CCME

2022 External Quality Review

TRILLIUM HEALTH RESOURCES

Submitted: January 13, 2023

Prepared on behalf of
North Carolina Medicaid

Table of Contents

EXECUTIVE SUMMARY

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

Goals of the review are to:

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

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

A. Overall Findings

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

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

Due to the COVID-19 pandemic, CCME implemented a focused review. This decision was based on the issuance by the State of the COVID-19 flexibilities PIHP Contract Amendment #11. This amendment stated PIHPs "shall be held harmless for any documentation or other PIHP errors identified through the EQR that are not directly related to member health and safety through the Term of the Amendment."

The focused review included comprehensive review of the PIHP's health systems' capabilities and provider credentialing and recredentialing documentation and processes. The review includes validation of the PIHP's PIPs, PMs, and Encounter data. Lastly, a thorough review of the PIHP's Utilization Management, Grievances, and Appeals processes were conducted. The PIHP's network adequacy, availability of services, subcontractual relationships, and Clinical Practice Guidelines (*42 CFR § 438.206, § 438.207, § 438.230, and § 438.236,* respectively*)* were not reviewed.

To assess the health plan's compliance with federal regulations and its *NC Medicaid Contract*, CCME's review was divided into six areas. The following is a high-level summary of the review results for those areas. Additional information regarding the reviews, including Strengths, Weaknesses, and Recommendations, are included in the narrative of this report.

B. Overall Recommendations

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

Administration

42 CFR § 438.224 and 42 CFR § 438.242

In the 2021 EQR, Trillium met 100% of the Administrative standards and received two Recommendations regarding the submission of Diagnosis-Related Groups (DRGs) and ICD-10 Procedure codes into NC Tracks.

In the 2022 EQR, Trillium reported the two 2021 Recommendations were set to be implemented in 2023. Trillium again met 100% of the Administrative standards in the 2022 EQR, and the prior year Recommendations were issued again. One new Recommendation was issued for Trillium to continue to work with their providers to reduce the number of days between the initial denial and the date of resubmission to NC Tracks.

Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

In the 2021 EQR, Trillium met 100% of the Credentialing/Recredentialing standards, resulting in no Corrective Actions. CCME issued a Recommendation focused on reconciling conflicting information regarding voting membership and the determination of adequate voting membership attendance for conducting committee meetings, including voting on applications. Trillium partially addressed the Recommendation. Trillium made some revisions in the Credentialing Committee Member List and to the structure of the Credentialing Committee meeting minutes but did not revise the *Credentialing Committee By-Laws* or the Credentialing and Re-Credentialing Process procedure as recommended in the 2021 EQR.

In the 2022 EQR, Trillium met 100% of the Credentialing/Recredentialing standards. CCME issued no Corrective Actions. Per the direction of the North Carolina Department of Health and Human Services, credentialing has now shifted from the PIHPs completing credentialing and recredentialing to the PIHPs verifying credentialing completed by NCTracks. Trillium completed the in-process credentialing and recredentialing files in May 2022. Therefore, although the Recommendation from 2021 was only partially implemented, CCME is issuing no Recommendations in the 2022 EQR of Credentialing/Recredentialing.

Quality Improvement

42 CFR § 438.330

In the 2021 EQR, Trillium met 100% of the Quality standards and received three Recommendations related to the Performance Improvement Projects (PIPs) that were validated. Trillium implemented all three Recommendations related to the Super Measure Mental Health (MH), Super Measure Substance Use (SU), and Utilization of Emergency Department (ED) PIPs. The (b) Waiver measure validation noted a substantial decline for three PMs with a Recommendation to continue monitoring (b) Waiver performance measure rates, determining if rates with substantial improvement or decline represent a continued trend or an anomaly in the PMs.

For the 2022 EQR, Trillium met all standards with no Corrective Actions. All PIPs were validated in the High Confidence range with Recommendations for three PIPs all related to the lack of rate improvement. No rate improvement was seen in the Super Measure MH, Utilization of ED, or the Multi-Systemic Therapy (MST) Utilization PIPs. Specific Recommendations were issued to address and monitor rate improvement for these three PIPs. Trillium was Fully Compliant for (b) Waiver and (c) Waiver Performance Measures. There were two (c) Waiver measures without reported rates, and therefore, not validated. The Trillium file noted that “Results were null due to rule changes with Covid and therefore not included in figure. Check sheets were no longer required after

3/1/2020." Per the Onsite discussion, as part of the COVID-19 flexibilities for the annual process, the PIHP was not required to submit reports. The (b) Waiver measure validation noted a substantial decline for one PM with a Recommendation issued to continue to monitor (b) Waiver Performance Measure rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the PMs.

Utilization Management

42 CFR § 438.208

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

In the 2021 EQR, Trillium met 98% of the standards, and one Corrective Action was issued to address concerns noted within the Care Coordination enrollee files reviewed. Four of the eleven files submitted by Trillium for this review showed a pattern of documentation errors and gaps in engagement by Care Coordination. The Corrective Action centered around Trillium's efforts to enhance the current process for reviewing enrollee files to better identify compliance and/or engagement issues.

In the 2022 EQR, Trillium met 92% of the standards. While overall compliance improvement was noted in the 11 files submitted for this year's EQR, one of the three I/DD files showed a high percentage of late progress notes, gaps in engagement and a late notification to the appropriate Department of Social Services when the enrollee discharged from the Innovations Waiver. Similarly, one of the four TCLI files also showed a gap in engagement following the enrollee's discharge from the Emergency Department. In both files, the lack of engagement posed potential health, safety, and access to care issues for the enrollees. Therefore, CCME issued two Corrective Actions for Trillium to enhance their monitoring of enrollee files to proactively identify Care Coordinator engagement and compliance issues.

Grievances and Appeals

42 CFR § 438, Subpart F, 42 CFR 483.430

In the 2021 Grievance and Appeal EQR, Trillium met 100% of the standards, and CCME did not issue Corrective Actions or Recommendations. A review of 10 Grievance files showed acknowledgement and resolution notifications were sent within required timeframes. Grievances that involved health and safety issues were appropriately staffed by the Chief Medical Officer (CMO) and documented within the Grievance. Throughout the 10 Appeal files reviewed for the 2021 EQR, the files showed all Appeal notifications were issued

within the required timeframes, and guardianship was routinely checked and documented in the file.

In this 2022 Grievance and Appeal EQR, Trillium met 100% of the standards and there were no Corrective Actions or Recommendations issued by CCME. Within the 10 Grievance files reviewed, all notifications were timely and compliant. Grievances that involved potential health and safety concerns were appropriately staffed by the CMO. Trillium reported they employed a new Engagement Manager in July 2022. The new manager implemented a process change that allows all team members to know the timeline for active Grievances, which means the cases can be covered in the absence of the primary assigned staff member. This change improved the internal Grievance monitoring process.

Of the 10 Appeal files reviewed in the 2022 Appeal EQR, six were standard, two were expedited/denied, one was invalid, and one was withdrawn. Appeal files contained documentation of verification of guardianship for adult members who have guardians. All Appeal files were resolved with all required oral and written notifications provided timely.

Program Integrity

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

In the 2021 EQR, Trillium met 100% of Program Integrity (PI) Standards and no Corrective Actions or Recommendations were issued. During the last EQR, it was highlighted that Trillium has a strong commitment to the timely closure of investigations related to fraud, waste, and abuse. This trend continued in the 2022 EQR as 92% of investigations were closed during the period under review.

In this 2022 EQR, Trillium has again met 100% PI Standards, with no identified Weaknesses, Corrective Actions, or Recommendations. The Strengths highlighted for this year's review include several improvements to Trillium's PI processes, including the increase of sampling for Explanation of Benefits (EOB) distribution. Additionally, Trillium staff also reported a third-party vendor completed a risk assessment this past year and found Trillium's Compliance Department is operating at a high level with low risk.

Encounter Data Validation

The analyses of Trillium's encounter data showed the data submitted to NC Medicaid are complete and accurate. There is an issue with the Other Diagnosis codes that Trillium should review and perform outreach to providers who only submit the Primary Diagnosis codes. Overall, Trillium has corrected other issues identified in previous encounter data validation reports and made significant strides in ensuring that they are submitting complete and accurate data to NC Medicaid.

Missing Other Diagnosis codes on Professional and Institutional claims do not impact the ability to price the claims, and, therefore, do not end up being reported as denials. However, the lack of data may impact NC Medicaid's ability to provide proper oversight, including measurement of quality of care and setting appropriate fees and rates. Trillium is encouraged to work with its providers to make sure they are documenting and coding all diagnoses.

For the next review period, Aqurate is recommending the encounter data from NCTracks be reviewed for 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 Medicaid Management Information System (MMIS) is handling the encounter claims and could be reconciled back to reports requested from Trillium. The goal is to ensure Trillium is reporting all paid claims as encounters to NCTracks.

Corrective Actions and Recommendations from Previous EQR

During the previous EQR, there was one standard scored as “Partially Met” and no standard scored as “Not Met”. Following the 2021 EQR, Trillium submitted a Corrective Action Plan to address the identified deficiencies. CCME reviewed and accepted Trillium’s Corrective Action Plan on January 26, 2022.

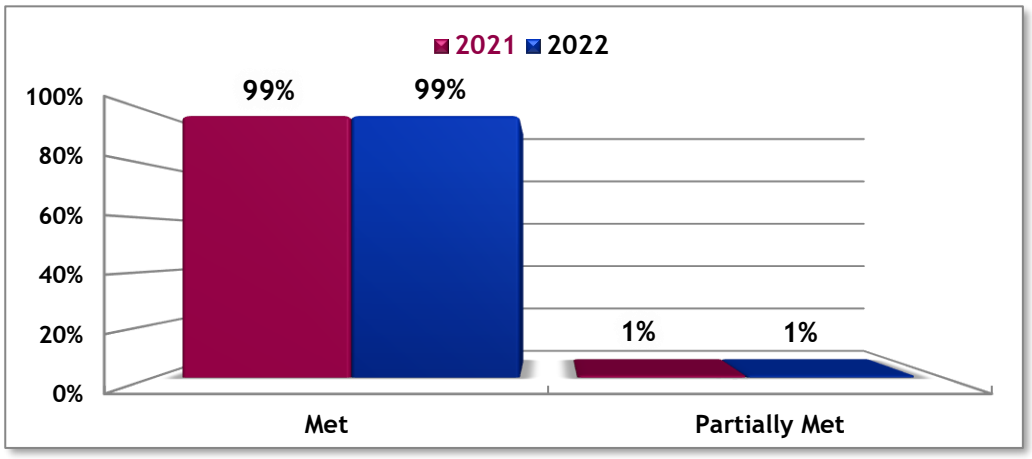
During the current EQR, CCME assessed the degree to which Trillium implemented the actions to address these deficiencies and found the Corrective Action Plan. Additional details regarding the Trillium’s 2021 Corrective Actions Plan, the PIHP’s response, and evidence, or lack thereof, of PIHP implementation of the 2021 Corrective Actions are detailed in the Utilization Management Section of this report.

Conclusions

Overall, Trillium has met the requirements set forth in their contract with NC Medicaid. The 2022 Annual EQR shows that Trillium has achieved a “Met” score for 99% of the standards reviewed. As the following chart indicates, 1% of the standards were scored as “Partially Met,” and none of the standards scored as “Not Met”.

Figure 1: Annual EQR Comparative Results, provides an overview of the scoring of the current annual review as compared to the findings of the 2021 review.

Figure 1: Annual EQR Comparative Results



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

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

	Strengths	Weaknesses	Corrective Actions/ Recommendations
Quality	Trillium has the ability to submit all ICD-10 Diagnosis codes that are submitted on a claim on the encounter data extracts to NC Medicaid.	Trillium does not have the ability to submit ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks.	***Recommendation: Update Trillium's encounter data submission process to submit ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks.***
	Trillium's MyLearning Campus offers free online trainings and tip sheets accessible to Trillium staff and providers 24/7.	Trillium does not have the ability to submit DRG codes on Institutional encounter data extracts to NCTracks.	***Recommendation: Update Trillium's encounter data submission process to submit DRG codes on Institutional encounter data extracts to NCTracks.***

	Strengths	Weaknesses	Corrective Actions/ Recommendations
	Trillium's (b) Waiver Measure materials included all necessary documentation, and measures were reported according to specifications.	The (b) Waiver measure validation noted a substantial decline for one PM.	***Recommendation: Continue to monitor (b) Waiver performance measure rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the PMs.***
	Trillium's (c) Waiver Measures that were validated met or exceeded State benchmark rates.	PIP rates did not improve for three of the five validated PIPs.	***Recommendation: For the Supermeasure MH PIP: Determine if in-process interventions including provider meetings, quarterly meetings with discharge providers, incentive contract, data sharing, provider education, and member engagement will improve rates. For the ED Utilization PIP: Continue to monitor now that Wellness Recovery Homes and SUD Host Homes are open to improve access to care. Monitor the ED dashboard which includes more tracking outcomes to determine if rates show more substantial improvement. For the MST Utilization PIP: Determine if suggested interventions including member location analysis, MST service engagement/provider outreach, and staffing pattern review will improve the rate.***
	All Trillium PIPs were in the High Confidence range.	One of the three I/DD files selected by Trillium and reviewed by CCME showed a pattern of late case contact notes, a lack of engagement and monitoring with the Innovations enrollee, and untimely notification to DSS re: the enrollee's discharge from the Innovations Waiver.	***Corrective Action: Enhance the current enrollee file review process to better identify and address trends of late case contact notes, gaps in engagement with enrollees, and required notifications to DSS when an enrollee discharges from the Innovations Waiver as required by NC Medicaid Contract, Section 4, Enrollment, 4.6.***

	Strengths	Weaknesses	Corrective Actions/ Recommendations
	Trillium reported recent improvements to their internal Grievance monitoring process.	One of the four TCLI files selected by Trillium and reviewed by CCME showed a 29-day gap in engagement directly following the enrollee's discharge from the hospital for mental health reasons.	***Corrective Action: Enhance the current TCLI enrollee file review process to ensure enrollees are seen by a provider within seven days of their discharge, as required by Trillium's Procedure Care Coordination Procedure, Coordination of Services Following Hospitalization.***
	Trillium staff reported they have increased the sampling for Explanation of Benefits distribution.		
	Trillium staff also reported a third-party vendor completed a risk assessment in the past year and found Trillium's Compliance Department is operating at a high level with low risk.		
Timeliness	98.83% of Institutional claims and 99.81% of Professional claims were auto adjudicated by Trillium.	There is a significant increase in the amount of time between a claim being denied by NC Medicaid and its resubmission (increased from 19 days in 2020 to 73 days in 2021).	***Recommendation: Work with providers to help decrease response time, with the goal of reducing the number of days between initial denial and date of resubmission to NC Tracks.***
	Trillium uses the Trillium Business System software system to automate the Grievance and Appeal process, including generating acknowledgement and resolution letters.		

	Strengths	Weaknesses	Corrective Actions/ Recommendations
	Trillium has implemented a 45-day investigation case closure benchmark which contributes to the low number of PI investigations currently open.		
Access to Care	Enhancements to the Provider Directory make it easier for members to locate providers to meet their needs.		
	The addition of Quest Analytics enables Trillium to identify and quickly address network gaps.		
	Trillium reported they completed around 1,500 enrollee contacts inquiring about preparedness prior to the hurricane season. There was evidence of this outreach effort in the files reviewed for this EQR.		
	Trillium and the State reported that Trillium was able to fill around 80 Innovations slots in a short amount of time.		

METHODOLOGY

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

On October 18, 2022, CCME notified 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 PIHP to participate in a pre-Onsite conference call with CCME and NC Medicaid 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 November 23, 2022 and reviewed by CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. The Desk Review also included a review of Credentialing, Grievance, Utilization, Care Coordination, Program Integrity, and Appeal files.

The second segment of the EQR is typically a two-day Onsite review conducted at the PIHP's offices. However, due to COVID-19, this Onsite was conducted through a teleconference platform on December 15, 2022. This Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's onsite activities included:

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

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

FINDINGS

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

A. Administration

42 CFR § 438.224

Information Systems Capabilities Assessment (ISCA)

The review of Trillium's systems capabilities involved the use of the Information Systems Capabilities Assessment (ISCA) tool and review of supporting documentation, such as Trillium's claim audit reports, enrollment workflows, and Information Technology (IT) staffing patterns. This system analysis is completed as specified in the *Centers for Medicare and Medicaid Services (CMS) External Quality Review protocol*. During the Onsite review, Trillium staff presented an enrollment and claims system overview. Questions regarding the ISCA tool were also discussed with Trillium staff.

In the 2021 EQR, Trillium met 100% of the Administrative standards and received two Recommendations. During the Onsite discussion, Trillium stated the two Recommendations from the 2020 EQR, and the 2021 EQR related to ICD-10 Procedure codes and Institutional encounters were in their task to-do list but have not yet been implemented. As a result, CCME has reissued these 2020 and 2021 EQR Recommendations in the 2022 EQR Recommendations.

Table 2 outlines the Recommendations issued to Trillium in the 2021 EQR and CCME's follow up in the 2022 EQR.

Table 2: 2021 EQR Administrative Findings

2021 EQR Administrative Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	***Recommendations: Update Trillium's encounter data submission process to submit ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks.*** ***Update Trillium's encounter data submission process to submit Diagnosis-Related Group (DRG) codes on Institutional encounter data extracts to NCTracks.***	N

2021 EQR Administrative Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
2021 EQR follow-up: Trillium explained during the Onsite discussion these two Recommendations were in the implementation pipeline for launch by April 1, 2023. Therefore, these two 2021 EQR Recommendations will be re-issued for the 2022 EQR.		

Trillium uses the Trillium Business System (TBS) to process member enrollment, claims, submitted encounters, and generate reports. Since 2018, Trillium has full ownership of the TBS platform which is maintained within Trillium's Information Technology (IT) and Business Systems Department. No significant changes have taken place with the TBS system in the last three years.

The ISCA tool and supporting documentation clearly define the process for enrollment data updates in the TBS enrollment system. During the Onsite, Trillium provided a demonstration of the TBS enrollment system. This showed its capabilities, which included maintenance of the member's enrollment history as well as the capture of race, ethnicity, and language demographic information. The documentation provided in the ISCA tool indicates a nightly upload of the Global Eligibility File (GEF) with a report of processing exceptions generated. In addition, the data warehouse is loaded using SQL queries and has checks to ensure data completeness. Trillium indicated they did not encounter any errors or issues with the GEF file upload in the past year. Trillium staff stated the Eligibility Specialist manually updates the member's demographic information in TBS. Trillium identifies members via Medicaid ID, Client ID, and SSN. Enrollment information is maintained on a monthly basis and is reconciled with the 820 enrollment files to verify Medicaid eligibility via financial records.

Trillium stores the Medicaid identification number received on the GEF. Trillium explained during the Onsite, they rarely receive members with multiple IDs but are able to research and merge the information into one Member ID when this occurs. The most common case of multiple member IDs is when a member gets legally adopted. In such cases, the member's new ID is generated from the date of adoption going forward. The historical claims for the member are also merged into one Member ID. The Eligibility team proactively seeks out members with more than one ID to merge records.

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

Table 3: Enrollment Counts

2019	2020	2021
218,876	234,069	87,724

Trillium experienced nearly 63% reduction in enrollment from 2020 to 2021 due to transition of membership to NC Medicaid Managed Care. Trillium's authorizations and claims are processed in the TBS system. A review of Trillium's processes for collecting, adjudicating, and reporting claims was conducted through a review of Trillium's ISCA response. During the Onsite, a demonstration of Trillium's Provider web claims entry portal and the TBS claims processing system was performed.

Trillium receives claims from three methods: 837 electronic file, provider web portal, and paper claims. During the Onsite discussion, Trillium stated they receive Emergency Department (ED) claims and some Professional non-ED claims on paper. Table 4 details the percentage of 2021 claims received via the three methods.

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

Source	HIPAA File	Paper	Provider Web Portal
Institutional	85.279%	.165%	14.556%
Professional	87.607%	.115%	12.278%

Trillium adjudicates claims on a nightly basis. Approximately 99.81% of Professional claims and 98.83% of Institutional claims are auto adjudicated. Trillium processes encounters on a weekly basis. The Truven file, which is similar to an 835 file but with more explanations for the provider, is imported weekly for encounter reconciliation for accepted and rejected encounters. This is imported in conjunction with the Adam Holzman reports which are also built off of the Truven file.

Trillium captures up to 25 ICD-10 Diagnosis codes via the provider web portal and up to 41 ICD-10 Diagnosis codes via the HIPAA files for Institutional claims. For Professional claims, Trillium has the ability to receive and store up to 12 ICD-10 Diagnosis codes on both the provider web portal and via HIPAA files. Trillium captures ICD-10 Procedure codes and DRGs, if they are submitted on the claim.

During the Onsite discussion, Trillium stated staff conduct random audits on a daily basis on at least 3% of all claims processed. All paper claims are subjected to a separate audit. High dollar claims with a billed amount greater than $5,000 are also audited. Claims supervisors and managers review all claims processed.

The breakdown of encounter data acceptance/denial rates by claim service detail counts was provided for encounters submitted in 2021. Table 5 provides a comparison of 2020 and 2021.

Table 5: Volume of 2020 and 2021 Submitted Encounter Data

2021	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	49,351	478	361	50,190
Professional	1,226,915	25,003	7,150	1,259,068
2020	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	49,586	2,431	756	52,773
Professional	1,190,579	4,491	3,538	1,198,608

Trillium has an approximate 99.43% acceptance rate for both Professional and Institutional encounters with dates of service in 2021. The denial rates for 2021 were as follows: Institutional: 0.72%, Professional: 0.57% Total: 0.57%. During the Onsite discussion, Trillium provided the top two denial reasons for encounters submitted to NCTracks:

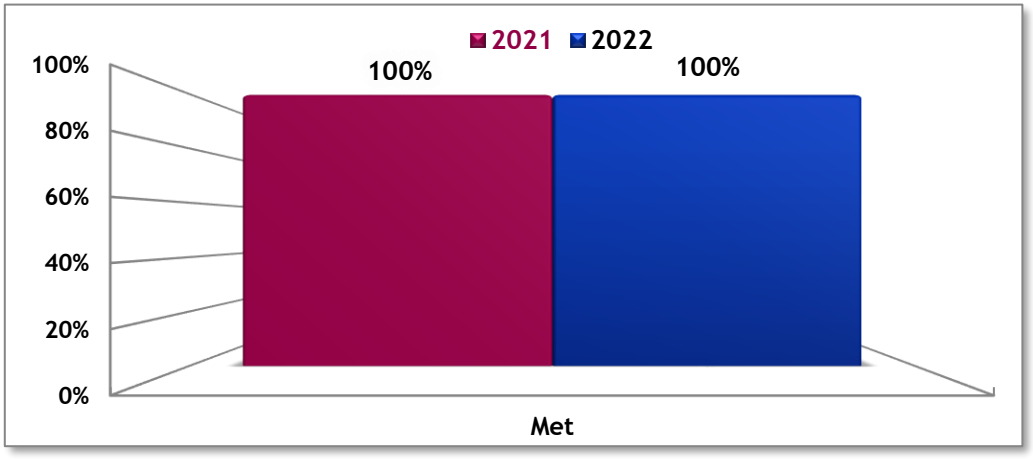
- Procedure code invalid for billing provider Taxonomy: Trillium staff provides technical assistance for every denial and works with the providers. This is done via providing a taxonomy cheat sheet on the website as well as sending frequent communications to the providers.
- Possible duplicate, same provider, same procedure, overlapping dates of service: Trillium confirmed many duplicates were caused due to resubmission of claims due to rate changes related to covid. The majority of duplicate denials are caused by voided claims related encounters and resubmitted claims, which in turn causes the system to flag them as duplicate. A void is created and submitted, then resubmitted claims are created and submitted. The underlying problem lies in the timing of when the state may process the encounters and the voided records may not be processed first, causing duplicate flags.

On average, Trillium submits an encounter to NC Medicaid within seven days from the time of adjudication. In 2021, it took Trillium an average of 73 days to correct and resubmit an encounter to NC Medicaid that was initially denied. Trillium uses the incoming 835 files, and Truven reports from NC Medicaid to identify encounters were denied. As stated in the ISCA, Trillium has 337 Institutional and 2746 Professional

encounters with dates of service in 2021, still awaiting resubmission as of November 7, 2022. Trillium exceeds the NC Medicaid standards for encounter submissions and has less than 0.6% denial rate of their encounter data submissions. Trillium is submitting up to 41 ICD-10 Diagnosis codes for Institutional encounters and up to 25 ICD-10 Diagnosis codes for Professional encounters. `

Figure 2 demonstrates Trillium met all of the Standards in the 2021 and 2022 Administrative EQR.

Figure 2: Administrative Comparative Findings



Strengths

- 98.83% of Institutional claims and 99.81% of Professional claims were auto adjudicated by Trillium.
- Trillium has the ability to submit all ICD-10 Diagnosis codes that are submitted on a claim on the encounter data extracts to NC Medicaid.

Weaknesses

- Trillium does not have the ability to submit ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks.
- Trillium does not have the ability to submit DRG codes on Institutional encounter data extracts to NCTracks.
- There is a significant increase in the amount of time between a claim being denied by NC Medicaid and its resubmission (increased from 19 days in 2020 to 73 days in 2021).

Recommendations

- Update Trillium's encounter data submission process to submit ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks.
- Update Trillium's encounter data submission process to submit DRG codes on Institutional encounter data extracts to NCTracks.
- Work with providers to help decrease response time, with the goal of reducing the number of days between initial denial and date of resubmission to NC Tracks.

B. Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

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

In the 2021 EQR, Trillium met 100% of the Credentialing/Recredentialing standards, resulting in no Corrective Actions. CCME issued a Recommendation focused on reconciling conflicting information regarding voting membership and the determination of adequate voting membership attendance for conducting committee meetings, including voting on applications. Trillium partially addressed the Recommendation from the 2021 EQR, as presented in Table 6.

Table 6: 2021 EQR Provider Services Findings

2021 EQR Credentialing/Recredentialing findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	***Recommendation: Reconcile documents to accurately reflect voting membership of the Credentialing Committee and to clarify the requirements to conduct meetings, including votes on applications.***	**N**

2021 EQR Credentialing/Recredentialing findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
2022 EQR Follow up: In this 2022 EQR, Trillium partially implemented the Recommendation. The submitted Credentialing Committee meeting minutes list Dr. Michael Smith, Chief Medical Officer (CMO), on a line separate from the "Voting Members" section of the minutes. However, the *2022-2023 Credentialing Committee Members List* continues to list Dr. Smith in the "Voting Members" section. Trillium added Dr. Paul Garcia, Deputy CMO, as an Ad Hoc member of the Credentialing Committee to the *2022-2023 Credentialing Committee Members List* but also listed Dr. Garcia in the "Voting Members" section. Trillium staff has confirmed that Dr. Garcia only attends meetings to cover in Dr. Smith's absence, and that neither the CMO nor the Deputy CMO would vote, except in the event of a tied vote. There were no revisions in the *Credentialing Committee By-Laws* (*By-Laws*) or in the Credentialing and Re-Credentialing Process procedure. For the 2022 EQR, Trillium submitted the same versions of these documents that were submitted for the 2021 EQR. Trillium also submitted the Credentialing and Re-credentialing Process rev 091622, but that is outside the scope of the 2022 EQR and is focused on the Trillium processes after credentialing and recredentialing were transitioned to NCTracks.		

In the 2022 EQR, Trillium met 100% of the Credentialing/Recredentialing standards. CCME issued no Corrective Actions. As noted, Trillium partially addressed the 2021 Recommendation. Trillium made some revisions in the *Credentialing Committee Members List* and to the structure of the Credentialing Committee meeting minutes but did not revise the *Credentialing Committee By-Laws (By-Laws)* or the Credentialing and Re-Credentialing Process as recommended in the 2021 EQR.

Per the direction of the North Carolina Department of Health and Human Services, credentialing has now shifted from the PIHPs completing credentialing and recredentialing to the PIHPs verifying credentialing completed by NCTracks. Trillium completed the in-process credentialing and recredentialing files in May 2022. Therefore, although the Recommendation from 2021 was only partially implemented, CCME is issuing no Recommendations in the 2022 EQR of Credentialing/Recredentialing.

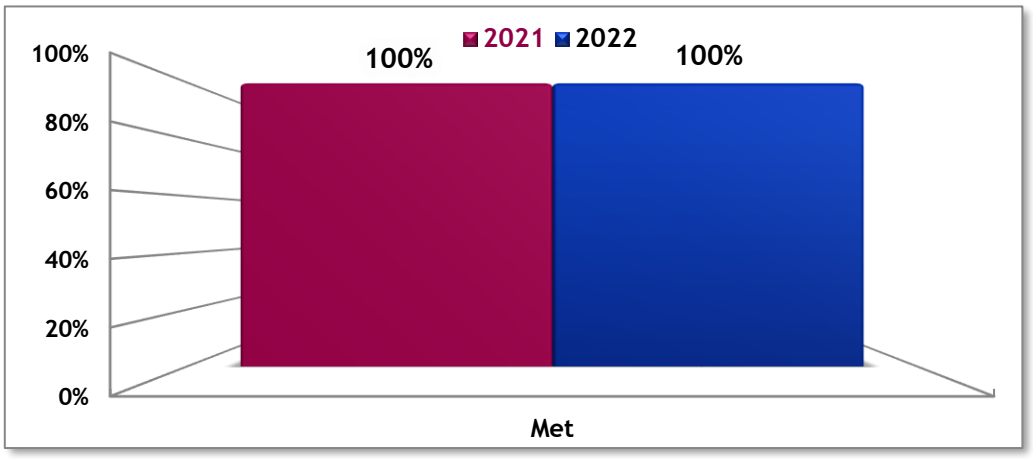
The *By-Laws* and several policies and procedures, including the Credentialing and Re-Credentialing Process procedure, guide the credentialing and recredentialing processes. CCME's review of the credentialing and recredentialing files showed they were organized and contained appropriate information. Dr. Michael Smith, Chief Medical Officer (CMO) and a board-certified psychiatrist, "oversees the Credentialing Program, has authority as delegated by the Credentialing Committee to approve Clean Applications", and chairs the Credentialing Committee Dr. Paul Garcia, a board-certified psychiatrist, chaired the Credentialing Committee meeting in Dr. Smith's absence. During Onsite discussion, Trillium staff clarified that Dr. Garcia is now the Associate Medical Director and Dr. Arthur Flores is the Deputy Chief Medical Officer. Trillium staff reported "Dr. Flores was hired with a focus on the Tailored Plan and physical health."

Per the *By-Laws*, a quorum "shall consist of the Committee Chair and 50 percent or more of the voting members, including at least 1 participating provider in person or via technology." The *By-Laws* state, "All matters considered at a meeting shall be decided by a majority vote of voting members present." As requested, Trillium submitted minutes from three Credentialing Committee meetings. The minutes reflect committee review of the list of "clean" applications approved by the CMO, and the review and discussion of "red flagged" applications, voted on by the committee. A quorum was present at the Credentialing Committee meetings for which minutes were submitted for this EQR.

During the Onsite discussion regarding Network Adequacy, Trillium staff provided updates of efforts to address the seven gaps identified at the last EQR. Trillium added providers and programs in numerous counties to not only address previously identified gaps, but to prepare for Tailored Plan implementation and for the 1115 Substance Use Disorder Waiver. Trillium also added providers and programs due to county realignments and in support of the NC Child and Family Improvement Initiative project. The addition of Quest Analytics has allowed Trillium to identify and quickly address network gaps.

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

Figure 3: Provider Services Comparative Findings



Strengths

- Enhancements to the Provider Directory make it easier for members to locate providers to meet their needs.
- The addition of Quest Analytics enables Trillium to identify and quickly address network gaps.
- Trillium's MyLearning Campus offers free online training and tip sheets accessible to Trillium staff and providers 24/7.

C. Quality Improvement

42 CFR § 438.330

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

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

Table 7: 2021 EQR PIP Recommendations

Project(s)	Recommendation	Recommendation Implemented in 2022 (Y/N/NA)
Super Measure MH	***Recommendation: Continue with analysis of validated State data once available to determine if improvement did occur for finalized rates.***	**Y**
Super Measure SU	***Recommendation: Continue with current active interventions including, RRT and Opioid Treatment Centers, and examine rate after review of State validated data.***	**Y**
ED Utilization	***Recommendation: Determine if specific processes at discharge or member education would improve the rate for Indicator #2 and increase follow-up treatment to 80% goal.***	**Y**

In the 2022 EQR, five projects were submitted, and all five were validated including: Super Measure MH (Clinical), Super Measure SU (Clinical), ED Utilization (Clinical), MST Utilization (Clinical), and TCLI 90 Day Contact PIP (Non-Clinical).

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

Table 8: 2021 EQR PIP Interventions

Project(s)	Interventions
Super Measure MH	Provider meetings, quarterly meetings with discharge providers, incentive contract, data sharing, provider education, and member engagement
Super Measure SU	One-on-one meetings with providers with high volume of served members and low follow-up rates, focused quarterly meetings with discharging providers, incentive contract for FBC, data sharing with providers regarding follow-up rates
ED Utilization	Wellness Recovery Homes, Substance Use Disorder host homes for transitional living residences, Project Transitions for SPMI members, ED dashboard
MST Utilization	Location analysis, MST service engagement/provider outreach, and staffing pattern review
TCLI 90 Day Contact PIP	Report pulled from TCLD to verify the status of In-Reach members; weekly reports sent to the In-Reach provider; staff monitoring of In-Reach provider's notes

Performance Measure Validation

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

Table 9: (b) Waiver Measures

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

Table 10: (c) Waiver Measures

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

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

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

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

(b) Waiver Measures Reported Results

Measures were reviewed for substantial changes (>10%) from last year to the current year. There was one measure that improved substantially: 30-Day readmissions rates for FBC improved 13% down to 12.8% from 26.8%. One measure had a substantial decline: Initiation and Engagement of Alcohol & Other Drug Dependence Treatment Ages 65+ (Initiation) declined from 58.7% to 44.1%, a -14.60% change. The current rate (FY 2021) in comparison to last year's rate is presented in Tables 11 through 20.

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

30-day Readmission Rates for Mental Health	FY 2020	FY 2021	Change
Inpatient (Community Hospital Only)	16.6%	15.0%	-1.60%
Inpatient (State Hospital Only)	15.4%	17.6%	2.20%
Inpatient (Community and State Hospital Combined)	16.6%	15.0%	-1.60%
Facility Based Crisis	26.8%	13.8%	**-13.00%**
Psychiatric Residential Treatment Facility (PRTF)	4.3%	3.7%	-0.60%
Combined (includes cross-overs between services)	16.5%	14.5%	-2.00%

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

30-day Readmission Rates for Substance Abuse	FY 2020	FY 2021	Change
Inpatient (Community Hospital Only)	15.1%	16.2%	1.10%
Inpatient (State Hospital Only)	0.0%	66.7%	66.70%*
Inpatient (Community and State Hospital Combined)	15.1%	17.6%	2.50%
Detox/Facility Based Crisis	16.8%	10.1%	-6.70%
Combined (includes cross-overs between services)	16.4%	11.3%	-5.10%

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

Follow-up after Hospitalization for Mental Illness	FY 2020	FY 2021	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	38.6%	36.8%	-1.80%
Percent Received Outpatient Visit Within 30 Days	57.9%	56.2%	-1.70%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	47.7%	40.4%	-7.30%
Percent Received Outpatient Visit Within 30 Days	63.6%	59.6%	-4.00%
PRTF			
Percent Received Outpatient Visit Within 7 Days	25.6%	17.5%	-8.10%
Percent Received Outpatient Visit Within 30 Days	44.9%	41.7%	-3.20%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	38.4%	36.1%	-2.30%
Percent Received Outpatient Visit Within 30 Days	57.7%	55.7%	-2.00%

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

Follow-up after Hospitalization for Substance Abuse	FY 2020	FY 2021	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	14.8%	13.7%	-1.10%
Percent Received Outpatient Visit Within 30 Days	20.9%	25.3%	4.40%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	51.1%	46.6%	-4.50%
Percent Received Outpatient Visit Within 7 Days	54.8%	52.2%	-2.60%
Percent Received Outpatient Visit Within 30 Days	61.4%	59.7%	-1.70%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	45.4%	46.1%	0.70%
Percent Received Outpatient Visit Within 30 Days	51.9%	54.3%	2.40%

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2020	FY 2021	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	44.7%	38.5%	-6.20%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	17.8%	10.7%	-7.10%
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	37.8%	34.0%	-3.80%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	24.0%	15.8%	-8.20%
Ages 21–34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	48.4%	47.4%	-1.00%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	34.8%	31.7%	-3.10%
Ages 35–64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	48.9%	46.9%	-2.00%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	37.0%	31.5%	-5.50%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	58.7%	44.1%	**-14.60%**
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	46.7%	37.8%	-8.90%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	48.1%	45.5%	-2.60%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	34.5%	29.4%	-5.10%

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

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3–12	Male	0.2	0.1	-0.1	18.6	19.3	0.7
	Female	0.1	0.2	0.1	11.2	13.7	2.5
	Total	0.1	0.1	0.0	15.4	15.4	0.0
13–17	Male	0.8	0.7	-0.1	12.3	14.8	2.5
	Female	1.6	1.5	-0.1	10.3	11.5	1.2
	Total	1.2	1.1	-0.1	11.0	12.6	1.6
18–20	Male	2.5	1.3	-1.2	8.2	9.6	1.4
	Female	1.7	1.2	-0.5	6.0	6.4	0.4
	Total	2.1	1.3	-0.8	7.2	7.9	0.7
21–34	Male	5.6	3.7	-1.9	8.0	8.8	0.8
	Female	1.6	1.1	-0.5	7.2	8.8	1.6
	Total	2.5	1.7	-0.8	7.6	8.8	1.2
35–64	Male	3.0	2.2	-0.8	8.4	8.8	0.4
	Female	2.1	1.4	-0.7	8.8	8.8	0.0
	Total	2.4	1.7	-0.7	8.6	8.8	0.2
65+	Male	0.3	0.3	0.0	24.6	13.1	-11.5
	Female	0.2	0.2	0.0	20.1	14.9	-5.2
	Total	0.3	0.2	-0.1	21.9	14.2	-7.7
Unknown	Male	0.0	0.0	0.0	0.0	0.0	0.0
	Female	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0
Total	**Male**	**1.3**	**1.0**	**-0.3**	**9.5**	**10.1**	**0.6**
	Female	**1.1**	**0.9**	**-0.2**	**8.8**	**9.7**	**0.9**
	Total	**1.2**	**0.9**	**-0.3**	**9.1**	**9.9**	**0.8**

Table 17: D.2. Mental Health Utilization -% of Members that Received at Least 1 Mental Health Service in the Category Indicated during the Measurement Period

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3-12	Male	13.48%	11.02%	-2.46%	0.23%	0.11%	-0.12%	0.27%	0.23%	-0.04%	13.43%	10.97%	-2.46%
	Female	9.72%	9.08%	-0.64%	0.16%	0.20%	0.04%	0.07%	0.05%	-0.02%	9.71%	9.06%	-0.65%
	Total	11.63%	10.06%	-1.57%	0.20%	0.16%	-0.04%	0.17%	0.14%	-0.03%	11.60%	10.03%	-1.57%
13-17	Male	16.28%	14.05%	-2.23%	0.99%	0.71%	-0.28%	0.36%	0.29%	-0.07%	16.19%	13.96%	-2.23%
	Female	18.34%	18.63%	0.29%	1.56%	1.56%	0.00%	0.19%	0.13%	-0.06%	18.23%	18.56%	0.33%
	Total	17.30%	16.30%	-1.00%	1.27%	1.13%	-0.14%	0.27%	0.21%	-0.06%	17.19%	16.22%	-0.97%
18-20	Male	11.11%	9.03%	-2.08%	1.89%	1.09%	-0.80%	0.05%	0.08%	0.03%	11.03%	8.94%	-2.09%
	Female	13.63%	13.31%	-0.32%	1.46%	1.17%	-0.29%	0.06%	0.11%	0.05%	13.50%	13.21%	-0.29%
	Total	12.47%	11.31%	-1.16%	1.65%	1.14%	-0.51%	0.05%	0.10%	0.05%	12.36%	11.21%	-1.15%
21-34	Male	24.15%	19.81%	-4.34%	3.98%	2.62%	-1.36%	0.23%	0.23%	0.00%	24.04%	19.72%	-4.32%
	Female	17.85%	15.81%	-2.04%	1.43%	1.05%	-0.38%	0.25%	0.30%	0.05%	17.74%	15.74%	-2.00%
	Total	19.33%	16.72%	-2.61%	2.03%	1.40%	-0.63%	0.25%	0.28%	0.03%	19.22%	16.64%	-2.58%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
35-64	Male	17.14%	15.73%	-1.41%	2.20%	1.83%	-0.37%	0.20%	0.20%	0.00%	16.97%	15.56%	-1.41%
	Female	21.63%	19.70%	-1.93%	1.64%	1.29%	-0.35%	0.26%	0.26%	0.00%	21.54%	19.60%	-1.94%
	Total	19.88%	18.20%	-1.68%	1.86%	1.49%	-0.37%	0.24%	0.24%	0.00%	19.76%	18.07%	-1.69%
65+	Male	5.74%	5.26%	-0.48%	0.34%	0.24%	-0.10%	0.06%	0.01%	-0.05%	5.65%	5.19%	-0.46%
	Female	5.96%	5.97%	0.01%	0.25%	0.21%	-0.04%	0.00%	0.01%	0.01%	5.92%	5.91%	-0.01%
	Total	5.89%	5.74%	-0.15%	0.28%	0.22%	-0.06%	0.02%	0.01%	-0.01%	5.83%	5.68%	-0.15%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**Male**	**14.68%**	**12.55%**	**-2.13%**	**1.11%**	**0.81%**	**-0.30%**	**0.24%**	**0.21%**	**-0.03%**	**14.59%**	**12.47%**	**-2.12%**
	Female	**14.62%**	**13.88%**	**-0.74%**	**0.97%**	**0.84%**	**-0.13%**	**0.15%**	**0.15%**	**0.00%**	**14.55%**	**13.82%**	**-0.73%**
	Total	**14.64%**	**13.32%**	**-1.32%**	**1.03%**	**0.83%**	**-0.20%**	**0.19%**	**0.18%**	**-0.01%**	**14.57%**	**13.25%**	**-1.32%**

Table 18: D.3. Identification of Alcohol and Other Drug Services

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3–12	Male	0.01%	0.02%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.02%	0.01%
	Female	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
	Total	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
13–17	Male	1.16%	0.92%	-0.24%	0.15%	0.11%	-0.04%	0.06%	0.09%	0.03%	1.07%	0.88%	-0.19%
	Female	0.91%	0.89%	-0.02%	0.16%	0.16%	0.00%	0.03%	0.03%	0.00%	0.83%	0.79%	-0.04%
	Total	1.04%	0.90%	-0.14%	0.16%	0.14%	-0.02%	0.05%	0.06%	0.01%	0.95%	0.84%	-0.11%
18–20	Male	3.30%	2.68%	-0.62%	0.46%	0.38%	-0.08%	0.49%	0.22%	-0.27%	3.17%	2.57%	-0.60%
	Female	2.48%	2.52%	0.04%	0.21%	0.25%	0.04%	0.44%	0.15%	-0.29%	2.37%	2.43%	0.06%
	Total	2.86%	2.60%	-0.26%	0.32%	0.31%	-0.01%	0.46%	0.18%	-0.28%	2.74%	2.50%	-0.24%
21–34	Male	8.85%	8.08%	-0.77%	1.21%	0.92%	-0.29%	1.49%	1.04%	-0.45%	8.45%	7.80%	-0.65%
	Female	8.14%	6.94%	-1.20%	0.44%	0.37%	-0.07%	1.81%	1.23%	-0.58%	7.91%	6.82%	-1.09%
	Total	8.31%	7.20%	-1.11%	0.62%	0.49%	-0.13%	1.74%	1.19%	-0.55%	8.04%	7.04%	-1.00%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
35–64	Male	9.01%	8.47%	-0.54%	0.94%	0.80%	-0.14%	2.10%	1.24%	-0.86%	8.53%	8.17%	-0.36%
	Female	7.14%	6.82%	-0.32%	0.50%	0.44%	-0.06%	1.62%	1.11%	-0.51%	6.87%	6.60%	-0.27%
	Total	7.87%	7.44%	-0.43%	0.67%	0.58%	-0.09%	1.81%	1.16%	-0.65%	7.52%	7.20%	-0.32%
65+	Male	2.03%	1.91%	-0.12%	0.11%	0.10%	-0.01%	0.69%	0.34%	-0.35%	1.70%	1.78%	0.08%
	Female	0.67%	0.61%	-0.06%	0.05%	0.01%	-0.04%	0.23%	0.11%	-0.12%	0.50%	0.55%	0.05%
	Total	1.10%	1.03%	-0.07%	0.07%	0.04%	-0.03%	0.37%	0.19%	-0.18%	0.88%	0.94%	0.06%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**Male**	**2.86%**	**2.67%**	**-0.19%**	**0.32%**	**0.27%**	**-0.05%**	**0.59%**	**0.36%**	**-0.23%**	**2.70%**	**2.57%**	**-0.13%**
	Female	**3.25%**	**3.15%**	**-0.10%**	**0.22%**	**0.20%**	**-0.02%**	**0.71%**	**0.50%**	**-0.21%**	**3.12%**	**3.06%**	**-0.06%**
	Total	**3.09%**	**2.95%**	**-0.14%**	**0.27%**	**0.23%**	**-0.04%**	**0.66%**	**0.44%**	**-0.22%**	**2.94%**	**2.85%**	**-0.09%**

Table 19: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	3-12			13-17			18-20			21-34		
Beaufort	0.03%	0.00%	-0.03%	1.87%	0.96%	-0.91%	3.65%	3.47%	-0.18%	9.24%	8.48%	-0.76%
Bertie	0.00%	0.07%	0.07%	0.64%	0.47%	-0.17%	2.16%	4.30%	2.14%	2.55%	4.44%	1.89%
Brunswick	0.03%	0.04%	0.01%	1.15%	0.82%	-0.33%	2.75%	3.63%	0.88%	7.06%	9.06%	2.00%
Camden	0.00%	0.00%	0.00%	0.00%	1.12%	1.12%	0.00%	1.39%	1.39%	3.31%	3.90%	0.59%
Carteret	0.06%	0.00%	-0.06%	1.34%	1.35%	0.01%	2.56%	2.10%	-0.46%	8.65%	9.21%	0.56%
Chowan	0.00%	0.10%	0.10%	0.00%	0.23%	0.23%	1.60%	2.19%	0.59%	4.93%	5.03%	0.10%
Columbus	0.02%	0.02%	0.00%	0.24%	0.52%	0.28%	2.34%	1.76%	-0.58%	6.14%	6.91%	0.77%
Craven	0.02%	0.00%	-0.02%	0.90%	0.87%	-0.03%	2.31%	2.44%	0.13%	7.21%	6.13%	-1.08%
Currituck	0.00%	0.00%	0.00%	0.97%	0.68%	-0.29%	0.00%	1.09%	1.09%	4.76%	6.79%	2.03%
Dare	0.00%	0.00%	0.00%	1.08%	1.44%	0.36%	2.84%	2.44%	-0.40%	5.72%	6.33%	0.61%
Gates	0.00%	0.00%	0.00%	0.36%	0.36%	0.00%	0.00%	0.00%	0.00%	2.98%	2.93%	-0.05%
Hertford	0.05%	0.00%	-0.05%	0.72%	0.62%	-0.10%	1.68%	1.05%	-0.63%	2.12%	3.08%	0.96%
Hyde	0.00%	0.00%	0.00%	0.85%	1.50%	0.65%	1.49%	1.72%	0.23%	6.25%	5.22%	-1.03%
Jones	0.00%	0.00%	0.00%	0.00%	1.00%	1.00%	3.91%	1.49%	-2.42%	6.53%	8.52%	1.99%
Martin	0.00%	0.00%	0.00%	1.19%	0.64%	-0.55%	4.39%	4.43%	0.04%	7.47%	6.57%	-0.90%
Nash	0.00%	0.01%	0.01%	0.73%	1.06%	0.33%	1.30%	1.55%	0.25%	4.62%	4.91%	0.29%
New Hanover	0.02%	0.00%	-0.02%	1.52%	1.41%	-0.11%	3.11%	4.47%	1.36%	8.20%	9.52%	1.32%

2022 External Quality Review

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	3-12			13-17			18-20			21-34		
Northampton	0.00%	0.00%	0.00%	0.31%	0.43%	0.12%	0.91%	0.97%	0.06%	2.79%	2.08%	-0.71%
Onslow	0.00%	0.01%	0.01%	0.31%	0.80%	0.49%	0.91%	2.08%	1.17%	2.79%	5.54%	2.75%
Pamlico	0.00%	0.00%	0.00%	0.77%	1.59%	0.82%	2.27%	2.31%	0.04%	5.09%	11.19%	6.10%
Pasquotank	0.00%	0.03%	0.03%	0.63%	0.16%	-0.47%	0.65%	1.82%	1.17%	9.42%	4.46%	-4.96%
Pender	0.00%	0.00%	0.00%	0.34%	1.21%	0.87%	1.01%	3.35%	2.34%	3.13%	8.09%	4.96%
Perquimans	0.00%	0.00%	0.00%	1.06%	0.29%	-0.77%	2.94%	2.44%	-0.50%	7.11%	5.49%	-1.62%
Pitt	0.00%	0.04%	0.04%	0.89%	1.24%	0.35%	3.97%	2.18%	-1.79%	6.31%	5.53%	-0.78%
Tyrrell	0.00%	0.00%	0.00%	1.43%	1.79%	0.36%	3.52%	2.33%	-1.19%	6.37%	6.94%	0.57%
Washington	0.00%	0.00%	0.00%	1.56%	0.24%	-1.32%	5.26%	3.55%	-1.71%	5.41%	3.24%	-2.17%
	35-64			65+			Unknown			Total		
Beaufort	8.12%	8.12%	0.00%	1.71%	0.98%	-0.73%	0.00%	0.00%	0.00%	3.62%	3.31%	-0.31%
Bertie	5.93%	5.20%	-0.73%	1.25%	1.26%	0.01%	0.00%	0.00%	0.00%	2.15%	2.35%	0.20%
Brunswick	6.37%	8.14%	1.77%	0.20%	0.34%	0.14%	0.00%	0.00%	0.00%	2.67%	3.36%	0.69%
Camden	6.31%	4.35%	-1.96%	0.00%	1.20%	1.20%	0.00%	0.00%	0.00%	1.83%	1.84%	0.01%
Carteret	7.32%	8.24%	0.92%	0.83%	1.14%	0.31%	0.00%	0.00%	0.00%	3.18%	3.48%	0.30%
Chowan	6.77%	6.87%	0.10%	1.31%	1.27%	-0.04%	0.00%	0.00%	0.00%	2.40%	2.55%	0.15%
Columbus	5.07%	6.92%	1.85%	0.60%	0.88%	0.28%	0.00%	0.00%	0.00%	2.21%	2.77%	0.56%
Craven	5.99%	6.50%	0.51%	0.64%	0.64%	0.00%	0.00%	0.00%	0.00%	2.53%	2.51%	-0.02%

2022 External Quality Review

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	35-64			65+			Unknown			Total		
Currituck	4.83%	5.66%	0.83%	0.50%	0.00%	-0.50%	0.00%	0.00%	0.00%	1.84%	2.24%	0.40%
Dare	4.83%	6.63%	1.80%	0.50%	0.00%	-0.50%	0.00%	0.00%	0.00%	1.84%	2.32%	0.48%
Gates	6.14%	2.52%	-3.62%	0.34%	0.46%	0.12%	0.00%	0.00%	0.00%	2.15%	1.00%	-1.15%
Hertford	2.96%	5.21%	2.25%	0.00%	1.22%	1.22%	0.00%	0.00%	0.00%	1.04%	1.96%	0.92%
Hyde	5.43%	3.41%	-2.02%	1.30%	0.70%	-0.60%	0.00%	0.00%	0.00%	1.95%	1.79%	-0.16%
Jones	2.76%	4.38%	1.62%	0.66%	0.00%	-0.66%	0.00%	0.00%	0.00%	1.63%	2.28%	0.65%
Martin	4.56%	6.05%	1.49%	0.00%	1.24%	1.24%	0.00%	0.00%	0.00%	2.10%	2.66%	0.56%
Nash	6.85%	5.58%	-1.27%	1.80%	1.05%	-0.75%	0.00%	0.00%	0.00%	3.05%	2.15%	-0.90%
New Hanover	5.55%	9.92%	4.37%	1.06%	1.75%	0.69%	0.00%	0.00%	0.00%	2.03%	4.12%	2.09%
Northampton	8.98%	7.66%	-1.32%	1.57%	1.13%	-0.44%	0.00%	0.00%	0.00%	3.65%	2.30%	-1.35%
Onslow	4.80%	6.20%	1.40%	1.12%	0.59%	-0.53%	0.00%	0.00%	0.00%	1.72%	2.32%	0.60%
Pamlico	6.45%	5.93%	-0.52%	1.28%	0.00%	-1.28%	0.00%	0.00%	0.00%	2.30%	3.06%	0.76%
Pasquotank	4.95%	5.90%	0.95%	0.37%	0.83%	0.46%	0.00%	0.00%	0.00%	2.41%	2.04%	-0.37%
Pender	4.78%	6.49%	1.71%	0.27%	0.78%	0.51%	0.00%	0.00%	0.00%	1.55%	2.81%	1.26%
Perquimans	5.74%	4.32%	-1.42%	1.03%	0.00%	-1.03%	0.00%	0.00%	0.00%	2.52%	1.97%	-0.55%
Pitt	4.46%	8.10%	3.64%	0.00%	1.74%	1.74%	0.00%	0.00%	0.00%	2.25%	2.85%	0.60%
Tyrrell	9.29%	2.58%	-6.71%	1.77%	0.87%	-0.90%	0.00%	0.00%	0.00%	3.31%	1.74%	-1.57%
Washington	0.00%	4.34%	4.34%	0.00%	0.76%	0.76%	0.00%	0.00%	0.00%	1.03%	1.77%	0.74%

Table 20: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	3-12			13-17			18-20			21-34		
Beaufort	12.80%	11.15%	-1.65%	16.49%	16.43%	-0.06%	12.20%	14.50%	2.30%	20.81%	22.20%	1.39%
Bertie	5.75%	5.32%	-0.43%	12.08%	11.96%	-0.12%	9.26%	9.46%	0.20%	11.80%	11.90%	0.10%
Brunswick	11.13%	11.16%	0.03%	16.47%	18.13%	1.66%	10.74%	11.10%	0.36%	15.44%	16.76%	1.32%
Camden	5.01%	4.86%	-0.15%	17.83%	14.53%	-3.30%	18.18%	18.06%	-0.12%	10.60%	7.79%	-2.81%
Carteret	17.45%	18.04%	0.59%	26.43%	28.72%	2.29%	15.02%	17.69%	2.67%	20.76%	22.06%	1.30%
Chowan	9.45%	5.45%	-4.00%	13.41%	12.76%	-0.65%	5.88%	10.38%	4.50%	13.15%	13.97%	0.82%
Columbus	9.32%	9.01%	-0.31%	10.85%	10.36%	-0.49%	6.04%	5.91%	-0.13%	10.06%	11.83%	1.77%
Craven	11.57%	10.47%	-1.10%	19.24%	19.50%	0.26%	12.99%	14.03%	1.04%	18.21%	17.99%	-0.22%
Currituck	11.94%	10.17%	-1.77%	17.72%	15.00%	-2.72%	8.00%	9.78%	1.78%	14.29%	14.48%	0.19%
Dare	7.97%	7.68%	-0.29%	11.77%	11.68%	-0.09%	8.87%	7.67%	-1.20%	11.07%	10.56%	-0.51%
Gates	8.01%	5.93%	-2.08%	11.83%	8.90%	-2.93%	6.90%	9.02%	2.12%	10.64%	8.79%	-1.85%
Hertford	6.13%	4.64%	-1.49%	10.17%	9.11%	-1.06%	6.71%	6.56%	-0.15%	10.61%	10.59%	-0.02%
Hyde	10.83%	9.91%	-0.92%	17.95%	10.53%	-7.42%	2.99%	6.90%	3.91%	17.19%	15.67%	-1.52%
Jones	13.48%	12.33%	-1.15%	19.67%	21.59%	1.92%	12.50%	13.43%	0.93%	21.99%	20.00%	-1.99%
Martin	10.94%	8.75%	-2.19%	15.96%	17.37%	1.41%	13.45%	13.30%	-0.15%	15.21%	17.10%	1.89%
Nash	6.23%	5.86%	-0.37%	10.30%	11.48%	1.18%	6.63%	7.32%	0.69%	9.90%	10.72%	0.82%

2022 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		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	3-12			13-17			18-20			21-34		
New Hanover	13.06%	12.06%	-1.00%	18.81%	18.17%	-0.64%	12.76%	15.39%	2.63%	17.34%	19.74%	2.40%
Northampton	6.47%	4.87%	-1.60%	15.18%	12.28%	-2.90%	7.90%	6.49%	-1.41%	10.45%	10.53%	0.08%
Onslow	12.16%	11.85%	-0.31%	21.06%	21.27%	0.21%	14.18%	14.00%	-0.18%	17.33%	18.11%	0.78%
Pamlico	19.02%	15.51%	-3.51%	22.57%	23.89%	1.32%	18.71%	15.61%	-3.10%	24.64%	21.30%	-3.34%
Pasquotank	7.94%	7.01%	-0.93%	17.61%	16.29%	-1.32%	10.10%	11.86%	1.76%	13.80%	15.07%	1.27%
Pender	10.11%	10.04%	-0.07%	15.59%	16.57%	0.98%	9.79%	11.41%	1.62%	15.54%	17.42%	1.88%
Perquimans	7.45%	8.67%	1.22%	11.24%	16.09%	4.85%	11.92%	11.59%	-0.33%	11.11%	14.29%	3.18%
Pitt	10.14%	9.51%	-0.63%	17.47%	18.27%	0.80%	11.21%	11.27%	0.06%	14.25%	14.76%	0.51%
Tyrrell	13.48%	8.80%	-4.68%	19.53%	15.18%	-4.35%	13.16%	6.98%	-6.18%	12.16%	16.67%	4.51%
Washington	9.61%	8.95%	-0.66%	13.57%	15.57%	2.00%	5.49%	11.17%	5.68%	11.26%	12.43%	1.17%
	35-64			65+			Unknown			Total		
Beaufort	23.06%	24.37%	1.31%	6.92%	7.28%	0.36%	0.00%	0.00%	0.00%	15.96%	16.01%	0.05%
Bertie	14.04%	14.30%	0.26%	5.00%	5.45%	0.45%	0.00%	0.00%	0.00%	9.43%	9.43%	0.00%
Brunswick	15.90%	17.21%	1.31%	3.80%	3.90%	0.10%	0.00%	0.00%	0.00%	12.96%	13.77%	0.81%
Camden	16.67%	15.65%	-1.02%	7.41%	8.43%	1.02%	0.00%	0.00%	0.00%	11.29%	10.29%	-1.00%
Carteret	22.34%	22.66%	0.32%	7.02%	7.55%	0.53%	0.00%	0.00%	0.00%	19.05%	20.10%	1.05%
Chowan	16.78%	17.17%	0.39%	7.83%	4.30%	-3.53%	0.00%	0.00%	0.00%	11.70%	10.36%	-1.34%
Columbus	10.62%	11.08%	0.46%	3.81%	3.21%	-0.60%	0.00%	0.00%	0.00%	9.10%	9.22%	0.12%

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	35-64			65+			Unknown			Total		
Craven	21.47%	21.77%	0.30%	8.57%	8.08%	-0.49%	0.00%	0.00%	0.00%	15.41%	15.14%	-0.27%
Currituck	16.99%	17.17%	0.18%	3.48%	3.90%	0.42%	0.00%	0.00%	0.00%	13.32%	12.39%	-0.93%
Dare	15.16%	13.75%	-1.41%	7.72%	7.69%	-0.03%	0.00%	0.00%	0.00%	10.27%	9.78%	-0.49%
Gates	12.84%	12.34%	-0.50%	3.65%	5.02%	1.37%	0.00%	0.00%	0.00%	9.34%	8.16%	-1.18%
Hertford	14.40%	14.44%	0.04%	5.45%	5.03%	-0.42%	0.00%	0.00%	0.00%	9.18%	8.56%	-0.62%
Hyde	14.29%	17.07%	2.78%	6.62%	6.34%	-0.28%	0.00%	0.00%	0.00%	12.02%	11.54%	-0.48%
Jones	17.34%	18.13%	0.79%	4.97%	4.89%	-0.08%	0.00%	0.00%	0.00%	15.02%	14.90%	-0.12%
Martin	18.10%	18.68%	0.58%	6.22%	7.97%	1.75%	0.00%	0.00%	0.00%	13.20%	13.31%	0.11%
Nash	13.24%	12.60%	-0.64%	6.63%	6.28%	-0.35%	0.00%	0.00%	0.00%	8.78%	8.80%	0.02%
New Hanover	20.88%	21.79%	0.91%	9.31%	9.70%	0.39%	0.00%	0.00%	0.00%	15.87%	16.16%	0.29%
Northampton	13.81%	15.91%	2.10%	7.71%	6.61%	-1.10%	0.00%	0.00%	0.00%	10.03%	9.50%	-0.53%
Onslow	23.60%	23.59%	-0.01%	10.45%	8.96%	-1.49%	0.00%	0.00%	0.00%	16.35%	16.34%	-0.01%
Pamlico	18.76%	19.63%	0.87%	9.96%	8.52%	-1.44%	0.00%	0.00%	0.00%	19.04%	17.45%	-1.59%
Pasquotank	19.78%	19.81%	0.03%	6.16%	6.76%	0.60%	0.00%	0.00%	0.00%	12.51%	12.37%	-0.14%
Pender	14.74%	15.51%	0.77%	7.67%	7.95%	0.28%	0.00%	0.00%	0.00%	12.34%	12.99%	0.65%
Perquimans	17.11%	19.17%	2.06%	4.98%	6.56%	1.58%	0.00%	0.00%	0.00%	10.70%	12.87%	2.17%
Pitt	20.37%	19.99%	-0.38%	7.27%	7.21%	-0.06%	0.00%	0.00%	0.00%	13.60%	13.48%	-0.12%
Tyrrell	13.84%	14.19%	0.35%	2.68%	4.35%	1.67%	0.00%	0.00%	0.00%	12.85%	10.84%	-2.01%
Washington	18.10%	17.86%	-0.24%	6.72%	6.87%	0.15%	0.00%	0.00%	0.00%	11.79%	12.27%	0.48%

*NR = Denominator is equal to zero; * denominator is < 30*

(b) Waiver Validation Results

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

Table 21: (b) Waiver Performance Measure Validation Scores

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

(c) Waiver Measures Reported Results

Five (c) Waiver Measures were chosen for validation. The rates reported by Trillium and the State benchmarks are displayed in *Table 22: (c) Waiver Measures Reported Results 2021 - 2022*. Documentation on data sources, data validation, source code, and calculated rate for the three reported measures was provided. Additionally, all reported rates exceeded the State Performance Benchmarks.

For the two measures without reported rates, the Trillium file noted that "Results were null due to rule changes with Covid and therefore not included in figure. Check sheets were no longer required after 3/1/2020." Per the Onsite discussion, as part of the COVID flexibilities for the annual process, reports were not required to be submitted by the PIHP. Documentation was not required, although services were sustained.

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

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	NR	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	NR	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	44/50 = 88%	85%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	1200/1200 = 100%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	11/11 = 100%	85%

** Latest reported rates are shown in Table from Excel files: "Innovations Waiver Annual Measures 11.1.21" and "Latest Reported Rates: Semi-Annual and Quarterly 5.1.22. NR: Not reported.*

(c) Waiver Validation

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

Table 23: C Waiver Performance Measures Validation Scores

Measure	Validation Score Received
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Not Reported- Not Validated
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Not Reported-Not Validated
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	100%
Percentage of beneficiaries who received appropriate medication. IW G5	100%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	100%
Average Validation Score & Audit Designation	**100% FULLY COMPLIANT**

Performance Improvement Project (PIP) Validation

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

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

PIP Validation Results

For the 2021 review, five projects were submitted, and all five were validated including: Super Measure MH (Clinical), Super Measure SU (Clinical), ED Utilization (Clinical), MST Utilization (Clinical), and TCLI 90 Day Contact PIP (Non-Clinical).

For this year's 2022 EQR, the same five PIPs were validated: The validation was conducted using *the CMS Protocol 1: Validating Performance Improvement Projects*.

Table 24: PIP Summary of Validation Scores

Project Type	Project	2021 Validation Score	2022 Validation Score
Clinical	Super Measure MH	78/79 = 100% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results
	Super Measure SU	73/74 = 99% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
	ED Utilization	78/79 = 99% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results
	MST Utilization	79/79 = 100% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results
Non-Clinical	TCLI 90 Day Contact	79/79 = 100% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results

There are no Corrective Actions for the validated PIPS. For three of five PIPs, there are Recommendations regarding monitoring interventions to assess for improvement. The project, section, reason, and Recommendations are displayed in Table 25.

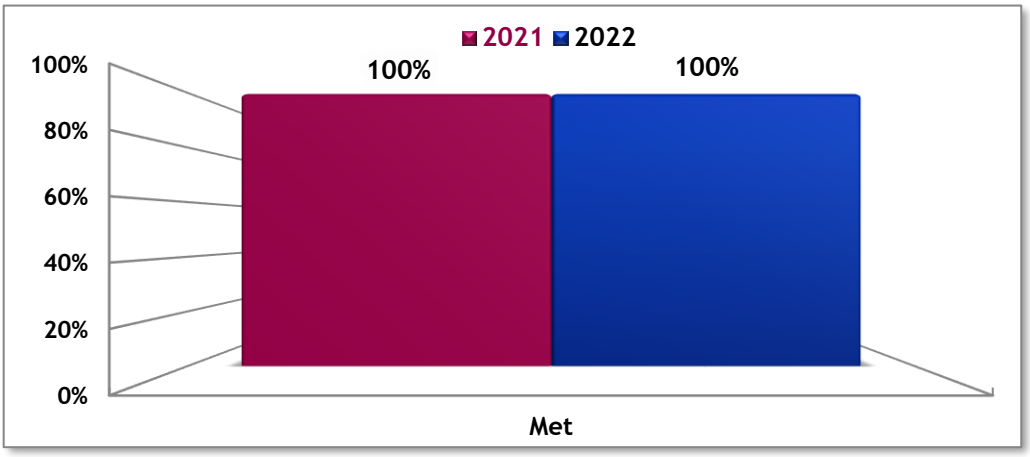
Table 25: Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Super Measure MH	Was there any documented, quantitative improvement in processes or outcomes of care	DHB rates declined from 48.5% in Apr – Jun 22 to 38.6% in Jul -Sept 22. DMH rates declined from 21.7% to 18.5%. The goal is 45% and local data were used since validated State data were not available as of the report submission.	Determine if in-process interventions including provider meetings, quarterly meetings with discharge providers, incentive contract, data sharing, provider education, and member engagement will allow for improvement in rates.
ED Utilization	Was there any documented, quantitative improvement in processes or outcomes of care	For measure #1 (reduce number to .66% or lower), the rate declined slightly from 1.48% in Jan-March 2022 to 1.46% in Apr-Jun 2022. For measure #2 (increase follow-up treatment percentage after ED visits to 80% or higher), the rate declined from 84.7% in Q1 22 to 82.28% in Q2 2022. For measure #3 (decrease number of IIH and ACTT members utilizing ED to 7.79% or lower), the rate improved (declined) from Q1 2022 at 8.58% to Q2 220 (8.11%).	Continue to monitor now that Wellness Recovery Homes and Substance Use Disorder Host Homes are open to improve access to care. Monitor ED dashboard which has more tracking outcomes to determine if rates show more substantial improvement.
MST Utilization	Was there any documented, quantitative improvement in processes or outcomes of care?	The most recent quarterly rate showed a rate of 5.63% which is a decline from the Jan-Mar 2022 rate of 9.03%. The goal is to increase the services rate to 14.7%.	Determine if suggested interventions including member location analysis, MST service engagement/provider outreach, and staffing pattern review will improve the rate.

Details of the validation activities for the PMs and PIPs and specific outcomes related to each activity may be found in *Attachment 3, CCME EQR Validation Worksheets*.

As demonstrated in Figure 4, Trillium met all the QI standards in the 2021 and 2022 EQR.

Figure 4: Quality Improvement Comparative Findings



Strengths

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

Weaknesses

- The (b) Waiver measure validation noted a substantial decline for one PM.
- PIP rates did not improve for three of the five validated PIPs.

Recommendations

- Continue to monitor (b) Waiver performance measure rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the PMs.
- For the Supermeasure MH PIP: Determine if in-process interventions including provider meetings, quarterly meetings with discharge providers, incentive contract, data sharing, provider education, and member engagement will improve rates.

- For the ED Utilization PIP: Continue to monitor now that Wellness Recovery Homes and SUD Host Homes are open to improve access to care. Monitor the ED dashboard which includes more tracking outcomes to determine if rates show more substantial improvement.

- For the MST Utilization PIP: Determine if suggested interventions including member location analysis, MST service engagement/provider outreach, and staffing pattern review will improve the rate.

D. Utilization Management

42 CFR § 438.208

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

Table 26 outlines the 2021 findings and CCME's follow up in the 2022 EQR regarding Trillium's implementation of those Recommendations.

Table 26: 2021 EQR Utilization Management Findings

2021 EQR Utilization Management Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP applies the Care Coordination policies and procedures as formulated.	For the 2021 EQR, Trillium showed significant improvement in the timeliness of case notes and other Care Management documentation. However, discrepancies in case notes and other Care Management documentation were found in four of the 11 files, to include: • An I/DD Support Intensity Scale (SIS) that was three years past the date an update was due. • I/DD case notes that listed the PHI (names) of other enrollees and did not accurately capture Care Management activities related to the development of an ISP. • An I/DD ISP with an annual team meeting date that did not align with the treatment team meeting dates listed in case notes. • Two gaps in MH/SUD case notes revealed Interdisciplinary Care Team meetings (ICTs) reviews were not included in case notes. • MH/SUD case notes show that no follow-up occurred with an enrollee who was hospitalized twice during that 46-day gap.	**N**

2021 EQR Utilization Management Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**

	During the Onsite, Trillium provided a more recent SIS dated February 5, 2019, and four ICT Review notes for two of the three gaps in MH/SUD case notes. Trillium acknowledged that ISPs and case notes lacked clarity, contained the PHI of other enrollees, and did not accurately capture Care Management activities and contacts. Further, Trillium explained that miscommunication during the process of transferring enrollees between care managers in the file where the member was hospitalized twice. Trillium has a departmental benchmark in place for Management to review at least 10 member notes, per staff member per month. However, findings from the MH/SUD/I/DD files reviewed for this EQR showed that this process is not capturing compliance issues within case notes and other Care Management documentation.
	
	Corrective Action:
	• *Implement an enhanced compliance review that routinely reviews Care Management documentation to identify:*
	  ○ *large gaps in Care Management contacts*
	  ○ *documentation that is not compliant with NC DHHS Record Management and Documentation Manual APSM 45-2 and Trillium's procedures*
	  ○ *documentation dating errors such as team meeting dates, ISP signature dates, and dates of other Care Management activities*
	• *Increase the number of case notes reviewed during the monitoring process*
	
	Develop and document a data-driven element to this review. For example, identify baseline scores, establish monthly benchmarks, review data on a monthly basis by region, department, and/or care manager to identify opportunities for improvement.	

2022 EQR Follow up: In the 2022 EQR Onsite, Trillium staff reported Care Coordinator/Manager training regarding engagement and documentation expectations was provided in the past year, and this training will be ongoing. However, while the files selected by Trillium and reviewed by CCME in the 2022 EQR showed continued improvement in compliance, there was still late case contact notes, gaps in engagement, and late notifications to DSS when an enrollee was discharged from the Innovations Waiver. This demonstrates that Trillium's documentation review process is not proactively identifying compliance issues within enrollee files.		

In the 2022 EQR, Trillium again selected three MH/SUD and three I/DD enrollee files for the review. One of the three I/DD files showed a lack of engagement and/or monitoring as is required by *Appendix K*. There was also a pattern of case contact notes submitted outside of Trillium's required 48 hours for documentation entry into the Care Management platform. Lastly, this file revealed a late notification to the county Department of Social Services (DSS) that was required by *NC Medicaid Contract, Section 4, Enrollment, 4.6* to be given within five business days. However, this notification didn't occur until 22 days after the enrollee's placement in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IDD).

Additionally, one of the four TCLI files selected by Trillium also showed a lack of engagement by Care Coordination. In this file, the enrollee was hospitalized for mental health reasons and no follow up occurred or was attempted for 29 days following the enrollee's discharge. This lack of engagement is out of compliance with Trillium's Care Coordination Procedure, Coordination of Services Following Hospitalization.

While the remaining files showed no compliance or engagement issues, there were similar concerns noted in Trillium's previous EQR around engagement and the potential risk to enrollee health, safety, and access to services. As a result, CCME has issued two Corrective Actions for Trillium to continue to enhance the monitoring of the Care Coordination enrollee files to more proactively identify and correct compliance issues. Further details around the 2022 EQR files findings are outlined in the tabular spreadsheet (Attachment 3).

Figure 5 shows 92% of the Utilization Management standards were scored as "Met" in the 2022 EQR and compares these to the 2021 EQR UM score.

Figure 5: Utilization Management Comparative Findings

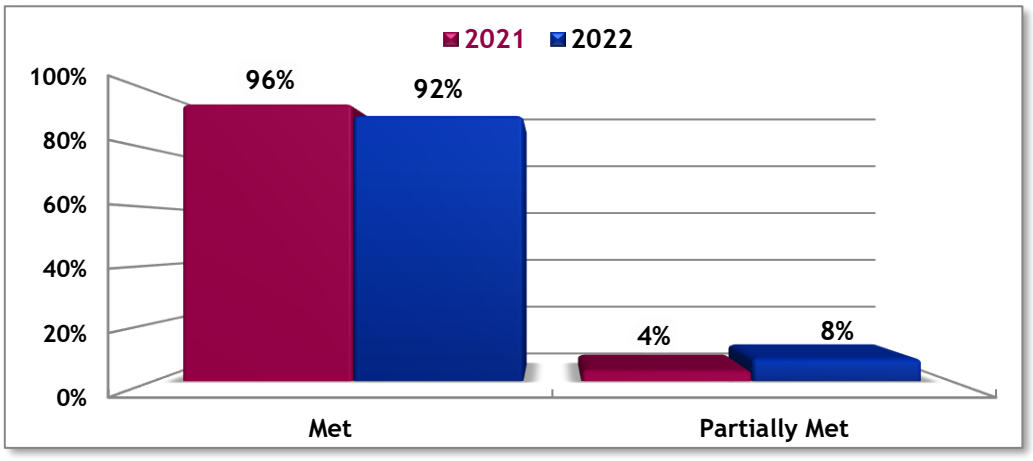


Table 27: Utilization Management Findings

Section	Standard	2021 Review
Care Coordination	The PIHP applies the Care Coordination policies and procedures as formulated.	**Partially Met**
TCLI	A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	**Partially Met**

Strengths

- Trillium reported they completed around 1,500 enrollee contacts inquiring about preparedness prior to the hurricane season. There was evidence of this outreach effort in the files reviewed for this EQR.
- Trillium and the State reported that Trillium was able to fill around 80 Innovations slots in a short amount of time.

Weaknesses

- One of the three I/DD files selected by Trillium and reviewed by CCME showed a pattern of late case contact notes, a lack of engagement and monitoring with the Innovations enrollee, and untimely notification to DSS re: the enrollee's discharge from the Innovations Waiver.
- One of the four TCLI files selected by Trillium and reviewed by CCME showed a 29-day gap in engagement directly following the enrollee's discharge from the hospital for mental health reasons.

Corrective Action

- Enhance the current enrollee file review process to better identify and address trends of late case contact notes, gaps in engagement with enrollees, and required notifications to DSS when an enrollee discharges from the Innovations Waiver as required by *NC Medicaid Contract, Section 4, Enrollment, 4.6*.
- Enhance the current TCLI enrollee file review process to ensure enrollees are seen by a provider within seven days of their discharge, as required by Trillium's Procedure Care Coordination Procedure, Coordination of Services Following Hospitalization.

E. Grievances and Appeals

42 CFR § 438, Subpart F

The Grievances and Appeals EQR included a Desk Review of policies and procedures, 10 Grievance and 10 Appeal files, the Grievance and Appeal Logs, the *Trillium Health Resources Provider Manual (March 2022), the Member and Recipient Handbook (April 2022),* and information about Grievances and Appeals available on the Trillium website. There was an Onsite discussion with Grievance and Appeal staff to further clarify the PIHP's documentation and processes.

In the 2021 EQR, Trillium met 100% of the Grievance and Appeal standards, resulting in no Corrective Actions or Recommendations. In this 2022 EQR, Trillium again met 100% of the Grievance and Appeal standards with no corresponding Corrective Actions or Recommendations.

Grievances

In the 2021 EQR of Grievances, there were no Recommendations or Corrective Actions.

Table 28: 2021 EQR Grievance Findings

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

In the 2022 EQR, there are no Recommendations or Corrective Actions. Trillium reported they employed a new Engagement Manager in July 2022. The new manager implemented a process change that allows all team members to know the timeline for active Grievances, which means the cases can be covered in the absence of the primary assigned staff member. This change improved the internal Grievance monitoring process.

Within the 10 Grievance files reviewed, all were resolved in accordance with *NC Medicaid Contract, Attachment M and 42 CFR § 438.408 (b)(1).* The Trillium Grievance Process and Scope procedure allows for a maximum resolution timeframe of 90 days. However, Trillium staff stated during the Onsite discussion that they strive to resolve Grievances within 30 days. All notifications were timely and compliant. Nine acknowledgement letters were issued the same day the Grievance was received, and one was issued three days after the Grievance was received. Nine resolution letters were issued within 30 days, and one was issued within 31 days after the Grievance was received. Grievances

that involved potential health and safety concerns were appropriately staffed by the Chief Medical Officer (CMO).

Appeals

In the 2021 EQR of Appeals, there were no Recommendations or Corrective Actions.

Table 29: 2021 EQR Appeal Findings

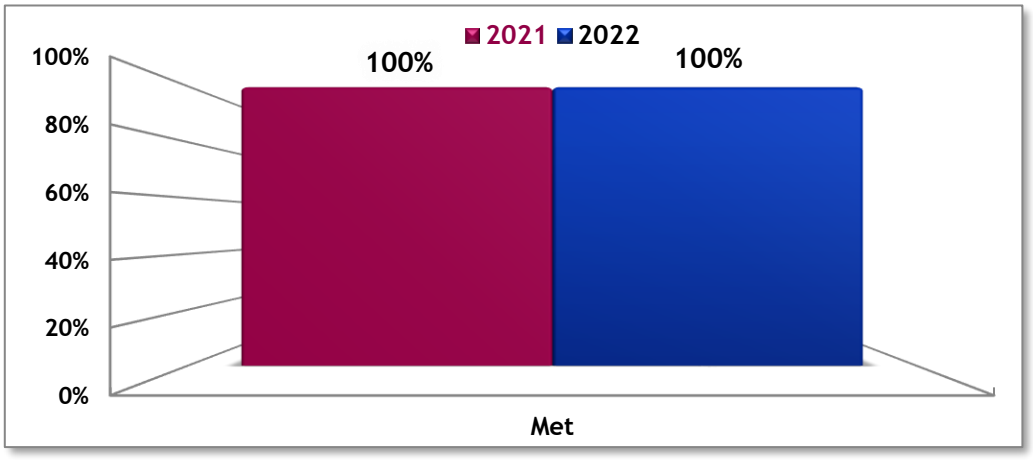
2021 EQR Appeals Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
2022 EQR Follow up: No Corrective Actions or Recommendations were issued in the 2021 EQR of Appeals.		

In the 2022 Appeals EQR, there are no Recommendations or Corrective Actions. Of the 10 files reviewed, six were standard, two were expedited/denied, one was invalid, and one was withdrawn. Both expedited requests were reviewed by the CMO and denied because there was not a health or safety issue that warranted the expedited process.

Both expedited/denied files were resolved with all required oral and written notifications provided and sent within two days. Files contained documentation of verification of guardianship for adult members who have guardians. All Appeals were resolved with resolution notification provided within 30 days and there were no timeliness deficiencies.

Figure 6 shows the 2022 EQR scores and compares those to the scores issued in the 2021 EQR.

Figure 6: Grievances and Appeals Comparative Findings



Strengths

- Trillium uses the Trillium Business System (TBS) software system to automate the Grievance and Appeal process, including generating acknowledgement and resolution letters.
- Trillium reported recent improvements to their internal Grievance monitoring process.

F. Program Integrity

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

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

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

Table 30: 2021 EQR Program Integrity Findings

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

In this EQR, it was noted Trillium's new CCO/GC joined the agency January 2022. The review of the Organization Chart showed Trillium's Unit Director in the Compliance Department is currently vacant. During the Onsite, Trillium staff clarified they are recruiting to fill the position and are evaluating the need to expand the SIU Department to meet demand if the need arises.

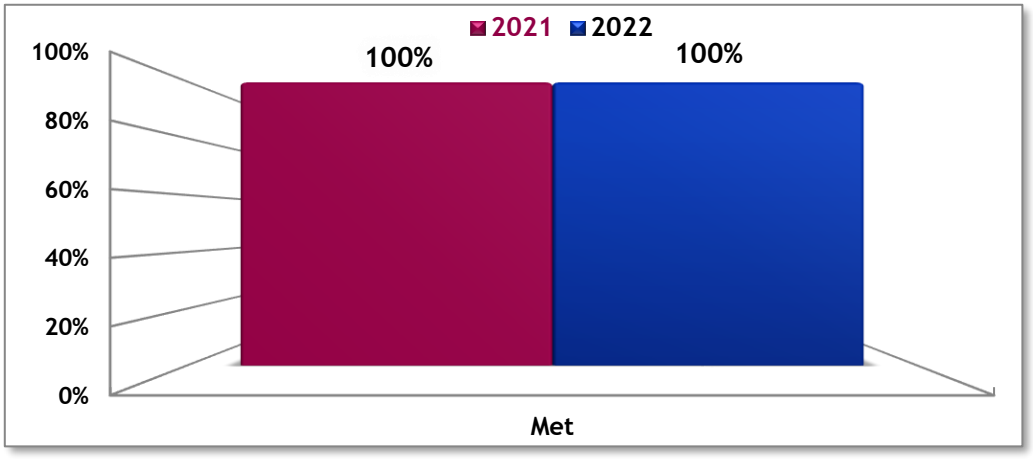
Trillium's Internal Communication Process for Provider Self-Audit Procedure outlines the provider self-audit process when that process is initiated by Trillium. During the Onsite,

Trillium clarified that procedure also outlines the process for self-audit findings initiated by the provider.

For this EQR, CCME reviewed 10 PI investigation cases for timeliness of investigations and to ensure all required elements documented in referrals to NC Medicaid. Review of the files showed all requirements were met and in accordance with Trillium's *NC Medicaid Contract* and procedures. During the 2022 Onsite, Trillium also shared they have implemented a 45-day case closure benchmark which contributes to the low number of investigations currently open. Other Strengths highlighted for this year's review include several improvements to Trillium's PI processes, including the increase of random sampling for Explanation of Benefits (EOB) distribution. Additionally, Trillium staff also reported a third-party vendor completed a risk assessment this past year and found Trillium's Compliance Department is operating at a high level with low risk.

Figure 7 shows the 2022 EQR scores and compares those to the scores issued in the 2021 EQR.

Figure 7: Program Integrity Comparative Findings



Strengths

- Trillium has implemented a 45-day investigation case closure benchmark which contributes to the low number of cases currently open.
- Trillium staff reported they have increased the sampling for Explanation of Benefits (EOB) distribution.
- Trillium staff also reported a third-party vendor completed a risk assessment in the past year and found Trillium's Compliance Department is operating at a high level with low risk.

G. Encounter Data Validation

The scope of our review, guided by the CMS Encounter Data Validation Protocol, focused on measuring the data quality and completeness of claims paid and submitted to NC Medicaid by Trillium for the period of January 2021 through December 2021. All claims paid by Trillium are expected to be submitted and accepted as valid encounters by NC Medicaid. Our approach to the review included:

- A review of Trillium's response to the Information Systems Capability Assessment (ISCA)
- Analysis of Trillium's Encounter Data elements
- A review of NC Medicaid 's Encounter Data acceptance report

Results and Recommendations

Issue: Additional Diagnosis Codes

Other Diagnosis codes were populated less than 18% of the time for Professional claims. This is similar to what was seen in 2021. The absence of Other Diagnosis codes does not appear to be a mapping issue within Trillium but may be driven by some providers' not coding beyond the Primary Diagnosis code. This value is not required by Trillium when adjudicating the claim. Therefore, certain providers may not be submitting Other Diagnosis codes even in cases where they are present when submitting claims via Provider Web Portal or 837P.

Recommendation:

Aqurate's analyses show some providers never submit Other Diagnosis codes. Trillium should work closely with their provider community and encourage them to submit all applicable Diagnosis codes, behavioral and medical. This information is key for measuring member health, identifying areas of risk, and evaluating quality of care.

Conclusion

The analyses of Trillium's Encounter Data showed the data submitted to NC Medicaid are complete and accurate. There is an issue with the Other Diagnosis codes that Trillium should review and perform outreach to providers that submit only the Primary Diagnosis codes. Overall, Trillium has corrected other issues identified in previous Encounter Data Validation reports and made significant strides in ensuring that they are submitting complete and accurate data to NC Medicaid.

Missing Other Diagnosis codes on Professional and Institutional claims do not impact the ability to price the claims, and, therefore, do not end up being reported as denials.

However, the lack of data may impact NC Medicaid's ability to provide proper oversight, including measurement of quality of care and setting appropriate fees and rates. Trillium is encouraged to work with its providers to make sure they are documenting and coding all diagnoses.

For the next review period, Aqurate is recommending the Encounter Data from NCTracks be reviewed for 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 Medicaid Management Information System (MMIS) is handling the encounter claims and could be reconciled back to reports requested from Trillium. The goal is to ensure Trillium is reporting all paid claims as encounters to NCTracks.

ATTACHMENTS

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

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

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

October 18, 2022

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

Dear Ms. Futrell,

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

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

The CMS EQR protocols can be found at:

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

Due to COVID-19 and the issuance of the contractual flexibilities issued by the State outlined in Contract Amendment #11, the 2022 EQR will be a focused review. The focus of this review will be on Trillium's Corrective Actions from the previous EQR and Trillium's functions that impact enrollee health and safety. Similarly, for the 2022 EQR, the two-day Onsite previously performed at Trillium's offices will be conducted during a one-day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **December 15, 2022**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

In preparation for the Desk Review, the items on the enclosed **Desk Materials List** are to be submitted electronically. **Please note that, to facilitate a timely review, there are three items on the Desk Materials List (items 9, 10, and 19.a) that should be submitted by no later than October 24, 2022,** and the remaining items are due by no later than **November 23, 2022**. Also, as indicated in item 20 of the Desk Materials List, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted with the other Desk Materials on **November 23, 2022**.

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

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

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 6
Cc: Kimberly Huneycutt, Trillium Director of Regulatory Affairs
Tasha Griffin, NC Medicaid Waiver Contract Manager
Deb Goda, NC Medicaid Associate Director, Behavioral Health and IDD
Christean Hunter, NC Medicaid Quality Management Specialist

Trillium Health Resources

Focused External Quality Review 2022

MATERIALS REQUESTED FOR DESK REVIEW

****Please note that the lists requested in items 9, 10, and 19.a must be uploaded by no later than October 24, 2022. The remaining items must be uploaded by no later than November 23, 2022.**

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

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

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

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

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

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

7. Minutes of committee meetings for the following committees:

   a) Credentialing (for the three most recent committee meetings)
   b) UM (for the three most recent committee meetings)

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

9. **By October 24, 2022, a copy of the complete Appeal log for the months of October 2021 through September 2022. Please indicate on the log: the Appeal type (standard, expedited, extended, withdrawn, or invalid), the service appealed, the date the Appeal was received, and the date of the Appeal resolution notification.

10. **By October 24, 2022, a copy of the complete Grievances log for the months of October 2021 through September 2022. Please indicate on the log: the nature of the Grievance, the date received, and the date of the Grievance resolution notification.

11. Copies of all Appeal notification templates used for expedited, invalid, extended, and withdrawn Appeals.
12. For Appeals and Grievances, please submit a description of your monitoring process that reviews compliance of oral and written notifications, completeness of documentation within the Appeal and Grievance records, accuracy of Appeal and Grievance logs, etc. Provide details regarding frequency of monitoring and any benchmarks, performance metrics, and reporting of monitoring outcomes.
13. Please submit a summary of new provider orientation processes and include a list of materials and training provided to new providers.
14. For MH/SUD, I/DD, and TCLI Care Coordination, please submit a description of your monitoring plan that reviews compliance of Care Coordinator documentation. Include in the description the elements reviewed (timeliness of progress notes, timeliness of Innovations monitoring, timeliness of Quality of Life surveys, review of quality, completeness of discharge notes, accuracy of documentation, etc.). Provide details regarding frequency of monitoring, and any benchmarks, performance metrics, and reporting of monitoring outcomes.
15. For Care Coordination enrollee files, please provide:
    a. three MH/SUD Care Coordination enrollee files (two active since 2020 and one recently discharged)
    b. three I/DD Care Coordination enrollee files (two active since 2020 and one recently discharged)
    c. four TCLI Care Coordination enrollee files (one active since 2020, one who received In-Reach, one who transitioned to the community and recently discharged).

    NOTE: Care Coordination enrollee files should include all progress notes, monitoring tools, Quality of Life surveys, and any notifications sent to the enrollees.
16. Information regarding the following selected Performance Measures:

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

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

Required information includes the following for each measure:

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

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

c. Reporting frequency and format;

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

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

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

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

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

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

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

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

18. Provide copies of the following files:

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

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

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

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

b. Insurance:

1. Proof of all required insurance, or a signed and dated statement/waiver/attestation from the practitioner/agency indicating why specific insurance coverage is not required.
2. For practitioners joining already-contracted agencies, include copies of the proof of insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.
   i. All PSVs conducted during the current process, including current supervision contracts for all LPAs and all provisionally-licensed practitioners (*i.e.*, LCAS-A, LCSW-A).
   ii. Ownership disclosure information/form.

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

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

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

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

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

ii. Insurance:

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

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

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

19. Provide the following for Program Integrity:

a. ****<u>File Review</u>:** Please produce a listing of all active files during the review period (October 2021 through September 2022) by October 24, 2022. The list should include the following information:

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

b. Program Integrity Plan and/or Compliance Plan.

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

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

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

f. Provider Manual and Provider Application.

g. Enrollee Handbook.

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

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

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

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

l. Code of Ethics and Business Conduct.

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

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

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

   i. NC Medicaid approved reporting templates.

p. Sample Data Mining Reports.

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

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

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

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

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

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

c. A copy of the IT Disaster Recovery Plan.

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

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

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

    a. Include all adjudicated claims (paid and denied) from January 1, 2021 – December 31, 2021. Follow the format used to submit encounter data to NC Medicaid (i.e., 837I and 837P). If you archive your outbound files to NC Medicaid, you can forward those to CCME for the specified time period. In addition, please convert each 837I and 837P to a pipe delimited text file or excel sheet using an EDI translator. If your EDI translator does not support this functionality, please reach out immediately to CCME.

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

NOTE: EDV information should also be submitted via CCME's SFTP. If you have any questions, please contact Kathy Niblock at kniblock@thecarolinascenter.org.

B. Attachment 2: EQR Validation Worksheets

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Improvement Project Validation Worksheet

PIHP Name:	**Trillium**
Name of PIP:	**DHB AND DMH MENTAL HEALTH 1-7 DAY FOLLOW-UP (CLINICAL)**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to processes of care and functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data values are reported for rate.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data are extracted from DMH HEARTS, NCTRACKs claims.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data extracted in a systematic manner.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are reported.

Component / Standard (Total Points)	Score	Comments
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is reported as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Informatics units runs report.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	DHB rates declined from 48.5% in Apr – Jun 22 to 38.6% in Jul -Sept 22. DMH rates decline from 21.7% to 18.5%. The goal is 45% and local data were used since validated State data were not available as of the report submission. ***Recommendation: Determine if in-process interventions including provider meetings, quarterly meetings with discharge providers, incentive contract, data sharing, provider education, and member engagement will allow for improvement in rates.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Rates did not improve.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not presented (not required as sampling was not utilized)
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the PIHP 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	The PIHP 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 Performance Improvement Project Validation Worksheet

PIHP Name:	**Trillium**
Name of PIP:	**SUPER MEASURE SU**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to processes of care and functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data values are reported and defined for rate.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data are NCTRACKS, NC Analytics warehouse.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data extracted in a systematic manner.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are reported.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is reported as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Informatics – Data Reporting team from the IT dept.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	DMH 2022 rates are reported. The most recent rate of 25.5% for July-Sept 22 was an improvement over the Apr – June 2022 rate of 24.3%. The goal is 45%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to the many interventions in place.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not presented (not required as sampling was not utilized)
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge as goal is not met.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the PIHP 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	The PIHP 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 Performance Improvement Project Validation Worksheet

PIHP Name:	**Trillium**
Name of PIP:	**ED UTILIZATION**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to processes of care.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data values are reported and defined for rates (three measures).
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data are from claims/encounters.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data extracted in a systematic manner.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are reported.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is reported as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	QM Senior Data Analyst.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters.

Component / Standard (Total Points)	Score	Comments
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	For measure #1 (reduce number to .66% or lower), the rate declined slightly from 1.48% in Jan-March 2022 to 1.46% in Apr-Jun 2022. For measure #2 (increase follow-up treatment percentage after ED visits to 80% or higher), the rate declined from 84.7% in Q1 22 to 82.28% in Q2 2022. For measure #3 (decrease number of IIH and ACTT members utilizing ED to 7.79% or lower), the rate improved (declined) from Q1 2022 at 8.58% to Q2 220 (8.11%). ***Recommendation: Continue to monitor now that Wellness Recovery Homes and SUD Host Homes are open to improve access to care and monitor ED dashboard and adding more*** tracking outcomes to determine if rates show more substantial improvement.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Improvement that occurred is very minimal, and thus, more data should be utilized to determine if face validity of improvement is a result of interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not presented (not required as sampling was not utilized)
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge as goal is not met.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the PIHP 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	The PIHP 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 Performance Improvement Project Validation Worksheet

PIHP Name:	**Trillium**
Name of PIP:	**MST UTILIZATION**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to processes of care and functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data values are reported for rate.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data are extracted from local claims and PH report.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data extracted in a systematic manner.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are reported.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is reported as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Informatics units runs report.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The most recent quarterly rate showed a rate of 5.63% which is a decline from the Jan-Mar 2022 rate of 9.03%. The goal is to increase the services rate to 14.7%. ***Recommendation: Determine if suggested interventions including member location analysis, MST service engagement/provider outreach, and staffing pattern review will improve the rate.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Rate did not improve.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not presented (not required as sampling was not utilized)
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the PIHP 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 Performance Improvement Project Validation Worksheet

PIHP Name:	**Trillium**
Name of PIP:	**TCLI 90 DAY CONTACT**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to processes of care and functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data values are reported and defined for rate.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data are from TCLD.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data extracted in a systematic manner.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are reported.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is reported as monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Data analyst in TCLI management staff.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Monthly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for monthly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several months
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The goal is 98%. The most recent rate improved from 90.5% in Sept 2022 to 91.7% in Oct 2022. This is still below the goal rate but is improving toward it after a low of 63.8% in June 2022.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to the many interventions in place or completed.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not presented (not required as sampling was not utilized)
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge as goal is not met.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the PIHP 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	The PIHP deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

C. Attachment 3: Tabular Spreadsheet

CCME PIHP Data Collection Tool

Plan Name:	**Trillium**
Collection Date:	2022

I. Information Systems Capabilities Assessment (ISCA)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I A. Management Information Systems						
1. Enrollment Systems						
1.1 The PIHP capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Trillium has standard processes in place for enrollment data updates. Trillium uploads the daily Global Eligibility File (GEF)files to the Trillium Business System (TBS) enrollment system. Trillium uses the monthly 820 file to verify Medicaid eligibility exists in TBS for all valid payments, to evaluate the validity of Medicaid eligibility in TBS where no payments are received, and to analyze the validity of recoupments on the 820 file. Demographic data is captured in the TBS system and patients IDs are unique to members. Historical enrollment information is captured and maintained for all members.
1.2 The PIHP is able to identify and review any errors identified during, or as a result, of the State enrollment file load process.	X					During the Onsite discussion, Trillium stated it captures and stores GEF records that are unable to be loaded to TBS. Trillium reported they have not encountered any errors in the past year.
1.3 The PIHP's enrollment system member screens store and track enrollment and demographic information.	X					During the Onsite, Trillium provided a live demonstration of its enrollment system (TBS). All historical data for members is stored and merged under one member ID.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Claims System						
2.1 The PIHP processes provider claims in an accurate and timely fashion.	X					The majority of claims received are electronic on a HIPAA file or through the provider web portal. Very few Emergency Department (ED) and Professional non-ED claims are received via. Approximately 99.81% of Professional claims and 98.83% of Institutional claims are auto adjudicated. Pended claims report is generated daily and reviewed to ensure all claims are adjudicated and removed from pend status.
2.2 The PIHP has processes and procedures in place to monitor review and audit claims staff.	X					Trillium has processes in place to routinely monitor and audit claims staff. Trillium audits a random sample of greater than 3% of all claims processed on a daily basis. High dollar claims greater than $5,000 are audited on a weekly basis. All claims processed by new hires are reviewed by Claims Supervisors and Managers.
2.3 The PIHP has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	X					During the Onsite review, Trillium demonstrated the TBS claims system and the capability of receiving and storing all ICD-10 Diagnosis codes. Trillium indicated ICD-10 Procedure codes, Revenue codes, and DRG codes are captured in the TBS system electronically and via the provider web portal. Up to 25 ICD-10 Diagnosis codes are captured via the web portal and up to 41 ICD-10 Diagnosis codes are captured via HIPAA files for Institutional claims. For Professional encounters, up to 12 ICD-10 Diagnosis codes are captured via Trillium's web portal and HIPAA files.
2.4 The PIHP's claim system screens store and track claim information and claim adjudication/payment information.	X					During the Onsite, Trillium demonstrated their provider web portal, claim system screens, and claim adjudication/payment information. Trillium demonstrated their claim systems ability to capture all the ICD-10 Diagnosis codes, DRGs, revenue codes, CPT/HCPCS, ICD-10 Procedure codes and adjudication information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Reporting						
3.1 The PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Trillium captures all required ICD-10 Diagnosis codes and is capable of capturing additional procedure, DRG, and Revenue codes are submitted on claims. Trillium stores the DRG and ICD-10 Procedure codes for reporting.
3.2 The PIHP has processes in place to back up the enrollment and claims data repositories.	X					During the Onsite discussion, Trillium stated they backup their servers and databases on a nightly basis. The Data Warehouse is loaded via SQL queries that check files for data completeness.
4. Encounter Data Submission						
4.1 The PIHP has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	X					Trillium submits all secondary ICD-10 Diagnosis codes for both Institutional and Professional encounters to NCTracks. DRG and ICD-10 Procedure codes are captured in the TBS system but are not submitted on Institutional encounters to NCTracks. Two Recommendations were issued in the 2020 and 2021 EQR to address this issue, but Trillium has not yet implemented a plan to correct these issues. ***Recommendation: Work with the providers to increase the number of ICD-10 Procedure codes submitted on a claim.*** ***Update Trillium's encounter data submission process to submit DRG codes on Institutional encounter data extracts to NCTracks.***
4.2 The PIHP has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					Trillium uses the incoming 835 and Truven files from NC Medicaid to identify and reconcile encounter data denials. Denied encounters are worked on by appropriate department for investigation and correction. During the Onsite discussion, Trillium stated their Business Systems team loads the Truven files with denied encounters to a database. The encounters are then sorted by the denial edit codes and assigned to the Provider Networks, Claims and Eligibility Staff.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.3 PIHP has policies and procedures in place to reconcile and resubmit encounter data denied by NC Medicaid.	X					Trillium has clear processes in place to address denied encounter submissions. Encounter denial reports were provided and ISCA documentation shows flow charts and procedures for encounter data submissions to NC Medicaid. Trillium has an encounter acceptance rate of 99.7%. Trillium has been able to maintain their high encounter acceptance rate since last year's EQR. Information in the ISCA regarding the average number of business days between initial denial and date encounters were accepted by NC Medicaid showed a marked increase from 2020 to 2021 (19 days in 2020 to 73 days in 2021). When discussed with Trillium staff, it was explained this delay is caused by a delay in provider response time. Trillium is actively providing providers technical support to help reduce this delay. ***Recommendation: Work with providers to help decrease response time, with the goal of reducing number of days between initial denial and date of resubmission and acceptance by NC Medicaid.***
4.4 The PIHP has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to NC Medicaid	X					As stated in the ISCA, Trillium has a workgroup that includes representatives from IT, Claims, Network, Utilization Management and Contracts and an Advisory Group that includes Managers and Directors from Claims, Contracts, Eligibility and Enrollment, Network, Utilization Management, and IT Departments that provides support and guidance to the Workgroup. The Advisory Group determines the reason for encounter denial to a functional area for addressing the denial. Trillium staff was able to speak to encounter data submissions and reconciliation process.

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 Committee By-Laws (By-Laws)* and several 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 and Re-credentialing Process procedure and the *By-Laws* define the roles and responsibilities of the Credentialing Committee. The Credentialing and Re-credentialing Process procedure states, "All potential applications must be approved for credentialing by either the Credentialing Committee or the Chief Medical Officer. The Chief Medical Officer oversees the Credentialing Program and has authority as delegated by the Credentialing Committee to approve Clean Applications." The procedure defines "red-flagged" applications and notes, "for red-flagged applications, the Credentialing Committee will make the final determination." The meeting minutes contain evidence of the committee discussion and decision-making. The Credentialing Committee meeting minutes indicate which members are "voting" members, which members are present, and the outcome of votes cast. However, as at the 2021 EQR, there is conflicting information across documents regarding voting membership, and there is no indication that a quorum is required to be present to conduct meetings, including votes on applications. Trillium made some revisions in the *Credentialing Committee Members List* and to the structure of the Credentialing Committee

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						meeting minutes but did not revise the Credentialing Committee By-Laws or the Credentialing and Re-Credentialing Process as recommended at the 2021 EQR. Per the direction of the NC Medicaid, credentialing has now shifted from the PIHPs completing credentialing and recredentialing to the PIHPs verifying credentialing completed by NCTracks. Trillium completed the in-process credentialing and recredentialing files in May 2022. Therefore, although the Recommendation from 2021 was only partially implemented, CCME is issuing no Recommendations in the 2022 EQR of Credentialing/ Recredentialing.
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Credentialing files reviewed for the EQR were organized and contained appropriate information. Several items were missing from the files submitted for Desk Review. Trillium submitted the items in response to CCME's request.
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
3.1.3 Valid DEA certificate; and/or CDS certificate	X					
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	X					
3.1.14 Names of hospitals at which the physician has admitting privileges if any	X					
3.1.15 Ownership Disclosure is addressed.	X					
3.1.16 Criminal background Check	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files reviewed for the EQR were organized and contained appropriate information. One file submitted for Desk Review was missing a couple of items, which Trillium submitted in response to CCME's request.

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

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.4 Review of provider profiling activities.	X					The Credentialing and Re-credentialing Process procedure states "Trillium staff collect information regarding the provider's performance within the network via the *Verification of Provider Standing* (VPS) form, for consideration during the recredentialing process." Collected information includes: "1. Site visit or desk review reports indicating compliance issues with network participation requirements 2. All substantiated quality of care complaints 3. Quality of service complaints/grievances" Completed VPS forms were in all recredentialing files reviewed for this EQR.
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 and Re-credentialing Process procedure states, "Re-credentialing may not be granted if terminated for quality of care issues." The Provider Sanctions procedure outlines the process of investigating violations or significant performance problems, 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					

III. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III. Quality Improvement						
III. A Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					All three validated (c) Waiver Measures were above the State benchmark rates. Two annual (c) Waiver measures had no rate reported due to COVID-19 PIHP Contract flexibilities. The overall validation scores for all Performance Measures (PMs) were in the Fully Compliant range, with an average validation score of 100% across the 10 (b) Waiver Measures. The (b) Waiver measure validation noted a substantial decline for one PM. ***Recommendation: Continue to monitor (b) Waiver performance measure rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the PMs.***
III. B Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					Trillium submitted five projects for this 2022 EQR, and all five were validated: Super Measure MH, Super Measure SU, TCLI 90-Day Contact, ED Utilization, and MST Utilization.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					All five validated Performance Improvement Projects (PIPs) scored in the High Confidence range, although three PIPs had sections with concerns that should be addressed by the Recommendations. ***Recommendations:*** • ***For the Supermeasure MH PIP: Determine if in-process interventions including provider meetings, quarterly meetings with discharge providers, incentive contract, data sharing, provider education, and member engagement will improve rates.*** • ***For the ED Utilization PIP: Continue to monitor now that Wellness Recovery Homes and SUD Host Homes are open to improve access to care. Monitor the ED dashboard which includes more tracking outcomes to determine if rates show more substantial improvement.*** • ***For the MST Utilization PIP: Determine if suggested interventions including member location analysis, MST service engagement/provider outreach, and staffing pattern review will improve the rate.***

IV. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. A Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					
2. The care coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					Trillium's Complex Case Management procedure details the process for assessing enrollee's needs. This procedure is in line with the requirements for assessment outlined in *NC Medicaid Contract, Section 6.11.3 (c).*
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.5 Quality monitoring and continuous quality improvement;	X					For the 2022 EQR, Trillium provided several documents describing their efforts to review Mental Health/Substance Use Disorder (MH/SUD) and Intellectual/Developmental Disability (I/DD) Care Manager documentation for compliance and quality improvement opportunities. Their processes include review of Care Manager performance on metrics such as timeliness of case contact notes and frequency of engagement and monitoring of enrollees. Additionally, Trillium provided documents describing departmental performance on a variety of metrics and performance goals. Examples, included: • Innovations' enrollee engagement with their Primary Care or preventive health service was 94.6% during the October 2021 to September 2022 period. • Follow up visits after an ED visit increased and achieved the goal of more than 80% for MH/SUD enrollees during the October 2021 to June 2022 period.
2.6 Determination of which Behavioral Health Services are medically necessary;	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					
2.8 Coordinate care with each Enrollee's provider;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.9 Provide follow-up activities for Enrollees;	X					
2.10 Ensure privacy for each Enrollee is protected.	X					
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					The *I/DD Monitoring Plan* reflects the service delivery monitoring requirements for residential services as outlined in *NC Medicaid Contract, Section 6.11.3 (h)* and *NC Clinical Coverage Policy 8P*.
3. The PIHP applies the Care Coordination policies and procedures as formulated.		X				In the 2021 EQR, Trillium selected and provided three MH/SUD and three I/DD enrollee files for the review. The review revealed compliance issues within Care Coordination documentation and engagement. CCME issued a Corrective Action to address these findings through improving management's process for reviewing enrollee files. In their 2021 Corrective Action Plan, Trillium responded by committing to establishing a more data-driven monitoring process, providing training to Care Coordinators around engagement and documentation expectations, and capitalizing on the reporting capabilities of their Care Management platform. This Corrective Action Plan was reviewed and approved by CCME in March of 2022. In the 2022 EQR, Trillium again selected three MH/SUD and three I/DD enrollee files for the review. Five of the six files reviewed showed an overall improvement in compliance from the 2021 EQR. However, one of the three I/DD files contained a pattern of compliance and engagement issues similar to those noted in the 2021 EQR.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						This I/DD file showed: • Late case contact notes: 45% of the case contact notes were submitted outside of 48 hours from the date of contact, as required by Trillium's *Care Management Monitoring Plan*. Two notes were submitted more than 18 days after the Care Manager's contact and one note, submitted five days after the contact on November 10, 2021, was cited as a late entry because "the next two days were holidays." However, no holiday occurred during the timeframe of the note. Further, Trillium's requirement for submission of case contact notes "within 48 hours" does not make an exception for holidays. • A lack of direct engagement and/or monitoring with the enrollee and guardian for over five months: While the *NC Medicaid 1915(c) Appendix K: Disaster Waiver Flexibilities* waives the face-to-face requirement for monitoring, the Appendix still requires at least monthly telephonic monitoring with individuals on the Innovations Waiver. Additionally, no contact was made or attempted with the legal guardian in these same five months. • Late notification to the county Department of Social Services (DSS) when the enrollee was discharged from the Innovations Waiver: *NC Medicaid Contract, Section 4, Enrollment, 4.6* requires Trillium to "notify the applicable county Department of Social Services within five (5) business days after PIHP becomes aware of changes to an Enrollee's circumstances that may affect eligibility." However, Trillium's notification to DSS in September 2022 occurred 22 days after the enrollee moved into an intermediate care facility, delaying the transition of the enrollee's Medicaid from Innovations for over a month.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The lack of any direct contact with this enrollee or the legal guardian for five months along with the delay in activating the enrollee's appropriate Medicaid posed potential health, safety, and access to care issues. Further, while Trillium reported in the 2022 EQR, the outcome of their review of enrollee files and Care Management performance is generally above 90%, one of the I/DD files they selected for this review showed significant performance issues, even in regard to timely contact documentation. CCME is again issuing a Corrective Action for Trillium to better identify and correct compliance issues, especially those related to a lack of engagement with enrollees and timely notification to DSS. ***Corrective Action: Enhance the current enrollee file review process to better identify and address trends of late case contact notes, gaps in engagement with enrollees, and required notifications to DSS when an enrollee discharges from the Innovations Waiver as required by NC Medicaid Contract, Section 4, Enrollment, 4.6.***
IV. B Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					The procedures and program descriptions specific to Transition to Community Living Initiative (TCLI) functions include: • Transition to Community Living In Reach Monitoring procedure • Transition to Community Living procedure • Care Management Program Description

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						• Person Centered Plan and Individual Support Plan procedure • Adult Care Home Resident Discharge Team procedure These procedures and descriptions were thoroughly reviewed and describe, at a high level, the TCLI processes and requirements as required by the US Department of Justice Settlement.
2.1 Care Coordination activities occur, as required.	X					For the 2022 EQR, Trillium provided several documents describing their efforts to review TCLI Care Manager documentation for compliance and quality improvement opportunities. Their processes include review of metrics such as timeliness of case contact notes and compliance with implementation of Quality of Life surveys. Trillium also reported performance on metrics such as the transition of 91 enrollees to housing and rehousing of 54 enrollees through the TCLI program during the October 2021 to September 2022 period.
2.2 Person Centered Plans are developed as required.	X					
2.3 Assertive Community Treatment, Peer Support, Supported Employment, Community Support Team, Psychosocial Rehabilitation, and other services as set forth in the DOJ Settlement are included in the individual's transition, if applicable.	X					Trillium's Transition to Community Living procedure outlines the expectation of TCLI staff to collaborate with providers who services such as Assertive Community Treatment Team (ACTT) services, Community Support Team (CST) services, Peer Support services, etc.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					
2.5 QOL Surveys are administered timely.	X					Trillium's Transition to Community Living procedure describes the requirements and timeframes for administering Quality of Life surveys.
3. Transition, diversion and discharge processes are in place for TCLI members as outlined in the DOJ Settlement and *DHHS Contract*.	X					
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.	X					
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.		X				In the 2022 EQR, Trillium selected and provided four TCLI files. Review of these files revealed all Quality of Life Surveys were implemented within the required timelines, and case contact notes were submitted within Trillium's requirement of 48 hours 94% of the time. However, one file showed a lack of engagement by TCLI Care Coordination following the enrollee's hospital admission for mental health. Trillium Care Coordination Procedure, Coordination of Services Following Hospitalization, requires Care Coordinators "ensure that members discharged from behavioral health inpatient facilities or residential services are seen within seven (7) calendar days." This file showed the enrollee was discharged from the Emergency Department and no contact with the enrollee was made or attempted for 29 days by Care Coordination. During the Onsite, this gap was reviewed with staff and no additional contacts or explanation were provided regarding this lack of follow up. As this lack of post-discharge engagement posed potential health, safety, and access to care issues for this enrollee, CCME is requiring additional action by Trillium to ensure adequate follow up care with enrollees hospitalized for mental health issues. ***Corrective Action: Enhance the current enrollee file review process to ensure enrollees are seen by a provider within seven days of their discharge, as required by Trillium's Procedure Care Coordination Procedure, Coordination of Services Following Hospitalization.***

V. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee Grievances in a manner consistent with contract requirements, including, but not limited to:						The Grievance Process and Scope procedure is the primary procedure that guides staff through the Grievance functions and requirements. The Complaint Process and Scope procedure is the primary procedure that guides staff through the Complaint functions and requirements.
1.1 Definition of a Grievance and who may file a Grievance;						Trillium defines a Grievance as, "any expression(s) of dissatisfaction about any matter other than an Adverse Benefit Determination filed by a member or by an individual who has been authorized in writing to file on behalf of a member." Trillium defines a Complaint as, "any expression of dissatisfaction about this organization or a provider when communicated by an external provider, stakeholder/organization, or family member who does not have written consent to file a Grievance on a member's behalf. Concerns filed about Trillium Health Resources by a member, guardian, or a member's authorized representative (with written authorization) do not fall within the scope of this procedure (Reference Grievance Process and Scope Procedure)."
1.2 The procedure for filing and handling a Grievance;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract;						In this 2022 EQR Grievance file review, all Grievances were resolved in accordance with *NC Medicaid Contract*, *Attachment M* and *42 CFR § 438.408 (b)(1)*. The Trillium Grievance Process and Scope procedure allows for a maximum resolution time of 90 days. Although, at the Onsite discussion, Trillium stated they strive to resolve Grievances within 30 days. For the 10 Grievance files reviewed for the 2022 EQR, all notifications were timely and compliant. Resolution notification letters were issued within 30 days for nine of the files and issued in 31 days for one file.
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;						In the Grievance file review, consultation with the Chief Medical Officer (CMO) was documented for every health and safety concern.
1.5 Maintenance of a Grievance log for oral Grievances and retention of this log and written records of disposition for the period specified in the contract.						Trillium's Grievance Process and Scope procedure states, "Trillium must provide for the retention of Grievance records for 10 years following a final decision", which exceeds the five-year timeframe required by the *NC Medicaid Contract, Attachment M, Section B.2*.
2. The PIHP applies the Grievance policy and procedure as formulated.						All 10 files reviewed showed the Grievance process followed the policies and procedures implemented at Trillium. Acknowledgement and resolution notifications were sent within the required timeframes. In nine of the files, Trillium issued the acknowledgement letter on the day the Grievance was received. In one file, Trillium issued the acknowledgement letter three days after receipt of the Grievance. Resolution notification letters were issued within 30 days for nine of the files and issued in 31 days for one file. Grievances that involved potential health and safety concerns were appropriately staffed by the CMO.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.						
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.						
V. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider Appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:						Trillium's procedure, Medicaid Clinical Reconsideration Process, is the primary procedure governing the Appeal process.
1.1 The definitions an Appeal and who may file an Appeal;						
1.2 The procedure for filing 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;						
1.4 A mechanism for expedited Appeal where the life or health of the enrollee would be jeopardized by delay;						
1.5 Timeliness guidelines for resolution of the Appeal as specified in the contract;						Resolution guidelines are specified in the Medicaid Clinical Reconsideration Process procedure.
1.6 Written notice of the Appeal resolution as required by the contract;						
1.7 Other requirements as specified in the contract.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP applies the Appeal policies and procedures as formulated.						Of the 10 files reviewed, six were standard, two were expedited/denied, one was invalid, and one was withdrawn. Both expedited requests were reviewed by the CMO and denied because there was not a health or safety issue that warranted the expedited process. Both expedited/denied files were resolved with all required oral and written notifications provided and sent within two days. Files contained documentation of verification of guardianship for adult members who have guardians. All Appeals were resolved with resolution notification provided within 30 days and there were no timeliness deficiencies.
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.						
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.						Trillium's Appeal procedure guides staff through the record release process. Additionally, all reviewed Appeal files included evidence of staff confirming guardianship prior to processing the Appeals or releasing the enrollee's Appeal record.

VI. PROGRAM INTEGRITY

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of *42 CFR 438.608* and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under NC Medicaid Contract in accordance with *42 CFR § 438.608(a)(1)(iv).*	X					Trillium's CCO/GC joined the organization in January 2022. According to the *Organizational Chart*, the CCO/GC reports directly to the Chief Executive Officer (CEO) and Board of Directors.
3. PIHP shall establish and implement a special investigation or program integrity unit.	X					Trillium has an established Special Investigation Unit (SIU). Since the last EQR, there has been one change in staff for the SIU. Currently, there are no open positions.
4. PIHP's written Compliance Plan shall, at a minimum include:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in *Section 1902 (a)(66)* of the *Social Security Act;*	X					
4.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing, and development of corrective action initiatives;	X					
4.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					
4.4 The PIHP supplies all data in a uniform format provided by NC Medicaid and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by the Division as provided in *NC Medicaid Contract Section 13.2-Monetary Penalties.*	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. In accordance with *42 CFR § 438.608 (a)(vii),* PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under *NC Medicaid Contract*, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under *NC Medicaid Contract*; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month.	X					
6. PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse.	X					
6.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure.	X					The 10 investigative case files reviewed in this EQR reflected Trillium's process for handling complaints from inception to closure. Of the 10 investigative cases, nine were closed, 66% of the cases were substantiated and 22% unfounded (i.e., not enough supporting evidence to determine outcome).
6.3 In accordance with Attachment Y - Audits/Self-Audits/investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					Trillium's Internal Communication Process for Provider Self-Audit Procedure outlines the provider self-audit process when that process initiated by Trillium. During the Onsite, Trillium clarified that procedure also outlines the process for self-audit findings initiated by the provider.
6.4 Process for tracking overpayments and collections based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on Attachment Y – Audits/Self Audits/investigations.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6.5 Process for handling self-audits and challenge audits.	X					
6.6 Process for using data mining to determine leads.	X					Trillium's Investigations of Fraud, Waste and Abuse Procedure describes Trillium's data mining processes. Trillium uses the Fraud and Abuse Management System (FAMS) to determine investigative leads. In this year's review, one case file reviewed in this EQR showed the investigation stemmed from FAMS analysis and Trillium's SIU substantiated the findings.
6.7 Process for informing PIHP employees, subcontractors, and providers regarding the *False Claims Act.*	X					
6.8 PIHP shall establish and maintain written policies for all employees, contractors, or agents that detail information about the *False Claims Act* and other federal and state laws as described in the *Social Security Act 1902 (a)(66)*, including information about rights of employees to be protected as whistleblowers.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid-standardized elements or a NC Medicaid-approved template;	X					Trillium's Member Explanation of Benefits (EOB) Detection of Fraud, Waste and Abuse Procedure outlines the use of EOBs to prevent and detect FWA. For the 2022 EQR, the EOB process was evident in one of the investigation case files reviewed in this EQR.
6.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available database or other search mechanism.	X					
7. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
8. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					For this EQR, CCME reviewed 10 Investigative case files. It was found that Trillium initiated all Investigative cases within 10 business days of receipt of the allegation.
9. In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						Three of the 10 Investigative case files reviewed in this EQR were referred to NC Medicaid. The review found the *DHB Program Integrity Referral* form was used to make the referrals. Additionally, the *PI Cases Listing 2021-2022* showed Trillium referred ten new cases to NC Medicaid for suspected FWA and four referrals providing additional information for potential FWA cases already under review by NC Medicaid.
9.1 Subject (name, Medicaid provider ID, address, provider type);	X					
9.2 Source/origin of complaint;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					
9.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated; and dates of suspected intentional misconduct;	X					
9.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					
9.6 All communications between PIHP and the Provider concerning the conduct at issue, when available.	X					
9.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.8.6 Legal and Administrative Status of Case	X					
10. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template.	X					Trillium had no enrollee fraud referrals to NC Medicaid during the period under review.
11. If PIHP uses FAMS, PIHP shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	X					
12. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP.	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Trillium's procedure, Internal Communication about Provider Payment Suspension from DHB, outlines the process for suspending and lifting Medicaid payments to providers based on instructions given by the Division of Health Benefits (NC Medicaid).
2. Upon receipt of a payment suspension notice from NC Medicaid Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of NC Medicaid Program Integrity's suspension and lasting until PIHP is notified by NC Medicaid Program Integrity in writing that the suspension has been lifted.	X					
3. PIHP shall provide to NC Medicaid all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid Program Integrity due to allegations of suspected fraud without prior written approval from NC Medicaid Program Integrity or the MFCU/MID.	X					

D. Attachment 4: Encounter Data Validation Report

Table of Contents

This page was intentionally left blank.

Background

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

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

Overview

The scope of the review, guided by the Centers for Medicare and Medicaid Services (CMS) External Quality Review Protocol for Encounter Data Validation, focused on measuring the data quality and completeness of claims paid and submitted to NCTracks by Trillium for the period of January 2021 through December 2021. All claims paid by Trillium are expected to be submitted and accepted as valid encounters by NCTracks. The approach to the review included:

- A review of Trillium's response to the Information Systems Capability Assessment (ISCA)
- Analysis of Trillium's Encounter Data elements
- A review of NC Medicaid'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. NC Medicaid requires each PIHP to submit their Encounter Data for all paid claims on a weekly basis via 837 Institutional and Professional transactions. The companion guides follow the standard ASC X12 transaction set with a few modifications to some segments. For example, the PIHP must submit their provider number and paid amount to NCTracks in the Contract Information CN104 and CN102 segment of Claim Information Loop 2300.

The 837 files are transmitted securely to NCTracks and parsed using an EDI validator to check for errors and produce a 999 response to confirm receipt and any compliance errors. The encounter claims are then validated by applying a list of edits provided by the state (See Appendix 1) and adjudicated accordingly by NCTracks. Utilizing existing Medicaid pricing methodology, 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 NCTracks edits marked as "DENY" in Appendix 1.

Based on claims with dates of service in 2021, Trillium submitted 1,309,258 unique encounters to the State. To date, 0.57% of all encounters submitted in 2021 have not been corrected and accepted by NCTracks. This figure represents continued improvement since 2018.

2021	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
Institutional	50,190	49,351	478	361	0.72%
Professional	1,259,068	1,226,915	25,003	7,150	0.57%
Total	1,309,258	1,276,266	25,481	7,511	0.57%

Trillium has made significant improvements to their encounter submission process, increasing their acceptance rate and quality of Encounter Data year over year. The table below reflects the increase in acceptance rate from 92% to 99.43% between 2017 and 2021, well above NC Medicaid 's expectations. Trillium’s high acceptance rate is even more notable when factoring in the increase in number of encounters over the past few years.

Year of Service	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
2017	874,434	735,008	70,931	68,495	7.83%
2018	949,025	919,907	16,897	12,221	1.29%
2019	1,119,305	1,117,926	640	739	0.07%
2020	1,251,381	1,240,165	6,922	4,294	0.34%
2021	1,309,258	1,276,266	25,481	7,511	0.57%

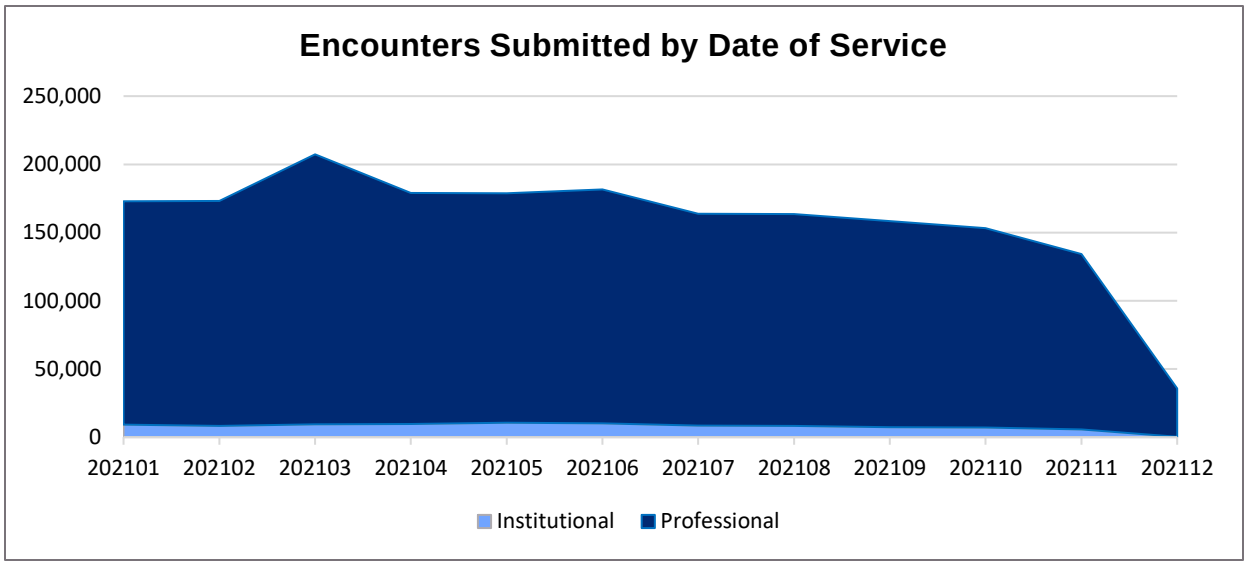
During the Onsite, Trillium provided an overview of the protocols they follow to submit Encounter Data and the follow up on denied encounters. Over the past few years, Trillium has implemented an efficient process for reviewing the denials and making the necessary changes to various parts of their information systems to prevent future encounter submissions from denying for the same denial reasons. Trillium enacts such changes very rapidly and much of that is owed to the Trillium staff who coordinate well and act swiftly to review the denials, identify root cause issues, and implement changes to stem the issues that are flagged by NCTracks.

In order to reduce the number of denied encounters going forward, Trillium continues to work on the timing of the void submissions and re-processed claims as well as provider education for taxonomy codes. Trillium continues to apply the following strategy laid out in prior reviews.

- Automate process for resending marked claims ready for resubmission
- Reviewing the denials and denial reasons to determine root cause issues
- Update claim edits to synchronize with NCTracks
- Enhance process to compare provider records based on Global Provider File (GPF) received from NC Medicaid to identify system differences
- Trillium Provider Network staff provide ongoing training to providers
- 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 NC Medicaid for all claims paid between January 1, 2021, and December 31, 2021. Trillium worked with their EDI vendor to convert each 837I and 837P file submitted to NCTracks during the requested audit period to an excel spreadsheet and sent to Aqurate via SFTP. This included 1,807,854 Professional and 93,833 Institutional claim lines. The files submitted during 2021 also contained resubmissions of older dates of service and line level details. Therefore, these figures are expected to differ from Trillium's ISCA responses, which summarizes at the claim header level. The graph below represents the dates of services of all claims submitted to NCTracks in 2021.



In order to evaluate the data, Aqurate processed and combined all batch encounter files and loaded them to a consolidated database. After data onboarding was completed, Aqurate 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 table below depicts the specific data expectations and validity criteria applied.

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Recipient ID	Should be valid ID as found in the State's eligibility file. Can use State's ID unless State also accepts Social Security Number.	100% valid. Medicaid IDs are 9 numeric long followed by 1 alpha.
Recipient Name	Should be captured in such a way that makes separating pieces of name easy. Expect data to be present and of good quality	85% present. Lengths may vary, but there should be at least some last names of >8 digits and some first names of < 8 digits, validating that fields have not been truncated.
Recipient Date of Birth	Should not be missing and should be a valid date.	Existence of a valid date

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
PIHP ID	Critical Data Element	100% valid for PIHP
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	10 digits
Attending Provider ID	Should be an enrolled provider listed in the provider enrollment file (will accept the MD license number if it is listed in the provider enrollment file).	> 85% match with provider file using either provider ID or MD license number. 10 digits
Provider Location	Minimal requirement is county code, but zip code is strongly advised.	> 95% with valid county code > 95% with valid zip code (if available)
Place of Service	Should be routinely coded, especially for physicians.	> 95% valid for physicians > 80% valid across all providers Standard UB POS
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% non-missing and valid on physician or other applicable provider type claims (e.g., other practitioners). This is the taxonomy code and is a standard code set.
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid ICD codes for practitioner providers. Codes should be within standard ICD 9 and 10 code sets. ICD-9s have generally stopped appearing on files for current records.
Other Diagnosis	This is not expected to be coded on all claims even with applicable provider types but should be coded with a fairly high frequency.	90% valid when present. Codes should be within standard ICD 9 and 10 code sets. ICD-9s have generally stopped appearing on files for current records.

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Dates of Service	Dates should be evenly distributed across time.	Valid date Dates spread throughout reporting year.
Unit of Service (Quantity)	The number should be routinely coded.	The number should be routinely coded. Current Procedural Terminology (CPT) code is in 99200–99215 or 99241–99291 range.
Procedure Code	Critical Data Element	There should be a wide range of procedures appropriate for the services covered by the PIHP
Procedure Code Modifier	Important to separate out surgical procedures/ anesthesia/assistant surgeon, not applicable for all procedure codes.	Expect a variety of modifiers both numeric (CPT) and Alpha (Healthcare Common Procedure Coding System [HCPCS])
Patient Discharge Status Code (Hospital)	Should be valid codes for inpatient claims, with the most common code being “Discharged to Home.” For outpatient claims, the code can be “not applicable.”	Expect a variety of values, with "Discharge to Home" being most common, and includes "Still-in" and transfers
Revenue Code	If the facility uses a UB04 claim form, this should always be present	Valid code is present

Encounter Accuracy and Completeness

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

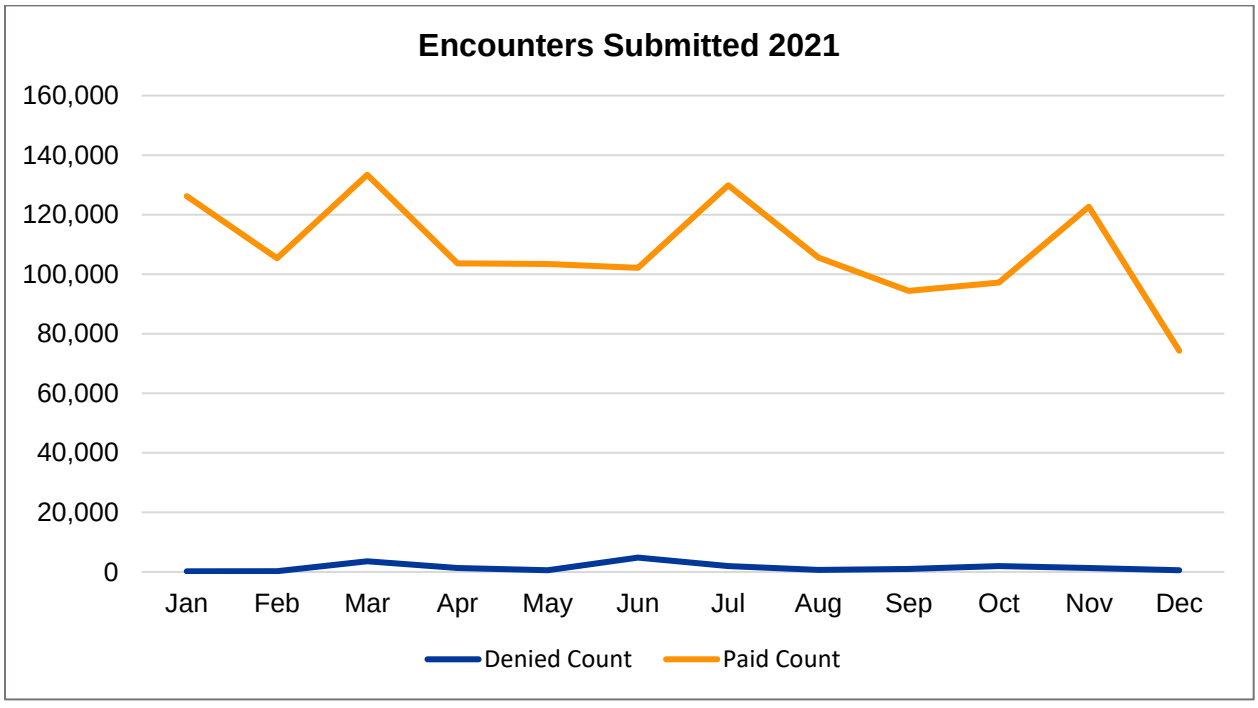
Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%
Recipient Name	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%
Recipient Date of Birth	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%
PIHP ID	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%
Provider ID	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%
Attending/Rendering Provider ID	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%
Provider Location	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%
Place of Service	2,112,118	100.00%	2,112,118	100.00%	2,112,118	100.00%	2,112,118	100.00%
Specialty Code / Taxonomy - Billing	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%
Specialty Code / Taxonomy - Rendering / Attending	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%
Principal Diagnosis	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%
Other Diagnosis	422,949	20.03%	422,949	20.03%	422,949	20.03%	422,949	20.03%
Dates of Service	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%
Unit of Service (Quantity)	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%	2,112,124	100.00%
Procedure Code	2,063,050	97.68%	2,063,050	97.68%	2,063,050	97.68%	2,063,050	97.68%
Procedure Code Modifier	1,676,705	79.39%	1,676,705	79.39%	1,676,705	79.39%	1,676,705	79.39%
Patient Discharge Status Code Inpatient	107,401	100.00%	107,401	100.00%	107,401	100.00%	107,401	100.00%
Revenue Code	107,401	100.00%	107,401	100.00%	107,401	100.00%	107,401	100.00%

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 NC Medicaid's encounter acceptance report. Institutional claims contained complete and valid data in 15 of the 18 key fields (83.3%). The Other Diagnosis code field was populated 62%, and the Procedure code field was populated only 54.3% of the time. Procedure code modifiers were present only 23% of the time.

Professional encounter claims submitted contained complete and valid data in 14 of the 16 key Professional fields (88%). The primary issue identified for professional claims involved Other Diagnosis codes being populated infrequently (under 18%). Minor issues were also noted with procedure code modifier not being present.

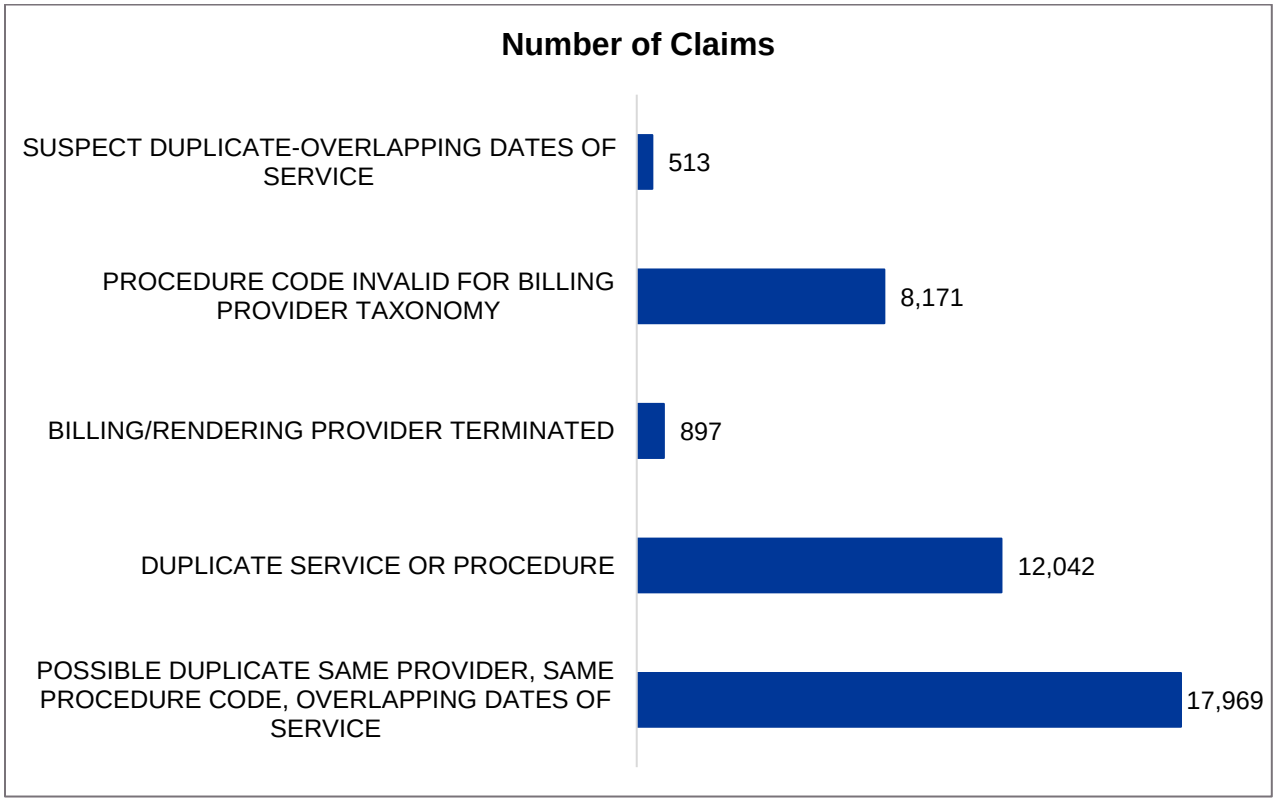
Encounter Acceptance Report

In addition to performing evaluation of the Encounter Data submitted, Aqurate reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write and excludes duplicate or resubmitted claims which made it difficult to tie back to the ISCA response as some of the submissions were for dates of services prior to 2021. Additionally, the converted encounter 837 files we receive from PIHPs contain claim line level details, which increases the number of records compared to ISCA responses and some DMA reports which report results at the claim header level. During the 2021 weekly check write schedule, Trillium submitted a total of 1,316,791 encounters to NCTracks. Overall, 1.40% of all encounters submitted were denied.

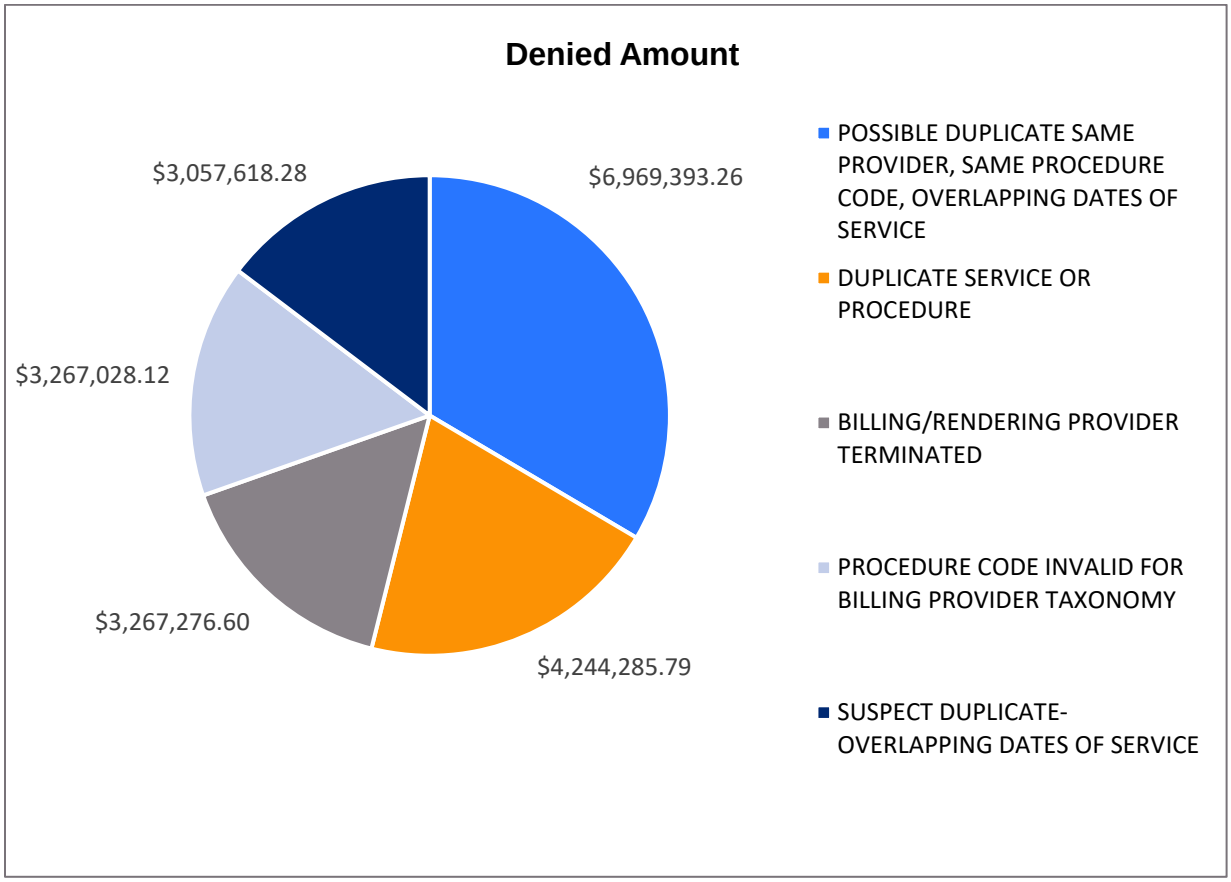


Evaluation of the top denials for Trillium encounters correlates with the data deficiencies identified by the Aqurate analyst in the Key Field analysis above. Encounters were denied primarily for:

- Suspect duplicate-overlapping dates of service
- Procedure code invalid for billing provider Taxonomy
- Billing/rendering Provider terminated
- Duplicate service or procedure
- Possible duplicate same provider, same procedure, overlapping dates of service



The chart below reflects the top 5 denials by paid amount.



Results and Recommendations

Issue: Additional Diagnosis Codes

Other Diagnosis codes were populated less than 18% of the time for Professional claims. This is similar to what was seen in 2021. The absence of Other Diagnosis codes does not appear to be a mapping issue within Trillium but likely driven by some providers' not coding beyond the Primary Diagnosis code. This value is not required by Trillium when adjudicating the claim, therefore, certain providers may not be submitting Other Diagnosis codes even in cases where they are present when submitting claims via Provider Web Portal or 837P.

Recommendation:

Aqurate's analyses shows some providers never submit Other Diagnosis codes. Trillium should work closely with their provider community and encourage them to submit all applicable Diagnosis codes, behavioral and medical. This information is key for measuring member health, identifying areas of risk, and evaluating quality of care.

Conclusion

The analyses of Trillium's Encounter Data showed the data submitted to NC Medicaid are complete and accurate. There is an issue with the Other Diagnosis codes that Trillium should review and perform outreach to providers that submit only the Primary Diagnosis codes. Overall, Trillium has corrected other issues identified in previous Encounter Data Validation reports and made significant strides in ensuring that they are submitting complete and accurate data to NC Medicaid.

Missing Other Diagnosis codes on Professional and Institutional claims do not impact the ability to price the claims, and, therefore, do not end up being reported as denials. However, the lack of data may impact NC Medicaid's ability to provide proper oversight, including measurement of quality of care and setting appropriate fees and rates. Trillium is encouraged to work with its providers to make sure they are documenting and coding all diagnoses.

For the next review period, Aqurate is recommending the Encounter Data from NCTracks be reviewed for 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 Medicaid Management Information System (MMIS) is handling the encounter claims and could be reconciled back to reports requested from Trillium. The goal is to ensure Trillium is reporting all paid claims as encounters to NCTracks.

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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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 NC MEDICAID 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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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