Minutes elaborated on collaborative discussions of productive meetings.
7. PIHP shall also make Regulatory Compliance minutes and Program Integrity minutes,	X					Trillium submitted Program Integrity Committee meeting minutes as evidence of appropriate regulatory compliance.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
redacted as deemed appropriate by PIHP, available for review upon request by DMA.						
8. PIHP's written Compliance Plan shall, at a minimum include:						
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(66) of the Social Security Act;	X					This requirement is addressed in the *Compliance Plan 2017-2018* (pages 7 and 8). Trillium submitted training modules for both internal and external trainings and orientation presentations for employees, contractors and providers.
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing and development of corrective action initiatives;	X					Provisions for internal and external monitoring, auditing and development of corrective action initiatives are addressed on pages 18 and 19 of the *Compliance Plan 2017-2018*.
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					This requirement is addressed in the *Disciplinary Actions* procedure. Sanctions and disciplinary guidelines are also addressed in Trillium's subcontractor agreement at Appendix B as well as communicated to providers on pages 31-34 of the *Provider Manual*.
8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including DMA or MFCU/MID, and including promptly supplying all data and information requested for their respective investigations	X					The *Compliance Plan 2017-2018* addresses the requirement that the PIHP comply with applicable federal, state and local laws, rules and regulations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9. In accordance with 42 CFR 436.606(a)(vii), PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under DMA Contract, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under DMA Contract; and making documentation of investigations and compliance available as requested by the State.	X					The *Compliance Plan 2017-2018* addresses the requirement that the PIHP shall establish and implement systems and procedures that require use of dedicated staff for routine internal monitoring and auditing of compliance risks as require under the *DMA Contract*.
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					This requirement is addressed in the *Compliance Plan 2017-2018* and in the *Investigations of Suspected Fraud, Waste, and Abuse* procedure.
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse;	X					This requirement is addressed in the *Compliance Plan 2017-2018* and in the *Investigations of Suspected Fraud, Waste, and Abuse* procedure.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure. This process shall include procedures for logging the complaint, determining if the complaint is valid, assigning the complaint, investigating, appeal, recoupment, and closure. The detailed workflow needs to differentiate the steps taken for fraud versus abuse; PIHP shall establish and implement policies for treatment of recoveries of all overpayments from PIHP to Providers and contracted agencies, specifically including retention policies for treatment of recoveries of overpayments due to fraud, waste, or abuse. The retention policies shall include processes, timeframes, and required documentation for payment of recoveries of overpayments to the State in situations where PIHP is not permitted to retain some or all of the recoveries of overpayments. This provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.	X					This requirement is addressed in Program Integrity Workflow – Fraud and in Program Integrity Workflow – Abuse. Trillium submitted its training modules for internal and external training as well as its internal all staff training on EthicsPoint, its reporting program. This training provides the procedures denoted in the requirement.

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 *Program Integrity Reporting* procedure and the *Plan of Correction* procedure.
10.4 Process for tracking overpayments and collections, and reporting on Attachment Y – Audits/Self-Audits/Investigations;	X					This requirement is addressed in *the Program Integrity Reporting* procedure, the Internal communication process for provider self-audit request, and the *Reporting Suspected Violations of Fraud, Waste and Abuse* procedure.
10.5 Process for handling self-audits and challenge audits;	X					This requirement is addressed in the Internal Communications Process for Providers
10.6 Process for using data mining to determine leads;	X					Trillium submitted data analysis reports, provider procedure reports, report cards, and extracted claims data as evidence of how the PIHP uses its data. In addition, the data mining process is described on page 2 of the *Investigations of Suspected Fraud Waste and Abuse* procedure.
10.7 Process for informing PIHP employees, subcontractors and providers regarding the False Claims Act;	X					This requirement is communicated to the PIHP's employees through employee training (Program Integrity Annual Training slides 13-14). This requirement is communicated to the providers on page 41 of the *Provider Manual*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						This requirement is communicated to the PIHP's subcontractors and providers on slide 45 of the External Training documentation, and in the *Procurement Contract*.
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					The Social Security Act is mentioned on page 34 in the *Compliance Plan 2017-2018.* The *Social Security Act* procedure addresses this requirement.
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains DMA-standardized elements or a DMA-approved template;	X					This requirement is addressed on page 19 of the *Compliance Plan 2017-2018.* Trillium submitted the External Monitoring DHHS Routine Monitoring Tool which contains guidelines for the review tools used by the PIHP to verify compliance with this requirement. These tools include a Post-Payment Review Tool, and a Claims Compliance Review Tool.
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					The *Claims Adjudication, Adjustments, Paybacks, and Exceptions* procedure addresses the requirement that the PIHP have a process in place for Network Providers regarding overpayments. Trillium submitted evidence of its provider monitoring templates which includes monitoring reports for paybacks and fees due from the provider.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.	X					Pages 2 and 3 of the *Claims Adjudication, Adjustments, Paybacks, and Exceptions* procedure addresses this requirement. Providers wishing to dispute actions taken by the PIHP can file a Claims Request Form which is available on Trillium's website. This information is communicated to the provider on page 76 of the *Provider Manual*.
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to DMA within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					The *Compliance Plan 2017-2018* states that the role of the Compliance Officer includes identification, detection, and prevention of fraud, waste, and abuse. Additionally, the *Investigation of Suspected Fraud, Waste and/or Abuse* procedure delineates Program Integrity processes.
13. In each case where PIHP refers to DMA an allegation of fraud involving a Provider, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:						
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. <u>File Review Results:</u> 15 of 15 files that were reviewed contained this requirement.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.2 Source/origin of complaint;	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: 15 of 15 files that were reviewed contained this requirement.
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: 15 of 15 files that were reviewed contained this requirement.
13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations or policies violated; and dates of suspected intentional misconduct;	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: 15 of 15 files that were reviewed contained this requirement.
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: 15 of 15 files that were reviewed contained this requirement.
13.6 All communications between PIHP and the Provider concerning the conduct at issues, when available.	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: 15 of 15 files that were reviewed contained this requirement.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: 15 of 15 files that were reviewed contained this requirement.
13.8 Sample/exposed dollar amount, when available.	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: 15 of 15 files that were reviewed contained this requirement.
14. In each case where PIHP refers suspected Enrollee fraud to DMA, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:						
14.1 The Enrollee's name, birth date, and Medicaid number;	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: No file within the sample of 15 involved a case of suspected enrollee fraud that was substantiated and warranted a referral to DMA. Moving forward, there is opportunity for Trillium to further capture enrollee fraud, waste, and abuse through data mining systems.
14.2 The source of the allegation;	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: No file within the sample of 15 involved a case of suspected enrollee fraud that was substantiated and warranted a referral to DMA.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Moving forward, there is opportunity for Trillium to further capture enrollee fraud, waste, and abuse through data mining systems.
14.3 The nature of the allegation, including the timeframe of the allegation in question;	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: No file within the sample of 15 involved a case of suspected enrollee fraud that was substantiated and warranted a referral to DMA. Moving forward, there is opportunity for Trillium to further capture enrollee fraud, waste, and abuse through data mining systems.
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: No file within the sample of 15 involved a case of suspected enrollee fraud that was substantiated and warranted a referral to DMA. Moving forward, there is opportunity for Trillium to further capture enrollee fraud, waste, and abuse through data mining systems.
14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: No file within the sample of 15 involved a case of suspected enrollee fraud that was substantiated and warranted a referral to DMA. Moving forward, there is opportunity for Trillium to further capture enrollee fraud, waste, and abuse through data mining systems.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: No file within the sample of 15 involved a case of suspected enrollee fraud that was substantiated and warranted a referral to DMA. Moving forward, there is opportunity for Trillium to further capture enrollee fraud, waste, and abuse through data mining systems.
14.7 The legal and administrative status of the case.	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: No file within the sample of 15 involved a case of suspected enrollee fraud that was substantiated and warranted a referral to DMA. Moving forward, there is opportunity for Trillium to further capture enrollee fraud, waste abuse through data mining systems.
15. PIHP and DMA shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of State and Federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: No file within the sample of 15 involved a case of suspected enrollee fraud that was substantiated and warranted a referral to DMA. Moving forward, there is opportunity for Trillium to further capture enrollee fraud, waste, and abuse through data mining systems.
16. PIHP shall use the DMA Fraud and Abuse Management System (FAMS) or a DMA approved alternative data mining technology solution to detect and prevent fraud, waste and abuse in managed care.	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						No file within the sample of 15 involved a case of suspected enrollee fraud that was substantiated and warranted a referral to DMA.
17. If PIHP uses FAMS, PIHP shall work with the DMA designated Administrator to submit appropriate claims data to load into the DMA Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the DMA designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: No file within the sample of 15 involved a case of suspected enrollee fraud that was substantiated and warranted a referral to DMA.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
18. PIHP shall submit to the DMA Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month. Section 9.8 Fraud and Abuse Reports. In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to DMA Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to DMA Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: No file within the sample of 15 involved a case of suspected enrollee fraud that was substantiated and warranted a referral to DMA.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
19. On a quarterly basis, DMA shall review a sample of cases where the PIHP's Special Investigation Unit has identified overpayments, investigated or audited a provider. The results of these reviews will be discussed during the PIHP monthly Program Integrity meetings to assure that DMA is providing consistent guidance on expectations with regard to referrals for potential cases of fraud. DMA shall also determine what additional technical assistance may be available to PIHP to support PIHP's efforts in making referrals.	X					This requirement is addressed in the *LME/MCO Suspected Provider Fraud DMA Program Integrity Referral Form*. File Review Results: No file within the sample of 15 involved a case of suspected enrollee fraud that was substantiated and warranted a referral to DMA.
VIII C. Provider Payment Suspensions and Overpayments						
1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, DMA Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If DMA determines that a full investigation is warranted, DMA shall make a referral within five (5) business days of such determination to the MFCU/ MID and will suspend payments in accordance with 42 CFR § 455.23. At least monthly, DMA shall provide written notification to PIHP of the status of each such referral. If MFCU/ MID indicates that suspension will not impact their investigation, DMA may send a payment suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates that payment suspension will impact the						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
investigation, DMA shall temporarily withhold the suspension notice and notify PIHP. Suspension of payment actions under this Section 14.3 shall be temporary and shall not continue if either of the following occur: PIHP or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider; or Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.						
1.1 In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.	X					This requirement is addressed in the *Internal Communications about Provider Payment Suspension from DMA* procedure.
2. Upon receipt of a payment suspension notice from DMA Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of DMA Program Integrity's suspension and lasting until PIHP is notified by DMA Program Integrity in writing that the suspension has been lifted.	X					This requirement is addressed in the *Internal Communications about Provider Payment Suspension from DMA* procedure.
3. PIHP shall provide to DMA all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					This requirement is addressed in *the Investigations of Suspected Fraud, Waste and Abuse* procedure.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to DMA Program Integrity due to allegations of suspected fraud without prior written approval from DMA Program Integrity or the MFCU/MID.	X					This requirement is addressed in the *Investigations of Suspected Provider and Beneficiary Fraud to DMA* procedure.
5. Notwithstanding the foregoing, nothing herein shall be construed as prohibiting PIHP from taking any action against a Network Provider in accordance with the terms and conditions of any written agreement with a Network Provider, including but not limited to prepayment review, identification and collection of overpayments, suspension of referrals, de-credentialing, contract nonrenewal, suspension or termination or other sanction, remedial or preventive efforts necessary to ensure continuous, quality care to Enrollees, regardless of any ongoing investigation being conducted by DMA, MFCU/MID or other oversight agency, to the extent that such action shall not interfere with Enrollee access to care or with any such ongoing investigation being conducted by DMA, MFCU/MID or other oversight agency.	X					This requirement is addressed on page 19 of the *Compliance Plan 2017-2018* as well as the *Procurement Contract*.
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,	X					The *Claims Adjudication, Adjustments, Paybacks and Exceptions* procedure addresses the requirement that the PIHP have a process in place for Network Providers regarding overpayments. Trillium also provided DHHS Notices of Outstanding balance/payment notices to delineate the PIHP compliance to this requirement.

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

IX. FINANCIAL SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IX. Financial						
1. The PIHP has policies and systems in-place for submitting and reporting financial data.	X					Trillium provided detailed desk procedures from both finance and claims processing on submitting the DMA reports.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP has and adheres to a cost allocation plan that meets the requirements of 42 CFR 433.34.	X					Trillium submits a *Cost Allocation Plan* to DMA on an annual basis. The administrative costs are based on service revenue, and currently the Medicaid percentage of administrative costs is 85%. This plan is approved by DMA and no costs were disallowed.
3. PIHP maintains detailed records of the administrative costs and expenses incurred as required by the DMA contract. (DMA Contract, Section 8.3).	X					The administrative costs are identified within the chart of accounts in Great Plains. The Medicaid portion of administrative costs is recorded on the monthly DMA report.
4. Maintains an accounting system in accordance with 42 CFR 433.32 (a).	X					Trillium uses Great Plains accounting system. Claims are processed using the CIE system.
5. The PIHP follows a record retention policy of retaining records for ten years.		X				Trillium indicated in the Onsite interview that they are following the state guidelines, and most records are retained five to seven years. However, the most recent *DMA contract* requires 10-year retention. ***Corrective Action: Retain financial records for ten years per the DMA Contract.*** ***Recommendation: Document financial record retention with a formal policy and/or procedure.***
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution.	X					Trillium's risk reserve is maintained at Southern Bank. Trillium's accounting manager makes certain funds are transferred within five days and the Senior Accountant reconciles the DMA payment.
7. The required minimum balance of the Risk Reserve Account meets the requirements of the DMA contract. (DMA Contract, Section 1.8 Restricted Risk Reserve Account)	X					Trillium has met the minimum requirements of contributing 2% to the Risk Reserve Account monthly. All deposits were made timely and there were no unauthorized withdrawals. Trillium currently reached 9.7% of their required percentage of annualized capitation maximum (15%), with a balance of $37,689,098.
8. All funds received by PIHP are accounted for by tracking Title XIX Medicaid expenditures separately from services provided using	X					The administrative costs are allocated using a flat percentage method based on share of revenue. The segregation of Medicaid funds

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
other funding, as required by the DMA contract (DMA Contract, Section 1.9).						is done by funding source. All reports and systems separately identify Medicaid funds.
9. The Medical Loss Ratio (MLR) meets the requirements of 42 CFR 438.8 and the DMA contract (Amendment 2, Section 12.3 Item k).	X					Trillium exceeds the requirements of *42 CFR 438.8*. Trillium's year-to-date medical loss ratio was 93.5% on March 31, 2018 (benchmark is 85%).

E. Attachment 5: Encounter Data Validation Report

Trillium Health Resources

Encounter Data Validation Report

performed on behalf of

North Carolina Department of Health and Human Services, Division of Medical Assistance

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June 20, 2018

Prepared By:

hms

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Background

Health Management Systems (HMS) has completed a review of the encounter data submitted by Trillium to the North Carolina Department of Health and Human Services (NC DHHS), Division of Medical Assistance (DMA), as specified in The Carolinas Center for Medical Excellence (CCME) agreement with DMA. CCME contracted with HMS to perform encounter data validation for each PIHP. North Carolina Senate Bill 371 requires that each PIHP submit encounter data "for payments made to providers for Medicaid and State-funded mental health, intellectual and developmental disabilities, and substance abuse disorder services. DHHS may use encounter data for purposes including, but not limited to, setting PIHP capitation rates, measuring the quality of services managed by PIHP s, 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, DMA must be able to certify the data complete and accurate.

Overview

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

- A review of Trillium's response to the Information Systems Capability Assessment (ISCA)
- Analysis of Trillium's converted 837 encounter files
- A review of DMA's encounter data acceptance report

Review of Trillium's ISCA response

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

DMA 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 DMA in the Contract Information CN104 and CN102 segment of Claim Information Loop 2300.

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

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

Looking at claims with dates of service in 2017, Trillium submitted 874,434 unique encounters to the State. To date, 8% of all encounters submitted have not been corrected and accepted by DMA. The rejection rate is significantly better than 2016, which was 29%.

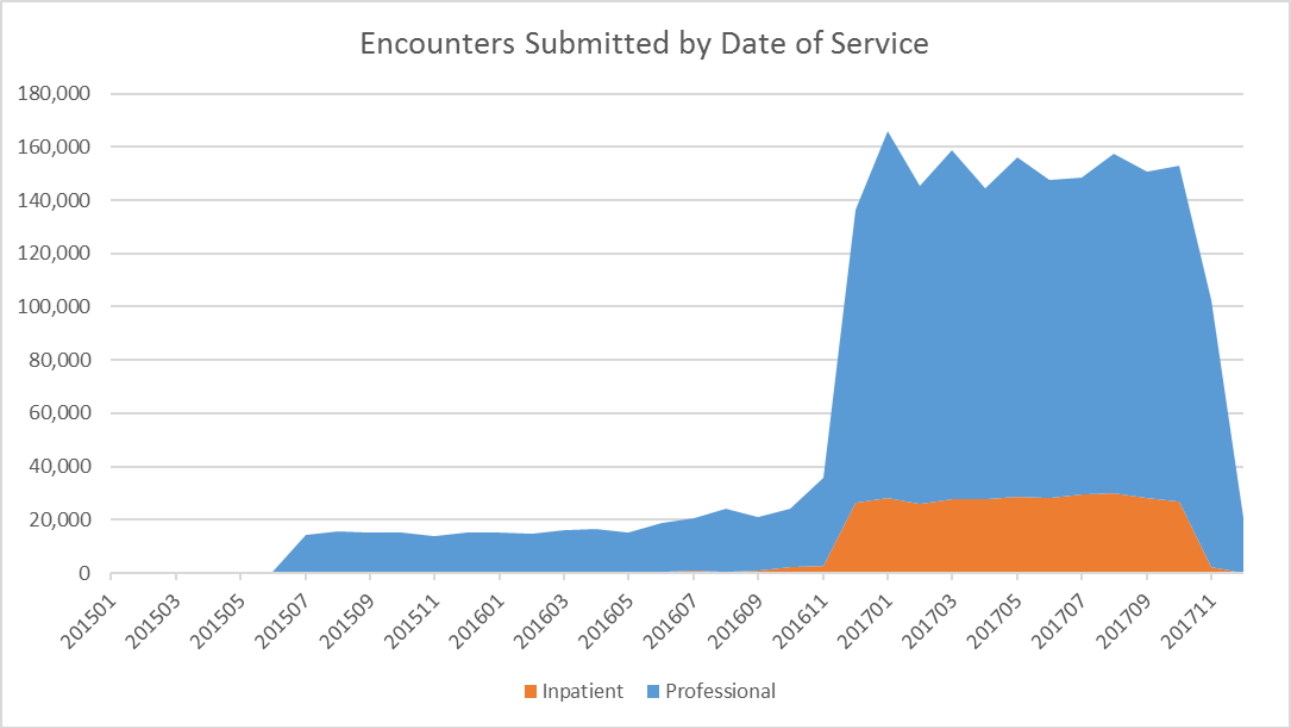
2017	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	46,723	46,335	26	362	1%
Professional	827,711	688,673	70,905	68,133	8%
Total	874,434	735,008	70,931	68,495	8%

According to Trillium's response and the evaluation of the submitted encounter data, most of the outstanding and ongoing denials are related to invalid taxonomy codes for the billing provider ID. In order to reduce the number of denied encounters going forward, Trillium is continuing to apply the following strategy laid out in the 2016 review.

Automate process for resending marked claims ready for resubmission
Enhance process to compare provider records based on Global Provider File (GPF) received from DMA to identify system differences.
Trillium Provider Network staff will review differences with Provider
Update CIE contract(s) and/or NCTracks via PUF or MCR submitted by Provider accordingly
Limit eligible provider taxonomy codes on claim forms (CIE data)
Develop reconciliation process for claims based on workflow developed
Develop first level adjudication at service to taxonomy code level
Educate providers and staff

Analysis of Encounters

The analysis of encounter data evaluated whether Trillium submitted complete, accurate, and valid data to DMA for all claims paid between January 1, 2017 through December 31, 2017. Trillium worked with their EDI vendor to convert each 837I and 837P file submitted to DMA during the requested audit period to an excel spreadsheet and sent to HMS via SFTP. This included more than 1.7 million professional claims and 324,071 institutional claims. The files submitted contained resubmissions of old dates of service as well as new claims. The following graph represents the dates of services of all claims submitted to DMA in 2017.



To evaluate the data, HMS ingested and combined all 120 batch encounter files, and loaded them into a consolidated database. After data onboarding was completed, HMS applied proprietary, internally designed data analysis tools to review each data element, focusing on the data elements defined as required. These tools evaluate the presence of data in each field within a record as well as whether the value for the field is within accepted standards. Results of these checks were compared with general expectations for each data field and to the CMS standards adopted for encounter data. The following table 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

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

Data Element	*Expectation*	*Validity Criteria*
		truncated. Also, a high percentage of names should have at least a middle initial.
Recipient Date of Birth	Should not be missing and should be a valid date.	< 2% missing or invalid
MCO/PIHP ID	Critical Data Element	100% valid
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	95% valid
Attending Provider ID	Should be an enrolled provider listed in the provider enrollment file (will accept the MD license number if it is listed in the provider enrollment file).	> 85% match with provider file using either provider ID or MD license number
Provider Location	Minimal requirement is county code, but zip code is strongly advised.	> 95% with valid county code > 95% with valid zip code (if available)
Place of Service	Should be routinely coded, especially for physicians.	> 95% valid for physicians > 80% valid across all providers
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% nonmissing and valid on physician or other applicable provider type claims (e.g., other practitioners)
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)

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

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

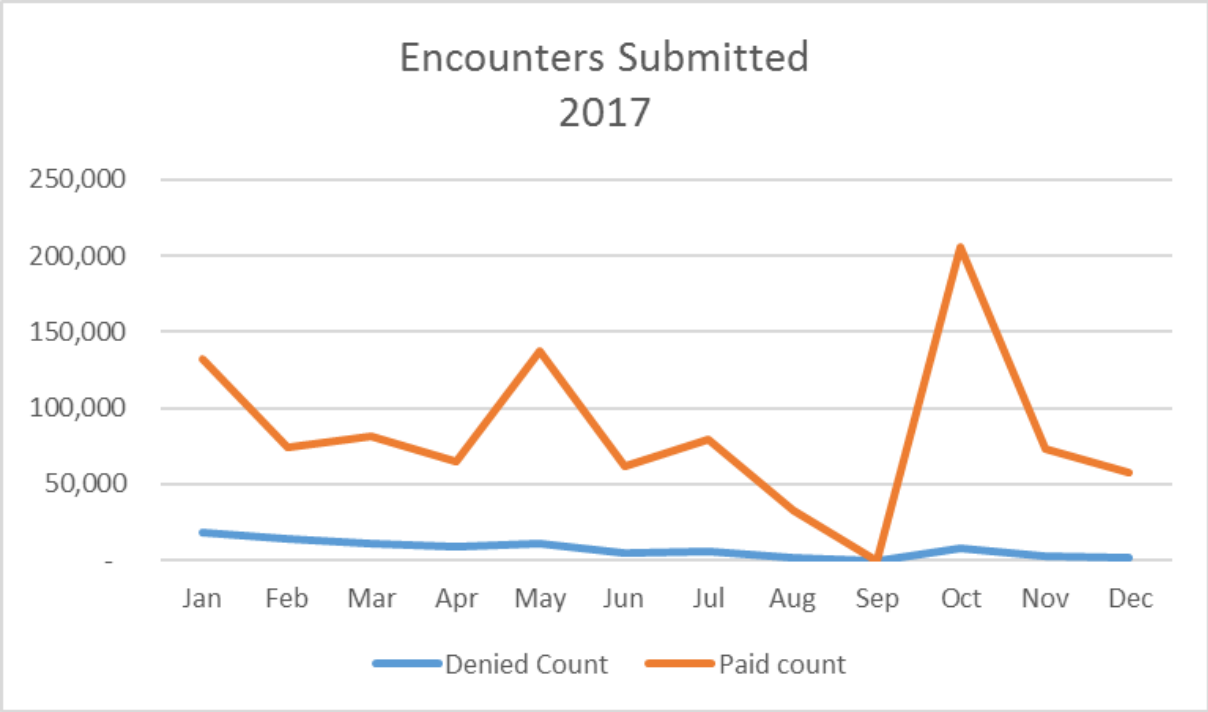
Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%
Recipient Name	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%
Recipient Date of Birth	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%
MCO/PIHP ID	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%
Provider ID	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%
Attending/Renderring Provider ID	1,021,389	48.47%	1,021,389	48.47%	1,021,389	48.47%	1,021,389	48.47%
Provider Location	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%
Place of Service	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%
Specialty Code / Taxonomy - Billing	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%
Specialty Code / Taxonomy - Rendering / Attending	1,013,303	48.09%	1,013,303	48.09%	1,013,303	48.09%	1,013,303	48.09%
Principal Diagnosis	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%
Other Diagnosis	460,377	21.85%	460,377	21.85%	460,377	21.85%	460,377	21.85%
Dates of Service	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%	2,107,075	100.00%
Unit of Service (Quantity)	2,107,040	100.00%	2,107,040	100.00%	2,107,040	100.00%	2,107,040	100.00%
Procedure Code	2,013,792	95.57%	2,013,792	95.57%	1,925,988	91.41%	1,925,988	91.41%
Procedure Code Modifier	549,827	26.09%	549,827	26.09%	549,827	26.09%	549,827	26.09%
Patient Discharge Status Code Inpatient	324,071	100.00%	324,071	100.00%	324,071	100.00%	324,071	100.00%
Revenue Code	324,071	100.00%	324,071	100.00%	324,071	100.00%	312,183	96.33%

Overall, the inconsistencies in the data pointed back to the same encounter submission and denial issues that were highlighted in Trillium's ISCA response and DMA's encounter acceptance report. Institutional claims contained complete and valid data in 17 of the 18 key fields (94%) with noted issues for the procedure code. During our last review, the billing taxonomy was not populated for institutional claims and is a significant driver in NCTracks to adjudicate a claim properly. The data was correct for our 2017 review, however, it's still one of the drivers for the top denials. The procedure code field was populated consistently, but not with expected values. Procedure codes provided were labeled as "Line Level Procedure Code", but contained mixed values of HCPCS and revenue codes. Revenue codes should not be populated in the HCPCS field.

Professional encounter claims submitted contained complete and valid data in 13 of the 15 key professional fields (86%). The primary issue is the completeness of the rendering provider ID and specialty/taxonomy. The specialty code or taxonomy value was populated at 100% when the rendering provider ID was provided, however, the Rendering Provider Id was only populated 39% of the time.

Encounter Acceptance Report

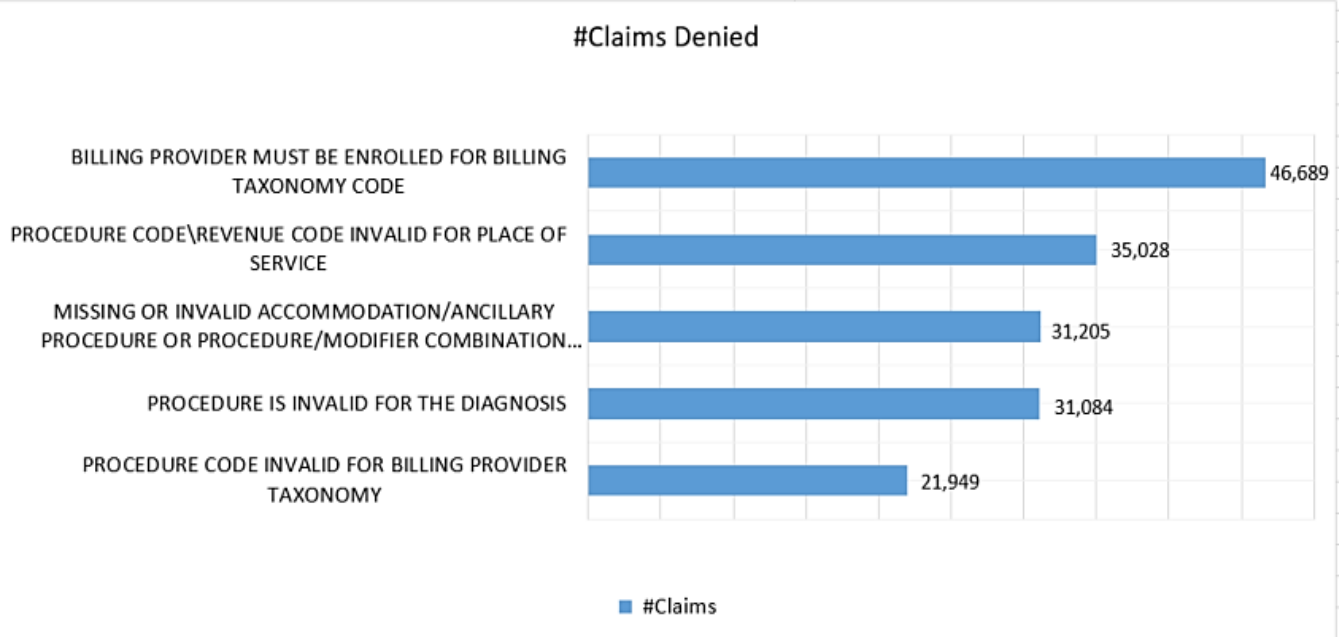
In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by DMA. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write which made it difficult to tie back to the ISCA response and converted encounter files since only the Date of Service for each is available. During the 2017 weekly check write schedule, Trillium submitted a total of 1,002,180 encounters to DMA. On average, 9% of all encounters submitted were denied.

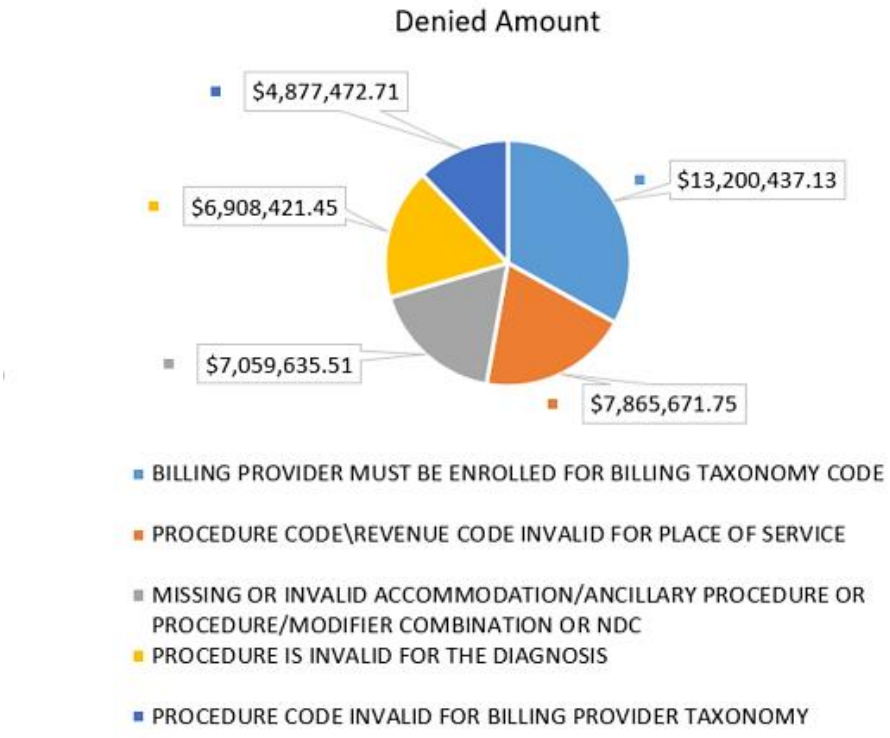


Evaluation of the top denials for Trillium encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis above. Encounters were denied primarily for:

- Billing provider must be enrolled for billing taxonomy code
- Procedure code / Revenue code invalid for place of service
- Missing or invalid accomodation/ancillary procedure
- Procedure is invalid for the diagnosis
- Procedure code invalid for billing provider taxonomy

The following charts reflect the top 5 denials by paid amount.





Results and Recommendations

Issue: Taxonomy code for billing and rendering providers

Taxonomy values were consistently populated for institutional claims; however, both the Rendering/Attending Provider Id and Specialty were missing for 61% of the claims. This is the primary denial for all Trillium encounters submitted. This information is key for passing the front end edits put in place by the State and to effectively price the claim. NCTracks is expecting the correct combination of NPI, taxonomy and procedure code. The taxonomy code did not always match up with the taxonomy values enrolled in NCTracks for the Billing and/or Rendering Provider. These errors result in denials by the DMA that must be corrected and resubmitted.

Resolution:

As outlined in their ISCA response, Trillium has a process in place to review denials and correctly resubmit encounters to the State that were denied due to invalid or missing taxonomy. Trillium should continue to follow their current process and HMS will continue to monitor to ensure that the issue improves.

Issue: Procedure Code

The procedure code should be populated 99% of the time. In the encounter files provided, HMS found that the procedure code was populated more than 85% of the time with invalid values for institutional claims. The professional claims were accurate for 100% of the claims received. For institutional claims, the procedure code was populated with a mix of valid procedure codes and revenue codes. Revenue codes should never be received or populated in the procedure code field.

Resolution:

Procedure codes are a required field in order to pay the claim appropriately. Trillium should check their claims processing system and data warehouse to ensure the field is required and being captured appropriately. Trillium should also ensure that the appropriate data validation checks are in place in their provider portal to prevent revenue codes being submitted in the procedure code fields. If captured correctly, Trillium should double check their 837 encounter creation process and EDI translator to ensure the data was not lost during transformation.

Conclusion

Based on the analysis of Trillium's encounter data, we have concluded that the data submitted to DMA is not complete or accurate as defined by DMA standards.

Trillium should take corrective action to resolve the issues identified specifically with taxonomy denials and procedure codes for institutional claims. As indicated in Trillium's ISCA response, they have already defined a strategy to address issues with invalid or missing taxonomy codes, as well as a reconciliation

process to address all DMA denials noted in the report above. Compared to claims reviewed from 2016, Trillium's denial rate has dropped from 29% to 9%.

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

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 DMA 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