CCME

2021 External Quality Review

TRILLIUM HEALTH RESOURCES

Submitted: January 21, 2022

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 the Trillium Health Resources (Trillium). This report contains a description of the process and the results of the 2021 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of 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 EQR process is 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 a Medicaid program integrity review of the PIHP.

A. Overall Findings

Federal regulations require MCOs 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 are 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 a COVID-19 flexibilities PIHP Contract Amendment #9. This PIHP contract 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 evaluation of the PIHP's health systems capabilities and provider credentialing and recredentialing documentation and processes. The review includes validation of the PIHP's Performance Improvement Projects, Performance Measures, and Encounter data. Lastly, a thorough review of the PIHP's Utilization Management, Grievances, and Appeals processes were conducted. What was not reviewed were 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).

To access Trillium's compliance with federal regulations and their contract with NC Medicaid, CCME's review was divided into eight 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. The following provides a global or high-level summary of the status of the Recommendations and Corrective Action items from the 2020 EQR and 2021 EQR findings. 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 2020 EQR, Trillium met 100% of the Administration standards and received three Recommendations. During the Onsite, Trillium stated the two Recommendations from the 2020 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 EQR Recommendations in the 2021 EQR Recommendations. The third Recommendation related to historical claims that were pending resubmission. This issue was first identified during the 2018 EQR. During the Onsite, Trillium clarified NC Medicaid advised them regarding encounters prior to July 1, 2015. These historical, denied encounters cannot be resubmitted and should be removed from any future EQR compliance findings.

Outside of these two Recommendations carried over from the 2020 EQR, Trillium met 100% of the Administration standards in the 2021 EQR.

Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

In the 2020 EQR of Trillium's Credentialing/Recredentialing, 100% of the standards in the Provider Services review were scored as "Met", and no Corrective Actions were issued. CCME issued a Recommendation in the "Ownership Disclosure is addressed" standard in both the Credentialing and Recredentialing sections. Trillium addressed both Recommendations.

In the 2021 EQR, Trillium met 100% of the Credentialing/Recredentialing standards. CCME issued no Corrective Actions. There is conflicting information across documents regarding voting membership and the determination of adequate voting membership attendance for conducting committee meetings including voting on applications. CCME issued a Recommendation to reconcile documents to accurately reflect voting membership of the Credentialing Committee and to clarify the requirements to conduct meetings, including votes on applications.

Quality Improvement

42 CFR § 438.330

In the 2020 EQR, Trillium met 100% of the Quality standards and received three Recommendations related to three PIPs that were validated. All three Recommendations were implemented.

For the 2021 EQR, Trillium met all standards with no Corrective Actions. There are three Recommendations regarding the assessment of interventions and consideration for additional interventions to improve PIP rates, which were validated in the High Confidence range.

In the 2021 EQR, Trillium was Fully Compliant for (b) Waiver and (c) Waiver PMs, but three (b) Waiver PMs showed a decline in rate compared to the previous measurement year. CCME issued a Recommendation for monitoring to determine if rates with substantial improvement or decline represent trends or anomalies in the PMs.

Utilization Management

42 CFR § 438.208

In the 2020 EQR, Trillium met 100% of Utilization Management (UM) standards and received five Recommendations. One Recommendation encouraged Trillium to revise the Complex Case Management procedure to reflect the age requirement for Children with Complex Needs, as listed in the *NC Medicaid Contract*. Two Recommendations targeted the issues noted in the review of Care Management files and encouraged Trillium to implement a data-driven process to better identify compliance issues within Care Management documentation. The remaining two Recommendations aimed to improve

Individual/Developmental Disabilities (I/DD) service delivery monitoring and TCLI case notes to ensure compliance with Trillium's documentation requirements and the *NC Medicaid Contract Section 6.11.3 (h)* monitoring requirements. Trillium implemented all five Recommendations.

In the 2021 EQR, Trillium met 98% of UM standards. The review of Mental Health/Substance Use Disorder (MH/SUD) and I/DD enrollee files found case notes that lacked clarity, accuracy, included the Private Health Information of other enrollees, and did not include all Care Manager activities. Additionally, annual treatment team meeting dates on ISPs did not match activities documented in case notes. In another file, it was discovered that no follow up or engagement occurred with an enrollee who was hospitalized twice during a 46-day period. CCME has issued one Corrective Action for Trillium to enhance the current compliance review of I/DD and MH/SUD Care Management documentation to include a data-driven approach and better identify areas needing improvement.

Grievances and Appeals

42 CFR § 438, Subpart F, 42 CFR 483.430

In the 2020 EQR, Trillium met 90% of the Grievance and Appeal standards and received three Corrective Actions and one Recommendation in Grievances and one Corrective Action and four Recommendations in Appeals. In the 2020 Grievances EQR, the Corrective Actions and Recommendation issued primarily targeted incorrect and missing language within Trillium's Grievance procedure and Complaint procedure. In the 2020 Appeals EQR, the Corrective Action issued required Trillium to add language to the Appeals procedure outlining the process by which staff release the Appeal record, while also protecting the enrollee's PHI. The four Recommendations issued in the 2020 Appeals EQR aimed to correct Appeal information in *Trillium Health Resources Provider Manual* and the *Trillium Health Resources Member and Recipient Handbook* and to bolster the process Trillium uses to monitor Appeal files for compliance issues. In the 2021 EQR, there is evidence that Trillium implemented all Recommendations and Corrective Actions issued in the 2020 EQR.

In the 2021 Grievances EQR, Trillium met 100% of the Grievance and Appeal standards. A review of all 10 files showed Grievance 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 these consultations were documented within the Grievance. There were no Corrective Actions or Recommendations issued by CCME regarding Trillium's processes and procedures around Grievances.

Throughout the 10 Appeal files reviewed for the 2021 EQR, there was an overall improvement when compared to the last EQR. The files showed all Appeal notifications were issued within the required timeframes, and guardianship was routinely checked and

documented in the Appeal file. CCME issued no Corrective Actions or Recommendations regarding Trillium's Appeal processes and procedures.

Program Integrity

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

In the 2020 and 2021 EQRs, Trillium met 100% of the Program Integrity (PI) standards and no Corrective Actions or Recommendations were issued in this year's EQR. In the 2021 Desk Review, it was noted that Trillium's Chief Compliance Officer (CCO) was currently vacant but filled on an interim basis by Trillium's Internal Compliance and Medicaid Contract Manager. During the Onsite, Trillium staff stated Trillium is on target to hire a new CCO by February 1, 2022.

During the Onsite, Trillium also described their increased efforts in PI outreach and education to enrollees and providers. This effort resulted in an increase of external referrals, and Trillium's current ration of external to internal referrals is almost an even split of internal (48.1%) and external (49.4%) referral sources for possible fraud, waste, and abuse cases.

Trillium case files were well documented and consistently organized. A review of Trillium's PI case report confirmed all but one case have been closed. Final reports were detailed and organized, and where applicable, referrals to NC Medicaid were complete and contained all investigative elements required by *NC Medicaid Contract, Section 14.29*.

Encounter Data Validation

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

There is a minor issue with the Other Diagnosis codes that Trillium should review and perform outreach to providers who submit only the Primary Diagnosis codes. Overall, Trillium has corrected all 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.

For the next review period, HMS recommends a review of the encounter data from NCTracks to look at encounters that pass front end edits and are adjudicated to either a paid or denied status. It is difficult to reconcile the various tracking reports with the data submitted by the PIHP. Reviewing an extract from NCTracks would provide insight into how the 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 that Trillium is reporting all paid claims as encounters to NC Medicaid.

2020 EQR Corrective Actions

During the previous EQR, there were two standards scored as "Partially Met" and no standard scored as "Not Met". Following the 2020 EQR, Trillium submitted a Corrective Action Plan to address the identified deficiencies. CCME reviewed and accepted Trillium's Corrective Action Plan on July 21, 2021. The following is a high-level summary of those deficiencies:

- Neither the Grievance procedure nor the Complaint procedure include the notifications required when Trillium extends the Grievance or Complaint resolution timeframe (per *42 CFR § 438.408 (c)*.
- Trillium's Appeal procedure does not detail the steps staff should take to protect the enrollee's PHI when releasing the Appeal record.

During the current EQR, CCME assessed the degree to which Trillium implemented the actions to address these deficiencies and found the 2020 EQR Corrective Action Plan was implemented. The following Corrective Actions were implemented by Trillium:

- Both the Complaint and Grievance Procedures have been revised to correct the issues identified in the Corrective Action Plan.
- The Appeal procedure has been revised, referencing the "Member Access to Protected Health Information" procedure. Further, the Appeal files reviewed in the 2021 EQR showed staff taking steps required by the "Member Access to Protected Health Information" procedure.

In additional details regarding the PIHP's 2020 Corrective Actions Plan, the PIHP's response and evidence, or lack thereof, of PIHP implementation of the 2020 Corrective Actions are detailed in the respective sections of this report.

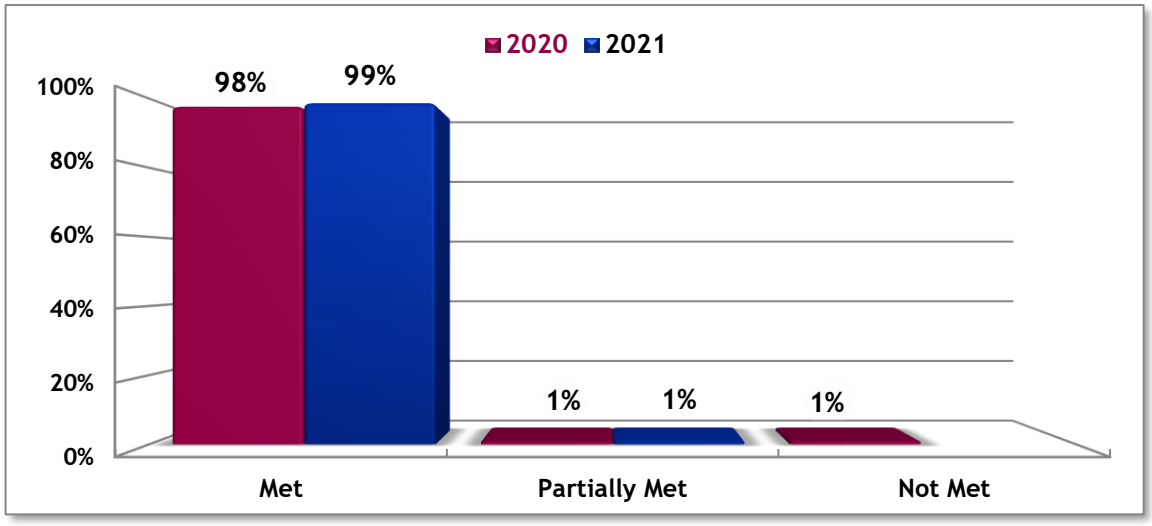
Conclusions

Overall, Trillium has met the requirements set forth in their contract with NC Medicaid. The 2021 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 2020 review.

B. Overall Score

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

Figure 1: Annual EQR Comparative Results



The following is a summary of 2021 EQR key findings and Recommendations or opportunities for improvement. Specific details of strengths, Weaknesses, and Recommendations can be found in the sections that follow below.

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

	Strengths	Weaknesses	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 Diagnosis Related Group (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	Recommendations
	All PIPs were in the High Confidence range.	There is conflicting information across documents regarding voting membership and the determination of adequate voting membership attendance for conducting committee meetings, including voting on applications.	***Recommendation: Reconcile documents to accurately reflect voting membership of the Credentialing Committee and to clarify the requirements to conduct meetings, including votes on applications.***
	Trillium has received full Management Behavioral Health Organization (MBHO) accreditation from NCQA.	The (b) Waiver measure validation noted substantial decline for three Performance Measures (PMs).	***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.***
	Interdepartmental coordination was evident in the Grievance and Appeal files reviewed.	PIP rates did not improve for three of the validated PIPs.	***Recommendations:*** • ***Super Measure MH PIP: Continue with analysis of validated State data once available to determine if improvement did occur for finalized rates*** • ***Super Measure SU PIP: Continue with current active interventions including RRT and Opioid Treatment Centers and examine rate after review of State validated data*** • ***Utilization of ED PIP: Determine if specific processes at discharge or member education would improve the rate for Indicator #2 and increase follow-up treatment to 80% goal.***
	Trillium has provided increased outreach and education to its members and providers leading to increased external Program Integrity referrals.		

	Strengths	Weaknesses	Recommendations
Timeliness	Trillium auto-adjudicates claims; 98.87% of Institutional claims and 99.86% of Professional claims.		
	Trillium has demonstrated a strong commitment to the timely investigation of all cases of possible fraud, waste, and abuse evidenced by a 98.8% closure rate during the review period.		
Access to Care	There is a separate toll free Provider Support Service Line and a separate toll free number for administrative and business matters.	Trillium's process for reviewing MH/SUD and I/DD Care Management documentation is not adequately identifying compliance issues within the enrollee record.	***Corrective Actions:*** • ***Implement an enhanced compliance review that routinely reviews Care Management documentation*** • ***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.***
	Credentialing and recredentialing files contain checklists to help guide the process.		
	Trillium applies a whole-person Care Management approach to ensure enrollees' physical and behavioral health needs are met.		
	The review of TCLI files for this EQR found that Trillium's procedures and NC TCLI Manuals are being followed.		

METHODOLOGY

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

On November 1, 2021, 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, Trillium was invited 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 November 23, 2021 and reviewed by CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. The Desk Review also included a review of Credentialing, Grievance, Utilization, Care Coordination, and Appeal files.

The second segment of the EQR is typically a two-day, Onsite review conducted at the PIHP's offices. However, due to COVID-19, this Onsite was conducted through a teleconference platform on December 16, 2021. This Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's Onsite activities included:

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

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

FINDINGS

The findings of the EQR are summarized in the following pages of this report and are based on the regulations set forth in *42 CFR § 438.358* and the *NC Medicaid Contract* requirements between 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. Information Systems Capabilities Assessment (ISCA)

42 CFR § 438.224 and 42 CFR § 438.242

The review of Trillium's systems capabilities involves 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 Medicaid and Medicare Services (CMS) protocol. During the Onsite, Trillium staff presented a live demonstration of member and claims systems capabilities. Trillium addressed questions regarding Trillium's responses on the ISCA tool.

In the 2020 EQR, Trillium met 100% of the Administrative standards and received three Recommendations. During the Onsite, Trillium stated the two Recommendations from the 2020 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 EQR Recommendations in the 2021 EQR Recommendations. The third Recommendation related to historical claims that were pending resubmission. This issue was first identified during the 2018 EQR. During the Onsite, Trillium clarified NC Medicaid advised them regarding encounters prior to July 1, 2015. These historical, denied encounters cannot be resubmitted and should be removed from any future EQR compliance findings.

Table 2, outlines the Recommendations issued to Trillium in the 2020 EQR and CCME's follow up in the 2021 EQR.

Table 2: 2020 EQR Administrative Findings

2020 EQR Administrative Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	ICD-10 Procedure codes and Diagnosis Related Group (DRG) codes received from the provider can be captured. However, currently Trillium does not receive ICD-10 Procedure codes on claims from providers. ***Recommendation: Work with the providers to increase the number of ICD-10 Procedure codes submitted on a claim.***	**N**
2021 EQR follow-up: During the Onsite, Trillium stated this Recommendation is on their task to-do list, but has not yet been implemented.		
The MCO has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	DRG codes are captured in the Trillium's TBS system, but are not included for encounter data submissions. ***Recommendation: Update Trillium's encounter data submission process to submit DRG codes on Institutional encounter data extracts to NCTracks.***	N
2021 EQR follow-up: During the Onsite, Trillium stated this Recommendation is on their task to-do list, but has not yet been implemented.		

Trillium uses the Trillium Business System (TBS) to process member enrollment, claims, submit 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.

The ISCA tool and supporting documentation clearly define the process for enrollment data updates in the TBS enrollment system. The system maintains a member's enrollment history. The Global Eligibility File (GEF) file is imported daily into the TBS. During the Onsite, Trillium indicated they did not encounter any errors during the GEF file upload in the past year. Trillium staff stated their Eligibility Specialist manually updates the member's demographic information in TBS.

Trillium stores the Medicaid identification number received on the GEF. During the Onsite, staff stated they rarely see members with multiple IDs but are able to research and merge the information into one Member ID when this occurs. The historical claims for the member are also merged into one Member ID.

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

Table 3: Enrollment Counts

2018	2019	2020
248,932	217,876	234,069

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 during the Onsite.

Trillium receives claims from three methods: 837 electronic file, provider web portal, and paper claims. During the Onsite, Trillium stated they receive Emergency Department (ED) claims and some Professional non-ED claims on paper. Table 4 details the percentage of 2020 claims received via the three methods.

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

Source	HIPAA File	Paper	Provider Web Portal
Institutional	85.49%	.252%	14.258%
Professional	85.708%	.03%	14.262%

Trillium adjudicates claims on a nightly basis. Approximately 99.86% of Professional claims and 98.87% of Institutional claims are auto adjudicated.

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, the plan 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 Diagnosis Related Groups (DRGs), if they are submitted on the claim. During the Onsite, Trillium confirmed they are also able to capture and submit Telehealth modifier codes during the ongoing COVID-19 pandemic.

During the Onsite, Trillium stated staff conduct random audits on a daily basis of greater than 3% of all claims processed. All paper claims are subjected to a separate audit. High dollar claims that have billed in an amount greater than $5,000 are audited on a weekly basis. Claims Supervisors and Managers review all claims processed by newly hired claim managers.

During the Onsite, Trillium indicated its database is backed up at the server level and at the database level, on a nightly basis. Trillium reported they did not have any negative business impact due to the ongoing COVID-19 pandemic and demonstrated seamless operations and resilience during natural disasters such as hurricanes.

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

Table 5: Volume of 2019 and 2020 Submitted Encounter Data

2020	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	49,586	2,431	756	52,773
Professional	1,190,579	4,491	3,538	1,198,608
2019	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	52,170	289	420	52,879
Professional	1,059,492	264	181	1,059,937

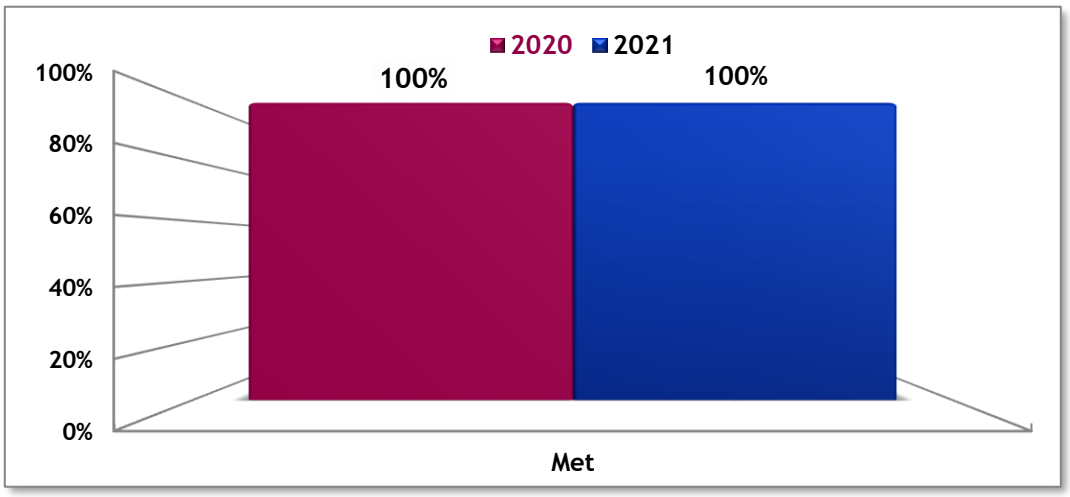
Trillium has an approximate 99.7% acceptance rate for both Professional and Institutional encounters with dates of service in 2020. During the Onsite, Trillium provided the top two denial reasons for encounters submitted to NCTracks:

- Electronic Visit Verification (EVV) Denials
- Possible Duplicates

On average, Trillium submits an encounter to NC Medicaid within seven days from the time of adjudication. It takes approximately 19 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 that were denied. As stated in the ISCA, Trillium has 404 Institutional and 1,736 Professional encounters with dates of service in 2020, still awaiting resubmission as of November 17, 2021. Trillium exceeds the NC Medicaid standards for encounter submissions and has less than 0.4% denial rate of their encounter data submissions. Trillium is submitting up to 41 ICD-10 Diagnosis codes for Institutional encounters and up to 12 ICD-10 Diagnosis codes for Professional encounters.

Figure 2 demonstrates Trillium met all of the Standards in the 2020 and 2021 Administrative EQR.

Figure 2: Administrative Comparative Findings



Strengths

- Trillium auto-adjudicates claims: 98.87% of Institutional claims and 99.86% of Professional claims.
- 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.

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.

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 2020 EQR, Trillium met 100% of the Credentialing/Recredentialing standards, resulting in no Corrective Actions. CCME issued a Recommendation in both Credentialing and Recredentialing in the "Ownership Disclosure is addressed" standard. Trillium has received either a Corrective Action or a Recommendation regarding Ownership Disclosure in each EQR since 2016. Trillium addressed both Recommendations from the 2020 EQR, as presented in Table 6.

Table 6: 2020 EQR Provider Services Findings

2020 EQR Provider Services findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Credentialing: Ownership Disclosure is addressed	***Recommendation: Ensure credentialing files include Ownership Disclosure information, in addition to the disclosure regarding ownership of "5% or more in the organizations that bill Medicaid for services." See NC Medicaid Contract, Attachment O and Section 1.13 and Section 1.14. As noted on the Desk Review Materials list, "For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file."***	Y
2021 EQR Follow up: All credentialing files submitted for the 2021 EQR included Ownership Disclosure information.		
Recredentialing: Ownership Disclosure is addressed	***Recommendation: Ensure recredentialing files include Ownership Disclosure information, in addition to the disclosure regarding ownership of "5% or more in the organizations that bill Medicaid for services." See NC Medicaid Contract, Attachment O and Section 1.13 and Section 1.14. As noted on the Desk Review Materials list, "For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file."***	Y
2021 EQR Follow up: All recredentialing files submitted for the 2021 EQR included Ownership Disclosure information.		

In the 2021 EQR, Trillium met 100% of the Credentialing/Recredentialing standards. CCME issued a Recommendation for Trillium to reconcile documents to accurately reflect voting membership of the Credentialing Committee and to clarify the requirements to conduct meetings, including voting on applications. There are no Corrective Actions in the current EQR of Credentialing/Recredentialing.

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. 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, chairs the Credentialing Committee. In the absence of the CMO, Dr. Paul Garcia, Deputy Chief Medical Officer (Deputy CMO) and a board-certified psychiatrist, chairs the Credentialing Committee.

Discussion at the Onsite addressed conflicting information regarding voting membership and the determination of adequate voting membership attendance for conducting the Credentialing Committee meetings, including voting on applications. The submitted *Credentialing Committee Member List* includes seven provider representatives and three Trillium staff members, including Dr. Smith, CMO, as voting members. The "Voting Members" section of the submitted Credentialing Committee meeting minutes includes Dr. Smith, CMO, and Dr. Paul Garcia, Deputy CMO. The *Credentialing Committee By-Laws* (*By-Laws*) stipulate the CMO "shall not vote except in case of a tie, in which event he/she shall cast the deciding vote", and Dr. Garcia is not listed on the submitted *Credentialing Committee Member List*. At the Onsite, Trillium staff verified that Dr. Smith only votes in the event of a tie, and that Dr. Garcia is not a voting member of the committee.

The *By-Laws* state, "A quorum at any regular or special meeting 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* also state, "All matters considered at a meeting shall be decided by a majority vote of voting members present", but do not state that a quorum is required to conduct meetings and votes.

The Credentialing and Re-credentialing Process procedure states, "The Chief Medical Officer oversees the Credentialing Program and has authority as delegated by the Credentialing Committee to approve Clean Applications." The reviewed Credentialing Committee meeting minutes reflect committee review of the list of "clean" applications approved by the CMO, and review and discussion of "red flagged" applications, voted on by the committee.

Halifax County realigned with Trillium from another PIHP effective December 1, 2021, and Bladen County will be realigned from another PIHP effective February 1, 2021. During

the Onsite, Trillium staff reported they began outreach to providers in those two counties months in advance, to ensure providers were onboarded and contracts were in place, to avoid disruption of services, and that claims are paid timely.

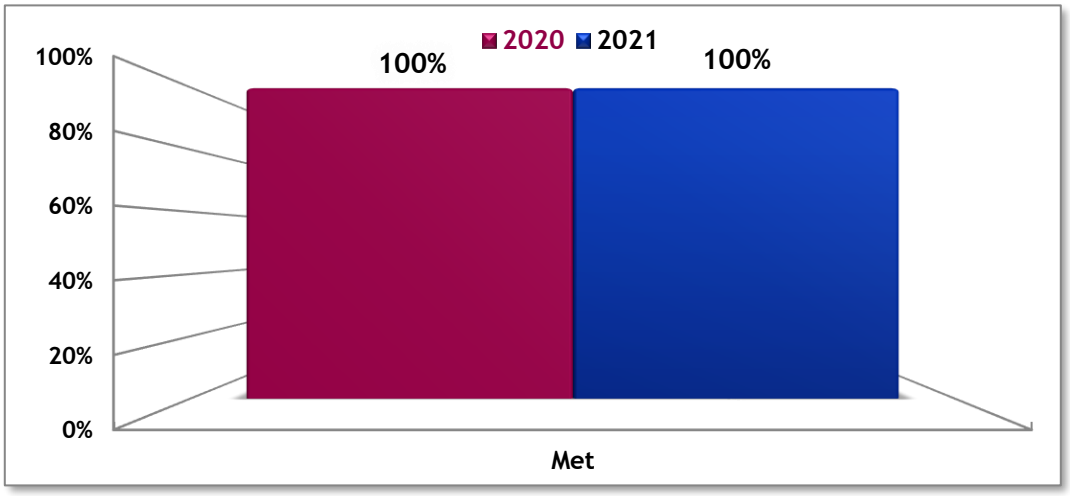
Within five days of contract execution, the Network Department sends all new providers a New Provider Welcome Packet, which includes information about the New Provider Orientation requirement. The packet also informs providers about the online learning platform (My Learning Campus), which includes free trainings and tip sheets. The News, Events & Training section on the Trillium website includes links to "community events and important Trillium news", including items such as news releases, the Trillium Newsletter, and Upcoming Events.

Under the COVID-19 flexibilities as outlined in *NC Medicaid Contract Amendment #9*, the annual *Network Adequacy and Accessibility Analysis* (Gaps Analysis) will be submitted "no later than ninety (90) calendar days after termination of the Amendment." At the last EQR, Trillium staff reported the PIHP "has made significant progress in closing those gaps", with program additions for Medicaid-funded Psychosocial Rehabilitation (PSR), Partial Hospital, Substance Abuse Comprehensive Outpatient Treatment (SA-COT), and Opioid Treatment programs.

During the Onsite for the current EQR, Trillium staff highlighted efforts regarding gaps, including providing updates on the status of Medicaid-funded Psychosocial Rehabilitation, Partial Hospital, SA-COT, Opioid Treatment, Child and Adolescent Day Treatment, Substance Abuse Non-Medical Community Residential Treatment, and Substance Abuse Medically Monitored Community Residential Treatment. Several programs have been added, with many in the process of obtaining licensure, which has been delayed due to COVID-19.

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

Figure 3: Provider Services Comparative Findings



Strengths

- There is a separate toll-free Provider Support Service Line and a separate toll free number for administrative and business matters.
- Credentialing and recredentialing files contain checklists to help guide the process.
- Trillium's MyLearning Campus offers free online trainings and tip sheets accessible to Trillium staff and providers 24/7.

Weaknesses

- There is conflicting information across documents (e.g., the *Credentialing Committee By-Laws*, the *Credentialing Committee Members 2021-2022* list, and the submitted Credentialing Committee meeting minutes) regarding voting membership and the determination of adequate voting membership attendance for conducting committee meetings, including voting on applications.

Recommendations

- Reconcile documents to accurately reflect voting membership of the Credentialing Committee and to clarify the requirements to conduct meetings, including votes on applications.

C. Quality Improvement

42 CFR § 438.330

The 2021 Quality Improvement (QI) EQR included Performance Measures (PMs) and Performance Improvement Projects (PIPs) validation. CCME conducted a Desk Review of the submitted (b) and (c) Waiver Performance Measures (PMs) and a review of each PIP's Quality Improvement Project (QIP) report for validation, using CMS standard validation protocols. During the Onsite, Trillium staff clarified measurement rates for each of the areas.

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

Table 7: 2020 EQR PIP Recommendations

Project(s)	Recommendation	Recommendation Implemented in 2021 (Y/N/NA)
MST Utilization	***Recommendation: Identify and implement a plan to determine if family refusal can be mitigated; continue working on improving access; continue interventions of childcare coordinator training, and education for families, schools, and DSS.***	**Y**
Super Measure MH	***Recommendation: Continue with current active interventions and examine rate after review of internal process and protocols for scheduling are completed; data analysis for dually covered members is recommended to assess impact on the measure***	**Y**
Super Measure SU	***Recommendation: Continue with current active interventions and examine rate after review of internal process and protocols for scheduling are completed; data analysis for dually covered members is recommended to assess impact on the measure.***	**Y**

Performance Measure Validation

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

Table 8: (b) Waiver Measures

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

Table 9: (c) Waiver Measures

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

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

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

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

(b) Waiver Measures Reported Results

These measures' rates as reported by Trillium for FY 2019 and FY 2020 are included in the following Table. 30-day Readmission rates for FBC increased by 11.6%, which is a substantial decline in the rate, since lower rates are better. The Follow Up After Hospitalization for Mental Illness for The Facility Based Crisis (FBC) Population declined almost 25% for the 7-Day Follow Up and declined 16.4% for the 30-Day Follow Up. Initiation for AODDT improved for 65+ year old members by 10.8% which is substantial improvement.

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

30-day Readmission Rates for Mental Health	FY 2019	FY 2020	Change
Inpatient (Community Hospital Only)	16.4%	16.6%	0.20%
Inpatient (State Hospital Only)	11.5%	15.4%	3.90%
Inpatient (Community and State Hospital Combined)	16.4%	16.6%	0.20%
Facility Based Crisis	15.2%	26.8%	11.60%
Psychiatric Residential Treatment Facility (PRTF)	10.2%	4.3%	-5.90%
Combined (includes cross-overs between services)	16.2%	16.5%	0.30%

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

30-day Readmission Rates for Substance Abuse	FY 2019	FY 2020	Change
Inpatient (Community Hospital Only)	19.1%	15.1%	-4.00%
Inpatient (State Hospital Only)	0.0%	0.0%	0.00%
Inpatient (Community and State Hospital Combined)	19.1%	15.1%	-4.00%
Detox/Facility Based Crisis	10.7%	16.8%	6.10%
Combined (includes cross-overs between services)	12.9%	16.4%	3.50%

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

Follow-up after Hospitalization for Mental Illness	FY 2019	FY 2020	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	36.4%	38.6%	2.20%
Percent Received Outpatient Visit Within 30 Days	57.4%	57.9%	0.50%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	72.5%	47.7%	-24.80%
Percent Received Outpatient Visit Within 30 Days	80.0%	63.6%	-16.40%
PRTF			
Percent Received Outpatient Visit Within 7 Days	18.3%	25.6%	7.30%
Percent Received Outpatient Visit Within 30 Days	52.4%	44.9%	-7.50%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	36.3%	38.4%	2.10%
Percent Received Outpatient Visit Within 30 Days	57.5%	57.7%	0.20%

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

Follow-up after Hospitalization for Substance Abuse	FY 2019	FY 2020	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	14.1%	14.8%	0.70%
Percent Received Outpatient Visit Within 30 Days	20.4%	20.9%	0.50%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	58.0%	51.1%	-6.90%
Percent Received Outpatient Visit Within 7 Days	62.9%	54.8%	-8.10%
Percent Received Outpatient Visit Within 30 Days	69.5%	61.4%	-8.10%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	49.9%	45.4%	-4.50%
Percent Received Outpatient Visit Within 30 Days	56.4%	51.9%	-4.50%

*NR = Denominator is equal to zero.

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2019	FY 2020	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	46.5%	44.7%	-1.8%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	17.7%	17.8%	0.1%
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	39.9%	37.8%	-2.1%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	25.5%	24.0%	-1.5%
Ages 21–34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	50.2%	48.4%	-1.8%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	36.3%	34.8%	-1.5%
Ages 35–64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	48.0%	48.9%	0.9%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	35.3%	37.0%	1.7%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	47.9%	58.7%	10.8%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	42.5%	46.7%	4.2%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	48.0%	48.1%	0.1%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	33.9%	34.5%	0.6%

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

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
3–12	Male	0.2	0.2	0.0	12.9	18.6	5.7
	Female	0.2	0.1	-0.1	9.9	11.2	1.3
	Total	0.2	0.1	-0.1	11.5	15.4	3.9
13–17	Male	1.0	0.8	-0.2	11.3	12.3	1.0
	Female	1.7	1.6	-0.1	9.3	10.3	1.0
	Total	1.3	1.2	-0.1	10.0	11.0	1.0
18–20	Male	2.1	2.5	0.4	7.6	8.2	0.6
	Female	1.5	1.7	0.2	6.6	6.0	-0.6
	Total	1.8	2.1	0.3	7.2	7.2	0.0
21–34	Male	5.3	5.6	0.3	8.6	8.0	-0.6
	Female	1.5	1.6	0.1	7.9	7.2	-0.7
	Total	2.4	2.5	0.1	8.3	7.6	-0.7
35–64	Male	3.0	3.0	0.0	8.6	8.4	-0.2
	Female	2.2	2.1	-0.1	9.0	8.8	-0.2
	Total	2.5	2.4	-0.1	8.8	8.6	-0.2
65+	Male	0.5	0.3	-0.2	15.0	24.6	9.6
	Female	0.3	0.2	-0.1	22.5	20.1	-2.4
	Total	0.4	0.3	-0.1	19.5	21.9	2.4
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**	**1.4**	**1.3**	**-0.1**	**9.3**	**9.5**	**0.2**
	Female	**1.1**	**1.1**	**0.0**	**9.1**	**8.8**	**-0.3**
	Total	**1.2**	**1.2**	**0.0**	**9.2**	**9.1**	**-0.1**

Table 16: D.2. Mental Health Utilization -% of Members that Received at Least 1 Mental Health Service in the Category Indicated during the Measurement Period

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
3-12	Male	14.43%	13.48%	-0.95%	0.28%	0.23%	-0.05%	0.28%	0.27%	-0.01%	14.40%	13.43%	-0.97%
	Female	9.72%	9.72%	0.00%	0.19%	0.16%	-0.03%	0.07%	0.07%	0.00%	9.71%	9.71%	0.00%
	Total	12.13%	11.63%	-0.50%	0.24%	0.20%	-0.04%	0.18%	0.17%	-0.01%	12.11%	11.60%	-0.51%
13-17	Male	16.50%	16.28%	-0.22%	1.10%	0.99%	-0.11%	0.37%	0.36%	-0.01%	16.38%	16.19%	-0.19%
	Female	18.42%	18.34%	-0.08%	1.70%	1.56%	-0.14%	0.14%	0.19%	0.05%	18.26%	18.23%	-0.03%
	Total	17.45%	17.30%	-0.15%	1.40%	1.27%	-0.13%	0.25%	0.27%	0.02%	17.31%	17.19%	-0.12%
18-20	Male	10.70%	11.11%	0.41%	1.81%	1.89%	0.08%	0.06%	0.05%	-0.01%	10.60%	11.03%	0.43%
	Female	13.34%	13.63%	0.29%	1.39%	1.46%	0.07%	0.04%	0.06%	0.02%	13.19%	13.50%	0.31%
	Total	12.12%	12.47%	0.35%	1.58%	1.65%	0.07%	0.05%	0.05%	0.00%	12.00%	12.36%	0.36%
21-34	Male	23.23%	24.15%	0.92%	3.81%	3.98%	0.17%	0.10%	0.23%	0.13%	22.98%	24.04%	1.06%
	Female	17.61%	17.85%	0.24%	1.32%	1.43%	0.11%	0.24%	0.25%	0.01%	17.54%	17.74%	0.20%
	Total	18.92%	19.33%	0.41%	1.90%	2.03%	0.13%	0.21%	0.25%	0.04%	18.80%	19.22%	0.42%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
35-64	Male	17.72%	17.14%	-0.58%	2.35%	2.20%	-0.15%	0.22%	0.20%	-0.02%	17.55%	16.97%	-0.58%
	Female	21.96%	21.63%	-0.33%	1.64%	1.64%	0.00%	0.18%	0.26%	0.08%	21.88%	21.54%	-0.34%
	Total	20.32%	19.88%	-0.44%	1.92%	1.86%	-0.06%	0.19%	0.24%	0.05%	20.21%	19.76%	-0.45%
65+	Male	5.89%	5.74%	-0.15%	0.46%	0.34%	-0.12%	0.00%	0.06%	0.06%	5.75%	5.65%	-0.10%
	Female	6.54%	5.96%	-0.58%	0.36%	0.25%	-0.11%	0.00%	0.00%	0.00%	6.50%	5.92%	-0.58%
	Total	6.34%	5.89%	-0.45%	0.39%	0.28%	-0.11%	0.00%	0.02%	0.02%	6.27%	5.83%	-0.44%
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**	**15.18%**	**14.68%**	**-0.50%**	**1.16%**	**1.11%**	**-0.05%**	**0.24%**	**0.24%**	**0.00%**	**15.08%**	**14.59%**	**-0.49%**
	Female	**14.72%**	**14.62%**	**-0.10%**	**0.99%**	**0.97%**	**-0.02%**	**0.12%**	**0.15%**	**0.03%**	**14.65%**	**14.55%**	**-0.10%**
	Total	**14.92%**	**14.64%**	**-0.28%**	**1.06%**	**1.03%**	**-0.03%**	**0.17%**	**0.19%**	**0.02%**	**14.84%**	**14.57%**	**-0.27%**

Table 17: D.3. Identification of Alcohol and Other Drug Services

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
3–12	Male	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
	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%	-0.11%
13–17	Male	1.29%	1.16%	-0.13%	0.13%	0.15%	0.02%	0.08%	0.06%	-0.02%	1.18%	1.07%	-0.11%
	Female	1.03%	0.91%	-0.12%	0.13%	0.16%	0.03%	0.05%	0.03%	-0.02%	0.94%	0.83%	-0.11%
	Total	1.16%	1.04%	-0.12%	0.13%	0.16%	0.03%	0.07%	0.05%	-0.02%	1.06%	0.95%	0.08%
18–20	Male	3.38%	3.30%	-0.08%	0.56%	0.46%	-0.10%	0.42%	0.49%	0.07%	3.09%	3.17%	0.04%
	Female	2.51%	2.48%	-0.03%	0.18%	0.21%	0.03%	0.37%	0.44%	0.07%	2.33%	2.37%	0.06%
	Total	2.91%	2.86%	-0.05%	0.35%	0.32%	-0.03%	0.39%	0.46%	0.07%	2.68%	2.74%	0.31%
21–34	Male	8.72%	8.85%	0.13%	1.24%	1.21%	-0.03%	1.64%	1.49%	-0.15%	8.14%	8.45%	0.55%
	Female	7.63%	8.14%	0.51%	0.35%	0.44%	0.09%	1.87%	1.81%	-0.06%	7.36%	7.91%	0.50%
	Total	7.89%	8.31%	0.42%	0.55%	0.62%	0.07%	1.81%	1.74%	-0.07%	7.54%	8.04%	0.33%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
35–64	Male	8.85%	9.01%	0.16%	0.96%	0.94%	-0.02%	2.02%	2.10%	0.08%	8.20%	8.53%	0.63%
	Female	6.71%	7.14%	0.43%	0.47%	0.50%	0.03%	1.58%	1.62%	0.04%	6.24%	6.87%	0.52%
	Total	7.54%	7.87%	0.33%	0.66%	0.67%	0.01%	1.75%	1.81%	0.06%	7.00%	7.52%	0.28%
65+	Male	1.77%	2.03%	0.26%	0.02%	0.11%	0.09%	0.65%	0.69%	0.04%	1.42%	1.70%	0.02%
	Female	0.62%	0.67%	0.05%	0.02%	0.05%	0.03%	0.21%	0.23%	0.02%	0.48%	0.50%	0.11%
	Total	0.97%	1.10%	0.13%	0.02%	0.07%	0.05%	0.34%	0.37%	0.03%	0.77%	0.88%	0.00%
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%	0.11%
Total	**Male**	**2.81%**	**2.86%**	**0.05%**	**0.32%**	**0.32%**	**0.00%**	**0.57%**	**0.59%**	**0.02%**	**2.59%**	**2.70%**	**0.21%**
	Female	**3.10%**	**3.25%**	**0.15%**	**0.19%**	**0.22%**	**0.03%**	**0.71%**	**0.71%**	**0.00%**	**2.91%**	**3.12%**	**0.16%**
	Total	**2.98%**	**3.09%**	**0.11%**	**0.25%**	**0.27%**	**0.02%**	**0.65%**	**0.66%**	**0.01%**	**2.78%**	**2.94%**	**0.00%**

Table 18: D.5. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2019	2020	Change	2019	2020	Change	2019	2020	Change	2019	2020	Change
	3-12			13-17			18-20			21-34		
Beaufort	0.00%	0.03%	0.03%	2.23%	1.87%	-0.36%	4.25%	3.65%	-0.60%	9.17%	9.24%	0.07%
Bertie	0.00%	0.00%	0.00%	1.56%	0.64%	-0.92%	0.63%	2.16%	1.53%	3.05%	2.55%	-0.50%
Brunswick	0.00%	0.03%	0.03%	1.25%	1.15%	-0.10%	2.88%	2.75%	-0.13%	7.38%	7.06%	-0.32%
Camden	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.30%	0.00%	-1.30%	5.06%	3.31%	-1.75%
Carteret	0.00%	0.06%	0.06%	1.79%	1.34%	-0.45%	2.84%	2.56%	-0.28%	8.49%	8.65%	0.16%
Chowan	0.00%	0.00%	0.00%	0.96%	0.00%	-0.96%	2.26%	1.60%	-0.66%	3.59%	4.93%	1.34%
Columbus	0.06%	0.02%	-0.04%	0.91%	0.24%	-0.67%	2.22%	2.34%	0.12%	6.83%	6.14%	-0.69%
Craven	0.02%	0.02%	0.00%	0.90%	0.90%	0.00%	2.27%	2.31%	0.04%	7.07%	7.21%	0.14%
Currituck	0.00%	0.00%	0.00%	2.11%	0.97%	-1.14%	1.43%	0.00%	-1.43%	5.06%	4.76%	-0.30%
Dare	0.00%	0.00%	0.00%	1.71%	1.08%	-0.63%	1.72%	2.84%	1.12%	6.25%	5.72%	-0.53%
Gates	0.00%	0.00%	0.00%	0.36%	0.36%	0.00%	1.64%	0.00%	-1.64%	4.60%	2.98%	-1.62%
Hertford	0.00%	0.05%	0.05%	0.72%	0.72%	0.00%	0.90%	1.68%	0.78%	3.57%	2.12%	-1.45%
Hyde	0.00%	0.00%	0.00%	0.78%	0.85%	0.07%	2.56%	1.49%	-1.07%	8.09%	6.25%	-1.84%
Jones	0.00%	0.00%	0.00%	0.34%	0.00%	-0.34%	3.33%	3.91%	0.58%	5.17%	6.53%	1.36%
Martin	0.00%	0.00%	0.00%	1.31%	1.19%	-0.12%	3.06%	4.39%	1.33%	6.95%	7.47%	0.52%
Nash	0.01%	0.00%	-0.01%	0.67%	0.73%	0.06%	1.72%	1.30%	-0.42%	3.85%	4.62%	0.77%
New Hanover	0.01%	0.02%	0.01%	1.60%	1.52%	-0.08%	3.57%	3.11%	-0.46%	7.14%	8.20%	1.06%

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		
	2019	2020	Change	2019	2020	Change	2019	2020	Change	2019	2020	Change
	3-12			13-17			18-20			21-34		
Northampton	0.00%	0.00%	0.00%	0.89%	0.31%	-0.58%	0.56%	0.91%	0.35%	2.82%	2.79%	-0.03%
Onslow	0.01%	0.00%	-0.01%	0.67%	0.77%	0.10%	2.09%	2.27%	0.18%	4.55%	5.09%	0.54%
Pamlico	0.00%	0.00%	0.00%	0.00%	0.63%	0.63%	2.47%	0.65%	-1.82%	7.17%	9.42%	2.25%
Pasquotank	0.00%	0.00%	0.00%	0.34%	0.34%	0.00%	1.92%	1.01%	-0.91%	3.33%	3.13%	-0.20%
Pender	0.00%	0.00%	0.00%	0.67%	1.06%	0.39%	2.25%	2.94%	0.69%	6.27%	7.11%	0.84%
Perquimans	0.00%	0.00%	0.00%	0.30%	0.89%	0.59%	0.68%	3.97%	3.29%	2.15%	6.31%	4.16%
Pitt	0.03%	0.00%	-0.03%	1.53%	1.43%	-0.10%	3.22%	3.52%	0.30%	5.83%	6.37%	0.54%
Tyrrell	0.00%	0.00%	0.00%	0.00%	1.56%	1.56%	0.00%	5.26%	5.26%	5.06%	5.41%	0.35%
Washington	0.00%	0.00%	0.00%	1.32%	0.71%	-0.61%	3.68%	2.75%	-0.93%	5.62%	3.40%	-2.22%
	35-64			65+			Unknown			Total (Ages 3+)		
Beaufort	7.11%	8.12%	1.01%	1.10%	1.71%	0.61%	0.00%	0.00%	0.00%	3.46%	3.62%	0.16%
Bertie	5.22%	5.93%	0.71%	0.96%	1.25%	0.29%	0.00%	0.00%	0.00%	2.05%	2.15%	0.10%
Brunswick	6.29%	6.37%	0.08%	0.34%	0.20%	-0.14%	0.00%	0.00%	0.00%	2.73%	2.67%	-0.06%
Camden	4.57%	6.31%	1.74%	2.30%	0.00%	-2.30%	0.00%	0.00%	0.00%	1.96%	1.83%	-0.13%
Carteret	7.33%	7.32%	-0.01%	1.11%	0.83%	-0.28%	0.00%	0.00%	0.00%	3.24%	3.18%	-0.06%
Chowan	7.66%	6.77%	-0.89%	1.26%	1.31%	0.05%	0.00%	0.00%	0.00%	2.59%	2.40%	-0.19%
Columbus	4.86%	5.07%	0.21%	0.24%	0.60%	0.36%	0.00%	0.00%	0.00%	2.29%	2.21%	-0.08%
Craven	6.00%	5.99%	-0.01%	0.72%	0.64%	-0.08%	0.00%	0.00%	0.00%	2.55%	2.53%	-0.02%

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		
	2019	2020	Change	2019	2020	Change	2019	2020	Change	2019	2020	Change
	35-64			65+			Unknown			Total (Ages 3+)		
Currituck	4.73%	4.83%	0.10%	1.03%	0.50%	-0.53%	0.00%	0.00%	0.00%	2.12%	1.84%	-0.28%
Dare	7.41%	6.14%	-1.27%	0.00%	0.34%	0.34%	0.00%	0.00%	0.00%	2.41%	2.15%	-0.26%
Gates	3.73%	2.96%	-0.77%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.52%	1.04%	-0.48%
Hertford	5.81%	5.43%	-0.38%	1.66%	1.30%	-0.36%	0.00%	0.00%	0.00%	2.17%	1.95%	-0.22%
Hyde	2.98%	2.76%	-0.22%	0.00%	0.66%	0.66%	0.00%	0.00%	0.00%	1.89%	1.63%	-0.26%
Jones	5.60%	4.56%	-1.04%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.16%	2.10%	-0.06%
Martin	7.53%	6.85%	-0.68%	1.39%	1.80%	0.41%	0.00%	0.00%	0.00%	3.03%	3.05%	0.02%
Nash	5.66%	5.55%	-0.11%	1.03%	1.06%	0.03%	0.00%	0.00%	0.00%	1.98%	2.03%	0.05%
New Hanover	8.37%	8.98%	0.61%	1.64%	1.57%	-0.07%	0.00%	0.00%	0.00%	3.38%	3.65%	0.27%
Northampton	3.28%	4.80%	1.52%	1.22%	1.12%	-0.10%	0.00%	0.00%	0.00%	1.47%	1.72%	0.25%
Onslow	5.97%	6.45%	0.48%	0.84%	1.28%	0.44%	0.00%	0.00%	0.00%	2.09%	2.30%	0.21%
Pamlico	5.42%	4.95%	-0.47%	0.37%	0.37%	0.00%	0.00%	0.00%	0.00%	2.34%	2.41%	0.07%
Pasquotank	3.54%	4.78%	1.24%	0.27%	0.27%	0.00%	0.00%	0.00%	0.00%	1.37%	1.55%	0.18%
Pender	6.29%	5.74%	-0.55%	0.79%	1.03%	0.24%	0.00%	0.00%	0.00%	2.42%	2.52%	0.10%
Perquimans	3.66%	4.46%	0.80%	0.36%	0.00%	-0.36%	0.00%	0.00%	0.00%	1.21%	2.25%	1.04%
Pitt	8.43%	9.29%	0.86%	1.43%	1.77%	0.34%	0.00%	0.00%	0.00%	3.06%	3.31%	0.25%
Tyrrell	4.91%	0.00%	-4.91%	0.78%	0.00%	-0.78%	0.00%	0.00%	0.00%	1.54%	1.03%	-0.51%
Washington	6.81%	6.16%	-0.65%	1.27%	1.00%	-0.27%	0.00%	0.00%	0.00%	2.88%	2.28%	-0.60%

Table 19: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2019	2020	Change	2019	2020	Change	2019	2020	Change	2019	2020	Change
	3-12			13-17			18-20			21-34		
Beaufort	13.39%	12.80%	-0.59%	17.41%	16.49%	-0.92%	11.57%	12.20%	0.63%	20.61%	20.81%	0.20%
Bertie	6.87%	5.75%	-1.12%	15.42%	12.08%	-3.34%	6.27%	9.26%	2.99%	10.37%	11.80%	1.43%
Brunswick	11.16%	11.13%	-0.03%	16.25%	16.47%	0.22%	11.95%	10.74%	-1.21%	16.62%	15.44%	-1.18%
Camden	9.37%	5.01%	-4.36%	20.83%	17.83%	-3.00%	10.39%	18.18%	7.79%	10.76%	10.60%	-0.16%
Carteret	16.62%	17.45%	0.83%	24.50%	26.43%	1.93%	14.18%	15.02%	0.84%	21.10%	20.76%	-0.34%
Chowan	11.21%	9.45%	-1.76%	16.83%	13.41%	-3.42%	10.73%	5.88%	-4.85%	9.74%	13.15%	3.41%
Columbus	10.14%	9.32%	-0.82%	11.61%	10.85%	-0.76%	7.39%	6.04%	-1.35%	11.32%	10.06%	-1.26%
Craven	11.86%	11.57%	-0.29%	18.63%	19.24%	0.61%	10.39%	12.99%	2.60%	16.37%	18.21%	1.84%
Currituck	11.33%	11.94%	0.61%	18.97%	17.72%	-1.25%	12.14%	8.00%	-4.14%	12.18%	14.29%	2.11%
Dare	7.51%	7.97%	0.46%	15.42%	11.77%	-3.65%	7.93%	8.87%	0.94%	13.79%	11.07%	-2.72%
Gates	8.65%	8.01%	-0.64%	13.67%	11.83%	-1.84%	9.84%	6.90%	-2.94%	11.30%	10.64%	-0.66%
Hertford	6.01%	6.13%	0.12%	9.93%	10.17%	0.24%	4.94%	6.71%	1.77%	8.81%	10.61%	1.80%
Hyde	11.84%	10.83%	-1.01%	16.41%	17.95%	1.54%	5.13%	2.99%	-2.14%	16.18%	17.19%	1.01%
Jones	10.06%	13.48%	3.42%	17.29%	19.67%	2.38%	12.50%	12.50%	0.00%	22.07%	21.99%	-0.08%
Martin	11.37%	10.94%	-0.43%	17.61%	15.96%	-1.65%	12.23%	13.45%	1.22%	15.37%	15.21%	-0.16%
Nash	5.27%	6.23%	0.96%	9.51%	10.30%	0.79%	6.66%	6.63%	-0.03%	8.81%	9.90%	1.09%
New Hanover	13.20%	13.06%	-0.14%	18.65%	18.81%	0.16%	12.57%	12.76%	0.19%	15.99%	17.34%	1.35%

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		
	2019	2020	Change	2019	2020	Change	2019	2020	Change	2019	2020	Change
	3-12			13-17			18-20			21-34		
Northampton	8.47%	6.47%	-2.00%	12.87%	15.18%	2.31%	8.40%	7.90%	-0.50%	9.35%	10.45%	1.10%
Onslow	11.57%	12.16%	0.59%	19.41%	21.06%	1.65%	13.43%	14.18%	0.75%	16.47%	17.33%	0.86%
Pamlico	21.52%	19.02%	-2.50%	25.15%	22.57%	-2.58%	14.81%	18.71%	3.90%	17.92%	24.64%	6.72%
Pasquotank	8.74%	7.94%	-0.80%	16.37%	17.61%	1.24%	11.97%	10.10%	-1.87%	12.77%	13.80%	1.03%
Pender	10.28%	10.11%	-0.17%	15.60%	15.59%	-0.01%	9.99%	9.79%	-0.20%	16.21%	15.54%	-0.67%
Perquimans	9.60%	7.45%	-2.15%	16.96%	11.24%	-5.72%	11.64%	11.92%	0.28%	9.14%	11.11%	1.97%
Pitt	10.71%	10.14%	-0.57%	17.90%	17.47%	-0.43%	10.00%	11.21%	1.21%	14.81%	14.25%	-0.56%
Tyrrell	9.65%	13.48%	3.83%	19.49%	19.53%	0.04%	6.67%	13.16%	6.49%	10.13%	12.16%	2.03%
Washington	9.26%	9.61%	0.35%	12.97%	13.57%	0.60%	7.89%	5.49%	-2.40%	10.15%	11.26%	1.11%
	35-64			65+			Unknown			Total (Ages 3+)		
Beaufort	24.02%	23.06%	-0.96%	7.87%	6.92%	-0.95%	0.00%	0.00%	0.00%	16.60%	15.96%	-0.64%
Bertie	14.23%	14.04%	-0.19%	7.00%	5.00%	-2.00%	0.00%	0.00%	0.00%	10.19%	9.43%	-0.76%
Brunswick	16.67%	15.90%	-0.77%	4.39%	3.80%	-0.59%	0.00%	0.00%	0.00%	13.39%	12.96%	-0.43%
Camden	18.72%	16.67%	-2.05%	8.05%	7.41%	-0.64%	0.00%	0.00%	0.00%	13.25%	11.29%	-1.96%
Carteret	23.13%	22.34%	-0.79%	8.07%	7.02%	-1.05%	0.00%	0.00%	0.00%	18.76%	19.05%	0.29%
Chowan	16.03%	16.78%	0.75%	10.55%	7.83%	-2.72%	0.00%	0.00%	0.00%	12.75%	11.70%	-1.05%
Columbus	11.44%	10.62%	-0.82%	3.33%	3.81%	0.48%	0.00%	0.00%	0.00%	9.88%	9.10%	-0.78%
Craven	21.43%	21.47%	0.04%	9.38%	8.57%	-0.81%	0.00%	0.00%	0.00%	15.08%	15.41%	0.33%

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		
	2019	2020	Change	2019	2020	Change	2019	2020	Change	2019	2020	Change
	35-64			65+			Unknown			Total (Ages 3+)		
Currituck	20.00%	16.99%	-3.01%	3.08%	3.48%	0.40%	0.00%	0.00%	0.00%	13.73%	13.32%	-0.41%
Dare	15.68%	15.16%	-0.52%	6.11%	7.72%	1.61%	0.00%	0.00%	0.00%	10.89%	10.27%	-0.62%
Gates	16.08%	12.84%	-3.24%	2.42%	3.65%	1.23%	0.00%	0.00%	0.00%	10.72%	9.34%	-1.38%
Hertford	14.22%	14.40%	0.18%	5.75%	5.45%	-0.30%	0.00%	0.00%	0.00%	8.66%	9.18%	0.52%
Hyde	15.74%	14.29%	-1.45%	5.81%	6.62%	0.81%	0.00%	0.00%	0.00%	12.41%	12.02%	-0.39%
Jones	19.11%	17.34%	-1.77%	5.05%	4.97%	-0.08%	0.00%	0.00%	0.00%	14.03%	15.02%	0.99%
Martin	17.81%	18.10%	0.29%	8.91%	6.22%	-2.69%	0.00%	0.00%	0.00%	13.83%	13.20%	-0.63%
Nash	12.20%	13.24%	1.04%	6.56%	6.63%	0.07%	0.00%	0.00%	0.00%	7.96%	8.78%	0.82%
New Hanover	21.44%	20.88%	-0.56%	10.76%	9.31%	-1.45%	0.00%	0.00%	0.00%	15.90%	15.87%	-0.03%
Northampton	14.49%	13.81%	-0.68%	6.10%	7.71%	1.61%	0.00%	0.00%	0.00%	10.20%	10.03%	-0.17%
Onslow	22.66%	23.60%	0.94%	10.23%	10.45%	0.22%	0.00%	0.00%	0.00%	15.46%	16.35%	0.89%
Pamlico	22.29%	18.76%	-3.53%	12.31%	9.96%	-2.35%	0.00%	0.00%	0.00%	20.18%	19.04%	-1.14%
Pasquotank	18.16%	19.78%	1.62%	6.16%	6.16%	0.00%	0.00%	0.00%	0.00%	12.22%	12.51%	0.29%
Pender	17.30%	14.74%	-2.56%	7.90%	7.67%	-0.23%	0.00%	0.00%	0.00%	13.07%	12.34%	-0.73%
Perquimans	15.38%	17.11%	1.73%	6.41%	4.98%	-1.43%	0.00%	0.00%	0.00%	11.50%	10.70%	-0.80%
Pitt	20.29%	20.37%	0.08%	8.76%	7.27%	-1.49%	0.00%	0.00%	0.00%	13.99%	13.60%	-0.39%
Tyrrell	14.11%	13.84%	-0.27%	3.91%	2.68%	-1.23%	0.00%	0.00%	0.00%	10.90%	12.85%	1.95%
Washington	19.42%	18.10%	-1.32%	9.37%	6.72%	-2.65%	0.00%	0.00%	0.00%	12.18%	11.79%	-0.39%

(b) Waiver Validation Results

All measures received a validation score of 100% and were found Fully Compliant. The stored procedures have been updated to address NC Medicaid's most recent changes to the measures. Table 20 contains validation scores for each of the 10 (b) Waiver Performance Measures.

Table 20: (b) Waiver Performance Measure Validation Scores

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

(c) Waiver Measures Reported Results

Five (c) Waiver Measures were chosen for validation. The rates reported by Trillium and the State benchmarks are displayed in *Table 21: (c) Waiver Measures Reported Results 2020 - 2021*. Documentation on data sources, data validation, source code, and calculated rate for the five measures was provided. All measures were above the 85% State benchmark rate.

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

Performance Measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	1663/1671 = 99.52%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	1663/1671 = 99.52%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	37/42 = 88.10%	85%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	1214/1214 = 100%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	8/8 = 100%	85%

* Latest reported rates are shown in Table from Excel files: Innovations Waiver Annual Measures 11.1.20 (IW D9, IW D10) and Semi Annual and Quarterly- Innovations Waiver Performance Measures 11.1.21 Excel files

(c) Waiver Validation

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

Table 22: C Waiver Performance Measures Validation Scores

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

Performance Improvement Project (PIP) Validation

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

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

PIP Validation Results

For the 2020 EQR, there were five PIPs submitted, which were all validated. All PIPs scored in the High Confidence range.

In the 2021 EQR, there are five PIPs submitted and all five were validated: Super Measure MH (Clinical), Super Measure SU (Clinical), Utilization of ED (Clinical), MST Utilization (Clinical), and TCLI 90 Day Contact PIP (Non-Clinical). The validation was conducted using *the CMS Protocol 1: Validating Performance Improvement Projects*.

Table 23: PIP Summary of Validation Scores

Project Type	Project	2020 Validation Score	2021 Validation Score
Clinical	Super Measure MH	73/74 = 99% High Confidence in Reported Results	78/79 = 100% High Confidence in Reported Results
	Super Measure SU	73/74 = 99% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results
	Utilization of ED	79/79 = 100% High Confidence in Reported Results	78/79 = 99% High Confidence in Reported Results
	MST Utilization	73/74 = 99% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
Non-Clinical	TCLI 90 Day Contact	84/84 = 100% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results

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

Table 24: 2021 Review PIP Interventions

Project(s)	Interventions
MST Utilization	Educating schools on MST services, DSS training, family education from care coordinators
Super Measure MH	Claims data review and assessment, data unit reports weekly, denials alignment in files, communication between contract managers and designated provider caseloads, provider education, Rapid Response Team
Super Measure SU	Health Connex ADT report, Opioid Treatment Centers, Rapid Response Team, provider education
ED Utilization	Wellness Recovery Homes, SUD Host Homes, ACCT Plus Pilot, BHUCs, Power BI Dashboard reporting
TCLI 90-Day Contact	Early report runs in Incedo, weekly report to RI, discrepancy data review, status checks on in-reach members for eligibility

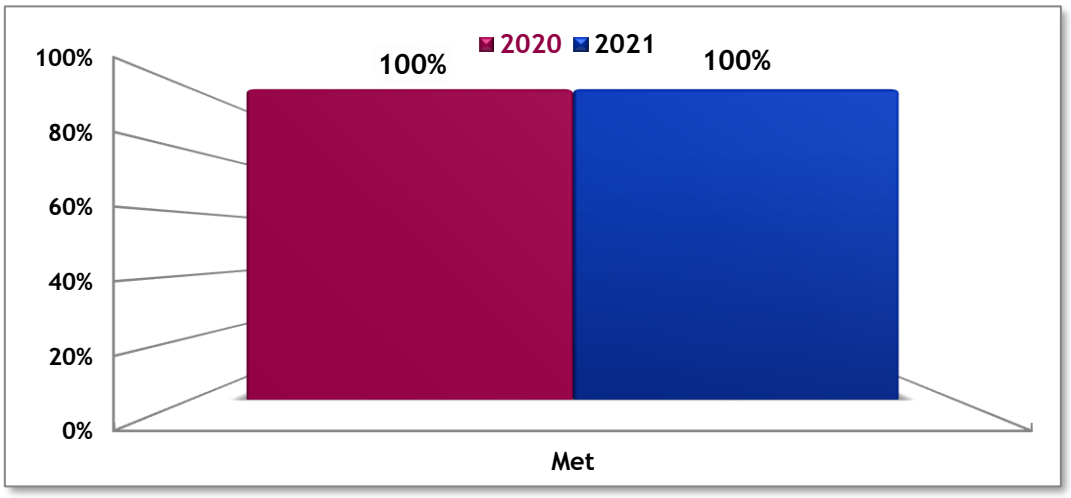
There are no Corrective Actions for the validated PIPS. For three of five PIPs, there are Recommendations regarding the assessment of interventions and consideration for additional interventions to improve rates. The project, section, reason, and Recommendations are displayed in Table 25.

Table 25: Performance Improvement Project Recommendations

Project(s)	Section	Reason	Recommendation
Super Measure MH	Was there any documented, quantitative improvement in processes or outcomes of care?	NC Medicaid rate declined from 43.6% to 41.4% and is below the Trillium goal rate of 45%. The DMH rate improved from 20.0% to 22.7%, although it was below the goal rate of 45%.	Continue with analysis of validated State data once available to determine if improvement did occur for finalized rates.
Super Measure SU	Was there any documented, quantitative improvement in processes or outcomes of care?	For NC Medicaid, the follow up rate declined from 50.3% to 48.6% and for DMH, the rate decline from 41.7% to 29.5% for the most recent local data findings.	Continue with current active interventions including, RRT and Opioid Treatment Centers, and examine rate after review of State validated data.
Utilization of ED	Was there any documented, quantitative improvement in processes or outcomes of care?	For measure #1, rate decreased from .54 to .65 but is still below the goal. Measure #2 decreased from 76.95% to 75.59%, which is not an improvement as the goal is 80%. Measure #3 declined from 6.39 to 6.13, which is an improvement and remains below the goal of 7.79%.	Determine if specific processes at discharge or member education would improve the rate for Indicator #2 and increase follow-up treatment to 80% goal.

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 Quality Improvement (QI) standards in the 2021 EQR.

Figure 4: Quality Improvement Comparative Findings



Strengths

- All PIPs were in the High Confidence range.
- Trillium has received full Management Behavioral Health Organization (MBHO) accreditation from NCQA.

Weaknesses

- The (b) Waiver measure validation noted substantial decline for three PMs.
- PIP rates did not improve for three of the 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.
- Super Measure MH PIP: Continue with analysis of validated State data once available to determine if improvement did occur for finalized rates.
- Super Measure SU PIP: Continue with current active interventions including RRT and Opioid Treatment Centers and examine rate after review of State validated data.
- Utilization of ED PIP: Determine if specific processes at discharge or member education would improve the rate for Indicator #2 and increase follow-up treatment to 80% goal.

D. Utilization Management

42 CFR § 438.208

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

In the 2020 EQR, Trillium met 100% of UM standards. CCME issued no Corrective Actions and five Recommendations. Four Recommendations targeted concerns noted in the 2020 EQR of Trillium's Care Management files. The remaining Recommendations encouraged Trillium to update its procedure for Complex Case Management. The implementation of the Recommendations is presented in Table 26.

Table 26: 2020 EQR Utilization Management Findings

2020 EQR Utilization Management findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Assess each Medicaid enrollee identified as having special health care needs;	***Recommendation: Update the procedure for Complex Case Management to reflect the age requirement listed in NC Medicaid Contract, Section 6.11.3 (c), g, for Children with Complex Needs.***	Y
2021 EQR Follow up: It was noted in the 2021 EQR Trillium updated the Complex Case Management Procedure to reflect the age requirement listed in *NC Medicaid Contract, Section 6.11.3 (c), g*, for Children with Complex Needs.		
Quality monitoring and continuous quality improvement;	***Recommendation: Revise the current monitoring plans for I/DD, MH/SUD and TCLI to implement a data-driven process that identifies the frequency of Care Manager contacts, departmental benchmarks for compliance, and how and when outcomes of member contacts are captured, reviewed, and reported.***	Y
2021 EQR Follow up: It was noted in the 2021 EQR that Trillium updated the monitoring plans for MHSUD, I/DD and TCLI Departments to include compliance review of the frequency of Care Managers contacts, departmental benchmarks, and internal reporting. However, the files reviewed for this 2021 EQR showed the monitoring plan is not effectively identifying compliance issues within Care Management documentation.		

2020 EQR Utilization Management findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	***Recommendation: Revise the I/DD Monitoring Plan to reflect 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.***	**Y**
2021 EQR Follow up: Trillium revised the monitoring plan for the I/DD Department to reflect Innovations monitoring requirements of enrollees receiving residential services, as outlined in *NC Medicaid Contract, Section 6.11.3 (h)* and *NC Clinical Coverage Policy 8P*. The review of the I/DD Care Management files submitted by Trillium were compliant with the required monitoring of enrollees receiving residential supports.		
The PIHP applies the Care Coordination policies and procedures as formulated.	***Recommendation: Document and implement a process that routinely reviews I/DD Care Manager contacts to ensure members participating in residential supports receive monthly, face-to-face contacts. Include in this process a routine review of the HCBS Monitoring Check Sheets for compliance with NC Medicaid Contract, Section 6.11.3.h., NC Clinical Coverage Policy 8P and NCDHHS HCBS Final Rule Transition Plan.***	**Y**
2021 EQR Follow up: Trillium implemented a process that routinely reviews I/DD Care Manager contacts with members receiving residential supports and HCBS Monitoring Check Sheets.		
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.	***Recommendation: Document and implement a process that routinely reviews TCLI Care Managers' progress notes to ensure this documentation is in compliance with the TCLI Care Management Monitoring Plan.***	**Y**
2021 EQR Follow up: It was noted in the 2021 EQR that Trillium implemented a process that routinely reviewed TCLI Care Managers' progress notes to ensure compliance with the TCLI Care Management Monitoring Plan. The files reviewed also showed improvement from the previous year's EQR.		

In the 2021 EQR, Trillium met 98% of the UM standards and has received one Corrective Action and no Recommendations. The review of I/DD files found that case notes and Individual Support Plans (ISPs) lacked clarity, contained the Protected Health Information (PHI) of other enrollees, and did not accurately capture Care Management activities. As an example of the compliance issues noted during the review, in one I/DD file, the

review found an email from a community provider that was merged into a case note. The email listed the names of several other enrollees receiving services from the provider. According to *NC DHHS Record Management and Documentation Manual, APSM 45-2,* information that personally identifies other individuals receiving services should not be entered into the case file.

Additionally, the review of MH/SUD files found large gaps in Care Management activities with enrollees deemed by Trillium as active in Care Management. For example, one MH/SUD file showed the Care Manager did not contact the enrollee, Legally Responsible Person (LRP) or provider for 46 days. During the 46-day gap in services, the enrollee was hospitalized for psychiatric reasons twice. CCME's review found that Trillium did not follow the *Coordination of Services Following Hospitalization* procedure that outlines the roles and responsibilities of Care Managers and/or Call Center Staff for enrollees being discharged from inpatient hospitalizations. This procedure requires follow-up with the community provider after the enrollee's discharge and prior to the next appointment to ensure information regarding the inpatient care and discharge is communicated and documented. During the Onsite, Trillium acknowledged the gap in Care Management and stated miscommunication during the process of transferring enrollees between care managers.

In the 2020 EQR, it was recommended that Trillium revise the process of reviewing MH/SUD, I/DD and TCLI Care Management documentation for compliance issues. This Recommendation also encouraged Trillium to implement a data-driven process to better identify areas needing improvement. In the 2021 EQR, it was noted this Recommendation was addressed by Trillium through the implementation of a routine file review process. This process includes review of at least 10 member notes, per staff member per month. However, findings from the 2021 Care Management file review showed this documentation review is not adequately identifying compliance issues within I/DD and MH/SUD Care Management documentation. It should be noted that the Care Management files reviewed in the 2020 and 2021 EQRs were selected by Trillium, yet both EQRs identified compliance issues around required Care Management engagement, late progress notes, and data entry errors. In this year's EQR, CCME has issued a Corrective Action for Trillium to enhance the current compliance review plan to implement a data driven process that will better identify compliance issues within MH/SUD and I/DD Care Management documentation.

Figure 5, demonstrates Trillium met 98% of the UM standards in the 2021 EQR and compares that score to percentage of standards met in the 2020 UM EQR.

Figure 5: Utilization Management Comparative Findings

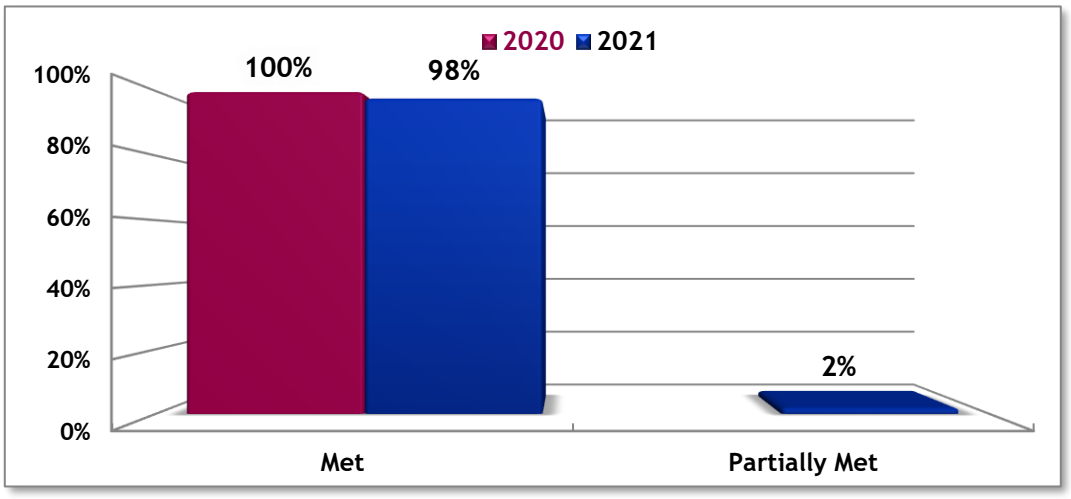


Table 27: Utilization Management

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

Strengths

- Trillium applies a whole-person Care Management approach to ensure enrollees' physical and behavioral health needs are met.
- The review of TCLI files for this EQR found that Trillium's procedures and NC TCLI Manuals are followed.

Weaknesses

- Trillium's process for reviewing MH/SUD and I/DD Care Management documentation is not adequately identifying compliance issues within the enrollee record.

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.

- Develop and document a data-driven element to this review. For example, identify baseline scores, establish monthly benchmarks, and review data on a monthly basis by region, department, and/or care manager to identify opportunities for improvement.

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*, the *Trillium Health Resources Member and Recipient Handbook*, 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 2020 EQR, Trillium met 90% of the Grievance and Appeal standards and received three Corrective Actions and one Recommendation in Grievances and one Corrective Action and four Recommendations in Appeals. Follow up to the 2020 EQR Grievance and Appeal Corrective Actions and Recommendations is detailed in the following respective sections.

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

Grievances

In the 2020 EQR, three Corrective Actions and one Recommendation were issued, primarily targeting incorrect or missing language within Trillium's Grievance procedure and Complaint procedure. In the 2021 EQR, there was evidence that Trillium addressed all 2020 EQR Corrective Actions and the Recommendation.

Table 28 outlines CCME's review to ensure those Corrective Actions and Recommendation were implemented by Trillium.

Table 28: 2020 EQR Grievance Findings

2020 EQR Grievance Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Timeliness guidelines for resolution of the Grievance as specified in the contract	***Corrective Action: Revise the Grievance Process and Scope procedure to ensure the 90-day Grievance resolution timeframe is applied to all types of Grievances, not only provider-related Grievances.***	**Y**
2021 EQR Follow Up: The Grievance Process and Scope procedure was updated to include the 90-day Grievance resolution timeframe applies to all type of Grievances.		
Timeliness guidelines for resolution of the Grievance as specified in the contract	***Corrective Action: Ensure the process required by 42 CFR § 438.408 (c) is documented in the Grievance procedure to reflect all Grievances may be extended by Trillium.***	**Y**
2021 EQR Follow Up: Trillium revised the Grievance Process and Scope procedure to include the following required notifications when Trillium extends the Grievance resolution timeframe: • Make reasonable efforts to give the enrollee prompt oral notice of the delay. • Within two calendar days, give the enrollee written notice of the reason for the decision to extend the timeframe. • Inform the enrollee of the right to file a Grievance if he or she disagrees with that decision.		
Timeliness guidelines for resolution of the Grievance as specified in the contract	***Corrective Action: Ensure the process required by 42 CFR § 438.408 (c) is documented in the Complaint procedure to reflect all complaints may be extended by Trillium.***	**Y**
2021 EQR Follow Up: The Complaint Process and Scope procedure was revised to define the process when Trillium extends the Complaint resolution timeframe, as required by 42 CFR § 438.408 (c), including that Trillium may extend the complaint resolution timeframe up to 14 calendar days if: • The enrollee requests the extension. • Trillium shows (to the satisfaction of NC Medicaid, upon its request) that there is need for additional information and how the delay is in the enrollee's interest. • Trillium extends the complaint resolution timeframes, Trillium will: Make reasonable efforts to give the enrollee prompt oral notice of the delay. Within two calendar days, give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if he or she disagrees with that decision.		

2020 EQR Grievance Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
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	***Recommendation: Include in the Grievance Process and Scope procedure how and where consultations with the Chief Medical Officer (CMO) and other members of the Executive Team are captured within Grievance files.***	**Y**
2021 EQR Follow Up: Page two section V of the Grievance Process and Scope procedure now states, "Documentation of any consultation and/or notification to the Chief Medical Officer or other Clinical Leadership, will be entered in the software platform Grievance module, under the specific Grievance record."		

In the 2021 Grievances EQR, all 10 files had timely acknowledgement letters and resolutions. All Grievances were resolved in accordance with *NC Medicaid Contract, Attachment M and 42 CFR § 438.408 (b)(1)*. Additionally, the Trillium Grievance Process and Scope procedure states, "A standardized resolution letter is sent to the member and all affected parties. For all Medicaid grievances, this will occur within thirty (30) calendar days and no more than ninety (90) calendar days. Clinically urgent matters will be resolved as expeditiously as the member's health and safety requires." All Grievances were resolved in 30 days or less, per data within the Grievance Log and the 10 Grievance files reviewed. Data within the Grievance files also matched the data within the Grievance Log submitted by Trillium. Three files showed Grievance notifications were sent outside of the 30 days, but well within the 90 days required by Trillium's procedures. Cases of health and safety were appropriately staffed by the Chief Medical Officer (CMO) and documented within the Grievance file. Page two section V of the Grievance Process and Scope procedure was updated and states, "Documentation of any consultation and/or notification to the Chief Medical Officer or other Clinical Leadership, will be entered in the software platform Grievance module, under the specific Grievance record." There were no Corrective Actions or Recommendations issued.

Appeals

In the 2020 EQR of Appeals, CCME issued one Corrective Action and four Recommendations. The Corrective Action was issued to add documentation to the Appeals procedure that guides staff to protect the members health information when they release information to anyone other than the member. The four Recommendations issued were for incorrect or missing documentation in the *Provider Manual*, *Member and Recipient Handbook*, and the Appeals monitoring process.

Table 29 outlines CCME's review to ensure Trillium implemented the Corrective Action and Recommendations.

Table 29: 2020 EQR Appeals Findings

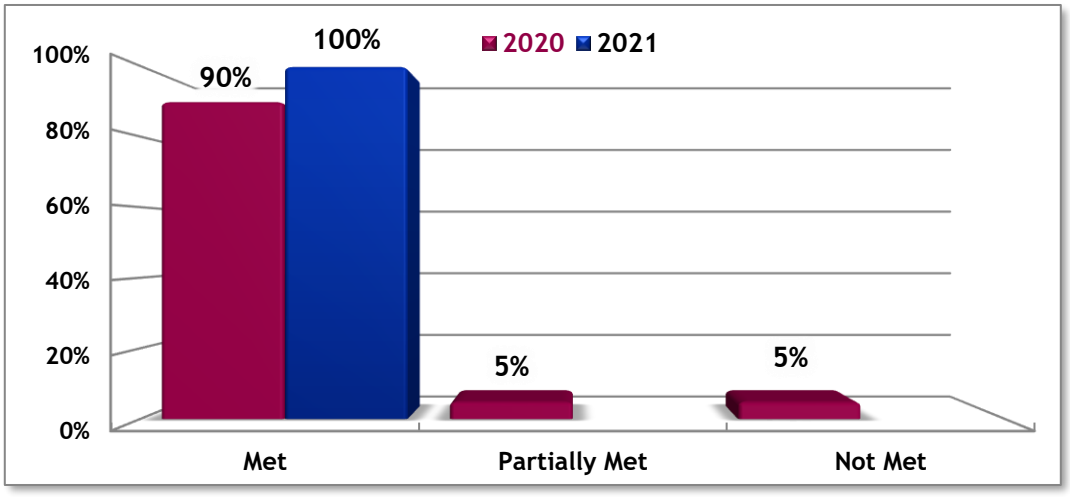
2020 EQR Appeal Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Other requirements as specified in the contract.	***Corrective Action: Detail in the Appeal procedure the process staff follow when releasing the Appeals record or reference the Member Access to Protected Health Information procedure in the Medicaid Clinical Reconsideration Process procedure.***	**Y**
2021 EQR Follow Up: Page 3, G, of the Medicaid Clinical Reconsideration Process procedure explains that Trillium will provide protected information/documentation according to their Member Access to Protected Health Information Procedure.		
The procedure for filing an Appeal	***Recommendation: Revise the Provider Manual and the Member and Family Handbook to clarify that any written request can initiate the Appeal process.***	**Y**
2021 EQR Follow Up: Page 59 of the *Provider Manual* states, "A member, or a network provider that has been authorized in writing to act on the member's behalf, may file requests for Appeals orally or in writing."		
The procedure for filing an Appeal	***Recommendation: Revise the Member and Family Handbook to consistently state that enrollees have 60 days from the mailing date of the Adverse Benefit Determination notification to request an Appeal.***	**Y**
2021 EQR Follow Up: On page 66 of the *Member and Recipient Handbook,* Trillium documented that an appeal request needs to be received within 60 days of the mailing date of the adverse benefit determination letter to be on time.		
Timeliness guidelines for resolution of the Appeal as specified in the contract	***Recommendation: Add to the Provider Manual and the Member and Family Handbook that Trillium is required to notify the enrollee of their right to file a Grievance if Trillium extends the Appeal resolution timeframe.***	**Y**
2021 EQR Follow Up: Page 62 of the *Provider Manual* and page 68 of the *Member and Recipient Handbook* explains that Trillium will inform members of their right to file a Grievance if they disagree when Trillium extends the Appeal resolution timeframe.		

2020 EQR Appeal Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP applies the Appeal policies and procedures as formulated	***Recommendation: Monitor all Appeal notifications to ensure required contractual language is not deleted through the automation process.***	**Y**
2021 EQR Follow Up: This was pertaining to an expedited, denied Appeal. In the 2021 EQR there were no expedited, denied files to review. During the Onsite discussion, Trillium explained they implemented a "double review" of notifications before they are released to catch any missing language.		

Throughout the 10 Appeal files reviewed in the 2021 EQR, overall improvement was seen compared to the last EQR. All the files reviewed show Appeal acknowledgement notifications, and Appeal resolution notifications were sent within the required timeframes. During the Onsite discussion, Trillium explained they now implement a "double review" of notifications before they are released to catch any missing language. The *Provider Manual* and the *Member and Recipient Handbook* were updated to explain that Trillium informs members of their right to file a Grievance if they disagree when Trillium extends the Appeal resolution timeframe. Additionally, there was evidence in all the Appeal files reviewed of staff confirming guardianship prior to processing the Appeals or releasing the enrollee's Appeal record. There were no Corrective Actions or Recommendations issued.

Figure 6 demonstrates Trillium's percentage of the 2021 standards met in Grievances and Appeals EQR and compares those scores to the 2020 EQR scores.

Figure 6: Grievances and Appeals Comparative Findings



Strengths

- Interdepartmental coordination was evident in the Grievance and Appeal files reviewed.

F. Program Integrity

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

The Program Integrity (PI) EQR involves an assessment of Trillium's compliance with federal and state regulations regarding PI functions. A Desk Review of Trillium's documentation was conducted and included review of Trillium's policies, procedures, training materials, Organizational Charts, job descriptions, committee meeting minutes and reports, provider agreements, enrollment application, PI workflows, *Trillium Health Resources Provider Operations Manual*, Employee Handbook, newsletters, conflict of interest forms, and Trillium's Compliance Plan. Additionally, 15 PI files were selected from the period under review. The Onsite interviews were conducted to discuss the findings within the Desk Materials and PI files.

In the 2020 and 2021 EQRs, Trillium met 100% of the PI standards. In the 2021 Desk Review, it was noted that Trillium's Chief Compliance Officer (CCO) was currently vacant but filled on an interim basis by Trillium's Internal Compliance and Medicaid Contract Manager. During the Onsite, Trillium staff stated this interim individual possessed a high level of knowledge of and involvement with the PI department and its requirements and Trillium is on target to hire a new CCO by February 1, 2022.

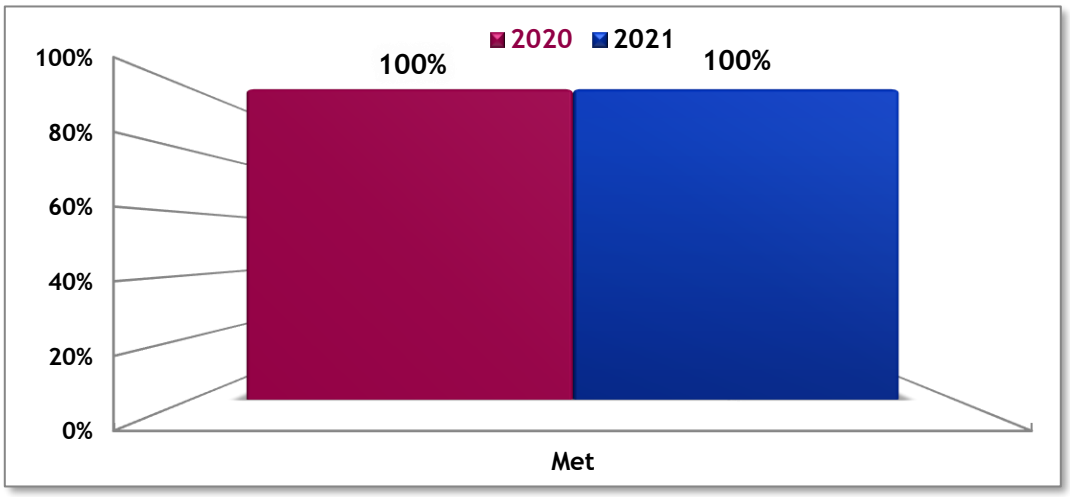
A review of Trillium's PI case report confirmed that of the 82 PI cases opened during the review period, all but one has been closed. During Onsite interviews, the NC Medicaid PI liaison assigned to Trillium also highlighted Trillium's timeliness of investigations as evidenced by only one case remaining open beyond one year.

During the Onsite, Trillium also described their increased efforts in PI outreach and education to enrollees and providers. This effort resulted in an increase of external referrals and Trillium's current ration of external to internal referrals is almost an even split of internal (48.1%) and external (49.4%) referral sources for possible fraud, waste, and abuse cases.

Trillium case files were well documented and consistently organized. Final reports were detailed and organized and referrals to NC Medicaid, where applicable, were complete and contained all investigative elements required by *NC Medicaid Contract, Section 14.29.*

Figure 7, demonstrates Trillium met 100% of the PI standards in the 2020 and 2021 EQRs.

Figure 7: Program Integrity Comparative Findings



Strengths

- Trillium has provided increased outreach and education to its members and providers leading to increased external PI referrals.
- Trillium has demonstrated a strong commitment to the timely investigation of all cases of possible fraud, waste, and abuse evidenced by a 98.8% closure rate during the review period.

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 2020 through December 2020. 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 a slight improvement compared to just under 17% that was seen on 2019 dates of

service. 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:

Our analyses shows that some provider 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

Based on the analysis of Trillium's encounter data, the data submitted to NC Medicaid is complete and accurate as defined by NC Medicaid standards.

There is a minor issue with the Other Diagnosis codes that Trillium should review and perform outreach to provider who submit only the Primary Diagnosis codes. Overall, Trillium has corrected all 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.

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

ATTACHMENTS

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

Attachment 1: Initial Notice, Materials Requested for Desk Review

November 1, 2021

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

Dear Ms. Wainwright;

At the request of the North Carolina Medicaid (NC Medicaid) this letter serves as notification that the 2021 External Quality Review (EQR) of 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 #9, the 2021 EQR will be a focused review. The focus of this review will be on the PIHP's Corrective Actions from the previous EQR and PIHP functions that impact enrollee health and safety. Similarly, for the 2021 EQR, the two day Onsite previously performed at PIHP offices will conducted during a one day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **December 16, 2021**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

In preparation for the Desk Review, the items on the enclosed **Desk Materials List** are to be submitted electronically. **Please note that, to facilitate a timely review, there are three items on the Desk Materials List (items 9, 10, and 19.a) that should be submitted by no later than November 5, 2021,** and the remaining items are due by no later than **November 23, 2021**. Also, as indicated in item 20 of the Desk Materials List, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted with the other Desk Materials on **November 23, 2021.**

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

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 5

Cc: Kimberly Huneycutt, Trillium Medicaid Contract Manager
Tasha Griffin, NC Medicaid Waiver Contract Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager
Hope Newsome, NC Medicaid Quality Specialist
Doreatha McCoy, NC Medicaid Quality Specialist

Trillium

Focused External Quality Review 2021

MATERIALS REQUESTED FOR DESK REVIEW

__Please note that the lists requested in items 9, 10, and 19.a must be uploaded by no later than November 5, 2021. The remainder of items must be uploaded by no later than November 23, 2021.__**

1. Copies of all current policies and procedures, as well as a complete index which includes policy and procedure name, number, and department owner. The date of the addition/review/revision should be identifiable on each policy/procedure. *(Please do not embed files within word documents.)*
2. Organizational Chart of all staff members including names of individuals in each position including their degrees, licensure, and any certifications required for their position. Include any current vacancies. In addition, please include any positions currently filled by outside consultants/vendors.
3. Description of major changes in operations such as expansions, new technology systems implemented, etc. Include any major changes to PIHP functions related to COVID-19.
4. A summary of the status of all Corrective Action items from the previous External Quality Review. Please include evidence of Corrective Action implementation.
5. List of providers credentialed/recredentialed in the last 12 months (October 2020 through September 2021). Include the date of approval of initial credentialing and the date of approval of recredentialing.
6. A description of the Quality Improvement, Utilization Management, and Care Coordination Programs. Include a Credentialing Program Description and/or Plan, if applicable.
7. Minutes of committee meetings for the following committees:
   a) Credentialing (for the three most recent committee meetings)
   b) UM (for the three most recent committee meetings)
   c) Any clinical committee meeting minutes showing discussion of Clinical Practice Guidelines impacted by COVID-19.
8. Membership lists and a committee matrix for all committees, including the professional specialty of any non-staff members. Please indicate which members are voting members. Include the required quorum for each committee.
9. ****By November 5, 2021**, a copy of the complete Appeal log for the months of October 2020 through September 2021. Please indicate on the log: the appeal type (standard, expedited, extended, withdrawn, or invalid), the service appealed, the date the appeal was received, and the date of appeal resolution notification.

10. **By November 5, 2021, a copy of the complete Grievances log for the months of October 2020 through September 2021. Please indicate on the log: the nature of the grievance, the date received, and the date of grievance resolution.
11. Copies of all appeal notification templates used for expedited, invalid, extended, and withdrawn appeals.
12. For appeals and grievances, please submit a description of your monitoring process that reviews compliance of oral and written notifications, completeness of documentation within the appeal and grievance records, accuracy of appeal and grievance logs, etc. Provide details regarding frequency of monitoring and any benchmarks, performance metrics, and reporting of monitoring outcomes.
13. Please submit a summary of new provider orientation processes and include a list of materials and training provided to new providers.
14. For MH/SU, I/DD, and TCLI Care Coordination, please submit a description of your monitoring plan that reviews compliance of Care Coordinator documentation. Include in the description the elements reviewed (timeliness of progress notes, timeliness of Innovations monitoring, timeliness of Quality of Life surveys, review of quality, completeness of discharge notes, accuracy of documentation, etc.). Provide details regarding frequency of monitoring, and any benchmarks, performance metrics, and reporting of monitoring outcomes.
15. For Care Coordination enrollees files, please provide:
    a. three MH/SU Care Coordination enrollee files (two active since 2019 and one recently discharged)
    b. three I/DD Care Coordination enrollee files (two active since 2019 and one recently discharged)
    c. four TCLI Care Coordination enrollee files (one active since 2019, one who received In-Reach, one who transitioned to the community and recently discharged).

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

16. Information regarding the following selected Performance Measures:

B WAIVER MEASURES	
A.1. Readmission Rates for Mental Health	D.1. Mental Health Utilization - Inpatient Discharges and Average Length of Stay
A.2. Readmission Rate for Substance Abuse	D.2. Mental Health Utilization
A.3. Follow-up After Hospitalization for Mental Illness	D.3. Identification of Alcohol and other Drug Services
A.4. Follow-up After Hospitalization for Substance Abuse	D.4. Substance Abuse Penetration Rate
B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	D.5. Mental Health Penetration Rate
C WAIVER MEASURES	
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	
Proportion of beneficiaries reporting they have a choice between providers.	
Percentage of level 2 and 3 incidents reported within required timeframes.	
Percentage of beneficiaries who received appropriate medication.	
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.	

Required information includes the following for each measure:

a. Data collection methodology used (administrative, medical record review, or hybrid) including a full description of those procedures;
b. Data validation methods/ systems in place to check accuracy of data entry and calculation;
c. Reporting frequency and format;
d. Complete exports of any lookup / electronic reference tables that the stored procedure / source code uses to complete its process;
e. Complete calculations methodology for numerators and denominators for each measure, including:

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

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

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

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

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

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

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

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

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

        i. Insurance:

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

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

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

iii. Ownership disclosure information/form.

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

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

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

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

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

ii. Insurance:

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

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

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

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

v. Ownership disclosure information/form.

NOTE: Appeals, Grievances, and Program Integrity files will be selected from the logs submitted on November 5, 2021. A request will then be sent to the plan to send electronic copies of the files to CCME. The entire file will be needed.

19. Provide the following for Program Integrity:
    a. **__File Review__: By November 5, 2021**, Please produce a listing of all active files during the review period (October 2020 through September 2021). The list should include the following information:
        i. Date case opened
        ii. Source of referral
        iii. Category of case (enrollee, provider, subcontractor)
        iv. Current status of the case (opened, closed)
    b. Program Integrity Plan and/or Compliance Plan.
    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.
    e. All 'Attachment Y' reports collected during the review period.
    f. All 'Attachment Z' reports collected during the review period.
    g. Provider Manual and Provider Application.
    h. Enrollee Handbook.
    i. Subcontractor Agreement/Contract Template.
    j. Training and educational materials for the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
    k. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse.
    l. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors, and employees.
    m. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other State or Federal agency.
    n. Code of Ethics and Business Conduct.
    o. Internal and/or external monitoring and auditing materials.
    p. Materials pertaining to how the PIHP captures and tracks complaints.
    q. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
        i. NC Medicaid approved reporting templates.
    r. Sample Data Mining Reports.

s. NC Medicaid Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
t. Monthly reports of NCID holders/FAMS-users in PIHP.
u. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
v. Corrective action plans including any relevant follow-up documentation.
w. Policies/Procedures for:
    i. Program Integrity
    ii. HIPAA and Compliance
    iii. Internal and external monitoring and auditing
    iv. Annual ownership and financial disclosures
    v. Investigative Process
    vi. Detecting and preventing fraud
    vii. Employee Training
    viii. Collecting overpayments
    ix. Corrective Actions
    x. Reporting Requirements
    xi. Credentialing and Recredentialing Policies
    xii. Disciplinary Guidelines

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

Section	Question Number	Attachment
Enrollment Systems	1b	Enrollment system loading process
Enrollment Systems	1f	Enrollment loading error process reports
Enrollment Systems	1g	Enrollment loading completeness reports
Enrollment Systems	2c	Enrollment reporting system load process
Enrollment Systems	2e	Enrollment reporting system completeness reports
Claims Systems	2	Claim process flowchart
Claims Systems	2p	Claim exception report.

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

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

21. Provide the following for Encounter Data Validation (EDV):
    b. Include all adjudicated claims (paid and denied) from January 1, 2020 – December 31, 2020. Follow the format used to submit encounter data to NC Medicaid (i.e., 837I and 837P). If you archive your outbound files to NC Medicaid, you can forward those to HMS for the specified time period. In addition, please convert each 837I and 837P to a pipe delimited text file or excel sheet using an EDI translator. If your EDI translator does not support this functionality, please reach out immediately to HMS.
    c. Provide a report of all paid claims by service type from January 1, 2020 – December 31, 2020. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

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

Attachment 2: EQR Validation Worksheets

- Mental Health (b Waiver) Performance Measures Validation Worksheet
  - Readmission Rates for Mental Health
  - Readmission Rates for Substance Abuse
  - Follow-up after Hospitalization for Mental Illness
  - Follow-up after Hospitalization for Substance Abuse
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
  - Mental Health Utilization –Inpatient Discharge and Average Length of Stay
  - Mental Health Utilization
  - Identification of Alcohol and Other Drug Services
  - Substance Abuse Penetration Rate
  - Mental Health Penetration Rate
- Innovations (c Waiver) Performance Measures Validation Worksheet
  - Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available
  - Proportion of beneficiaries reporting they have a choice between providers
  - Percentage of Level 2 and 3 incidents reported within required timeframes
  - Percentage of beneficiaries who received appropriate medication
  - Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required
- Performance Improvement Project Validation Worksheet
  - TCLI 90-Day Contact
  - Supermeasures MH
  - Supermeasures SU
  - ED Utilization
  - MST Utilization

CCME EQR PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator-Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator-Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA
SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

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

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

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

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

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

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

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

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

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM 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. IW G8
Reporting Year:	**2020**
Review Performed:	**2021**

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

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Trillium**
Name of PIP:	**MONITORING OF IN-REACH CONTACTS FOR TCLI – TCLI 90-DAY CONTACT**
Reporting Year:	**2021**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using Incedo report.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
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 tables.
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**	Goal is 98%. Rate improved from 93.66% to 98.98%. It is above the goal in October 2021.
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 interventions as rate improved and remained above the goal rate.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Rate to be evaluated through January 2023 to confirm sustained rate.

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	PHP deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%-69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

PIHP Name:	**Trillium**
Name of PIP:	**SUPERMEASURES MH**
Reporting Year:	2021
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

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 instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
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 tables.
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)**	**PARTIALLY MET**	NC Medicaid rate declined from 43.6% to 41.4% and is below the Trillium goal rate of 45%. The DMH rate improved from 20.0% to 22.7% although it below the goal rate of 45%. ***Recommendation: Continue with analysis of validated State data once available to determine if improvement did occur for finalized 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)**	**MET**	Improvement for the DMH rate appears to be related to interventions for data unit reports, data checking, and RRT
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early 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	5	5
9.3	NA	NA
9.4	NA	NA

Project Score	78
Project Possible Score	79
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	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 EQR PIP Validation Worksheet

PIHP Name:	**Trillium**
Name of PIP:	**SUPERMEASURES SU**
Reporting Year:	2021
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

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 instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
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 tables.
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**	For NC Medicaid, the follow up rate declined from 50.3% to 48.6% and for DMH the rate decline from 41.7% to 29.5% for the most recent local data findings. ***Recommendation: Continue with current active interventions including RRT and Opioid Treatment Centers and examine rate after review of State validated data.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement in rates.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early 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	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 EQR PIP Validation Worksheet

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

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

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 instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
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 tables.
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)**	**PARTIALLY MET**	For measure #1 rate decreased from .54 to .65 but is still below the goal; measure #2 decreased from 76.95% to 75.59% which does not support improvement as the goal is 80%; measure #3 declined from 6.39 to 6.13 which is improvement and remains below the goal of 7.79%. ***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.***
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 results of interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early 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	5	5
9.3	NA	NA
9.4	NA	NA

Project Score	78
Project Possible Score	79
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	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 EQR PIP Validation Worksheet

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

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
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 tables.
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**	Rate improved from 9.09% to 12.57% with a goal of 14.7%.
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 is related to interventions of education and training.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early 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	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	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.*

Attachment 3: Tabular Spreadsheet

I. Information Systems Capabilities Assessment (ISCA)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I A. Management Information Systems						
1. Enrollment Systems						
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Trillium has standard processes in place for enrollment data updates. Trillium uploads the daily GEF files to the 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. Trillium also uses the 820 file to determine member months for NC Medicaid Financial reporting. 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 MCO 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, Trillium stated it captures and stores GEF records that are unable to be loaded to TBS. Trillium reported they have not encountered any errors during the past year.
1.3 The MCO'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. 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 MCO 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 paper (approximately less than 0.5%). For claims received in 2020, 98.87% of Institutional and 99.86% of Professional claims were auto-adjudicated on a nightly basis. Pended claims report is generated daily and reviewed to ensure all claims are adjudicated and removed from pend status.
2.2 The MCO 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 MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	X					During the Onsite, 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 MCO'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 MCO'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 MCO has processes in place to back up the enrollment and claims data repositories.	X					During the Onsite, Trillium stated they backup their servers and databases on a daily basis.
4. Encounter Data Submission						
4.1 The MCO has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	X					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 EQR to address this issue, but Trillium has not yet implemented a plan to correct these issues. ***Recommendation: 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.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2 The MCO has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					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, 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.
4.3 MCO 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 very high encounter acceptance rate that was observed in last year's EQR review as well.
4.4 The MCO has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to NC Medicaid	X					As stated in the ISCA, Trillium has a workgroup that includes representatives from IT, Claims, Network, Utilization Management (UM) and Contracts and an Advisory Group that includes Managers and Directors from Claims, Contracts, Eligibility and Enrollment, Network, UM, 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* 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 Committee By-Laws* define the 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 notes 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, 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. ***Recommendation: Reconcile documents to accurately reflect voting membership of the Credentialing Committee and to clarify the requirements to conduct meetings, including votes on applications.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Credentialing files reviewed for the EQR were organized and contained appropriate information.
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
3.1.3 Valid DEA certificate; and/or CDS certificate	X					
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					

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

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.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.1 Recredentialing every three years;	X					The Trillium Credentialing and Re-credentialing Process procedure states, “Each provider must complete the re-credentialing process within three years of that date in order to prevent any lapse of credentialed status.”
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event; and query of the State Exclusion List;	X					
4.2.9 Requery of the SAM.	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (OIG LEIE);	X					
4.2.11 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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.14 Ownership Disclosure is addressed.	X					
4.3 Site reassessment if the provider has had quality issues.	X					
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					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 and the five (c) Waiver Measures. The (b) Waiver measure validation noted substantial improvement for one measure and substantial decline for three PMs. ***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 active projects for this 2021 EQR. These five were validated: Super Measure MH, Super Measure SU, TCLI 90-Day Contact, Utilization of ED, 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 PIPs scored in the High Confidence range, although three PIPs had sections with concerns that should be addressed by the Recommendations. ***Recommendations:*** • ***Super Measure MH PIP: Continue with analysis of validated State data once available to determine if improvement did occur for finalized rates.*** • ***Super Measure SU PIP: Continue with current active interventions including RRT and Opioid Treatment Centers and examine rate after review of State validated data.*** • ***Utilization of ED PIP: Determine if specific processes at discharge or member education would improve the rate for Indicator #2 and increase follow-up treatment to 80% goal.***

IV. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. A Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					
2. The case coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					During the 2020 EQR, CCME issued a Recommendation for Trillium to update the procedure for Complex Case Management to reflect the age requirement listed in *NC Medicaid Contract, Section 6.11.3 (c), g, for Children with Complex Needs*. This Recommendation was addressed by Trillium.
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					During the 2020 EQR, CCME recommended that Trillium revise the current process Trillium uses for identifying compliance issues within Care Management documentation. CCME recommended a data-driven process that identifies the frequency of Care Manager contacts, departmental benchmarks for compliance, and how and when outcomes of member contacts are captured, reviewed, and reported. This Recommendation was addressed as Trillium implemented a new process. However, there was evidence in the files reviewed for this EQR that suggest that this process is not effectively addressing compliance issues within Care Management documentation. This finding is detailed in standard 3 below.
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					
2.9 Provide follow-up activities for Enrollees;	X					
2.10 Ensure privacy for each Enrollee is protected.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					During the 2020 EQR, CCME issued a Recommendation for Trillium to revise the I/DD *Monitoring Plan* to reflect 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*. This Recommendation was addressed by Trillium.
3. The PIHP applies the Care Coordination policies and procedures as formulated.		X				During the 2020 EQR, CCME issued a Recommendation for Trillium to document and implement a process that routinely reviews I/DD Care Manager contacts to ensure enrollees participating in residential supports receive monthly, face-to-face contacts. The process should routinely review Home and Community Base Service Monitoring Check Sheets for compliance with *NC Medicaid Contract*, *Section 6.11.3.h.*, *NC Clinical Coverage Policy 8P*, and *NCDHHS HCBS Final Rule Transition Plan*. This Recommendation was addressed by Trillium. 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. During the Onsite, Trillium provided a more recent SIS dated February 5, 2019 and four ICT Review notes for two of the three gaps

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						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* ○ *and 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.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. B Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					
2.1 Care Coordination activities occur, as required.	X					
2.2 Person Centered Plans are developed as required.	X					
2.3 Assertive Community Treatment, Peer Support, Supported Employment, Community Support Team, Psychosocial Rehabilitation, and other services as set forth in the DOJ Settlement are included in the individual's transition, if applicable.	X					
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.5 QOL Surveys are administered timely.	X					For the 2021 EQR, all Quality of Life surveys and In-Reach Transition Tools were completed within the required timeframes.
3. Transition, diversion and discharge processes are in place for TCLI members as outlined in the DOJ Settlement and *DHHS Contract*.	X					
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.	X					
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					
6. A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	X					During the 2020 EQR, CCME issued a Recommendation that Trillium document and implement a process that routinely reviews TCLI Care Managers' progress notes to ensure documentation is compliant with the TCLI Care Management *Monitoring Plan*. This Recommendation was implemented by Trillium and review of 2021 TCLI files found that Trillium is following procedural requirements.

V. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					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;	X					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;	X					

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;	X					In the 2020 EQR, CCME issued a Corrective Action to correct the language in Trillium's Grievance and Complaint procedures around the resolution timeframe for Grievances and Complaints and the required notifications when Trillium extends the Grievance or Complaint resolution timeframes. Trillium addressed the Corrective Action the procedures are now in compliance with *42 CFR § 438.408 (c)*. In this 2021 EQR Grievance file review, all Grievances were resolved in accordance with *NC Medicaid Contract*, *Attachment M* and *42 CFR § 438.408 (b)(1)*. Additionally, the Trillium Grievance Process and Scope procedure states, "A standardized resolution letter is sent to the member and all affected parties. For all Medicaid grievances, this will occur within thirty (30) calendar days and no more than ninety (90) calendar days. Clinically urgent matters will be resolved as expeditiously as the member's health and safety requires." All Grievances were resolved in 30 days or less, per data within the Grievance Log and the 10 Grievance files reviewed. Data within the Grievance files also matched the data within the Grievance Log submitted by Trillium. Three files showed Grievance notifications were sent outside of the 30 days, but well within the 90 days required by Trillium's procedures.
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					There was a Recommendation issued in the 2020 EQR for Trillium to include in the Grievance Process and Scope procedure how and where consultations with the Chief Medical Officer (CMO) and other subject matter experts are captured within Grievance files. Page two section V of the Grievance Process and Scope procedure now states, "Documentation of any consultation and/or notification to the Chief Medical Officer or other Clinical Leadership, will be entered in the software platform Grievance module, under the specific Grievance record." In the Grievance file review, there was evidence this consultation with CMO occurred and were documented in files.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.5 Maintenance of a grievance log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					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.	X					All 10 files showed Grievance acknowledgement and resolution notifications were sent within the required timeframes. Grievances that involved potential health and safety concerns were appropriately staffed by the CMO.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					
V. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider Appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					Trillium's procedure, Medicaid Clinical Reconsideration Process, is the primary procedure governing the Appeal process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 The definitions an appeal and who may file an appeal;	X					
1.2 The procedure for filing an appeal;	X					There were two Recommendations issued in the 2020 EQR that were both implemented by Trillium. Trillium revised the *Provider Manual* and the *Member and Recipient Handbook* to clarify that any written request can initiate the Appeal process. Trillium has also revised the *Member and Recipient Handbook* to clearly state that enrollees have 60 days from the mailing date of the Adverse Benefit Determination notification to request an Appeal.
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					In the 2020 EQR it was a Recommendation to document in the *Provider Manual* and the *Member and Recipient Handbook* that Trillium is required to notify the enrollee of their right to file a Grievance if Trillium extends the Appeal resolution timeframe.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						In the 2021 EQR, it was noted on page 62 of the *Provider Manual* and page 68 of the *Member and Recipient Handbook* that Trillium explains that they will inform members of their right to file a Grievance if they disagree when Trillium extends the Appeal resolution timeframe.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The PIHP applies the appeal policies and procedures as formulated.	X					In the 2020 EQR of the Appeal files, one file reviewed showed Trillium did not notify the enrollee of their right to file a grievance when Trillium denied a request to expedite an appeal. In the 2020 EQR, staff reported this was due to some deleted language from the letter during automation efforts at Trillium. CCME recommended Trillium monitor all Appeal notifications to ensure required contractual language is not deleted through the automation process. In the 2021 EQR, there were no files reviewed where the request to expedite the Appeal was denied by Trillium. During the Onsite discussion, Trillium explained they now implement a "double review" of notifications before they are released to catch any missing language.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					In the 2020 EQR, a Corrective Action was issued that required Trillium to detail in the Appeal procedure the process for releasing the enrollee's Appeal record, as there was evidence Appeal staff were not confirming guardianship prior to releasing the PHP within the Appeal record. This Corrective Action was implemented, and language was added to Trillium's Appeal procedure to guide staff through the record release process. Additionally, there was evidence in all the Appeal files reviewed 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					The requirement that the PIHP be familiar and comply with *Section 1902 (a)(68)* of the *Social Security Act, 42 CFR § 438.455* and *1000* through *1008* is addressed in the Compliance Plan.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents', and subcontractors,' compliance with the requirements of this *Section 14* of the *NC Medicaid Contract*.	X					
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					
VI B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with *42 CFR § 438.608* that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the NC Medicaid Contract Administrator on an annual basis.	X					

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					The requirement that the PIHP designate a Compliance Officer, establish a regulatory compliance committee, and establish and implement policies outlining a system for training and education is addressed in the Compliance Plan, the Program Integrity Organizational Chart, and associated job descriptions, and Staff Training Program procedure.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. PIHP shall establish and implement a special investigations or program integrity unit, however named, that is responsible for PIHP program integrity activities, including identification, detection, and prevention of fraud, waste, and abuse in the PIHP Closed Provider Network. PIHP shall identify an appropriately qualified contact for Program Integrity and Regulatory Compliance issues as mutually agreed upon by PIHP and NC Medicaid. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator. In addition, PIHP shall identify a primary point of contact within the Special Investigations Unit to receive and respond to data requests from MFCU/MID. The MFCU/ MID will copy the PIHP Contract Administrator on all such requests.	X					
4. PIHP shall participate in quarterly Program Integrity meetings with NC Medicaid Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. PIHP shall send staff to participate in monthly meetings with NC Medicaid Program Integrity staff either telephonically or in person, at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.	X					
6. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information	X					The requirement that the PIHP designate appropriately qualified staff to attend the monthly meetings is evidenced in the monthly meeting minutes, agenda and list of attendees submitted by Trillium.
7. Within seven (7) business days of a request by the Division, PIHP shall also make portions of the PIHP's Regulatory Compliance and Program Integrity minutes relating to Program Integrity issues available for review, but the PIHP may, redact other portions of the minutes not relating to Regulatory Compliance or Program Integrity issues.	X					NC Medicaid Program Integrity staff reported Trillium has been submitting Regulatory Compliance and Program Integrity (PI) minutes to the State as required.
8. PIHP's written Compliance Plan shall, at a minimum include:						
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
policies and procedures and the False Claims Act as identified in *Section 1902 (a)(66)* of the *Social Security Act;*						
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing, and development of corrective action initiatives;	X					
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					
8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including NC Medicaid or MFCU/MID, and including supplying all data in a uniform format provided by NC Medicaid and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by the Division as provided in *NC Medicaid Contract Section 13.2-Monetary Penalties.*	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9. In accordance with *42 CFR § 438.608 (a)(vii),* PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under *NC Medicaid Contract*, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under *NC Medicaid Contract*; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month. PIHP shall be penalized One Hundred Dollars ($100) for each overpayment that is not specified in an Attachment Y Report within the applicable month. In addition, PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse.						
10.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure. This process shall include procedures for logging the complaint, determining if the complaint is valid, assigning the complaint, investigating, appeal, recoupment, and closure. The detailed workflow needs to differentiate the steps taken for fraud versus abuse; PIHP shall establish and implement policies for treatment of recoveries of all overpayments from PIHP to Providers and contracted agencies, specifically including retention policies for treatment of recoveries of overpayments due to fraud, waste, or abuse. The retention policies shall include processes, timeframes, and required documentation for payment of	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
recoveries of overpayments to the State in situations where PIHP is not permitted to retain some or all of the recoveries of overpayments. This provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.						
10.3 In accordance with Attachment Y - Audits/Self-Audits/investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					
10.4 Process for tracking overpayments and collections based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on Attachment Y –	X					A random check of Trillium's PI case file list against the Attachment Y reports demonstrated agreement of the data from the internal document and the reports to the State.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
Audits/Self-Audits/investigations.						
10.5 Process for handling self-audits and challenge audits.	X					
10.6 Process for using data mining to determine leads.	X					
10.7 Process for informing PIHP employees, subcontractors, and providers regarding the *False Claims Act.*	X					Trillium provided provider, employee and community newsletters which refer to Fraud, Waste, and Abuse reporting.
10.8 If PIHP makes or receives annual payments of at least $5,000,000, PIHP shall establish and maintain written policies for all employees, contractors, or agents that detail information about the *False Claims Act* and other federal and state laws as described in the *Social Security Act 1902 (a)(66)*, including information about rights of employees to be protected as whistleblowers.	X					
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid-standardized elements or a NC Medicaid-approved template;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available database or other search mechanism.	X					
11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.	X					Trillium's Provider Sanctions procedure outlines the provider overpayment and underpayment processes and requirements. The provider internal dispute resolution is also detailed in this procedure.
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case	X					Of fifteen provider PI cases reviewed, two cases had been referred by the PIHP to NC Medicaid. Both PI case files reviewed met showed the preliminary investigation was initiated within ten business days of receipt, as required by Trillium's *NC Medicaid Contract*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
records shall be stored electronically by PIHP.						
13. In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						All case files provided by the PIHP contained required documentation.
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					
13.2 Source/origin of complaint;	X					
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					
13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated; and dates of suspected intentional misconduct;	X					
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
misconduct, whichever is greater;						
13.6 All communications between PIHP and the Provider concerning the conduct at issue, when available.	X					
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					
13.8 Total Sample Amount of Funds Investigated per Service Type	X					
13.8.1 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					
13.8.2 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.8.3 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					
13.8.4 Information on Biller/Owner;	X					
13.8.5 Additional Provider Locations that are related to the allegations;	X					
13.8.6 Legal and Administrative Status of Case.	X					
14. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						No cases involving enrollee fraud, waste or abuse were presented for this year's EQR. Trillium's procedures adequately detailed the process for resolving allegations of enrollee fraud, waste, and abuse.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.1 The Enrollee's name, birth date, and Medicaid number;	X					
14.2 The source of the allegation;	X					
14.3 The nature of the allegation, including the timeframe of the allegation in question;	X					
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	X					
14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;	X					
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and	X					
14.7 The legal and administrative status of the case.	X					
14.8 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					
14.9 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					
14.10 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.11 Information on Biller/Owner;	X					
14.12 Additional Provider Locations that are related to the allegations;	X					
14.13 Legal and Administrative Status of Case.	X					
15. PIHP and NC Medicaid shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of State and Federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.	X					
16. PIHP shall use the NC Medicaid Fraud and Abuse Management System (FAMS) or a NC Medicaid approved alternative data mining technology solution to detect and prevent fraud, waste, and abuse in managed care.	X					Trillium submitted reports to demonstrate their use of FAMs data mining.
17. If PIHP uses FAMS, PIHP shall work with the NC Medicaid designated Administrator to submit appropriate claims data to load into the NC Medicaid Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	X					

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

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
2. Upon receipt of a payment suspension notice from NC Medicaid Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of NC Medicaid Program Integrity's suspension and lasting until PIHP is notified by NC Medicaid Program Integrity in writing that the suspension has been lifted.	X					
3. PIHP shall provide to NC Medicaid all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid Program Integrity due to allegations of suspected fraud without prior written approval from NC Medicaid Program Integrity or the MFCU/MID. If PIHP takes administrative action, including issuing a Notice of Overpayment based on such fraud that precedes the submission date of a Division referral, the State will adjust the PIHP capitated payment in the amount of the original overpayment identified or One Thousand Dollars ($1,000) per case, whichever amount is greater.	X					The requirement that Trillium not take administrative action regarding allegations of suspected fraud on any referred providers is outlined in Trillium's Desk Top Protocol. The Fraud Program Integrity Workflow clearly defines when only NC Medicaid has authorization to proceed with an investigation and related actions.

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

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

Attachment 4: Encounter Data Validation Report

Trillium Health Resources

Encounter Data Validation Report

performed on behalf of

North Carolina Medicaid

January 5, 2022

Prepared By:

ehms

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

Table of Contents

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Background

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

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

Overview

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

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

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

Looking at claims with dates of service in 2020, Trillium submitted 1,251,381 unique encounters to the State. To date, 0.34% of all encounters submitted in 2020 have not been corrected and accepted by NC Medicaid. This figure represents an improvement over the past few years.

2020	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
Institutional	52,773	49,586	2,431	756	1.43%
Professional	1,198,608	1,190,579	4,491	3,538	0.30%
Total	1,251,381	1,240,165	6,922	4,294	0.34%

Each year, 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 99.66% between 2017 and 2020, well above NC Medicaid 's expectations. Trillium's very 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%

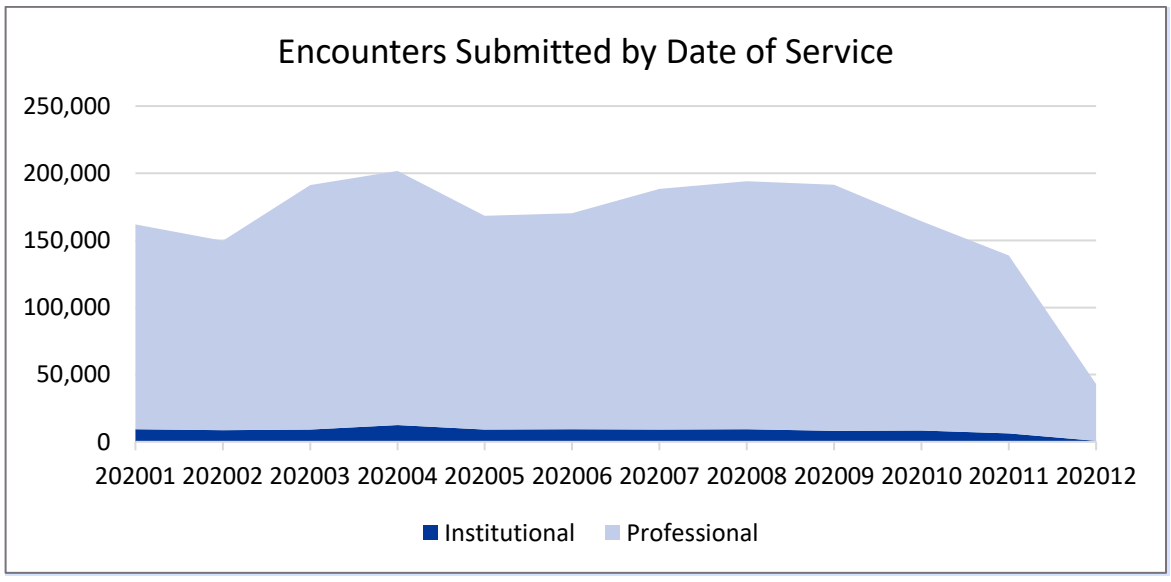
During the latest audit, Trillium provided an overview of the protocols they follow to submit encounter data and following up on the denials. Over the past few years, Trillium has implemented a highly efficient process for reviewing the denials and making the necessary changes to various parts of their information systems to prevent future encounter submissions from denying for the same denial reasons 2019 and 2020 figures show, Trillium enacts such changes very rapidly and we believe much of that success 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.

According to Trillium's response and the evaluation of the submitted encounter data, most of the outstanding and ongoing denials are related to invalid Taxonomy codes. In order to reduce the number of denied encounters going forward, they are continuing 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 will review differences with Provider
- Update CIE contract(s) and/or NCTracks via PUF or MCR submitted by Provider accordingly
- Limit eligible Provider Taxonomy codes on Claim Forms (CIE Data)
- Develop reconciliation process for claims based on workflow developed
- Develop first level adjudication at service to Taxonomy code level
- Educate providers and staff

Analysis of Encounters

The analysis of encounter data evaluated whether Trillium submitted complete, accurate, and valid data to NC Medicaid for all claims paid between January 1, 2020 and December 31, 2020. Trillium worked with their EDI vendor to convert each 837I and 837P file submitted to NC Medicaid during the requested audit period to an excel spreadsheet and sent to HMS via CCME's web portal. This included 1,994,328 Professional and 113,630 Institutional claim lines. The files submitted during 2020 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 NC Medicaid in 2020.



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

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

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

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

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

Encounter Accuracy and Completeness

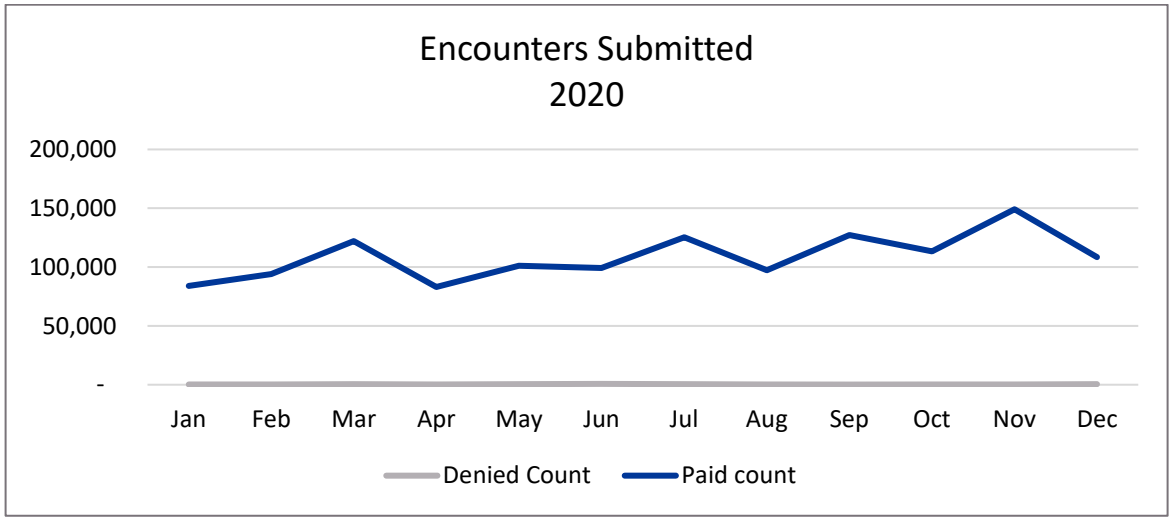
The table below outlines the key fields that were reviewed to determine if information was present, whether the information was the correct type and size, and whether or not the data populated was valid. Although we looked at the complete data set and validated all data values, the fields below are key 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	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%
Recipient Name	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%
Recipient Date of Birth	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%
PIHP ID	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%
Provider ID	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%
Attending/Rendering Provider ID	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%
Provider Location	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%
Place of Service	2,107,283	100.00%	2,107,283	100.00%	2,107,283	100.00%	2,107,283	100.00%
Specialty Code / Taxonomy - Billing	2,107,290	100.00%	2,107,269	100.00%	2,107,269	100.00%	2,107,269	100.00%
Specialty Code / Taxonomy - Rendering / Attending	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%
Principal Diagnosis	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%
Other Diagnosis	408,688	19.39%	408,688	19.39%	408,688	19.39%	408,688	19.39%
Dates of Service	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%
Unit of Service (Quantity)	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%	2,107,290	100.00%
Procedure Code	2,086,754	99.03%	2,086,754	99.03%	2,086,754	99.03%	2,086,754	99.03%
Procedure Code Modifier	1,435,548	68.12%	1,435,548	68.12%	1,435,548	68.12%	1,435,548	68.12%
Patient Discharge Status Code Inpatient	112,962	100.00%	112,962	100.00%	112,962	100.00%	112,962	100.00%
Revenue Code	112,962	100.00%	112,962	100.00%	112,962	100.00%	112,962	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 18 of the 18 key fields (100%). The Procedure code field was populated consistently and with expected values. This represents an improvement compared to 2017 and 2018 when some Procedure codes provided were labeled as "Line Level Procedure Code", but contained mixed values of CPT/HCPCS and Revenue codes. Professional encounter claims submitted contained complete and valid data in 14 of the 15 key Professional fields (93%). Minor issues were noted with Other Diagnosis codes.

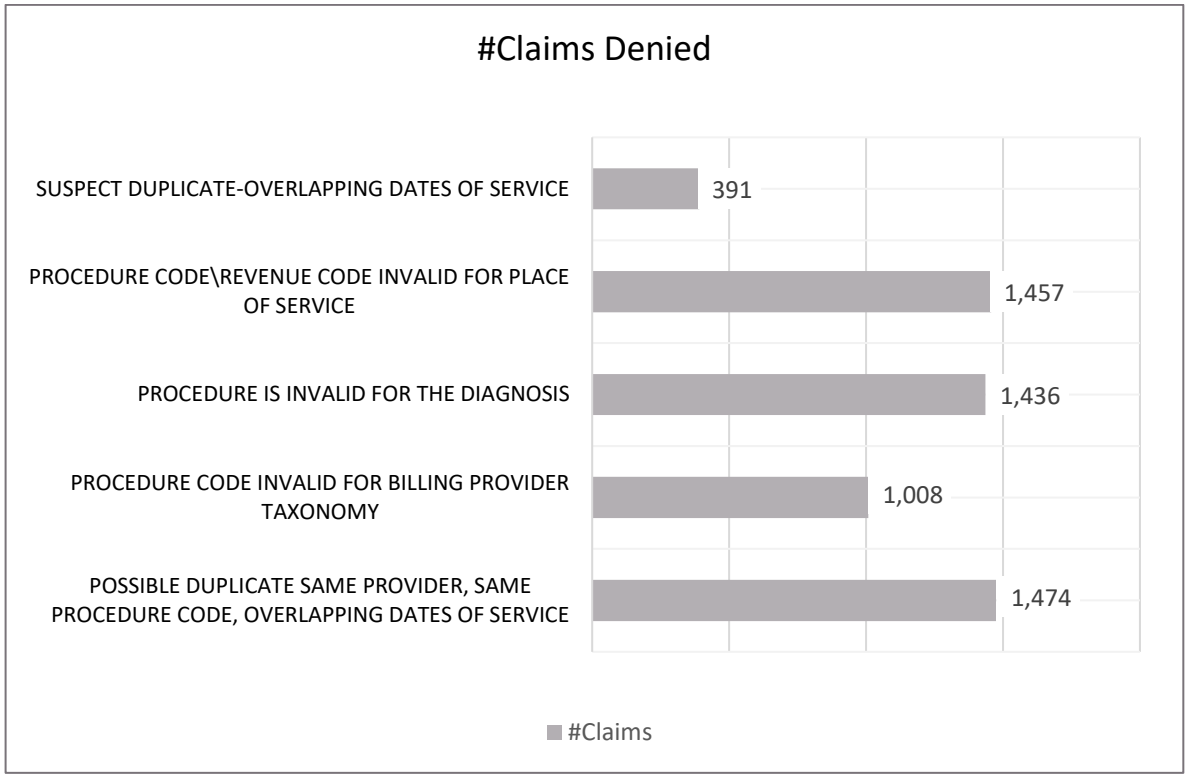
Encounter Acceptance Report

In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write which makes it difficult to tie back to the ISCA response as some of the submissions were for dates of services prior to 2020. 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 NC Medicaid reports which report results at the claim header level. During the 2020 weekly check write schedule, Trillium submitted a total of 1,251,381 encounters to NC Medicaid. Overall, 0.34% of all encounters submitted were denied.

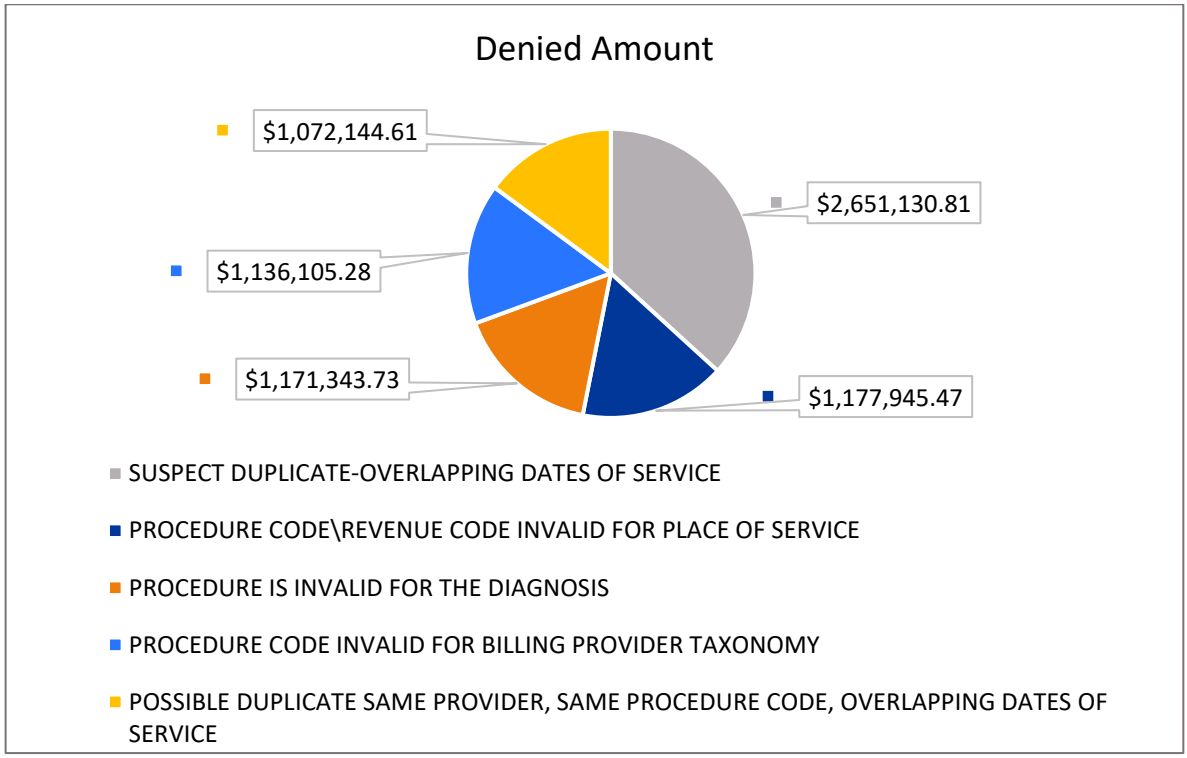


Evaluation of the top denials for Trillium encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis above. Encounters were denied primarily for:

- Suspect duplicate-overlapping dates of service
- Procedure code/Revenue code invalid for place of service
- Procedure is invalid for the diagnosis
- Procedure code invalid for billing provider Taxonomy
- 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 a slight improvement compared to just under 17% that was seen on 2019 dates of service. 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:

Our analyses shows that some provider 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

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

There is a minor issue with the Other Diagnosis codes that Trillium should review and perform outreach to provider who submit only the Primary Diagnosis codes. Overall, Trillium has corrected all 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.

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

Appendix 1

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

00106	UNABLE TO DETERMINE MEDICARE	PAY AND REPORT
00117	ONLY ONE DOS ALLOWED/LINE	PAY AND REPORT
00126	TOOTH SURFACE MISSING/INVALID	IGNORE
00127	QUAD CODE MISSING/INVALID	IGNORE
00128	PROC CDE DOESNT MATCH TOOTH #	IGNORE
00132	HCPCS CODE REQ FOR REV CODE	IGNORE
00133	HCPCS CODE REQ BILLING RC 0636	IGNORE
00135	INVL POS INDEP MENT HLTH PROV	PAY AND REPORT
00136	INVLD POS FOR IDTF PROV	PAY AND REPORT
00140	BILL TYPE/ADMIT DATE/FDOS	DENY
00141	MEDICAID DAYS CONFLICT	IGNORE
00142	UNITS NOT EQUAL TO DOS	PAY AND REPORT
00143	REVIEW FOR MEDICAL NECESSITY	IGNORE
00144	FDOS AND TDOS MUST BE THE SAME	IGNORE
00146	PROC INVLD - BILL PROV TAXON	PAY AND REPORT
00148	PROC\REV CODE INVLD FOR POS	PAY AND REPORT
00149	PROC\REV CD INVLD FOR AGE	IGNORE
00150	PROC CODE INVLD FOR RECIP SEX	IGNORE
00151	PROC CD/RATE INVALID FOR DOS	PAY AND REPORT
00152	M/I ACC/ANC PROC CD	PAY AND REPORT
00153	PROC INVLD FOR DIAG	PAY AND REPORT
00154	REIMB RATE NOT ON FILE	PAY AND REPORT
00157	VIS FLD EXAM REQ MED JUST	IGNORE
00158	CPT LAB CODE REQ FOR REV CD	IGNORE

00164	IMMUNIZATION REVIEW	IGNORE
00166	INVALID VISUAL PROC CODE	IGNORE
00174	VACCINE FOR AGE 00-18	IGNORE
00175	CPT CODE REQUIRED FOR RC 0391	IGNORE
00176	MULT LINES SAME PROC, SAME TCN	IGNORE
00177	HCPCS CODE REQ W/ RC 0250	IGNORE
00179	MULT LINES SAME PROC, SAME TCN	IGNORE
00180	INVALID DIAGNOSIS FOR LAB CODE	IGNORE
00184	REV CODE NOT ALLOW OUTPAT CLM	IGNORE
00190	DIAGNOSIS NOT VALID	DENY
00192	DIAG INVALID RECIP AGE	IGNORE
00194	DIAG INVLD FOR RECIP SEX	IGNORE
00202	HEALTH CHECK SHADOW BILLING	IGNORE
00205	SPECIAL ANESTHESIA SERVICE	IGNORE
00217	ADMISSION TYPE CODE INVALID	PAY AND REPORT
00250	RECIP NOT ON ELIG DATABASE	DENY
00252	RECIPIENT NAME/NUMBER MISMATCH	PAY AND REPORT
00253	RECIP DECEASED BEFORE HDR TDOS	DENY
00254	PART ELIG FOR HEADER DOS	PAY AND REPORT
00259	TPL SUSPECT	PAY AND REPORT
00260	M/I RECIPIENT ID NUMBER	DENY
00261	RECIP DECEASED BEFORE TDOS	DENY
00262	RECIP NOT ELIG ON DOS	DENY
00263	PART ELIG FOR LINE DOS	PAY AND REPORT

00267	DOS PRIOR TO RECIP BIRTH	DENY
00295	ENC PRV NOT ENRL TAX	IGNORE
00296	ENC PRV INV FOR DOS	IGNORE
00297	ENC PRV NOT ON FILE	IGNORE
00298	RECIP NOT ENRL W/ THIS ENC PRV	IGNORE
00299	ENCOUNTER HMO ENROLLMENT CHECK	PAY AND REPORT
00300	BILL PROV INVALID/ NOT ON FILE	DENY
00301	ATTEND PROV M/I	PAY AND REPORT
00308	BILLING PROV INVALID FOR DOS	DENY
00313	M/I TYPE BILL	PAY AND REPORT
00320	VENT CARE NO PAY TO PRV TAXON	IGNORE
00322	REND PROV NUM CHECK	IGNORE
00326	REND PROV NUM CHECK	PAY AND REPORT
00328	PEND PER 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
00613	PRIM DIAG MISSING	DENY
00628	BILLING PROV ID REQUIRED	IGNORE
00686	ADJ/VOID REPLC TCN INVALID	DENY
00689	UNDEFINED CLAIM TYPE	IGNORE
00701	MISSING BILL PROV TAXON CODE	DENY
00800	PROC CODE/TAXON REQ PSYCH DX	PAY AND REPORT
00810	PRICING DTE INVALID	IGNORE
00811	PRICING CODE MOD REC M/I	IGNORE
00812	PRICING FACTOR CODE SEG M/I	IGNORE
00813	PRICING MOD PROC CODE DTE M/I	IGNORE
00814	SEC FACT CDE X & % SEG DTE M/I	IGNORE
00815	SEC FCT CDE Y PSTOP SEG DT M/I	IGNORE
01005	ANTHES PROC REQ ANTHES MODS	IGNORE
01060	ADMISSION HOUR INVALID	IGNORE

01061	ONLY ONE DOS PER CLAIM	IGNORE
01102	PRV TAXON CHCK - RAD PROF SRV	IGNORE
01200	INPAT CLM BILL ACCOM REV CDE	DENY
01201	MCE - ADMIT DTE = DISCH DTE	DENY
01202	M/I ADMIT AND DISCH HRS	DENY
01205	MCE: PAT STAT INVLD FOR TOB	DENY
01207	MCE - INVALID AGE	PAY AND REPORT
01208	MCE - INVALID SEX	PAY AND REPORT
01209	MCE - INVALID PATIENT STATUS	DENY
01705	PA REQD FOR CAPCH/DA/CO RECIP	PAY AND REPORT
01792	DME SUPPLIES INCLD IN PR DIEM	DENY
02101	INVALID MODIFIER COMB	IGNORE
02102	INVALID MODIFIERS	PAY AND REPORT
02104	TAXON NOT ALLOWED WITH MOD	PAY AND REPORT
02105	POST-OP DATES M/I WITH MOD 55	IGNORE
02106	LN W/ MOD 55 MST BE SAME DOS	IGNORE
02107	XOVER CLAIM FOR CAP PROVIDER	IGNORE
02111	MODIFIER CC INTERNAL USE ONLY	IGNORE
02143	CIRCUMCISION REQ MED RECS	IGNORE
03001	REV/HCPCS CD M/I COMBO	IGNORE
03010	M/I MOD FOR PROF XOVER	IGNORE
03012	HOME HLTH RECIP NOT ELG MCARE	IGNORE
03100	CARDIO CODE REQ LC LD LM RC RI	IGNORE
03101	MODIFIER Q7, Q8 OR Q9 REQ	IGNORE

03200	MCE - INVALID ICD-9 CM PROC	DENY
03201	MCE INVLD FOR SEX PRIN PROC	PAY AND REPORT
03224	MCE-PROC INCONSISTENT WITH LOS	PAY AND REPORT
03405	HIST CLM CANNOT BE ADJ/VOIDED	DENY
03406	HIST REC NOT FND FOR ADJ/VOID	DENY
03407	ADJ/VOID - PRV NOT ON HIST REC	DENY
04200	MCE - ADMITTING DIAG MISSING	DENY
04201	MCE - PRIN DIAG CODE MISSING	DENY
04202	MCE DIAG CD - ADMIT DIAG	DENY
04203	MCE DIAG CODE INVLD RECIP SEX	PAY AND REPORT
04206	MCE MANIFEST CODE AS PRIN DIAG	DENY
04207	MCE E-CODE AS PRIN DIAG	DENY
04208	MCE - UNACCEPTABLE PRIN DIAG	DENY
04209	MCE - PRIN DIAG REQ SEC DIAG	PAY AND REPORT
04210	MCE - DUPE OF PRIN DIAG	DENY
04506	PROC INVLD FOR DIAG	IGNORE
04507	PROC INVLD FOR DIAG	IGNORE
04508	PROC INVLD FOR DIAG	IGNORE
04509	PROC INVLD FOR DIAG	IGNORE
04510	PROC INVLD FOR DIAG	IGNORE
04511	PROC INVLD FOR DIAG	IGNORE
07001	TAXON FOR ATTND/REND PROV M/I	DENY
07011	INVLD BILLING PROV TAXON CODE	DENY
07012	INVLD REND PROV TAXONOMY CODE	DENY

07013	INVLD ATTEND PROV TAXON CODE	PAY AND REPORT
07100	ANESTH MUST BILL BY APPR PROV	IGNORE
07101	ASC MODIFIER REQUIREMENTS	IGNORE
13320	DUP-SAME PROV/AMT/DOS/PX	DENY
13420	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
13460	POSSIBLE DUP-SAME PROV/PX/DOS	PAY AND REPORT
13470	LESS SEV DUPLICATE OUTPATIENT	PAY AND REPORT
13480	POSSIBLE DUP SAME PROV/OVRLAP	PAY AND REPORT
13490	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13500	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13510	POSSIBLE DUP/SME PRV/OVRLP DOS	PAY AND REPORT
13580	DUPLICATE SAME PROV/AMT/DOS	PAY AND REPORT
13590	DUPLICATE-SAME PROV/AMT/DOS	PAY AND REPORT
25980	EXACT DUPE. SAME DOS/ADMT/NDC	PAY AND REPORT
34420	EXACT DUP SAME DOS/PX/MOD/AMT	PAY AND REPORT
34460	SEV DUP-SAME PX/PRV/IM/DOS/MOD	DENY
34490	DUP-PX/IM/DOS/MOD/$$/PRV/TCN	PAY AND REPORT
34550	SEV DUP-SAME PX/IM/MOD/DOS/TCN	PAY AND REPORT
39360	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
39380	EXACT/LESS SEVERE DUPLICATE	PAY AND REPORT
49450	PROCDURE CODE UNIT LIMIT	PAY AND REPORT
53800	Dupe service or procedure	PAY AND REPORT
53810	Dupe service or procedure	PAY AND REPORT
53820	Dupe service or procedure	PAY AND REPORT

53830	Dupe service or procedure	PAY AND REPORT
53840	Limit of one unit per day	PAY AND REPORT
53850	Limit of one unit per day	PAY AND REPORT
53860	Limit of one unit per month	PAY AND REPORT
53870	Limit of one unit per day	PAY AND REPORT
53880	Limit of 24 units per day	DENY
53890	Limit of 96 units per day	DENY
53900	Limit of 96 units per day	DENY