CCME

2019 External Quality Review

TRILLIUM HEALTH RESOURCES

Submitted: July 3, 2019

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

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EXECUTIVE SUMMARY

The *Balanced Budget Act of 1997* requires State Medicaid Agencies that contract with Prepaid Inpatient Health Plans (PIHPs) to evaluate their compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358 (42 CFR § 438.358)*. This review determines the level of performance demonstrated by the Trillium Health Resources (Trillium). This report contains a description of the process and the results of the 2019 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of North Carolina Medicaid (NC Medicaid).

Goals of the review are to:

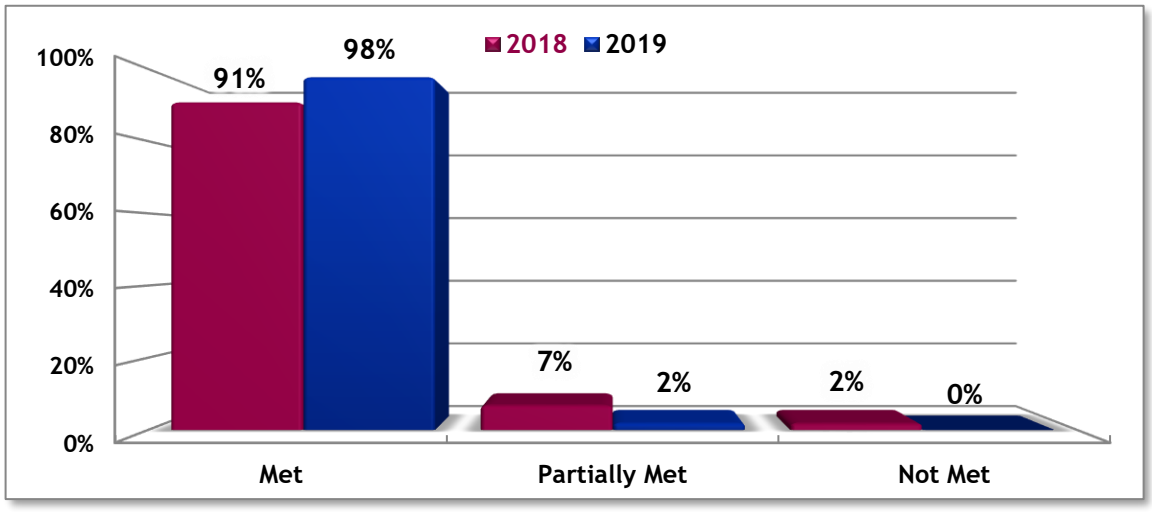
- Determine if Trillium complies with service delivery as mandated by their *NC Medicaid Contract*
- Provide feedback for potential areas of further improvement
- Verify the delivery and determine the quality of contracted health care services

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

A. Overall Findings

The 2019 Annual EQR reflects that Trillium achieved a "Met" score for 98% of the standards reviewed. As *Figure 1* indicates, 2% of the standards were scored as "Partially Met," and less than 1% of the standards were scored as "Not Met." *Figure 1* provides a comparison of Trillium's 2018 review results to 2019 results.

Figure 1: Annual EQR Comparative Results



B. Overall Recommendations

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

Administration

Trillium met 100% of the Administrative EQR. Recommendations were made to improve upon the management of Trillium's policy and procedure set and to better represent staffing patterns within the Organizational Chart. Items that Trillium can address moving forward include correcting submitted third-party payer claims to have the appropriate COB identifier filled and addressing the submission of appropriately mapped HCPCS (Healthcare Common Procedure Coding System) codes to revenue codes required for lab, drug, and radiologic services.

Provider Services

Trillium met 97% of the Provider Services standards in the current EQR. There are two Corrective Actions and four Recommendations focused on processes in the Credentialing/Recredentialing areas. The Corrective Actions are both related to items missing from the recredentialing files. Three of the Recommendations are to correct broken links to items on the Trillium website, which was an issue at the last EQR. Another Recommendation repeated from the last EQR is to include appointment wait times in the *Trillium Call Center Training for New Providers* (the *Provider Manual* has the appointment wait times). The final Recommendation is to revise the *Member and Family*

Handbook to notify members that, if a network specialist is not available, the member may use an out-of-network provider with no benefit penalty.

Enrollee Services

Trillium met 100% of the Enrollee Services standards in the current EQR. There are three Recommendations given. The Recommendations were focused on adding information in the *Network Provider Directory* regarding locations of Post Stabilization services, a website link that yielded a "page not found" message, and the need to add member procedures for obtaining out-of-state coverage of services.

Quality Improvement

Trillium met 94% of the Quality standards in the current EQR. There is one Corrective Action and two Recommendations given. The Corrective Action and one Recommendation are centered around conclusions from the *Experience of Care in Health Outcomes (ECHO)* Survey. Conclusions do not include plans to improve survey items that were identified as low scoring. Trillium needs to improve lower scoring areas of the 2018 Adult and Child *ECHO Surveys* and discuss the intervention progress with QIC throughout the year and adjust as needed. CCME recommends that Trillium adjust the *ECHO Survey* goal percentage for "overall satisfaction" to a fixed target, and work to achieve that target. Currently the goal is set for the "state average", which will be different each year. The last Recommendation is to include the QIP Annual Report within the Annual Quality Management Program Evaluation, embedded or as an appendix.

Utilization Management

Trillium met 98% of the Utilization Management (UM) standards in the current EQR. There is one Corrective Action and two Recommendations in the UM section. One Corrective Action includes the identification of a review criterion "for children 3-6 years old" and to add the criteria into policy and procedure. Recommendations include adding the peer reviewer name and credentials to the Treatment Authorization Request documentation and include information about Incedo within the Care Coordination Program Description, to support the care coordination supervision, monitoring, and data analytics it provides to care coordination.

Grievances and Appeals

Trillium met 100% of the Grievance and Appeals standards in this year's EQR. Five recommendations were given to better hone Trillium's Grievance and Appeals procedures. Review of the Grievance and Appeal files resulted in five recommendations that will assist Trillium staff in documenting internal steps taken during the resolution of Grievances and Appeals. Recommendations were also given to assist Trillium in analyzing and reporting Appeals data that is more meaningful and ensuring Trillium's *Provider*

Manual fully informs providers that acknowledgement notifications are sent when a Medicaid appeal is received.

Delegation

Trillium has six delegated entities, with fully executed Delegation Agreements and Business Associates Agreements with all six. Trillium conducted annual monitoring with all delegates. Trillium met 100% of the Delegation standards for this year's EQR.

Program Integrity

Trillium met 100% of the Program Integrity (PI) standards in this year's EQR. Trillium case files were 99% compliant as one of the 15 files reviewed was missing one of eight required elements. A recommendation is made to capture the key elements of each PI file in an executive summary. This will also serve as a cross check to ensure all elements are present in the PI files. The review of Trillium PI documentation showed two PI processes related to overpayments, assessment, or fines due to the State are not captured in policies or procedures. Two recommendations were given to ensure Trillium PI policies and procedures are in alignment with these *NC Medicaid Contract* requirements.

Financial Services

The 2019 Financial Services EQR review included an offsite review of finance Desk Materials including audit reports, NC Medicaid financial cost reports, and policies and procedures. The Onsite review involves interviewing Trillium staff to evaluate whether Trillium meets nine financial EQR standards. Trillium received eight "Met" scores, and one "Not Met" score for not meeting the 85% Medical Loss Ratio as required by *42 CFR* § *438.8*. CCME's *Corrective Action Plan* states that Trillium needs to create a plan to monitor and correct the Medical Loss Ratio to meet the 85% contract requirement within three months. Trillium had completed the prior year's suggestion of adding language citing the 10-year record retention requirement to the Financial Record Retention procedure. Trillium's current ratio exceeded the minimum requirements and all financial reports were submitted on time.

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 are minor issues with the procedure code value in both the Professional and Institutional encounters that Trillium should review and revise in their 837 mapping. Overall, Trillium has corrected all issues previously identified in the 2016 and 2017

encounter data validation reports and made significant strides ensuring they are submitting complete and accurate data to NC Medicaid.

METHODOLOGY

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

On April 17, 2019, CCME sent notification to Trillium that the annual EQR was being initiated (see *Attachment 1*). This notification included:

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

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

The review consisted of two segments. The first was a Desk Review of materials and documents received from Trillium on May 8, 2019 and reviewed in the offices of CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement (QI) and Medical Management Programs. Also included in the Desk Review was a review of Credentialing, Grievance, Utilization, Care Coordination, Care Management, and Appeal files.

The second segment was a two-day, Onsite review conducted on June 5 and June 6, 2019 at Trillium's corporate office in Greenville, North Carolina. CCME's Onsite visit focused on areas not covered in the Desk Review along with areas needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's Onsite activities included:

- Entrance and Exit Conferences
- Interviews with Trillium administration and staff
- Claims systems demonstration.

FINDINGS

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

A. Administration

The Administration review focuses on the Trillium's policies, procedures, *Organizational Chart*, staffing patterns, confidentiality practices, information systems, and encounter data capture and reporting. In this year's EQR, Trillium scored a "Met" in 100% of the Administrative standards.

Policies & Procedures

A thorough review was completed of Trillium's 108 policies, 174 procedures, policies and procedures governing policy and procedure management, Quality Improvement Committee (QIC) minutes, the *Master Policy Tracking List*, and the *Master Procedure Tracking List*.

Policies and procedures are revised as needed, as is evidenced in the master tracking lists and footers of each policy and procedure. The QIC is involved in the annual review of policies and procedures and final approval is issued by the Chief Executive Officer.

There was evidence of errors in the management of the tracking lists, policies and procedures submitted. For example, the *Enrollee Access to PHI* procedure was renamed *Member Access to PHI* but the *Procedure Tracking List* was not updated. The *UM, Claims, Contracts & Training* procedure sets showed the last annual review was in March 2018, but the individual procedures show the last review was in March 2019. One procedure and three policies were not accounted for in the Desk Material upload for this year's EQR; Post Payment Review, Board Attorney, Contracting with Non-Medicaid Providers, and Complaints and Grievances. It is likely these policies and procedure were renamed, merged into another policy or procedure, or retired. The *Training* procedure still showed tracked changes in the footer, even though it had recently been reviewed and approved.

During the Onsite discussion, staff explained the Master Tracking Lists were for audit purposes only. Actual tracking of policies and procedures is within a smartsheet that is updated by an administrative support person and used by the QIC. Overall, Trillium's policies and procedure were organized and accounted for, however, Onsite discussion and recent QIC minutes showed a major project of policy and procedure revision in preparation for NCQA accreditation. CCME recommends that any tracking sheets utilized, including the QIC Smartsheet, are reconciled with each policy and procedure. This will ensure all active policies and procedures are accounted for, correctly titled, and/or designated as retired prior to any upcoming audits, accreditations, or EQRs. This will also guarantee staff are utilizing the most up-to-date policies and procedures.

Organizational Staffing/ Management

Overall, Trillium is staffed to manage required PIHP functions. Onsite discussion provided clarification of a potentially significant staffing issue concern within the Call Center. Within the Call Center's Customer Service area, the *Organizational Chart* showed seven Customer Service vacancies of the available eleven positions. Staff explained that six temporary staff are not reflected on the *Organizational Chart*, leaving only one vacant position. CCME recommends this staffing structure is updated on the Call Center portion of the *Organizational Chart* to clearly reflect positions filled by temporary staff. This will more accurately reflect the current Trillium staffing structure. A recommendation was given last year to correct typos within the Network Development Department on the *Organizational Chart*. These corrections were made by Trillium.

In the previous EQR, the retirement of Trillium's Medical Director was discussed. A recommendation was made to ensure all *NC Medicaid Contract* requirements were addressed before retirement. This year, the Associate Medicaid Director, Dr. Michael Smith, has moved into the Chief Medical Officer (CMO) role. Onsite discussion and review of committee minutes showed a gradual transition of Dr. Smith into this role. A thorough review of his involvement with projects and committees showed he is providing significant oversight of the various quality, credentialing, utilization management, and clinical functions at Trillium. Trillium is currently recruiting for two physician positions to provide additional support to the UM Department. Back up to Chief Medical Officer functions have been mutually agreed upon between Vaya and Trillium, should either CMO need to be away for any length of time. At this time, there are no concerns regarding adequate oversight by a Chief Medical Officer, however, concerns are noted in the Delegation portion of this report. These concerns are focused on the liabilities within the documentation establishing the Chief Medical Officer coverage agreement between Trillium and Vaya.

Confidentiality

No specific concerns were raised during the review of confidentiality policies and procedures or Trillium practices. Trillium ensures new staff are oriented to Trillium's confidentiality requirements prior to allowing staff access to Protected Health Information (PHI). Staff are also provided an annual refresher course on PHI requirements.

Concerns were raised about the process for releasing PHI in the Appeals and Grievances EQR and the documentation by staff of guardianship verification. These concerns are discussed in further detail in the Appeals and Grievances section of this report.

Information Systems Capabilities Assessment (ISCA)

As required by its contract with CCME, IPRO conducted a review of Trillium Health Resources' information system capabilities utilizing the ISCA, as specified in the CMS protocol.

Upon receipt of the completed ISCA tool from Trillium along with supporting documentation, IPRO reviewed the responses and followed up on areas requiring clarification via interviews. Additionally, staff provided a member and claims systems review during the Onsite. Trillium employees were prepared to speak on existing processes and reports at the Onsite review. Questions regarding the ISCA tool and follow-up on last year's findings were discussed with Trillium staff.

Trillium uses the CIE to process member enrollment data, claims, submit encounters, and generate reports. As discussed, Onsite and viewed within the ISCA tool, Trillium attained full ownership of the CIE system in 2018. A new business unit with new staff was created to learn and oversee the operations of the platform. As of November 2018, the transition has been successful. Despite the transition and a hurricane which caused significant, community damage in 2018, there have been no significant disruptions to existing processes and the business continues to operate successfully due to established disaster recovery systems and back-up processes in place.

Enrollment Systems

In prior years, Trillium experienced steady growth. Monthly enrollment numbers saw an increase in 2018 compared to the 2017 monthly reported enrollment counts. It was discussed Onsite that Columbus county members had transitioned from Eastpointe over to Trillium late in 2018 and no issues were encountered in the transition. *Table 1* shows Trillium's enrollment across the last three years.

Table 1: Enrollment Counts

2016	2017	2018
192,046	207,479	248,932

The ISCA tool details the member enrollment updates, and this was discussed at the Onsite review. The Global Eligibility File (GEF) file is imported daily into the CIE system. If the GEF file is not downloaded, an email is generated to troubleshoot the issue. The daily eligibility file is compared to existing eligibility in the CIE system. New recipients are added to the CIE system with their accompanying eligibility information. Enrollees are identified by unique patient IDs. It is rare for Trillium to see members with multiple IDs, but they are able to research and merge the information into one ID. For existing recipients, base information is modified and existing information on enrollment start and end dates are updated. Member deaths are captured through the GEF file, obituaries, and notifications from family members or providers.

Providers have access to the member's information and can submit information changes to enrollee information. Internal employees will review submitted changes, approve or deny the change, and submit it back to the provider.

Eligibility is compared between the CIE system and the daily GEF file, and exception reports are generated. Trillium utilizes the monthly 820 capitation file to verify Medicaid eligibility exists in CIE for all valid payments, to analyze eligibility for members where no payments are received, and for validating recoupments.

At the Onsite review, staff displayed the enrollment information that is viewable and captured within CIE. The CIE system is able to capture demographic data like race and language.

Trillium staff was asked if they were capturing information for members where Medicare or another payer was the primary insurer, and if so, were they submitting these claims to NC Medicaid. Trillium stated that Medicare data was stored separately, and that Medicare/dual eligible members were tracked in the CIE system for coordination of benefits. Staff also discussed how this information would be displayed on the member enrollment screen. Trillium stated that claims attributed to these members are submitted to NC Medicaid, but upon review, HMS determined that Coordination of Benefits (COB) information is not captured accurately. There is a placeholder in the data to identify COB claims; however, HMS does not see that the payer ID is populated for these particular claims and will need to research if this is captured correctly.

Claims Systems

Trillium's claims are processed in the CIE system. Claims payments occur within the accounting system, Great Plains Dynamic Accounting system. ISCA responses, claims process workflows, daily denial reports, and sample audit reports provided an overview of Trillium's claims processing and reporting.

Trillium receives claims from three methods: 837 electronic file, provider web portal, and paper claims. *Table 2* details the percentage of 2018 claims received via the three methods.

Table 2: Claim Method Percentages

Source	HIPAA File	Paper	Provider Web Portal
Institutional	4.48%	0.01%	0.72%
Professional	79.4%	0.01%	15.38%

Claims are processed nightly with approximately 99% of professional claims and 98% of institutional claims being auto-adjudicated. In accordance with NC Medicaid requirements, determinations on claims (approved, denied or additional information needed) are made within 18 days of receipt, and if approved, claims are paid within 30 days of receipt. If required fields are missing from a claim, the provider portal will not allow the claim to be processed, and for other electronically-submitted claims, providers receive a 999 transaction file letting them know data elements are missing on the submitted claims. Edits and checks in place for institutional and professional encounters include, but are not limited to, provider matches, validation of Diagnosis-related groups (DRGs), duplicate claim checks, and coordination of benefits.

If incorrect or missing information is found on paper claims, staff will not key in the information but reach out to the provider for correction and resubmission. As discussed, Onsite, common denials may be for duplicate claims, timely filing issues, or incorrect taxonomy codes attributed to out-of-state providers. In addition to the ISCA review from the prior year, an accounting review found no significant findings.

Audits are conducted on all claims received via paper and entered manually into the CIE system. A sample daily claims audit report and claims exception report was submitted in the Desk Review documentation to demonstrate monitoring and oversight of claims processing in the CIE system.

Trillium captures ICD procedure codes and DRGs if they are submitted on the claim. As recently as May 2019, Trillium has addressed last year's corrective action to capture and

submit up to 25 ICD-10 diagnosis codes on institutional encounter data. Trillium captures up to 25 ICD-10 diagnosis codes via the web portal and up to 41 ICD-10 codes via HIPAA files for institutional encounters. For professional encounters, Trillium captures and submits up to 12 diagnosis codes.

As discussed Onsite, Trillium has the capability to capture and submit HealthCare Common Procedure Coding System (HCPCS) codes along with required revenue codes for specific claims regarding lab, drug or radiology services. As demonstrated Onsite with the CIE system, Trillium demonstrated they are able to capture procedure codes associated with revenue codes. However, a system issue showed that, when no relevant procedure codes are available for that service, the revenue code was mapped into the procedure code field. Trillium stated this was a system issue they would correct. When reporting these lab, drug, and radiologic service encounters to NC Medicaid, it is recommended that Trillium map HCPCS codes appropriately to corresponding revenue codes. If there is no corresponding HCPCS code for that revenue code, this field should be kept blank.

Reporting

Since bringing the CIE system in-house, Trillium has successfully managed to staff and train a new business unit to oversee and maintain processes within the CIE system.

Trillium's CIE system captures and stores enrollment and claims information. Full enrollment history is maintained in the CIE system. The claims database is backed up nightly to a repository where 30 days' worth of copied information is archived.

A disaster recovery procedure document was provided prior to the Onsite audit for review and was discussed at the Onsite. CIE is hosted with Navasite with claims centers and employees dispersed across multiple locations. The email system is a hosted system. When asked Onsite if there were any unplanned events, disasters, or disruptions to their enrollment, claims or encounter submission processes, Trillium discussed how their systems, business, and processes survived and were left intact during and after Hurricane Florence in 2018. There was no service disruption to their Medicaid enrollees and no facilities were closed.

Internal claims reports were provided as supplemental documentation for the ISCA review. A sample claim exception report, the claims lag report, and the sample claims audit reports indicate Trillium has oversight and monitoring of its claims processes.

Encounter Data Submissions

The number of professional and institutional encounters submitted to NC Medicaid in 2018 was not significantly different from prior year, as is demonstrated in *Table 3*.

Table 3: Unique Encounter Submissions

Source	2017	2018
Institutional	51,527	53,403
Professional	927,889	967,120

The number of professional and institutional encounters accepted, denied and not yet accepted, and denied but accepted on resubmission counts are shown in *Table 4* for 2018 and 2017. Denied institutional encounters increased two full percentage points from 2017 to 2018. Although the count of institutional encounters submitted decreased slightly from 2017, there is a noticeable increase in encounters denied but accepted in resubmission (10 in 2017 to 296 in 2018). In a summary paragraph, Trillium explained: *"Following review of the data and processes for pulling this information, the following contributed to the reason for the increase of the denials: The previous year, 2017, data was regenerated using the most current data and claims status. Claim lag more prevalent for 2018 claim data versus 2017 data, especially in relation to institutional claims. Taxonomies remain highest denial reason, which in most cases require provider intervention to correct."*

Table 4: Encounter Submissions Acceptance and Denial Counts

	Institutional		Professional	
	2017	2018	2017	2018
Initially Accepted	50,416	47,787	851,056	872,120
Denied, Accepted on Resubmission	10	296	14,599	16,601
Denied, Not Yet Accepted	832	1,481	4,749	10,740
Total	51,258	49,564	870,404	899,461
% of Submissions Initially Accepted	98.4%	96.4%	97.8%	97.0%

Trillium has a defined process in place for encounter data submission, with 837 files submitted to NC Medicaid on a weekly basis, and 835 files received back from NC Medicaid through the NCTracks system. The 835 file from NCTracks is utilized to review denials. Trillium has the ability to track claims from the adjudication process to their encounter submissions status. It was noted in the ISCA tool that Trillium had made some revisions to the 835 reconciliation process. As an Onsite follow-up, Trillium provided the following explanation to clarify that response: *Please note that these changes were made to the State / DMH 835 Reconciliation Report only. Here is an overview of the most recent changes:*

1. *Added one day to the end date in the final where clause*
2. *Reasons codes were added / updated*
3. *Remark codes were added*
4. *Modification of the database to include all og837 tables (outgoing)"*

It takes about 7 days from the time of adjudication for a claim to be submitted to NC Medicaid. Encounter records are never altered by staff. Information on denied encounters is received on the 835 reconciliation report. If an encounter is denied due to taxonomy issues, this will be corrected and resubmitted. If a denied encounter is based on member's eligibility having changed, this may be a situation in which the encounter is not resubmitted. As of December 2018, denied encounters are grouped by a denial code, matched against a tracking log (SQL database), and submitted to the appropriate department(s) for investigation and resubmission. A screenshot of the current denial report was provided.

Due to continuous improvement processes, Trillium has improved their encounter data submissions greatly from 2017 reported values. The PIHP meets NC Medicaid standards for encounter submissions and has less than a 1% denial rate of encounter data submissions.

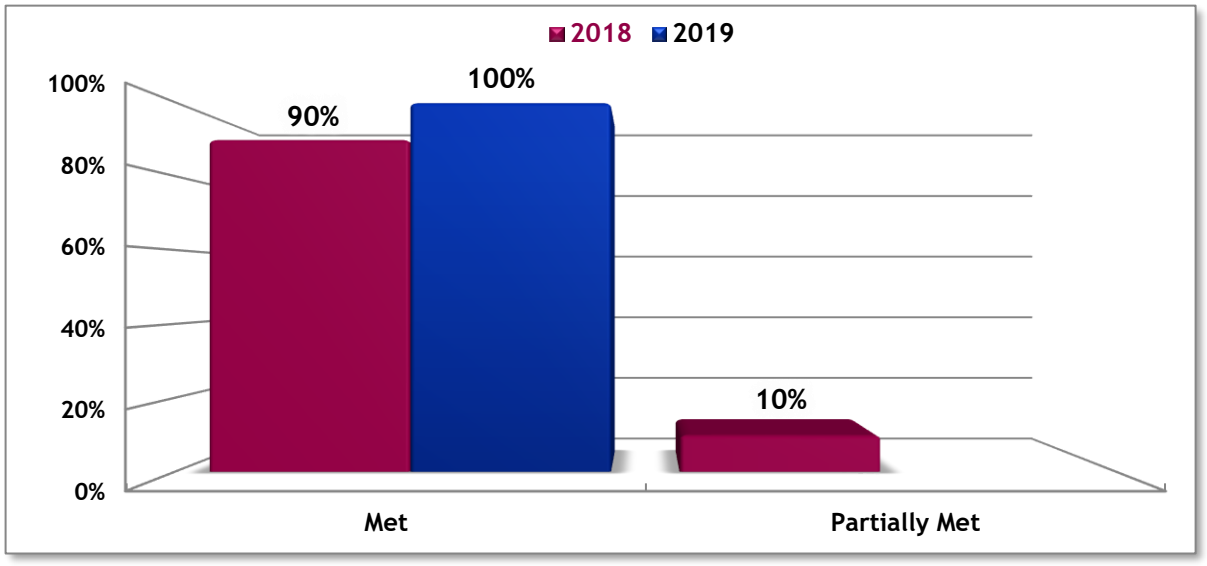
Trillium responded to ISCA corrective action findings from last year regarding not capturing and submitting all required ICD-10 diagnosis codes for institutional claims. Trillium now submits up to 25 ICD-10 diagnosis codes on Institutional claims and 12 ICD-10 diagnosis codes on professional claims as of May 2019.

It was recommended to Trillium that if lab, drug, or radiologic services have a revenue code that cannot be mapped to an appropriate HCPCS procedure code, it is best to leave that procedure code field blank. As viewed Onsite, the CIE system has the capability of capturing procedure codes for these services. For those services not having a procedure code, the revenue codes were populated in the procedure code field on the CIE system screen. This is a system bug Trillium acknowledged and stated they would fix.

CCME also recommends that, if encounter data for third party payers are included in submissions, Trillium needs to populate the payer ID appropriately to help flag encounters listed for coordination of benefits.

Figure 2 provides a comparison of Trillium's current Administrative Review results to the 2018 review results.

Figure 2: Administration Comparative Findings



Strengths

- Trillium has a comprehensive enrollment and claims processing system.
- As of Spring 2019, Trillium can capture up to 25 diagnosis codes on institutional claims and can also submit up to 25 diagnosis codes for institutional encounter data submissions. This was a Corrective Action Plan item from the prior year.
- The transition of the CIE system to Trillium's ownership was successful, as was the implementation of a new business unit to oversee CIE. There were no significant disruptions to the service members received this past year, including during and after Hurricane Florence.

Weaknesses

- Third party payer encounter submissions may be missing the appropriate payer ID to identify coordination of benefits.
- The number of denied institutional encounters increased from 2017 to 2018. Trillium did explain this may be attributed to a lag in reporting data. However, a 2018 denial rate ((denied, not yet accepted + denied, accepted upon readmission)/(total

institutional encounters submitted)) of 3.6% is near to 2016's reported value of 2.9% of institutional encounters denied.

Recommendations

- Leave procedure codes blank if the HCPCS code provided does not map to the revenue code for a lab, drug, or radiology service encounter.
- For encounters associated with third-party payers and are submitted to NC Medicaid, fill in the appropriate payer ID field to ensure these encounters are identified for coordination of benefits.

B. Provider Services

The Provider Services review is comprised of Credentialing and Recredentialing, Network Adequacy, Provider Accessibility, Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, and Practitioner Medical Records. CCME reviewed relevant policies and procedures, the *Provider Manual*, the *Credentialing Program Description*, the *Credentialing Committee By-Laws*, Credentialing Committee meeting minutes, Clinical Advisory Committee meeting minutes, credentialing/recredentialing files, provider network information, practice guidelines, provider training materials, the *2017 Network Adequacy & Accessibility Analysis (finalized 2018)*, and the Trillium website. An Onsite interview included personnel from the Trillium Network, Contracts/Training, and Research and Development Departments.

There were seven items requiring Corrective Action at the last EQR. Due to a change in the *NC Medicaid Contract*, one of the items is no longer an issue. Of the six remaining Corrective Action items, five were found in the current EQR to have been resolved, with changes maintained. The issue of provider performance profiling is unresolved and discussed later in this report.

At the last EQR, there were five Recommendations in the Credentialing/Recredentialing area. Changes were made and retained in four of the five. An unresolved issue in the current EQR is regarding failure to obtain Ownership Disclosure information from LIPs, which now requires Corrective Action. There were two Recommendations in the Network Adequacy section of the last EQR, and issues regarding both of those items continue in the current EQR.

Trillium experienced several personnel changes in the Network area in the past year. The Network Director and Network Services Manager position were combined to create a Vice President of Network position. The Credentialing/Re-Credentialing Unit moved to the Research and Development area in December 2018 but will be moving back to the Network Department in July 2019.

Dr. Michael Smith, CMO, chairs and is a voting member of the Credentialing Committee. Additional voting members of the Credentialing Committee include network providers representing several licensure categories and specialty areas, and various Trillium staff members.

The *Credentialing Program Description* and several procedures, including the *Credentialing and Re-Credentialing Process* procedure, address the credentialing process. The *Credentialing Program Description* indicates the Credentialing Committee "meets as often as necessary to fulfill its responsibilities, but no less than quarterly, with additional meetings held as needed to fulfill responsibilities". There were 11 Credentialing Committee meetings between April 2018 and March 2019. Electronic votes were taken on items when needed, and evidence of those votes was submitted for review.

There were 11 voting members of the Credentialing Committee from April 2018 until December 2018. Two members of the Credentialing Committee were no longer on the Committee beginning with the December meeting, and have not been replaced. A quorum of voting members was present for all meetings.

The credentialing and recredentialing file review showed the files were organized and contained appropriate information. The file review included verifying the inclusion of the evidence of the required Primary Source Verifications (PSVs). A few items were not located during the Desk Review. Most items were later located and provided either in response to the Onsite Documents Request, or during the Onsite visit. Details regarding these items are contained in the *Attachment 4: Tabular Spreadsheet*.

As required by NC Medicaid, Trillium conducts an annual *Network Adequacy and Accessibility Analysis (Gaps Analysis),* which includes obtaining feedback from members, providers and other stakeholders, as well as Geo-Access studies. The *2017 Network Adequacy & Accessibility Analysis (Finalized 2018)* details the steps Trillium pursued to increase member/family and stakeholder input into the process. Trillium's concerted efforts resulted in a 39.76% increase in stakeholder survey responses and a 102% increase in member and family survey responses.

A cross-departmental Recruitment and Retention Workgroup meets monthly to review development requests that have been submitted by Trillium employees or providers. Network expansion is based on verified need. Client Specific Agreements are used to obtain services when an in-network provider is not available.

Trillium reported a smooth transition for the addition of Columbus County last July, though there were some disruptions created by the effects of Hurricane Florence in September. To prepare Columbus County for inclusion within the Trillium PIHP, a "fair" and seven "Listening Sessions" were offered throughout Columbus County, to educate

that community on services Trillium offers. Over 50 provider locations were added as a result of the Columbus County realignment.

The following chart shows 97% of the standards in the Provider Services section scored as "Met." The "Partially Met" scores are related to items in the credentialing/ recredentialing process, as detailed later in this report. *Figure 3* provides a comparison of the 2018 scores versus the 2019 scores.

Figure 3: Provider Services Comparative Findings

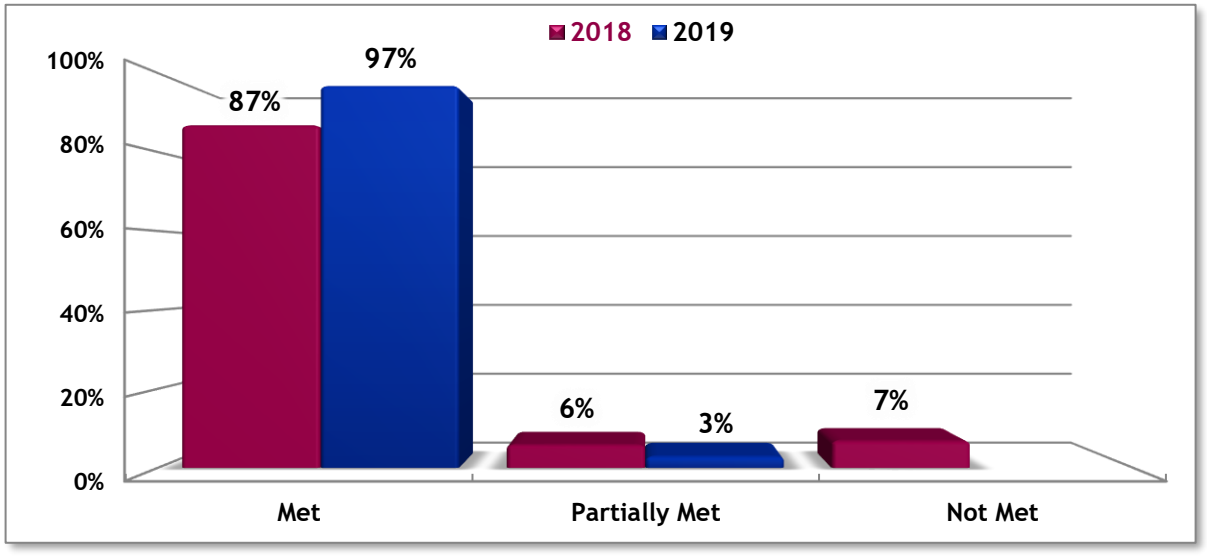


Table 5: Provider Services

Section	Standard	2019 Review
Credentialing and Recredentialing	Recredentialing: Ownership Disclosure is addressed	Partially Met
	Review of provider profiling activities	Partially Met

Strengths

- Trillium's strategies to increase member/family and stakeholder input for the *Gaps Analysis* resulted in a 39.76% increase in stakeholder survey responses and a 102% increase in member and family survey responses.
- There are separate toll-free numbers for administrative and business matters.

- Trillium instituted changes in the credentialing and recredentialing processes, eliminating some of the issues found in previous EQRs.
- Trillium uses a ticketing system for provider questions, concerns, and needs, in order to track and trend requests to the Network Department.
- Trillium has a Learning Portal with training/education materials that is accessible to providers on demand.
- The *Provider Manual* includes a table of "Correspondence Timelines and Address References", a list of "Important Email Addresses", and a list of "Resources and Web Links" to assist providers.

Weaknesses

- The Credentialing Committee reviews "flagged"/"red-flagged" applications. No documents define or give examples of what constitutes a "flag"/"red flag" or an adverse "hit".
- The PSVs of the DEA certificates and the NPPES queries for practitioners, and some of the PSVs of accreditation in organizational files do not include the URL of the website nor the date of the query.
- There are inconsistencies in the evidence of the query of the *State Exclusion List*.
- Some of the *Supplemental & LIP Re-Credentialing Checklist* list items are relevant to an agency (i.e. accreditation verification, Articles of Incorporation, facility license), but do not include some of the PSVs relevant to practitioners, such as the PSV of the practitioner's clinical license. The PSVs are in the files.
- The six LIP recredentialing files submitted for Desk Review do not contain complete Ownership Disclosure information, and Trillium confirmed it was not obtained as part of the recredentialing process.
- Trillium uses the *Verification of Provider Standing (VPS*) form to document provider performance for consideration at recredentialing. The submitted recredentialing files of the six LPs/"Supplementals" did not have the *Complaints & Grievances* or *Network* sections of the form completed, and the Supplemental & LIP Re-Credentialing Checklists indicates the VPS is only needed from Program Integrity for "supplemental" practitioners.
- The *Member and Family Handbook* references out-of-network providers in several places, but does not clearly communicate that, if medically necessary treatment is required but specialty services are not available in-network, the member may use an out-of-network specialist with no benefit penalty.
- The Trillium *Provider Manual* includes a link to the *Cultural Competency Plan* on the Trillium website; however, the link goes to "Page not found". A search of the Trillium

website for the *Cultural Competency Plan* provides three results, but none of the results link directly to the *Cultural Competency Plan*.

- The Trillium *Provider Manual* includes a link to the Clinical Practice Guidelines on the Trillium website; however, when the link is clicked, a new email opens, and the URL is inserted in the "To" field. The link does not go to the website, though the Clinical Practice Guidelines are posted on the Trillium website.
- As indicated at the last two EQRs, the Trillium *Call Center Training for New Providers* has correct timeframes for Access Standards but does not contain any information regarding appointment wait times.

Corrective Action

- 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." Ensure the required criminal background check and required exclusion checks are conducted for all persons with "an ownership or control interest", as required by the *NC Medicaid Contract*, *Attachment O* and *Sections 1.13* and *1.14*.
- As indicated in the Corrective Action for the last EQR, and to comply with Trillium's *Credentialing and Recredentialing Process* procedure and the *NC Medicaid Contract, Section 7.6,* ensure provider performance is taken into consideration at recredentialing. If Trillium is using the *Verification of Provider Standing (VPS)* forms for this process, confirm all completed *VPS* forms have been received prior to submitting the recredentialing application packet for approval by the CMO or Credentialing Committee.

Recommendations

- In the *Credentialing and Recredentialing Process* procedure and other documents that describe the credentialing/recredentialing process, provide a definition or examples of items that are considered an (adverse) "hit" or a "flag" that would result in a file being reviewed by the Credentialing Committee.
- Include the URL of the website and the date of the query on the PSV printouts, such as the queries of the DEA and the NPPES for practitioner files and on the PSV printouts of queries of accreditation for organizational files.
- Standardize the query process of the *State Exclusion List* to include the details of how the query needs to be conducted and saved, for purposes of the PSV.
- Revise the *Credentialing Checklist* and the *Recredentialing Checksheet* to include the PSV of required items such as the practitioner clinical license and document the date the PSV is conducted.

- Revise the *Member and Family Handbook* to clearly indicate that, if a network specialist is not available, the member may use an out-of-network specialist with no benefit penalty.
- Correct the link in the *Provider Manual* to the *Cultural Competency Plan*. Have a staff member periodically check links to ensure they work. Enable a direct link on the website from a "Search" to the *Cultural Competency Plan*.
- Correct the link in the *Provider Manual* to the Clinical Practice Guidelines. Have a staff member periodically check links to ensure they work.

C. Enrollee Services

Enrollee Services includes a review of the Enrollee Rights and Responsibilities, enrollee program education, behavioral health and chronic disease management Education, and the Call Center. Enrollee Services was assessed through the review of policies and procedures, the *Member and Family Handbook*, the *Network Provider Directory*, staff training documentation, call center monitoring, and the Trillium website. Three corrective actions and two recommendations were implemented and maintained from the 2018 EQR.

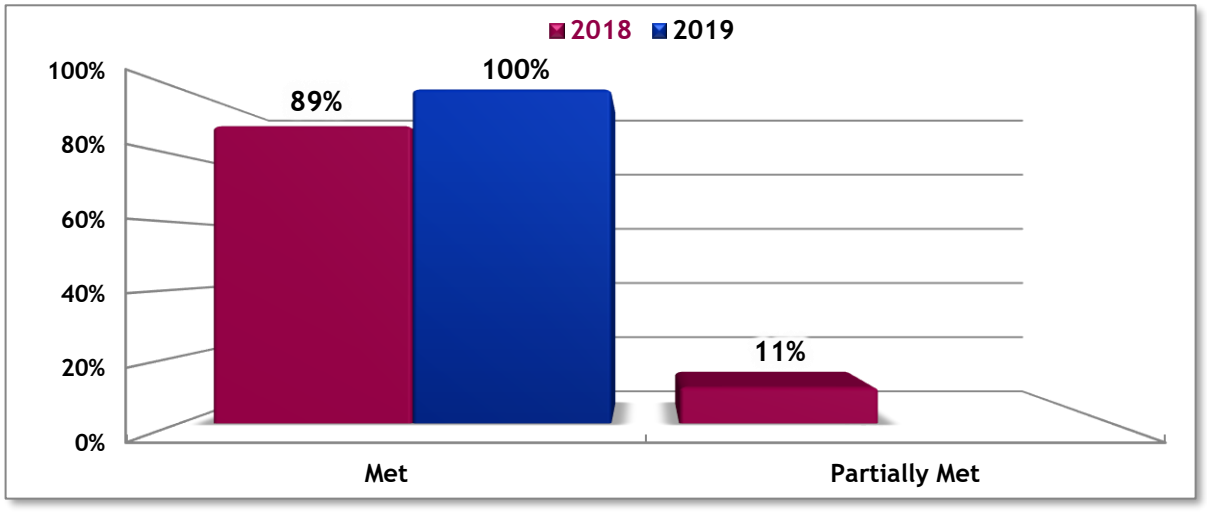
All required enrollee rights and responsibilities were documented in the procedure titled *Member Rights and Responsibilities* and includes both member rights and the procedure for informing enrollees of these rights. The member rights are documented in the *Member and Family Handbook* for easy access by the members.

The *New Member Form Letter* is sent to members with 14 days of requesting service and explains how to access the website at www.TrilliumHealthResources.org for information including: the *Member and Family Handbook*, Enrollee rights and responsibilities, Benefit Plan Information, Service Definitions, a "Welcome to Trillium" presentation, the *Network Provider Directory*, and an "Educational Opportunities" section. The Access to Care phone number is provided for members 24 hours a day, 365 days a year. There were three weaknesses within this area of the review centering around adding information in the *Network Provider Directory* about locations of Post Stabilization services. Three corresponding recommendations were made for the weaknesses.

Call Center staff use clinical triage questions to determine the level of urgency for each call. The Call Center Access Clinicians utilizes mobile crisis, if needed. They will dispatch mobile crisis, law enforcement, or EMS depending on which need is determined. Call Center staff stay on the line with the caller until services arrive. Staff use the Language Line service to determine the correct language for a member and translation service is provided to all non-English speaking callers. Call performance statistics for the period of April 2018 through March 2019 are within the parameters set by NC Medicaid.

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

Figure 4: Enrollee Services Comparative Findings



Strengths

- Three corrective actions and two recommendations were implemented and maintained from the 2018 EQR.
- Trillium staff reported they have implemented the Comprehensive Health Assessment for Teens (CHAT), a self-administered, 45-minute assessment that evaluates Mental Health and Substance Use in teens while at a non-crisis appointment.
- Trillium answered 913 calls on the crisis line for Hurricane Florence.
- Trillium staff reported The Call Center Access & Care Coordination Manager is attending disaster training to help with planning for future natural disasters.

Weaknesses

- In the *Network Provider Directory* online search, there is a filter for Service Category. The category "Emergency Department" brings up a list of 238 locations for Emergency Departments. Onsite interview confirmed that the 238 locations include walk-in clinics as well. There is no Service Category for Post Stabilization services.
- Out-of-area coverage is discussed and easy to understand in the *Member and Family Handbook*. Although, there is no explanation of out-of-state coverage.
- The New Member Orientation and Community Training Survey link on the Trillium website resulted in a "page not found" message.

Recommendations

- In the online *Network Provider Directory*, add Post Stabilization services as a Service Category search criteria in addition to Emergency Services. The search for both Emergency and Post Stabilization services should return only those providers that offer both services.
- In the *Member and Family Handbook,* add member procedures for obtaining out-of-state coverage of services, if special procedures exist.
- Correct the New Member Orientation and Community Training Survey link on the Trillium website to display the correct information.

D. Quality Improvement

The Quality Improvement (QI) section covers the QI Program, QI Committees, provider participation in QI, the QI Annual Evaluation, performance measures, and Performance Improvement Projects (PIPs). Several documents were reviewed prior to the Onsite interview including: *The 2018-2019 Quality Management Plan*, the Quality Improvement Committee (QIC) minutes and supporting documentation, The Global QIC (GQIC) minutes and supporting documentation, The *Quality Management (QM) Work Plan*, QM policies and procedures, *Trillium Provider Manual* revised May 2019, *The Annual Quality Management Program Evaluation Fiscal Year 2017-2018,* PIPs, and Performance Measures data. The Onsite interview involved staff from Trillium's Quality and IT Departments.

Since the last EQR, the QM Department has reorganized to directly report to Dr. Michael Smith, Chief Medical Officer. The Data Analyst positions have reorganized under the Information Technology (IT) Department, and there is a new Director of QM. *The 2018-2019 Quality Management Plan* and the *QM Work Plan* provide structure and accountability for the QM program.

The *Annual 2018-2019 Quality Management Plan* explains how surveys are administered, results reviewed and analyzed by QIC, results compared to previous annual survey data, discussed in committees, and conclusions documented in meeting minutes. All of these steps were followed for the *Experience of Care in Health Outcomes (ECHO) Surveys*. Although, conclusions do not include plans to improve survey items that were identified as low scoring. Trillium needs to improve lower scoring areas of the 2018 Adult and Child *ECHO Surveys* and discuss the intervention progress with QIC throughout the year and adjust as needed. This is the only area in this section identified for corrective action.

The QIC consists of a cross-functional team including members from various departments across the organization, in addition to the Trillium Health Resources Chief Medical Officer. The Chief Medical Officer and the Senior Director of Quality Management co-chair the committee. GQIC has provider representatives, Regional Consumer and Family

Advisory Committee members, and Trillium staff. Trillium staff do not have voting privileges. Recruiting was completed for vacant positions of the GQIC, except for a network physician, but a possible candidate has been identified.

Trillium recommends providers complete Quality Improvement Projects (QIPs) annually. Trillium states in the *Provider Manual* to work on "QIPs that demonstrate evidence of performance improvement related to organizational process/ structure, member outcomes, or other provider improvement activities." Technical assistance related to QIPs is provided if the provider requests it. *Provider Performance Reports* are created by the QM Data Unit. They are sent to providers quarterly to offer information on how they are performing in certain areas compared to other similar providers. Trillium provides a blinded peer review, primarily for QIP review of provider's individual QIPS. The Trillium QM Department has decided to discontinue monitoring of all provider QIPs but is considering a random sampling review in the future.

The Chief Medical Officer and Clinical Advisory Committee (CAC) review monitoring of practitioner adherence of selected elements of the Clinical Practice Guidelines on an annual basis and provide feedback and assistance to the provider agencies as needed. New Clinical Practice Guidelines will be monitored as a result of CAC voting to discontinue the previous process. The new process began around April 2019 and will involve HEDIS measures that relate to the newly targeted Clinical Practice Guidelines.

The *Annual Quality Management Program Evaluation Fiscal Year 2017-2018* document contains an Executive Summary, 2017-2018 highlights, 17 QM Program "Compliance Elements," and a Summary. The Compliance Elements each have goals, outcome analysis, Met/Not Met scores, and next steps. The Compliance Elements are a complete representation of the Trillium QM program. CCME recommends enhancing the QIP compliance element by including information documented in the *QIP Annual Report*. This will detail goals, barriers, interventions, measurement period, and grafting over time.

Trillium's *Detecting Over and Under Utilization* procedure describes a review process that includes using claims data to examine trends across multiple services, inpatient readmissions, outpatient visits, etc. This procedure also discusses outlier utilization and identification of high-risk members. The *QM 2018-2019 Work Plan*, CAC meeting minutes, and *Executive Dashboards* outline steps for monitoring under and over utilization, interventions to address issues identified, and completion status.

Performance Measure Validation

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

Table 6: (b) Waiver Measures

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

Table 7: (c) Waiver Measures

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

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

- Performance measure documentation
- Denominator data quality
- Validity of denominator calculation

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

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

(b) Waiver Measures Results

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

(b) Waiver measures were submitted with appropriate documentation, including data sources and calculations, as well as programming logic that was necessary. There were substantial improvements in facility-based crisis follow-up after hospitalization for mental illness in 7 days, detox and facility-based crisis follow-up after substance abuse hospitalization for the 3 day rate, and ages 65+ percent with two or more services or visits within 30 days after initiation engagement. There were no measures that had a substantial decline in rate. The current rate in comparison to last year's rate is presented in the following *Tables 8* through *17*.

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

30-day Readmission Rates for Mental Health	FY 2017	FY 2018	Change
Inpatient (Community Hospital Only)	15.6%	16.7%	1.1%
Inpatient (State Hospital Only)	6.1%	6.3%	0.2%
Inpatient (Community and State Hospital Combined)	15.4%	16.6%	1.2%
Facility Based Crisis	15.9%	18.2%	2.3%
PRTF	5.7%	2.9%	-2.8%
Combined (includes cross-overs between services)	15.0%	16.2%	1.2%

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

30-day Readmission Rates for Substance Abuse	FY 2017	FY 2018	Change
Inpatient (Community Hospital Only)	7.0%	14.9%	7.90%
Inpatient (State Hospital Only)	0.0%	0.0%	0.0%
Inpatient (Community and State Hospital Combined)	7.0%	14.6%	7.6%
Detox/Facility Based Crisis	7.2%	10.6%	3.4%
Combined (includes cross-overs between services)	7.1%	11.6%	4.5%

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

Follow-up after Hospitalization for Mental Illness	FY 2017	FY 2018	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	40.8%	35.9%	-4.9%
Percent Received Outpatient Visit Within 30 Days	62.5%	57.2%	-5.3%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	39.4%	65.5%	26.1%
Percent Received Outpatient Visit Within 30 Days	60.6%	65.5%	4.9%
PRTF			
Percent Received Outpatient Visit Within 7 Days	19.2%	16.5%	-2.7%
Percent Received Outpatient Visit Within 30 Days	51.7%	46.2%	-5.5%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	39.7%	35.6%	-4.1%
Percent Received Outpatient Visit Within 30 Days	62.0%	56.9%	-5.1%

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

Follow-up after Hospitalization for Substance Abuse	FY 2017	FY 2018	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	15.6%	11.0%	-4.6%
Percent Received Outpatient Visit Within 30 Days	28.4%	23.2%	-5.2%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	43.1%	53.6%	10.5%
Percent Received Outpatient Visit Within 7 Days	51.5%	59.6%	7.1%
Percent Received Outpatient Visit Within 30 Days	59.8%	64.7%	4.9%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	43.5%	47.2%	3.7%
Percent Received Outpatient Visit Within 30 Days	52.5%	54.6%	2.1%

NR = Numerator is not reported.

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2017	FY 2018	Change
Ages 13–17			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	36.2%	44.3%	8.1%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	14.0%	21.3%	7.3%
Ages 18–20			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	38.8%	37.8%	-1.0%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	25.2%	23.6%	-1.6%
Ages 21–34			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	43.5%	49.0%	5.5%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	27.2%	33.2%	6.0%
Ages 35–64			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	38.5%	44.5%	6.0%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	22.7%	30.9%	8.0%
Ages 65+			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	37.2%	40.8%	3.0%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	23.1%	36.0%	**12.9%**
Total (13+)			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	40.0%	45.4%	5.0%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	23.8%	30.6%	6.0%

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

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		2017	2018	Change	2017	2018	Change
3–12	Male	0.4	0.3	-0.1	17.0	13.9	-3.1
	Female	0.2	0.2	0.0	13.7	13.7	0.0
	Total	0.3	0.2	-0.1	15.9	13.8	-2.1
13–17	Male	1.2	1.1	-0.1	17.6	15.1	-2.5
	Female	1.6	1.6	0.0	13.6	12.1	-1.5
	Total	1.4	1.3	-0.1	15.3	13.4	-1.9
18–20	Male	1.5	1.7	0.2	10.3	10.3	0.0
	Female	1.6	1.4	-0.2	7.8	7.7	-0.1
	Total	1.6	1.5	-0.1	9.0	9.0	0.0
21–34	Male	4.1	4.7	0.6	8.8	7.9	-0.9
	Female	1.4	1.4	0.0	9.1	6.9	-2.2
	Total	2.0	2.1	0.1	8.9	7.4	-1.5
35–64	Male	2.8	2.9	0.1	8.7	8.0	-0.7
	Female	2.2	2.3	0.1	9.1	7.8	-1.3
	Total	2.4	2.5	0.1	8.9	7.9	-1.0
65+	Male	0.4	0.4	0.0	13.4	14.5	1.1
	Female	0.4	0.3	-0.1	16.0	16.7	0.7
	Total	0.4	0.3	-0.1	15.2	15.9	0.7
Unknown	Male	0.0	0.0	0.0	0.0	0.0	0.0
	Female	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0
Total	**Male**	**1.4**	**1.3**	**-0.1**	**11.3**	**9.9**	**-1.4**
	Female	**1.1**	**1.1**	**0.0**	**10.2**	**8.9**	**-1.3**
	Total	**1.2**	**1.2**	**0.0**	**10.7**	**9.3**	**-1.4**

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

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Heath Service			Outpatient/ED Mental Health Service		
		2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
3-12	Male	17.76%	15.04%	-2.72%	0.36%	0.30%	-0.06%	0.42%	0.36%	-0.06%	17.70%	15.00%	-2.70%
	Female	11.63%	9.66%	-1.97%	0.18%	0.15%	-0.03%	0.11%	0.06%	-0.05%	11.62%	9.65%	-1.97%
	Total	14.77%	12.41%	-2.36%	0.27%	0.23%	-0.04%	0.27%	0.21%	-0.06%	14.73%	12.39%	-2.34%
13-17	Male	18.44%	16.85%	-1.59%	1.22%	1.10%	-0.12%	0.58%	0.43%	-0.15%	18.37%	16.75%	-1.62%
	Female	20.23%	18.22%	-2.01%	1.73%	1.65%	-0.08%	0.24%	0.18%	-0.06%	20.13%	18.10%	-2.03%
	Total	19.32%	17.53%	-1.79%	1.47%	1.37%	-0.10%	0.41%	0.31%	-0.10%	19.24%	17.42%	-1.82%
18-20	Male	10.18%	10.49%	0.31%	1.51%	1.40%	-0.11%	0.12%	0.12%	0.00%	10.11%	10.36%	0.25%
	Female	13.20%	13.24%	0.04%	1.48%	1.40%	-0.08%	0.11%	0.03%	-0.08%	13.10%	13.16%	0.06%
	Total	11.76%	11.98%	0.22%	1.50%	1.40%	-0.10%	0.12%	0.07%	-0.05%	11.67%	11.88%	0.21%
21-34	Male	24.02%	23.10%	-0.92%	3.20%	3.55%	0.35%	0.22%	0.19%	-0.03%	23.89%	22.98%	-0.91%
	Female	19.45%	17.00%	-2.45%	1.42%	1.26%	-0.16%	0.19%	0.21%	0.02%	19.37%	16.90%	-2.47%
	Total	20.51%	18.36%	-2.15%	1.83%	1.77%	-0.06%	0.20%	0.20%	0.00%	20.42%	18.26%	-2.16%
35-64	Male	21.03%	18.61%	-2.42%	2.56%	2.33%	-0.23%	0.20%	0.23%	0.03%	20.89%	18.47%	-2.42%
	Female	25.40%	22.56%	-2.84%	2.03%	1.84%	-0.19%	0.26%	0.22%	-0.04%	25.31%	22.45%	-2.86%
	Total	23.76%	21.05%	-2.71%	2.23%	2.03%	-0.20%	0.24%	0.23%	-0.01%	23.65%	20.93%	-2.72%
65+	Male	6.47%	6.36%	-0.11%	0.44%	0.43%	-0.01%	0.02%	0.00%	-0.02%	6.42%	6.23%	-0.19%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Heath Service			Outpatient/ED Mental Health Service		
		2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	Female	7.29%	7.15%	-0.14%	0.41%	0.30%	-0.11%	0.02%	0.03%	0.01%	7.25%	7.06%	-0.19%
	Total	7.05%	6.92%	-0.13%	0.42%	0.34%	-0.08%	0.02%	0.02%	0.00%	7.00%	6.82%	-0.18%
	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%
Unknown	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**Male**	**17.66%**	**15.74%**	**-1.92%**	**1.24%**	**1.12%**	**-0.12%**	**0.35%**	**0.30%**	**-0.05%**	**17.57%**	**15.65%**	**-1.92%**
	Female	**16.92%**	**14.82%**	**-2.10%**	**1.13%**	**1.00%**	**-0.13%**	**0.17%**	**0.13%**	**-0.04%**	**16.86%**	**14.74%**	**-2.12%**
	Total	**17.23%**	**15.21%**	**-2.02%**	**1.18%**	**1.05%**	**-0.13%**	**0.24%**	**0.20%**	**-0.04%**	**17.16%**	**15.13%**	**-2.03%**

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

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
3–12	Male	0.03%	0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%	0.02%	-0.01%
	Female	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
	Total	0.02%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.02%	0.00%
13–17	Male	1.58%	1.36%	-0.22%	0.14%	0.11%	-0.03%	0.13%	0.17%	0.04%	1.50%	1.23%	-0.27%
	Female	0.89%	0.99%	0.10%	0.15%	0.19%	0.04%	0.04%	0.05%	0.01%	0.82%	0.86%	0.04%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	Total	1.24%	1.17%	-0.07%	0.14%	0.15%	0.01%	0.09%	0.11%	0.02%	1.16%	1.05%	-0.11%
18–20	Male	2.93%	3.19%	0.26%	0.52%	0.40%	-0.12%	0.59%	0.45%	-0.14%	2.63%	2.97%	0.34%
	Female	2.80%	2.69%	-0.11%	0.25%	0.17%	-0.08%	0.52%	0.43%	-0.09%	2.67%	2.65%	-0.02%
	Total	2.86%	2.92%	0.06%	0.38%	0.27%	-0.11%	0.55%	0.44%	-0.11%	2.65%	2.80%	0.15%
21–34	Male	8.81%	9.18%	0.37%	0.90%	1.19%	0.29%	1.61%	1.75%	0.14%	8.42%	8.61%	0.19%
	Female	7.57%	7.39%	-0.18%	0.42%	0.36%	-0.06%	1.80%	1.65%	-0.15%	7.39%	7.12%	-0.27%
	Total	7.86%	7.79%	-0.07%	0.53%	0.54%	0.01%	1.76%	1.67%	-0.09%	7.63%	7.45%	-0.18%
35–64	Male	8.70%	8.43%	-0.27%	0.88%	0.81%	-0.07%	1.53%	1.73%	0.20%	8.37%	7.97%	-0.40%
	Female	5.94%	6.19%	0.25%	0.47%	0.49%	0.02%	0.99%	1.32%	0.33%	5.74%	5.87%	0.13%
	Total	6.97%	7.05%	0.08%	0.62%	0.61%	-0.01%	1.19%	1.48%	0.29%	6.73%	6.67%	-0.06%
65+	Male	1.14%	1.71%	0.57%	0.10%	0.11%	0.01%	0.34%	0.36%	0.02%	0.97%	1.50%	0.53%
	Female	0.49%	0.50%	0.01%	0.04%	0.02%	-0.02%	0.06%	0.16%	0.10%	0.44%	0.40%	-0.04%
	Total	0.68%	0.86%	0.18%	0.06%	0.05%	-0.01%	0.14%	0.22%	0.08%	0.60%	0.72%	0.12%
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%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
Total	Male	2.90%	2.76%	-0.14%	0.30%	0.29%	-0.01%	0.50%	0.52%	0.02%	2.76%	2.59%	-0.17%
	Female	3.10%	3.00%	-0.10%	0.22%	0.21%	-0.01%	0.60%	0.63%	0.03%	3.00%	2.85%	-0.15%
	Total	3.02%	2.90%	-0.12%	0.26%	0.24%	-0.02%	0.56%	0.58%	0.02%	2.90%	2.74%	-0.16%

Table 16: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Beaufort	0.02%	0.05%	0.03%	2.04%	1.57%	-0.47%	4.86%	3.87%	-0.99%	9.13%	10.42%	1.29%
Bertie	0.00%	0.00%	0.00%	0.75%	1.08%	0.33%	2.87%	0.64%	-2.23%	5.11%	3.42%	-1.69%
Brunswick	0.00%	0.01%	0.01%	1.34%	1.16%	-0.18%	3.73%	4.03%	0.30%	7.90%	7.81%	-0.09%
Camden	0.00%	0.00%	0.00%	0.61%	0.00%	-0.61%	1.45%	1.52%	0.07%	5.65%	4.73%	-0.92%
Carteret	0.00%	0.05%	0.05%	1.42%	1.10%	-0.32%	4.57%	4.65%	0.08%	9.49%	8.82%	-0.67%
Chowan	0.00%	0.00%	0.00%	1.77%	1.63%	-0.14%	8.90%	2.91%	-5.99%	5.23%	3.88%	-1.35%

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Columbus	NR	0.00%	NA	NR	0.00%	NA	NR	0.00%	NA	NR	0.00%	NA
Craven	0.01%	0.00%	-0.01%	0.93%	0.70%	-0.23%	3.64%	2.57%	-1.07%	8.71%	7.66%	-1.05%
Currituck	0.00%	0.00%	0.00%	0.69%	0.91%	0.22%	1.96%	1.39%	-0.57%	6.83%	4.66%	-2.17%
Dare	0.05%	0.00%	-0.05%	1.11%	1.57%	0.46%	3.05%	3.48%	0.43%	7.99%	5.72%	-2.27%
Gates	0.00%	0.00%	0.00%	0.00%	0.36%	0.36%	2.94%	2.61%	-0.33%	2.04%	5.62%	3.58%
Hertford	0.00%	0.00%	0.00%	1.08%	0.94%	-0.14%	2.97%	1.53%	-1.44%	3.71%	3.91%	0.20%
Hyde	0.00%	0.00%	0.00%	0.00%	1.50%	1.50%	0.00%	2.50%	2.50%	6.88%	4.86%	-2.02%
Jones	0.13%	0.00%	-0.13%	0.35%	0.33%	-0.02%	1.72%	2.40%	0.68%	5.47%	6.00%	0.53%
Martin	0.00%	0.00%	0.00%	0.79%	0.66%	-0.13%	3.11%	2.56%	-0.55%	6.67%	6.92%	0.25%
Nash	NR	0.01%	NA	NR	0.60%	NA	NR	1.58%	NA	NR	4.67%	NA
New Hanover	0.02%	0.02%	0.00%	2.03%	1.80%	-0.23%	3.66%	2.91%	-0.75%	6.99%	7.29%	0.30%
Northampton	0.00%	0.00%	0.00%	0.59%	0.71%	0.12%	1.91%	0.86%	-1.05%	3.61%	2.23%	-1.38%

2019 External Quality Review

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Onslow	0.00%	0.00%	0.00%	0.63%	0.68%	0.05%	1.70%	2.34%	0.64%	4.81%	4.84%	0.03%
Pamlico	0.00%	0.00%	0.00%	1.71%	0.60%	-1.11%	3.57%	1.84%	-1.73%	12.65%	10.43%	-2.22%
Pasquotank	0.03%	0.03%	0.00%	0.70%	0.92%	0.22%	1.61%	2.34%	0.73%	4.15%	4.12%	-0.03%
Pender	0.02%	0.00%	-0.02%	0.90%	1.29%	0.39%	1.66%	1.67%	0.01%	5.30%	5.07%	-0.23%
Perquimans	0.00%	0.00%	0.00%	0.28%	0.28%	0.00%	3.41%	3.07%	-0.34%	3.09%	3.63%	0.54%
Pitt	0.03%	0.04%	0.01%	1.48%	1.68%	0.20%	2.67%	3.02%	0.35%	5.89%	5.39%	-0.50%
Tyrrell	0.00%	0.00%	0.00%	0.95%	0.89%	-0.06%	5.88%	0.00%	-5.88%	6.10%	3.70%	-2.40%
Washington	0.08%	0.00%	-0.08%	0.86%	0.64%	-0.22%	3.69%	2.91%	-0.78%	5.16%	5.33%	0.17%
	35-64			65+			Unknown			Total (Ages 3+)		
Beaufort	7.32%	7.56%	0.24%	0.95%	1.19%	0.24%	0.00%	0.00%	0.00%	3.50%	3.62%	0.12%
Bertie	4.87%	5.49%	0.62%	0.55%	1.23%	0.68%	0.00%	0.00%	0.00%	2.17%	2.15%	-0.02%
Brunswick	5.73%	5.74%	0.01%	0.77%	0.14%	-0.63%	0.00%	0.00%	0.00%	2.84%	2.76%	-0.08%

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Camden	7.24%	5.53%	-1.71%	1.14%	0.00%	-1.14%	0.00%	0.00%	0.00%	2.65%	1.99%	-0.66%
Carteret	8.09%	6.88%	-1.21%	0.77%	0.95%	0.18%	0.00%	0.00%	0.00%	3.70%	3.25%	-0.45%
Chowan	7.84%	6.70%	-1.14%	1.69%	1.79%	0.10%	0.00%	0.00%	0.00%	3.33%	2.62%	-0.71%
Columbus	NR	0.00%	NA	NR	0.00%	NA	NR	0.00%	NA	NR	0.00%	NA
Craven	5.74%	5.74%	0.00%	0.37%	0.36%	-0.01%	0.00%	0.00%	0.00%	2.87%	2.60%	-0.27%
Currituck	4.59%	4.41%	-0.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.13%	1.73%	-0.40%
Dare	7.84%	7.30%	-0.54%	1.09%	1.02%	-0.07%	0.00%	0.00%	0.00%	2.86%	2.52%	-0.34%
Gates	3.62%	3.46%	-0.16%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.20%	1.66%	0.46%
Hertford	5.62%	5.94%	0.32%	0.77%	1.02%	0.25%	0.00%	0.00%	0.00%	2.14%	2.18%	0.04%
Hyde	5.65%	2.17%	-3.48%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.08%	1.42%	-0.66%
Jones	3.62%	4.47%	0.85%	0.63%	0.31%	-0.32%	0.00%	0.00%	0.00%	1.82%	1.98%	0.16%
Martin	4.86%	6.66%	1.80%	0.42%	1.44%	1.02%	0.00%	0.00%	0.00%	2.32%	2.81%	0.49%

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Nash	NR	4.44%	NA	NR	0.64%	NA	NR	0.00%	NA	NR	1.81%	NA
New Hanover	7.52%	8.17%	0.65%	1.27%	1.82%	0.55%	0.00%	0.00%	0.00%	3.21%	3.33%	0.12%
Northampton	4.15%	4.34%	0.19%	0.67%	1.32%	0.65%	0.00%	0.00%	0.00%	1.78%	1.64%	-0.14%
Onslow	4.66%	5.17%	0.51%	0.75%	0.68%	-0.07%	0.00%	0.00%	0.00%	1.96%	2.05%	0.09%
Pamlico	8.46%	7.01%	-1.45%	0.38%	0.00%	-0.38%	0.00%	0.00%	0.00%	4.03%	3.14%	-0.89%
Pasquotank	5.54%	4.97%	-0.57%	0.29%	0.41%	0.12%	0.00%	0.00%	0.00%	1.96%	1.91%	-0.05%
Pender	5.06%	5.68%	0.62%	0.23%	0.67%	0.44%	0.00%	0.00%	0.00%	2.06%	2.21%	0.15%
Perquimans	5.19%	4.67%	-0.52%	0.00%	0.35%	0.35%	0.00%	0.00%	0.00%	1.80%	1.81%	0.01%
Pitt	7.71%	8.32%	0.61%	0.89%	1.12%	0.23%	0.00%	0.00%	0.00%	2.81%	2.94%	0.13%
Tyrrell	3.64%	5.26%	1.62%	2.16%	2.96%	0.80%	0.00%	0.00%	0.00%	2.07%	2.03%	-0.04%
Washington	7.25%	7.00%	-0.25%	1.90%	1.05%	-0.85%	0.00%	0.00%	0.00%	2.96%	2.74%	-0.22%

Table 17: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Beaufort	12.50%	13.76%	1.26%	16.79%	17.05%	0.26%	13.95%	11.46%	-2.49%	16.14%	22.68%	6.54%
Bertie	8.27%	7.74%	-0.53%	17.34%	16.25%	-1.09%	8.28%	8.68%	0.40%	11.58%	12.05%	0.47%
Brunswick	10.50%	11.49%	0.99%	18.07%	17.64%	-0.43%	10.65%	11.14%	0.49%	13.83%	14.69%	0.86%
Camden	10.34%	11.78%	1.44%	20.25%	20.00%	-0.25%	10.14%	16.67%	6.53%	13.33%	11.24%	-2.09%
Carteret	16.97%	17.43%	0.46%	24.95%	23.85%	-1.10%	16.48%	16.28%	-0.20%	19.13%	19.87%	0.74%
Chowan	10.04%	8.24%	-1.80%	13.94%	13.95%	0.01%	9.42%	9.30%	-0.12%	11.52%	8.50%	-3.02%
Columbus	NR	0.00%	NA	NR	0.00%	NA	NR	0.00%	NA	NR	0.00%	NA
Craven	10.35%	10.32%	-0.03%	16.25%	17.63%	1.38%	10.52%	10.01%	-0.51%	14.36%	16.37%	2.01%
Currituck	9.97%	10.91%	0.94%	15.51%	18.64%	3.13%	11.11%	11.81%	0.70%	12.64%	10.49%	-2.15%
Dare	8.79%	8.78%	-0.01%	17.43%	14.49%	-2.94%	12.60%	10.80%	-1.80%	12.39%	11.45%	-0.94%
Gates	5.76%	5.09%	-0.67%	10.53%	9.78%	-0.75%	9.80%	11.30%	1.50%	8.92%	13.86%	4.94%

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Hertford	5.47%	6.00%	0.53%	9.38%	9.56%	0.18%	7.84%	5.60%	-2.24%	9.19%	9.71%	0.52%
Hyde	8.64%	12.04%	3.40%	14.60%	14.29%	-0.31%	3.80%	2.50%	-1.30%	11.87%	11.81%	-0.06%
Jones	13.19%	9.41%	-3.78%	19.86%	15.00%	-4.86%	12.93%	12.00%	-0.93%	14.98%	18.00%	3.02%
Martin	11.74%	11.08%	-0.66%	18.18%	18.90%	0.72%	12.71%	12.50%	-0.21%	14.15%	13.84%	-0.31%
Nash	NR	5.46%	NA	NR	8.65%	NA	NR	4.75%	NA	NR	8.85%	NA
New Hanover	13.92%	13.84%	-0.08%	21.28%	20.38%	-0.90%	14.09%	13.48%	-0.61%	17.49%	16.63%	-0.86%
Northampton	10.06%	10.75%	0.69%	17.98%	16.29%	-1.69%	9.84%	9.77%	-0.07%	11.66%	9.50%	-2.16%
Onslow	11.22%	11.55%	0.33%	18.99%	18.43%	-0.56%	14.33%	13.25%	-1.08%	16.01%	17.41%	1.40%
Pamlico	17.56%	17.98%	0.42%	26.78%	28.23%	1.45%	13.10%	12.27%	-0.83%	20.29%	18.40%	-1.89%
Pasquotank	10.54%	9.27%	-1.27%	15.66%	15.08%	-0.58%	10.04%	9.57%	-0.47%	13.30%	12.08%	-1.22%
Pender	10.31%	10.33%	0.02%	16.34%	15.26%	-1.08%	7.63%	7.51%	-0.12%	13.41%	13.23%	-0.18%
Perquimans	9.51%	9.34%	-0.17%	13.64%	17.95%	4.31%	11.36%	9.82%	-1.54%	12.19%	10.41%	-1.78%

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Pitt	12.46%	11.24%	-1.22%	18.39%	17.67%	-0.72%	10.62%	11.05%	0.43%	14.97%	14.02%	-0.95%
Tyrrell	8.42%	8.94%	0.52%	13.33%	15.18%	1.85%	11.76%	5.41%	-6.35%	9.98%	9.88%	-0.10%
Washington	5.96%	8.58%	2.62%	10.49%	13.09%	2.60%	7.83%	8.74%	0.91%	10.63%	11.05%	0.42%
	35-64			65+			Unknown			Total (Ages 3+)		
Beaufort	22.92%	23.95%	1.03%	7.38%	8.51%	1.13%	0.00%	0.00%	0.00%	16.14%	17.00%	0.86%
Bertie	16.06%	14.93%	-1.13%	6.22%	5.61%	-0.61%	0.00%	0.00%	0.00%	11.58%	10.90%	-0.68%
Brunswick	18.80%	17.67%	-1.13%	6.10%	5.54%	-0.56%	0.00%	0.00%	0.00%	13.83%	13.71%	-0.12%
Camden	18.10%	20.74%	2.64%	6.82%	6.98%	0.16%	0.00%	0.00%	0.00%	13.33%	14.77%	1.44%
Carteret	22.82%	23.26%	0.44%	6.26%	6.23%	-0.03%	0.00%	0.00%	0.00%	19.13%	18.89%	-0.24%
Chowan	16.81%	16.76%	-0.05%	5.08%	13.04%	7.96%	0.00%	0.00%	0.00%	11.52%	11.63%	0.11%
Columbus	NR	0.00%	NA	NR	0.00%	NA	NR	0.00%	NA	NR	0.00%	NA
Craven	21.52%	19.96%	-1.56%	7.70%	9.17%	1.47%	0.00%	0.00%	0.00%	14.36%	14.07%	-0.29%

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Currituck	18.37%	17.83%	-0.54%	3.65%	3.05%	-0.60%	0.00%	0.00%	0.00%	12.64%	12.83%	0.19%
Dare	17.88%	14.72%	-3.16%	5.80%	6.78%	0.98%	0.00%	0.00%	0.00%	12.39%	11.07%	-1.32%
Gates	14.73%	15.01%	0.28%	3.48%	5.31%	1.83%	0.00%	0.00%	0.00%	8.92%	9.34%	0.42%
Hertford	15.61%	14.95%	-0.66%	7.06%	6.65%	-0.41%	0.00%	0.00%	0.00%	9.19%	8.99%	-0.20%
Hyde	19.57%	15.22%	-4.35%	7.83%	7.59%	-0.24%	0.00%	0.00%	0.00%	11.87%	11.62%	-0.25%
Jones	19.72%	18.25%	-1.47%	5.06%	5.66%	0.60%	0.00%	0.00%	0.00%	14.98%	12.83%	-2.15%
Martin	20.14%	18.79%	-1.35%	7.49%	9.34%	1.85%	0.00%	0.00%	0.00%	14.15%	14.03%	-0.12%
Nash	NR	12.40%	NA	NR	6.02%	NA	NR	0.00%	NA	NR	7.79%	NA
New Hanover	24.27%	24.34%	0.07%	13.83%	13.15%	-0.68%	0.00%	0.00%	0.00%	17.49%	17.27%	-0.22%
Northampton	14.95%	14.22%	-0.73%	4.18%	6.89%	2.71%	0.00%	0.00%	0.00%	11.66%	11.47%	-0.19%
Onslow	23.91%	23.25%	-0.66%	10.52%	11.20%	0.68%	0.00%	0.00%	0.00%	16.01%	15.68%	-0.33%
Pamlico	23.16%	22.16%	-1.00%	15.41%	14.02%	-1.39%	0.00%	0.00%	0.00%	20.29%	19.53%	-0.76%

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Pasquotank	21.40%	19.08%	-2.32%	5.34%	5.81%	0.47%	0.00%	0.00%	0.00%	13.30%	12.15%	-1.15%
Pender	18.53%	17.87%	-0.66%	11.14%	10.32%	-0.82%	0.00%	0.00%	0.00%	13.41%	12.80%	-0.61%
Perquimans	18.89%	16.88%	-2.01%	4.81%	4.21%	-0.60%	0.00%	0.00%	0.00%	14.97%	11.71%	-3.26%
Pitt	21.31%	20.34%	-0.97%	6.95%	7.75%	0.80%	0.00%	0.00%	0.00%	9.98%	14.03%	4.05%
Tyrrell	11.52%	13.45%	1.93%	6.47%	5.19%	-1.28%	0.00%	0.00%	0.00%	10.63%	10.02%	-0.61%
Washington	18.72%	20.39%	1.67%	7.61%	8.14%	0.53%	0.00%	0.00%	0.00%	14.83%	12.20%	-2.63%

(b) Waiver Validation Results

The overall validation scores are "Fully Compliant" with an average validation score of 100% across the 10 measures. The stored procedures have been updated to address NC Medicaid's most recent changes to the measures.

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

Table 18: (b) Waiver Performance Measure Validation Scores 2018

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%

(c) Waiver Measures Reported Results

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

Table 19: (c) Waiver Measures: Reported Results 2018

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals. IW D1 ISP	Annual	1722/1722 = 100%	85%
Proportion of Individual Support Plans that address identified health and safety risk factors. IW D2 ISP	Semi Annually	1167/1167 = 100%	85%
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need. IW D3 ISP	Annually	1721/1722 = 99.83%	85%
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	1718/1722 = 99.77%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	1718/1722 = 99.77%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	54/59 = 91.53%	85%
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required. IW G3	Quarterly	2/2 = 100%	85%
Percentage of medication errors resulting in medical treatment. IW G4	Quarterly	0/0 = NA	15%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	1255/1255 = 100%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	23/25 = 92%	85%

(c) Waiver Validation

Validation scores are fully compliant with an average validation score of 100% across the ten measures. The validation scores are shown in *Table 20*, (c) Waiver Performance Measure Validation Scores 2018. Documentation on data sources, data validation, source code, and calculated rate for the ten (c) Waiver measures was provided. As well, all rates met or exceeded state performance benchmarks. The validation worksheets offer detailed information on point deduction when validating each (c) Waiver measure.

Table 20: (c) Waiver Performance Measure Validation Scores 2018

Performance Measure	Validation Score
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals. IW D1 ISP	100%
Proportion of Individual Support Plans that address identified health and safety risk factors. IW D2 ISP	100%
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need. IW D3 ISP	100%
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	100%
Proportion of beneficiaries reporting they have a choice between providers IW D10	100%
Percentage of level 2 and 3 incidents reported within required timeframes IW G2	100%
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required. IW G3	100%
Percentage of medication errors resulting in medical treatment. IW G4	100%
Percentage of beneficiaries who received appropriate medication. IW G5	100%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	100%

Performance Improvement Project (PIP) Validation

The validation of the PIPs was conducted in accordance with the protocol developed by CMS titled, EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

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

PIP Validation Results

For the 2018 review, three of the five submitted PIPs were validated. All three PIPs received excellent validation scores and there were no corrective actions resulting from the review in 2018. For the current review, there were four PIPs submitted, only one of which was validated last year, Supermeasures MH (Mental Health). The new PIPs for the 2019 review are Provider Satisfaction, Supermeasures SU (Substance Use), and In Reach Contacts for TCLI. All four active PIPs were validated, and scores are displayed in *Table 21* below.

Table 21: PIP Summary of Validation Scores

Project Type	Project	2018 Validation Score	2019 Validation Score
Clinical	Supermeasures SU	Not Submitted	85/85 = 100% High Confidence in Reported Results
	Supermeasures MH	77/77 = 100% High Confidence in Reported Results	84/85 = 99% High Confidence in Reported Results
Non-Clinical	Increasing Provider Satisfaction Related to the Appeals Process for Denial, Reduction, or Suspension of Service(s)	Not Submitted	90/90 = 100% High Confidence in Reported Results
	Monitoring of In-Reach Contacts for TCLI	Not Submitted	80/85 = 94% High Confidence in Reported Results

Tables 22 through *23* list the specific errors by project and include recommendations to correct the errors.

Table 22: Supermeasures MH

Section	Reasoning	Recommendation
Was there any documented, quantitative improvement in processes or outcomes of care?	Rates have improved for DMH members, but not for NC Medicaid members (as of most recent validated numbers in Measurement #2).	Continue interventions to improve rates for both member populations.

Table 23: Monitoring of In-Reach Contacts for TCLI

Section	Reasoning	Recommendation
Was an analysis of the findings performed according to the data analysis plan?	Analysis was conducted monthly starting on page 3 in Periodic measurements table, although data analysis plan is documented as weekly on page 2.	Clarify if analysis of rates will be conducted weekly or monthly. If analysis is weekly, then results table should include weekly rates, instead of monthly rates.

Figure 5 provides a comparison of the 2018 scores versus the 2019 scores. The 2019 review shows 96% of the standards were scored as "Met", and 6% of the standards were scored as "Partially Met." None of the standards were scored "Not Met."

Figure 5: Quality Improvement Comparative Findings

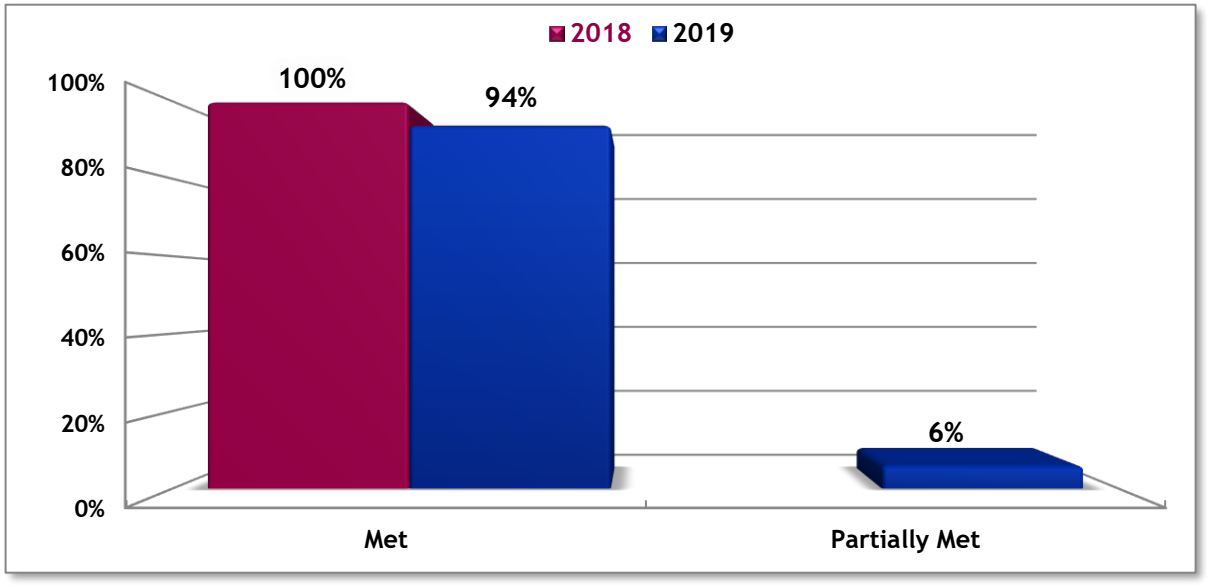


Table 24: Quality Improvement

Section	Standard	2019 Review
The Quality Improvement (QI) Program	The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.	**Partially Met**

Strengths

- All four validated PIPs were in the "High Confidence" range.
- Trillium staff reported the QM Department is working to meet NCQA accreditation with a July 2019 completion goal.
- Trillium has a blinded, provider peer review process for individual provider QIPs.

Weaknesses

- Trillium prepared a report that analyzed the 2017 and 2018 *ECHO Survey* results but none of the lower scoring survey results have been identified for quality improvement.
- On review of the *ECHO Survey* results, the conclusion reached by QIC was to change the goal percentage for "overall satisfaction" from 80% satisfaction to the state average of 70%.
- The QIP Compliance Element in the *Annual Quality Management Program Evaluation Fiscal Year 2017-2018* could be enhanced by including information documented in the *QIP Annual Report*. This details goals, barriers, interventions, measurement period, and grafting over time.
- Two PIPs have areas that could be improved.

Corrective Action

- Implement interventions to improve lower scoring areas of the Adult and Child *ECHO Surveys*. Discuss the intervention progress with QIC throughout the year and adjust as needed.

Recommendations

- Adjust the *ECHO Survey* goal percentage for "overall satisfaction" to a fixed target, and work to achieve that target. Currently the goal is set for the "state average," which will be different each year.

- Include the QIP Annual Report within the Annual Quality Management Program Evaluation, embedded or as an appendix.

- Refer to *Table 22* and *Table 23* for specific recommendations related to the two PIPs needing improvement.

E. Utilization Management

The Utilization Management (UM) EQR includes review of the Utilization Management, Care Coordination, and TCLI functions. Included in the review process are Desk Review of policies and procedures, the *UM Plan 2018-2019*, the *Utilization Management Program Annual Appraisal 2018-19*, the *Provider Manual*, the *Member and Family Handbook*, approval files and denial files. An Onsite discussion and demonstration of the Treatment Authorization process was provided.

The *NC Medicaid Contract Section 7.4.2*, requires that "for children ages 3 through 6, PIHP must use one of the following options to determine medical necessity reviews: a. the Early Childhood Services Intensity Instrument (ECSII) …b. the Children and Adolescent Needs and Strength (CANS) or c. Another validated assessment…" There was no reference to this type of assessment in any UM documentation and, during the Onsite, UM staff struggled to identify which assessment is required for this age group. Trillium eventually clarified that the ECSII was required to be completed by providers when providing services for this population. Trillium needs to ensure providers are trained in use of the ECSII and include this required assessment for children ages three to six in their procedures, UM Plan, and Provider Manual.

Trillium's process for entering denials of Treatment Authorizations into their UM platform includes steps in which the UM Care Manager attaches a hard copy of the full denial decision to the Treatment Authorization platform. This hard copy includes the name and credentials of the physician or psychologist rendering the denial decision. The Care Manager then copies and pastes the Peer Reviewer denial decision into the electronic Treatment Authorization section of the platform. The narrative copied does not include the name or credentials of the Peer Reviewer and gives the appearance that denial decisions are made by the Care Manager. As denial decisions are required to be made by physicians or psychologists, CCME recommends the name and credentials of the Peer Reviewer also be captured within the electronic Treatment Authorization section of the UM platform.

The implementation of the Incedo Care Coordination platform started in September 2017 and was completed in September 2018. The data entered into Incedo is used to create reports and data dashboards for supervision, and for monitoring service delivery, documentation completion, and outcome measures. Incedo provides reminders to the

care coordinator to complete various tasks such as quarterly and annual reviews, follow up activities related to case types, and other tasks for which the care coordinator requests a reminder.

The Care Coordination platform within Incedo provides essential support to the Care Coordination Department. This platform captures Care Coordination progress notes, assessments, and other essential activities, as well as provides a monitoring and data component that measures outcomes of Care Coordination. However, there is no mention of Incedo in any Care Coordination documentation. CCME recommends information regarding the functions of the Incedo Care Coordination Platform are added to the *Care Coordination Program Description*. This information needs to include details regarding how this platform is used to document Care Coordination activities, monitor Care Coordination interventions, and measure outcomes.

The review of the Transition to Community Living Initiative (TCLI) included the review of policies and procedures, review of the *Provider Manual* and the *Member and Family Handbook*. The TCLI procedures and job descriptions verify the TCLI functions are performed by appropriately trained staff. Peer Support Service (PSS) is included within the *Transitions to Community Living* procedure, as a result of a Corrective Action item in the 2018 EQR. The In-Reach services are contracted to Recovery International. Both PSS and Supported Employment (SE) are provided by network providers. Due to the ruralness of the region, Assertive Community Treatment (ACT) type services are provided as an unbundled service. The Onsite discussion confirmed that one-time transitional funds are monitored by both TCLI and accounting staff. All files showed evidence of staff linking TCLI members with appropriate services to support them in the community.

Figure 6 provides the scores for the 2019 EQR Utilization Management standards compared to the 2018 EQR.

Figure 6: Utilization Management Comparative Findings

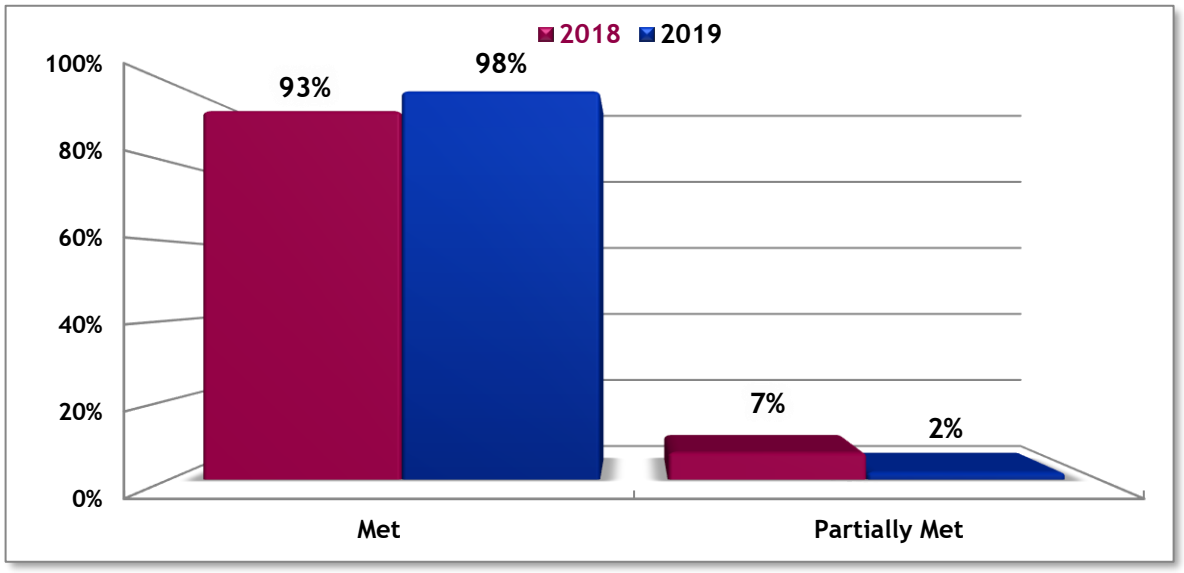


Table 25: Utilization Management

Section	Standard	2019 Review
Medical Necessity Determinations	Utilization Management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	Partially Met

Strengths

- Incedo is used to develop data dashboards to use for monitoring and includes algorithms that provide reminders to support Care Coordination task completion.
- TCLI has three housing navigators and moved 121 members into housing during the past year.

Weaknesses

- During the Onsite, UM staff struggled to identify which assessment is required for children ages three to six, and there was no reference to this type of assessment in any UM documentation.
- The UM denial decision narrative copied into the electronic portal does not include the name or credentials of the Peer Reviewer and gives the appearance that denial decisions are made by the Care Manager.

- The Care Coordination Program Description did not include information about the Incedo Care Coordination platform, which provides several essential functions to Care Coordination.

Corrective Action

- Include in procedures, the *UM Plan,* and *Provider Manual* that Trillium requires providers to utilize the *Early Childhood Services Intensity Instrument (ECSII)* when assessing children ages three to six for services.

Recommendations

- When copying and pasting the UM denial decision narrative into the electronic portal, ensure the name and credentials of the physician or psychologist that rendered the denial is included.
- Add information regarding Incedo in the *Care Coordination Program Description*. Include details regarding how this platform is used to document Care Coordination activities, monitor interventions, and measure outcomes.

F. Grievances and Appeals

Grievances

The Grievance EQR includes a Desk Review of policies and procedures, Grievance files, and the Grievance Log, as well as an Onsite discussion with Grievance and Call Center staff to further clarify Trillium's Grievance process.

Trillium processes Grievances within the Call Center. All staff are trained to receive and document Grievances within the Grievance module. Call Center staff receive additional training related to clarification of the Grievance resolution process. When a Grievance is entered in the PIHP's Grievance module, it triggers a notification to the Customer Services Manager who then assigns the Grievance to a Call Center staff member. The Grievance EQR review includes five Recommendations.

There are details missing from the *Grievance Process and Scope* procedure related to the notifications required from Trillium, if Trillium extends the Grievance resolution timeframe. Per 42 *CFR § 438.408 (c)(2*) Trillium must;

i. make reasonable efforts to give the enrollee prompt oral notice of the delay.
ii. Within 2 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 she/he disagrees with the decision.

While extensions to Grievance timeframes by Trillium are rare, it is recommended to add the above details to Trillium's procedure.

The timeliness guideline for resolution of a Grievance is included in the *Grievance Process and Scope* procedure, but only in reference to Grievances filed against providers. The timeliness guideline for resolution must apply to all Grievances within the procedure. This procedure needs to be revised to reflect the timeliness guideline for all Grievances. Additionally, ensure the number of days required by Trillium to resolve Grievances is congruent across the procedure, *Provider Manual,* and *Member and Family Handbook,* as some documentation says 30 days and other 90 days.

The *Grievance Process and Scope* procedure states, "Chief Medical Officer will provide consultation and direction to the staff in how to proceed with the investigative process." However, the procedure does not address how or where this consultation will be documented. Further, five of the files showed this consultation is not captured within the Grievance file. CCME recommends that Trillium include within *the Grievance Process and Scope* procedure how to document the Chief Medical Officer's (CMO) involvement to ensure CMO consultation is within the Grievance file.

The Grievance Log included Grievances that had been tallied, categorized, and reviewed for trends that would be used in the provider contracting process. During the Onsite interview, it was stated that an upgrade of the Grievance module platform had been completed over the past year. The upgrade included the ability to separate Grievances from complaints along with improved data analytics capabilities. This upgrade was stated to be a result of a 2018 EQR recommendation; to ensure monitoring and that Grievances are logged correctly and not duplicated.

The Grievance file review revealed a concern about the lack of detail captured in the Grievance resolution notifications sent to the Grievant. Review of these notifications showed three included adequate details regarding the steps taken and the outcome of the investigation. However, nine of the eleven Resolution Letters reviewed, this notification included general statements such as, "Trillium Health Resources completed an investigation." or "Reviewed Internal Findings Report and conducted interviews." These general statements were used even when the letter was capturing the resolution of multiple allegations within the Grievance. Two of the resolution notifications to Grievants contained good detail of each allegation, the steps taken and information reviewed to reach conclusions, and the resolution of each allegation. There was also good detail supporting which allegation was substantiated and why. There was no discernable pattern to explain the lack of detail within the nine resolution notifications identified as concerning. Trillium needs to ensure they consistently provide detailed and concise information within the Grievance resolution Letter to demonstrate to Grievants their concerns were adequately considered and thoroughly resolved.

Appeals

The EQR of Trillium's Appeals process involves thorough review of 30 Appeal files, policies and procedures guiding the Appeal process, the *Provider Manual*, *Member and Family Handbook*, Trillium's website and the Appeals Log submitted for this EQR that captures Medicaid Appeals from April 2018 to March 2019. Onsite discussion with Appeals staff provided additional information about Trillium's Appeals process.

Trillium met 100% of the Appeals standards. Seven recommendations have been made to address minor concerns with the analysis of Appeal data, Trillium's *Provider Manual*, Appeal file documentation, notifications, and the Trillium's Appeal procedure, *Medicaid Clinical Reconsideration Process.*

Trillium processed approximately 140 Appeals in the past year as compared to almost 300 in the previous year. While staff could explain this decrease anecdotally, there was no evidence that Trillium analyzes Appeal data to identify trends, inefficiencies, quality improvement opportunities, etc. Trillium collects Appeal data monthly. The data collected includes the number of each type of Appeal (i.e., clinical versus administrative, standard versus expedited.) and the number of Appeal outcomes for each month over the previous two years. These numbers are submitted to the QI Committee. However, there is no analysis of the data nor any evidence of review or discussion by the committee. An analysis of Appeal data (e.g., rates of Appeals as compared to UM denials, percentage of Appeals by service, seasonal spikes in expedited Appeal requests, Appeal outcomes by Peer Reviewer, etc.) along with review and discussion by committee would make this data more meaningful and help identify potential quality improvement opportunities. For example, in the previous year's EQR, ten percent of the Appeals processed involved administrative denials of requests for I/DD (Intellectual/Developmental Disability) services. This is three times the number of administrative denials Appeals from the previous year. As these Treatment Authorizations are submitted by Trillium staff, there is opportunity to explore this spike and target potential inefficiencies.

In the previous two EQRs, CCME has recommended Trillium add to the *Provider Manual* that an acknowledgement letter is sent to the enrollee by Trillium when an Appeal is received. This letter may be the only evidence available to providers, who may continue to provide services during the pendency of the Appeal, that an Appeal is being processed. In the previous year, Trillium did add this information to the *Provider Manual*, however, it was added only to the *Non-Medicaid Service Reconsideration Process* section of the manual. Additionally, the acknowledgement notification information added to the manual states, "Trillium acknowledges receipt of the Appeal in writing via a letter to the appellant dated the next working day." This timeframe is not supported by Trillium's *Medicaid Clinical Reconsideration Process* procedure and does not give a timeframe for sending acknowledgment letters.

The review of Trillium's *Appeal Log* and sample files showed Trillium is processing Appeals, both standard and expedited, in a timely manner. Concerns were only noted with the acknowledgement letters Trillium sends when processing expedited Appeals. Five expedited files were reviewed. In the two files where Trillium agreed to expedite the Appeal, the acknowledgment letter states the Appeal may take "up to 30 days" to resolve. This timeframe is inaccurate, as expedited Appeals must be resolved and notification given within 72 hours of receipt of the Appeal, per *NC Medicaid Contract, Attachment M, H.5*. This timeframe can be extended for an additional 14 days but should never take "up to 30 days", as outlined in Trillium's expedited acknowledgment letter.

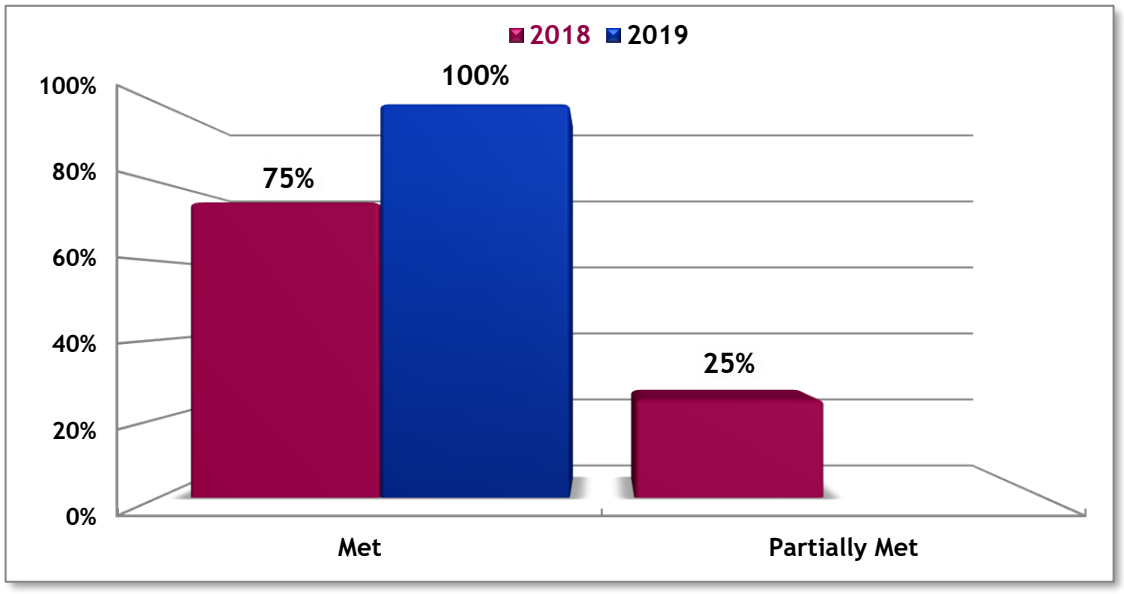
In the three files where Trillium did not agree to expedite the resolution of the Appeal, an acknowledgement letter was sent that informed the appellant of Trillium's decision. This acknowledgement letter did not inform the appellant of their right to file a Grievance against Trillium for denying the request to expedite an Appeal, nor did staff inform the appellant of this right when providing oral notification of the denial of their request to expedite the Appeal. The Appeals procedure, *Medicaid Clinical Reconsideration Process*, also does not include the right of an enrollee or authorized appellant to file a Grievance if Trillium denies a request to expedite an Appeal. This is required by *42 CFR § 438.410 (c)*.

The Trillium Appeals files reviewed had some evidence of guardianship documentation and releases of information when the appellant was not the enrollee. This suggests the staff takes steps to protect the enrollee's Protected Health Information (PHI). However, there were no notes delineating these steps in the Appeals files. Documenting these internal steps would provide solid evidence that staff routinely confirm guardianship and/or secure releases of information prior to disclosing PHI.

Trillium's Appeal procedure states, "Upon request, Trillium will provide the appellant/ authorized representative with the case/Reconsideration file, including medical records, and any other documents and records." However, this procedure does not describe steps staff follow to protect enrollee PHI when releasing the Appeal record. The procedure Member Access to Protected Health Information does detail the steps required by staff when releasing PHI. CCME recommends that either the Appeals procedure delineate a process for releasing the Appeal record that is in accordance with Trillium's Member Access to Protected Health Information procedure or reference it within the Appeals procedure. This will ensure staff have proper guidance when releasing the Appeal record.

Figure 7 demonstrates that Trillium met 100% of the Grievance and Appeal standards.

Figure 7: Grievances and Appeals Comparative Findings



Strengths

- Appeals staff provide detailed notes within the Appeal record of internal steps taken by staff during the resolution of the Appeal.

Weaknesses

- There are details missing from the *Grievance Process and Scope* procedure related to the notifications required from Trillium, if Trillium extends the Grievance resolution timeframe.
- In the *Grievance Process and Scope* procedure, details around the required timeframe for processing Grievances is only under the section describing Grievances against providers. Additionally, required timeframes for resolving Grievances are incongruent across this procedure, *Provider Manual*, and *Member and Family Handbook*.
- The *Grievance Process and Scope* procedure includes the "Chief Medical Officer will provide consultation and direction to the staff in how to proceed with the investigative process." However, the procedure does not address how or where this consultation and direction will be documented.
- In nine of the 11 Grievance files reviewed, the Grievance resolution notification sent to the Grievant provided minimal information about the steps Trillium took to resolve the Grievance and the outcome of the Grievance. This was true even when multiple allegations had been made within the Grievance.

- There is no analysis of Appeal data nor any evidence of review or discussion by the committee. Numbers of Appeals are simply reported to the QI Committee.
- The *Provider Manual* does not explain to providers that an acknowledgement letter is sent to the enrollee when an Appeal is received.
- In the two files where Trillium agreed to expedite the Appeal, the acknowledgment letter states the Appeal may take "up to 30 days" to resolve. This timeframe is inaccurate, as expedited Appeals must be resolved and notification given within 72 hours of receipt of the Appeal.
- In the three files where Trillium denied the appellants request for an expedited Appeal, the acknowledgement letter did not inform the appellant of their right to file a Grievance against Trillium for denying the request to expedite an Appeal. Additionally, staff did not inform the appellant of this right when providing oral notification of the denial of their request to expedite the Appeal.
- The Appeals *Medicaid Clinical Reconsideration Process* procedure does not include the right of an enrollee or authorized appellant to file a Grievance if Trillium denies a request to expedite an Appeal. This is required by *42 CFR § 438.410 (c)*.
- There was no documentation by staff showing the steps taken to protect the enrollee's PHI when interacting with appellants that were not the enrollee.
- The *Medicaid Clinical Reconsideration Process* procedure does not describe steps staff follow to protect enrollee PHI when releasing the Appeal record.

Recommendations

- Add to procedure, *Grievance Process and Scope,* the missing details regarding an extension by Trillium to the Grievance resolution timeframe. These details need to include:
    - Within 2 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 she/he disagrees with the decision.
- Revise procedure, *Grievance Process and Scope*, to reflect the timeliness guideline for all Grievances, not just Grievances against providers. Additionally, ensure that the timeframe guideline is consistent across the procedure, *Provider Manual,* and *Member and Family Handbook*.
- Include in the *Grievance Process and Scope* procedure how and where CMO consultation is captured within Grievance files.

- Ensure Grievance Resolution notifications provide detailed and concise information to demonstrate to Grievants their concerns were adequately considered and thoroughly resolved. This is particularly true for Grievances that include multiple allegations.
- Analyze the Appeals data and present this data to the QI Committee for review and discussion. Look for meaningful data that can identify potential quality improvement opportunities.
- Add to the *Provider Manual* under the Medicaid Services Appeal - Level 1 section, that Trillium sends an acknowledgement letter whenever an Appeal is received. Ensure the manual reflects the same timeframe for sending an acknowledgment letter as outlined in the *Medicaid Clinical Reconsideration Process* procedure.
- Ensure notifications to appellants reflect the correct timeframe Trillium follows for resolving and providing notice of the outcome of an expedited Appeal.
- When Trillium does not agree to expedite the resolution of the Appeal, ensure the appellant is informed of their right to file a Grievance against Trillium for the denial of the request to expedite the resolution and notification of an Appeal.
- Add the right of an enrollee to file a Grievance when a request for an expedited Appeal is denied by Trillium to the *Medicaid Clinical Reconsideration Process* procedure.
- Ensure any steps taken by staff to release PHI, secure guardianship documentation and/or a release of information, etc. are documented within the enrollee's Appeal record.
- Either include a process in the Appeal procedure that details the steps taken when releasing the Appeals record or reference the *Member Access to Protected Health Information* procedure in the *Medicaid Clinical Reconsideration Process* procedure.

G. Delegation

CCME's EQR of the Delegation section included a review of the *Delegation* procedure, the Delegate List, the Delegation Contracts/Letters of Agreement, and the Delegation Monitoring Tools. An Onsite interview included personnel from the Trillium Quality Management Department and the Contracts/Training Department.

At the last Provider Services EQR, there were no items requiring Corrective Action. There was one Recommendation at the last EQR. Trillium made the recommended revisions.

Trillium does not currently have any delegated credentialing. The header on the *Delegation Review Tool-Credentialing Verification Organization Updated* document is incorrectly named "*Delegation Assessment Tool-Peer and Appeal Review*". The form is not currently used, as Trillium has no delegated credentialing.

At the last EQR, the Credentialing Delegation section of the *Delegation Procedure* and *the Delegation Assessment Tool-Credentialing* document did not include information regarding a search of the *State Exclusion List*. Though Trillium did not have any delegated credentialing at the time, CCME recommended that Trillium revise its *Delegation Procedure* and the *Delegation Assessment Tool*, to include Primary Source Verification of the *State Exclusion List*, to comply with *NC Medicaid Contract, Section 7.6.4, Exclusions*. Trillium completed those revisions.

Trillium has six delegated entities, as evidenced in *Table 26*. Most of the contracts are auto-renew. The term of two contracts, Clear Messaging and RI International, was from July 1, 2017 through June 30, 2018. New contracts replacing those two contracts were fully executed prior to the expiration of the previous contract.

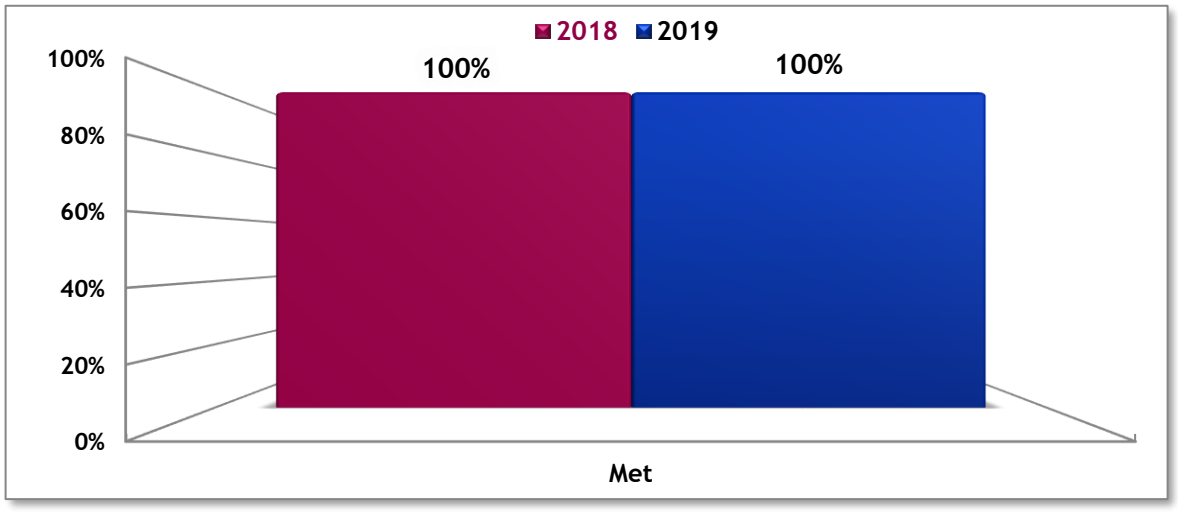
Table 26 lists the current delegated services.

Table 26: Delegated Entities

Delegated Entities	Service
Iron Mountain	Record Management and Shredding
Clear Messaging	Interpretation
BHM	Peer and Appeal Review
RI International	TCLI In-Reach
Shred It/Cintas	Record Management and Shredding
Fluent/Language Line	Interpretation
Iron Mountain	Record Management and Shredding
Clear Messaging	Interpretation
BHM	Peer and Appeal Review
RI International	TCLI In-Reach

Figure 8 provides a comparison of the 2018 scores versus the 2019 scores.

Figure 8: Delegation Comparative Findings



Strengths

- Trillium has an executed Delegation Agreement with each delegate, including Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreements with delegates with access to Protected Health Information (PHI).
- Trillium conducted the required annual monitoring for each delegate.
- Trillium made and retained the changes in the one Recommendation from the previous EQR.

H. Program Integrity

As required by its contract with CCME, IPRO is tasked with assessing PIHP compliance with federal and state regulations regarding program integrity functions. IPRO's review of Trillium Health Resources (Trillium) included a Desk Review of Trillium's program integrity files and related documentation. IPRO analyzed the files and documentation. Onsite interviews were conducted with the Chief Compliance Officer, Program Integrity managers, and representatives from NC Medicaid to review the offsite documentation and file review findings.

File Review

IPRO requested the universe of program integrity files from Trillium for the April 1, 2018 through March 31, 2019 review period and then selected a random sample of 15 files with a two file oversample for a total of 17 files. These files were thoroughly reviewed to ensure Trillium investigates a credible allegation of fraud and provides NC Medicaid Program Integrity with the information required on a NC Medicaid approved template.

This review showed that 14 of 15 files contained the required information, but one file was missing the NPI of the provider. It is recommended Trillium develop an executive summary for each file that captures key elements of the investigation including subject (name, Medicaid provider ID, address, provider type), source/origin of complaint, date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation, contact information for PIHP staff persons with practical knowledge of the working of the relevant programs, and an estimated or actual dollar value of funds exposed. This executive summary would provide a quick reference of key elements of the investigation and provide a cross check process that ensures all required elements are within each PI file.

Documentation

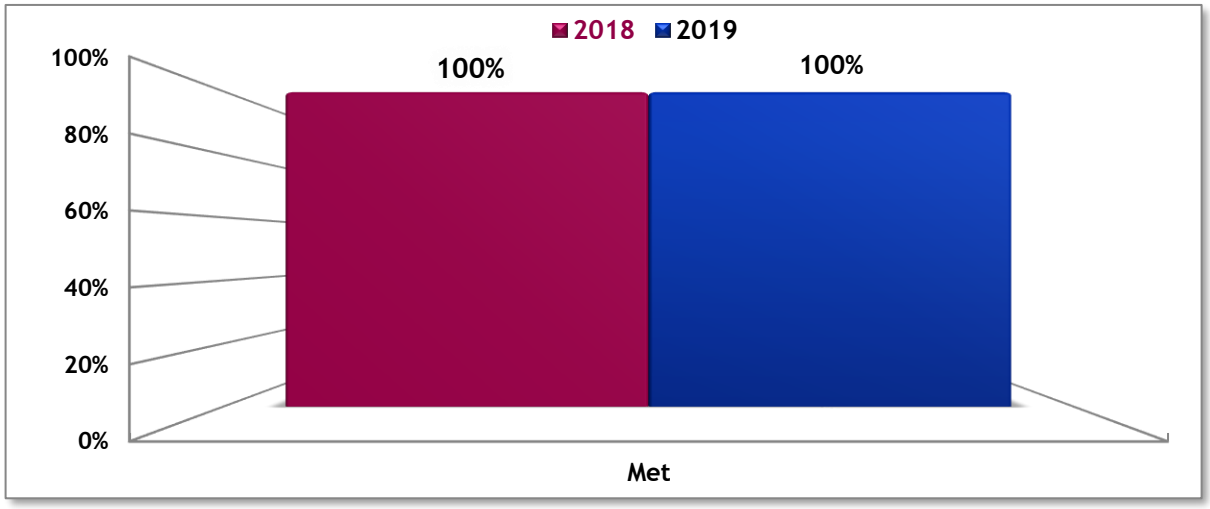
A Desk Review of Trillium's documentation was conducted to assess their compliance with federal and state regulations and the PIHP's contract with NC Medicaid. This encompassed a review of Trillium's policies, procedures, training materials, organizational charts, job descriptions, committee meeting minutes and reports, provider agreements, enrollment application, workflows, *Provider Manual*, *Member and Family Handbook*, newsletters, conflict of interest forms, and the *Compliance Plan*. Findings within the Desk Materials and PI files were discussed with the Compliance and Program Integrity Managers during the Onsite.

Review of Trillium's policies and procedures showed two areas not covered as required by Trillium's contract with NC Medicaid. Missing from policies and procedures was language around the requirements related to administrative actions by Trillium. *NC Medicaid Contract, Section 14.3.4* states, "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 DMA Program Integrity or the MFCU/MID."

Lastly, missing from policies and procedures was language explaining the requirements found in *NC Medicaid Contract, Section 14.3.5* which states, "In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery." Recommendations were made to ensure these functions are captured in Trillium's procedures.

Figure 9 demonstrates that Trillium met 100% of the EQR PI standards.

Figure 9: Program Integrity Comparative Findings



Strengths

- Trillium has formed a Sanctions Committee with senior representatives from their provider network, program integrity, quality, clinical operations, and claims functions, as well as the General Counsel who reviews all potential sanctions when an allegation of fraud is confirmed and a provider sanction is recommended.
- Trillium has increased PI referrals and MID acceptance rates this year.
- Trillium has zero staff turnover in the Special Investigations unit since 2005 and is staffed with accredited fraud investigators.
- Trillium has created new data mining reports utilizing in-house resources.

Weaknesses

- One of the 15 files reviewed was missing the NPI number of the provider.
- Procedure wording is not compliant with *NC Medicaid Contract, Section 14.3.4,* that requires Trillium to receive written authority to take administrative action against a provider suspected of fraud.
- Procedure wording is not compliant with *NC Medicaid Contract, Section 14.3.5,* that require Trillium to remit funds owed by providers to NC Medicaid when instructed to do so, in writing, by NC Medicaid.

Recommendation

- Develop an executive summary for each file that captures key elements of the investigation including subject (name, Medicaid provider ID, address, provider type), source/origin of complaint, date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation, contact information for PIHP staff persons with practical knowledge of the working of the relevant programs, and an estimated or actual dollar value of funds exposed.

- Add specific language to procedures that address the requirement that Trillium "shall not take administrative action against a 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." See *NC Medicaid Contract, Section 14.3.4.*
- Add specific language to procedures stating collection of funds due to NC Medicaid from providers when instructed in writing by NC Medicaid. *See NC Medicaid contract, Section 14.3.5,* which states, "In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery."

I. Financial Services

CCME reviewed the following Trillium Desk Review Materials prior to the Onsite visit:

- Financial policies and procedures
- Audited financial statements, compliance reports and footnotes dated June 30, 2018
- Balance sheet and income statements dated February 28, 2019, and March 31, 2019
- Medicaid monthly financial reports for February and March 2019
- Claims processing aging reports, as well as claims processing procedures
- Finance Department staffing structure
- Fiscal year budget ordinance for 2018-2019

- Budget to actual expenses report for Medicaid for February and March 2019
- Administrative Cost Allocation Plan FY 2019
- Medicaid risk reserve bank statements for February and March 2019
- Executive *Dashboard* March 2019

After reviewing Trillium's Desk Review materials, CCME conducted an Onsite visit and interview on June 6, 2019. In reviewing Trillium's financial operations, CCME used a standardized EQR Finance Desk Review and Onsite administrative interview guide. CCME also reviewed deficiencies from prior EQRs to determine whether they were corrected. In addition to the standardized Desk Review inquiries, CCME asked additional interview questions in the following areas:

- Policies and procedures development and staff communication
- Staffing changes in finance
- Accounting system and upgrade
- Transition for CIE claims management system
- Reinvestment spending and plans

Trillium demonstrates ongoing financial stability and is operating at a profit for both Medicaid and non-Medicaid activities for the current fiscal year. Trillium's audit report, as of June 30, 2018, has no audit findings with an unqualified opinion, and no findings or questioned costs for the auditor's compliance report for the same period. During fiscal year 2018, its total net position decreased by $13.8 million, primarily due to major reductions in state funding.

Trillium exceeded the contract benchmark for current ratio and Medical Loss Ratio (MLR). Trillium's Medicaid current ratio is 3.1 with a total current ratio of 2.92 for February 2019. The Medicaid current ratio is 2.92 with a total current ratio of 3.13 for March 2019 (benchmark is 1.00). Trillium's Medicaid year-to-date Medical Loss Ratio (MLR) is 80.3% before HCQI spending, and 83.3% after for February 2019. The MLR is 80.2% before HCQI and 83.2% after for March 2019 (benchmark is 85%). Trillium's Medicaid total assets on February 28, 2019 are $146,154,297 and overall total assets are $167,815,464. As of March 31, 2019, Medicaid total assets are $141,123,717 and total assets are $173,471,444.

Trillium meets standard *42 CFR § 433.32(a)* for maintaining an appropriate accounting system (Great Plains). Trillium uses the following Great Plains modules: General Ledger, Accounts Payable, Fixed Assets, and Cash Management. Trillium is currently using Great Plains version 2013 but has plans to upgrade to version 2018 prior to the beginning of the

fiscal year. Trillium uses CIE for claims processing and have assumed responsibility for programming of the system.

Trillium met the ten-year record retention standard required by the *NC Medicaid Contract*. It retains financial records for a minimum of ten years in their Ahoskie office location. Iron Mountain destroys records once they are ready to be purged. Within the Great Plains financial accounting system, records are not purged and remain accessible. Trillium keeps records longer if any unresolved audit findings exist. Trillium's *Financial Record Retention* procedure addresses compliance with Medicaid requirements for record retention for all financial records. This procedure had been updated to reflect the ten-year retention required by *NC Medicaid Contract, Section 8.3.2*.

Trillium reviews and updates, if necessary, all policies and procedures on an annual basis. All finance policies and procedures CCME reviewed reflect an annual review date of March 2019. Trillium has adequate policies and procedures documenting its Medicaid procedures. CCME recommends enhancing the procedures to cite *NC Medicaid Contract* and/or CFR requirements. Additionally, CCME recommends that Trillium add to the Financial Risk Management procedure the required timeframe for making the risk reserve payment. *NC Medicaid Contract, Section 1-General Provisions 1.8* requires, "Deposits shall be made within five (5) business days of receiving the monthly capitation payment."

Trillium's *Cost Allocation Plan* meets the requirements for allocating the administrative costs between federal, state, and local based on revenue as required by *42 CFR § 433.34*. Trillium had no disallowed costs per the audit report and Onsite interview. Annually, Trillium submits a cost allocation plan to Medicaid to determine the percentage of Medicaid's share of administrative costs. Currently this percentage is 87.5%. The administrative expenses are recorded by expense type in the general ledger and are then allocated to the different funding sources based on a percentage of total revenues received (except county funding). Medicaid funds are properly segregated through the chart of accounts in the Great Plains general ledger, examples of which were disclosed at the Onsite interview.

Trillium's Medicaid Risk Reserve account meets the minimum requirement of 2% of the capitation payment per month required by *NC Medicaid Contract, Section 1.9*. Trillium reached 10.7% of its required percentage of annualized capitation maximum (15%) as of March 31, 2019, with a balance of $46,504,747. Once Medicaid receives the capitation payment, the Senior Accountant calculates the risk reserve payment and the Accounting Manager reviews the calculation and pays the risk reserve contribution to the risk reserve account, by check, at Southern Bank within five business days. All deposits were made timely and CCME did not find any unauthorized withdrawals. Trillium provided CCME with bank statements demonstrating the risk reserve deposit and balance.

Trillium's Medical Loss Ratio did not meet the standard of *42 CFR 438.8* and *NC Medicaid Contract* standard (Amendment 2, Section 12.3 item k) of meeting or exceeding 85%. CCME recommends Trillium implement a corrective action plan to improve the medical loss ratio of 83.9% as of April 2019 (see below). This plan needs to include:

- Determining the level of spending to increase the MLR to 85%
- Determining if any prior spending is allowed as Quality Improvement Activities for calculating the Medical Loss Ratio
- Planning to spend for allowed Quality Improvement Activities such as those improving health outcomes, preventing hospital readmissions, improving patient safety, and wellness and health promotion activities, as appropriate
- Maintaining documentation for all QIA expenses
- Improving the MLR ratio to 85% within three months
- Communicating progress on raising the ratio with the State Medicaid office

Trillium met 8 of 9 (89%) standards in the Financial Services area as indicated in *Figure 10*.

Figure 10: Financial Services Comparative Findings

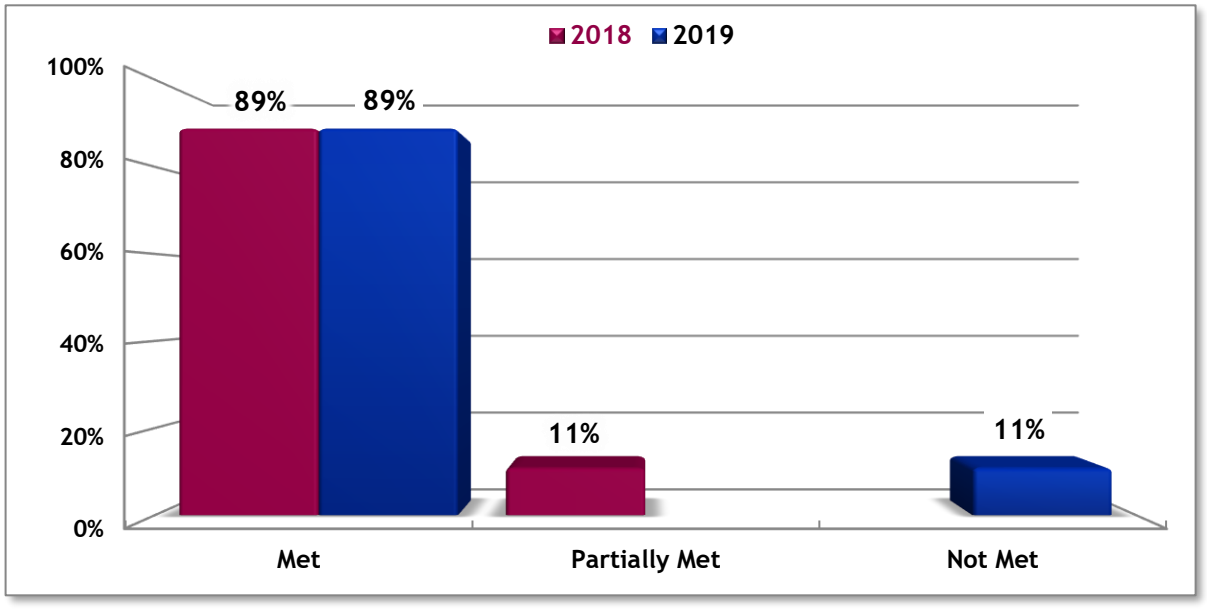


Table 28: Financial Services

Section	Standard	2019 Review
Financial Services	The Medical Loss Ratio (MLR) meets the requirements of *42 CFR § 438.8* and the *NC Medicaid Contract*	Not Met

Strengths

- Trillium has well-documented finance policies and procedures that are reviewed and updated annually.
- Trillium retains financial records for the contract required ten years.
- Trillium is properly segregating Medicaid funding from non-Medicaid funding.

Weaknesses

- Not all policies and procedures detail who is responsible for duties, nor do they cite contract requirements or contract due dates.
- Trillium's Medical Loss Ratio is under the 85% required by *42 CFR § 438.8* and the *NC Medicaid Contract*.

Corrective Action

- Trillium needs to implement a corrective action plan to improve the medical loss ratio of 83.9% as of April 2019, including:
  - Determining the level of spending to increase the MLR to 85%
  - Determining if any prior spending is allowed as Quality Improvement Activities for calculating the Medical Loss Ratio
  - Planning to spend for allowed Quality Improvement Activities such as those improving health outcomes, preventing hospital readmissions, improving patient safety, and wellness and health promotion activities as appropriate
  - Maintaining documentation for all QIA expenses
  - Improving the MLR ratio to 85% within three months
  - Communicating progress on raising the ratio with the State Medicaid office

Recommendations

- Update policies and procedures to add details regarding who is responsible for duties and citing contract requirements.

- Add to the *Financial Risk Management* procedure the required timeframe for making the risk reserve payment. *NC Medicaid Contract, Section 1-General Provisions 1.8* requires, "Deposits shall be made within five (5) business days of receiving the monthly capitation payment."

J. Encounter Data Validation

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

The scope the review, guided by the *CMS EDV Protocol*, was focused on measuring the data quality and completeness of claims paid by Trillium for the period of January 2018 through December 2018. All claims paid by Trillium should be submitted and accepted as a valid encounter to DMA. Our approach to the review included:

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

Results and Recommendations

Issue: Procedure Code

The Procedure Code should be populated 99% of the time with valid values. In the encounter files provided, HMS found that the procedure code was populated within the 99% threshold. However, for both institutional and professional claims, the procedure code was populated with a mix of valid procedure codes and revenue codes. Revenue codes should never be received or populated in the procedure code field.

Resolution:

During the onsite ISCA review, sample claims reviewed within their claims processing system showed that their provider portal allows the submission of invalid values. Trillium should ensure that the appropriate data validation checks are in place in their provider portal to prevent revenue codes from being submitted in the procedure code fields. Trillium should also update the 837 mapping to avoid submitting invalid values in the procedure code field.

Issue: Additional Diagnosis Codes

Additional diagnosis codes were populated less than 13% for professional claims. The missing diagnosis codes did not appear to be a mapping issue on Trillium's behalf, but likely driven by what providers are submitting. This value is not required by Trillium when

adjudicating the claim, therefore, not a requirement of the provider when submitting via Provider Portal or 837.

Resolution:

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 are minor issues with the procedure code value in both the professional and institutional encounters that Trillium should review and revise in their 837 mapping. Overall, Trillium has corrected all issues previously identified in the 2016 and 2017 encounter data validation reports and made significant strides ensuring they are submitting complete and accurate data to NC Medicaid.

ATTACHMENTS

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

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

April 16, 2019

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

Dear Ms. Wainwright,

At the request of the Department of Health and Human Services and NC Medicaid, this letter serves as notification that the 2019 External Quality Review (EQR) of Trillium Health Resources (Trillium). The review will be conducted by us, The Carolinas Center for Medical Excellence (CCME), and is a contractual requirement. The review will include both a Desk Review (at CCME) and a two-day Onsite visit at Trillium's office in Greenville, North Carolina that will address all contractually required services.

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

The CMS EQR protocols can be found at:

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

The CCME EQR review team plans to conduct the Onsite visit at Trillium on **June 5, 2019** through **June 6, 2019**. For your convenience, a tentative agenda for the two-day review is enclosed.

In preparation for the Desk Review, the items on the enclosed **Materials Requested for Desk Review** list are to be submitted electronically, and are due no later than **May 8, 2019**. As indicated in item 42 of the review list, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted by the aforementioned deadline.

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

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

The location for the file transfer site is:

https://eqro.thecarolinascenter.org

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 5

Cc: Kim Huneycutt, Trillium Contract Manager
Tasha Griffin, NC Medicaid Contract Manager
Renee Rader, NC Medicaid Quality Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager

External Quality Review 2019

MATERIALS REQUESTED FOR DESK REVIEW

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

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

3. Current Medical Director and Medical staff job descriptions.

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

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

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

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

8. List of new services added to the provider network in the past 12 months (April 2018 – March 2019) by provider.

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

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

11. A current provider manual and provider directory.

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

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

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

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

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

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

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

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

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

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

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

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

23. A copy of the complete Grievances log. Please indicate on the log the nature of the Grievance, the date received, and the date resolved. If the Grievance resolution timeframe was extended, please include who requested the extension.

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

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

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

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

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

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

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

31. Please provide an excel spreadsheet with a list of enrollees that have been placed in care coordination since April 2016. Please indicate the disability type (MH/SU, I/DD).

32. Please provide an excel spreadsheet with a list of enrollees that have been placed in the TCLI program since April 2016. Please include the following: number of individuals transitioned to the community, number of individuals currently receiving Care Coordination, number of individuals connected to services and list of services receiving, number of individuals choosing to remain in ACH connected to services and list of services receiving.

33. Information regarding the following selected Performance Measures:

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

Required information includes the following for each measure:

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

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

c. Reporting frequency and format;

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

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

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

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

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

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

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

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

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

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

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

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

    i. Insurance:

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

    B. For practitioners joining already-contracted agencies, include copies of the proof of insurance coverages for the agency, and verification that the

practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.

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

iii. Ownership disclosure information/form.

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

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

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

ii. Insurance:

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

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

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

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

v. Ownership disclosure information/form.

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

d. Ten MH/SU, ten I/DD and five TCLI files medical necessity denial files for any denial decisions made from April 2018 – March 2019. Include any medical information and physician review documentations used in making the denial determination. Please include all correspondence or notifications sent to

providers and enrollees. Please select MEDICAID ONLY files and submit the entire file.

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

39. Provide the following for Program Integrity:
    a. File Review: Please produce a listing of all active files during the review period (April 2018 – March 2019) including:
        i. Date case opened
        ii. Source of referral
        iii. Category of case (enrollee, provider, subcontractor)
        iv. Current status of the case (opened, closed)
    b. Program Integrity Plan and/or Compliance Plan.
    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.
    e. All '*Attachment Y*' reports collected during the review period.
    f. All '*Attachment Z*' reports collected during the review period.
    g. Provider Manual and Provider Application.
    h. Enrollee Handbook.
    i. Subcontractor Agreement/Contract Template.
    j. Training and educational materials for the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
    k. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse.
    l. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees.
    m. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other State or Federal agency.
    n. Code of Ethics and Business Conduct.
    o. Internal and/or external monitoring and auditing materials.
    p. Materials pertaining to how the PIHP captures and tracks complaints.
    q. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
        i. NC Medicaid approved reporting templates.
    r. Sample Data Mining Reports.
    s. NC Medicaid Monthly Meeting Minutes for entire review period, including agendas and attendance lists.

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

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

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

w. Policies/Procedures for:

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

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

a. A completed ISCA.

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

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

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

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

w. Any finance Corrective Action Plan

x. Detailed medical loss ratio calculation, including the following requirements under CFR § 438.8:

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

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

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

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

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

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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2019

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the Desk Materials were uploaded. Please upload into folder 15.

2. Credentialing Committee By-Laws. Please upload into folder 15.

3. Person Centered Planning Instructional Manual 2010. Please upload into folder 31.

4. ISP Planning Instructional Manual. Please upload into folder 31.

5. TCLI Data Dashboard -for 2018-19. Please upload into folder 32.

6. Financial Reporting-item 41c-scan of signed certification page or proof of date submitted. Please upload into folder 41.

7. All correspondence between the provider and Trillium for these voluntary terminations: Carteret Counseling, Starting Pointe, and ACI Support Specialists. Please upload into folder10.

Please upload to the aforementioned folders using this link :

https://eqro.thecarolinascenter.org

Also please title documents and folder within a minimum of 20 letters/characters to allow for easy transmission.

C. Attachment 3: EQR Validation Worksheets

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

- Innovations (C Waiver) Performance Measures Validation Worksheet
    - Proportion Of ISPs In Which Services And Supports Reflect Participant Assessed Needs And Life Goals
    - Proportion Of ISPs Address Identified That Address Identified Health And Safety Risk Factors
    - Percentage Of Beneficiaries Reporting That ISP Has Services They Need
    - Proportion Of Beneficiaries Reporting Care Coordinator Helps Them To Know What Waiver Services Are Available
    - Proportion Of Beneficiaries Reporting They Have A Choice Between Providers
    - Percentage Of Level 2 and 3 Incidents Reported Within Required Timeframes
    - Number And Percentage Of Deaths Where Required LME/PIHP Follow-Up Interventions Were Completed As Required
    - Percentage Of Medication Errors Resulting In Medical Treatment
    - Percentage Of Beneficiaries Who Received Appropriate Medication
    - Percentage Of Incidents Referred To The Division Of Social Services Or The Division Of Health Service Regulation, As Required

- Performance Improvement Project Validation Worksheet
    - Supermeasures-Substance Use
    - Supermeasures-Mental Health
    - Increasing Provider Satisfaction Related To The Appeals Process For Denial, Reduction, Or Suspension of Service(s)
    - Monitoring Of In-Reach Contacts For TCLI

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**READMISSION RATES FOR MENTAL HEALTH**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	06/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**READMISSION RATES FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	06/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	06/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	06/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	06/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**MENTAL HEALTH UTILIZATION- INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	06/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**MENTAL HEALTH UTILIZATION**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	06/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	06/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**SUBSTANCE ABUSE PENETRATION RATE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	06/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Trillium**
Name of PM:	**MENTAL HEALTH PENETRATION RATE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	06/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

Plan Name	**Trillium**
Name of PM	**Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals.**
Reporting Year	2017-2018
Review Performed	06/19

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N3. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate is in IW_Measures Excel file
R4. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Trillium**
Name of PM	**Proportion of Individual Support Plans that address identified health and safety risk factors**
Reporting Year	2017-2018
Review Performed	06/19

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G4. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G5. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D5. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D6. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N4. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N5. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R5. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate is in IW_Measures Excel file
R6. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Trillium**
Name of PM	**Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need.**
Reporting Year	2017-2018
Review Performed	06/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Trillium**
Name of PM	**Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available**
Reporting Year	2017-2018
Review Performed	06/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Trillium**
Name of PM	**Proportion of beneficiaries reporting they have a choice between providers**
Reporting Year	2017-2018
Review Performed	06/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Trillium**
Name of PM	**Percentage of level 2 and 3 incidents reported within required timeframes**
Reporting Year	2017-2018
Review Performed	06/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Trillium**
Name of PM	**Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required**
Reporting Year	2017-2018
Review Performed	06/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Trillium**
Name of PM	**Percentage of medication errors resulting in medical treatment**
Reporting Year	2017-2018
Review Performed	06/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Trillium**
Name of PM	**Percentage of beneficiaries who received appropriate medication**
Reporting Year	2017-2018
Review Performed	06/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Trillium**
Name of PM	**Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required**
Reporting Year	2017-2018
Review Performed	06/19

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

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

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

VALIDATION SUMMARY

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

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

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

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

AVERAGE VALIDATION PERCENTAGE & AUDIT DESIGNATION
100% FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

Plan Name:	**TRILLIUM**
Name of PIP:	**SUPERMEASURES SU**
Reporting Year:	2018
Review Performed:	2019

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

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

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

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology is same at baseline and remeasurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Rates have improved for DMH members and NC Medicaid members as of the latest validated rates (Measurement #2). Measurement #3 rates are reported, but not validated.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Awaiting most recent validated rates.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Awaiting most recent validated rates.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Awaiting most recent validated rates.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	85
Project Possible Score	85
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**TRILLIUM**
Name of PIP:	**SUPERMEASURES MH**
Reporting Year:	2018
Review Performed:	2019

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

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

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

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology is same at baseline and remeasurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	Rates have improved for DMH members, but not for NC Medicaid members (as of most recent validated numbers in Measurement #2). **Recommendation: Continue interventions to improve rates for both member populations.**
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Awaiting most recent validated rates.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Awaiting most recent validated rates.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Awaiting most recent validated rates.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	84
Project Possible Score	85
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**TRILLIUM**
Name of PIP:	**Increasing Provider Satisfaction Related to the Appeals Process for Denial, Reduction, or Suspension of Service(s)**
Reporting Year:	2018
Review Performed:	2019

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

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

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

Component / Standard (Total Points)	Score	Comments
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis of study data is included in PIP report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology is same at baseline and remeasurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Rates have improved as of the most recent survey.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Most recent rates appear to be result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing not conducted due to non-sampling methodology specific to this study.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge sustainment, as only baseline and measurement #1 are presented.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	90
Project Possible Score	90
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**TRILLIUM**
Name of PIP:	**Monitoring of In-Reach Contacts for TCLI**
Reporting Year:	2019
Review Performed:	2019

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not done for this study.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not done for this study.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not done for this study.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Source section (Incedo report).
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method is systematic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources will be pulled monthly.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis plan was documented as weekly on page 2.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data and compile report are listed in PIP document.

Component / Standard (Total Points)	Score	Comments
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions were noted and linked to barriers.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Not Met**	Analysis was conducted monthly starting on page 3 in Periodic measurements table, although data analysis plan is documented as weekly on page 2. **Recommendation: Clarify if analysis of rates will be conducted weekly or monthly. If analysis is weekly, then the results table should include weekly rates, instead of monthly rates.**
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	No statistical significance tests were conducted due to non-sampling methodology.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Discussion and analysis was noted in results section.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Same methodology at baseline and remeasurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	The post-Onsite submission showed an increase in contact rate.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Improvement did not occur.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No statistical analyses were conducted due to non sampling.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Improvement was not demonstrated thus, sustainment cannot be evaluated.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	**80**
Project Possible Score	**85**
Validation Findings	**94%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

D. Attachment 4: Tabular Spreadsheet

CCME PIHP Data Collection Tool

Plan Name:	**Trillium Health Resources**
Collection Date:	2019

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A. General Approach to Policies and Procedures						
1. The PIHP has in place policies and procedures that impact the quality of care provided to Enrollees, both directly and indirectly.	X					There was evidence of errors in the management of the tracking lists and the policies and procedures submitted. For example, the *Enrollee Access to PHI* procedure was renamed *Member Access to PHI* but the *Procedure Tracking List* was not updated. The UM, Claims, Contracts & Training procedure sets showed the last annual review was in March 2018 but the individual procedures show the last review was March 2019. One procedure and three policies were not accounted for in the upload for this year's EQR: *Post Payment Review, Board Attorney, Contracting with Non-Medicaid Providers*, and *Complaints and Grievances*. It is likely these policies and procedure were renamed, merged into another policy and procedure, or retired. The *Training* procedure also still had tracked changes in the footer, even though it had recently been reviewed and approved. Reconciliation between policies, procedures, and any tracking lists will ensure all active policies and procedures are accounted for, correctly titled, and/or designated as retired prior to any upcoming

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						audits, accreditations, or EQRs. This will also guarantee staff are utilizing the most up-to-date policies and procedures. ***Recommendation: Reconcile all tracking sheets, including the QIC Smartsheet, with each policy and procedure to ensure accurate and complete account of all policies and procedures, annual review dates, revision dates, and the current policy and procedure titles.***
I. B. Organizational Chart / Staffing						
1. The PIHP's resources are sufficient to ensure that all health care products and services required by the State of North Carolina are provided to enrollees. At a minimum, this includes designated staff performing in the following roles:						Within the Call Center's Customer Service area, the *Organizational Chart* showed seven vacancies of the available eleven positions. Staff explained that six temporary staff are not reflected in this section of the *Organizational Chart* and that only one existing position remains vacant. ***Recommendation: Update the Organizational Chart to clearly reflect any positions designated for or filled by temporary staff.***
1.1 A full time administrator of day-to-day business activities;	X					
1.2 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities.	X					Dr. Smith now serves as the Chief Medical Officer (CMO) and provides significant oversight of clinical and quality functions of Trillium. He is supported by a contracted physician at ECU's Brody School of Medicine and an agreement between Trillium's and Vaya's CMO is in place to provide back-up should either CMO need to be away for any length of time. Trillium is also currently recruiting for two physician positions to provide additional support to the UM Department.
2. Operational relationships of PIHP staff are clearly delineated.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all PIHP staff positions, including those that are required by NC Medicaid.	X					
I. C. Confidentiality						
1. The PIHP formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					
2. The PIHP provides HIPAA/confidentiality training to new employees and existing staff.	X					Trillium ensures new staff are oriented to Trillium's confidentiality requirements prior to allowing access by these staff to Protected Health Information (PHI). Staff are provided an annual refresher course on PHI requirements.
I D. Management Information Systems						
1. Enrollment Systems						
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Trillium has standard processes in place to download the daily Global Eligibility and have a SQL Server process that loads the data into the CIE system. Demographic data is captured in the CIE system and patients IDs are unique to members. There are validation checks in place to ensure member data is updated and correct. 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	X					Trillium has exception reports that are produced as part of their member enrollment updates. Providers can submit updated information

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
result, of the State enrollment file load process.						for members via the web portal, and Trillium staff can approve or deny changes.
1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.	X					The CIE system captures all historical information for members. All historical data for members is stored and merged under one member ID. Onsite review of the member enrollment screen shows the CIE system captures all relevant demographic information for members.
2. Claims System						
2.1 The MCO processes provider claims in an accurate and timely fashion.	X					The majority of claims received are electronic or through the provider web portal. Very few claims are received via paper. Claims are processed within 18 days after receipt and are approved, denied, or determined to need additional information. If approved, payment will be made within 30 calendar days after received.
2.2 The MCO has processes and procedures in place to monitor review and audit claims staff.	X					
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					Onsite review of the CIE claims system shows compliance with this listed element. ICD-10 procedure codes, revenue codes, and Diagnosis-related groups (DRG) codes are captured in the CIE system and are also included for encounter data submission reporting. Up to 25 diagnosis codes are captured for institutional claims received via the web portal and up to 41 diagnosis codes can be captured on institutional claims received electronically. For professional encounters, up to 12 diagnosis codes are captured electronically or via the web portal. Capture of additional diagnosis codes on institutional encounters satisfies the requirement of the prior EQR's Corrective Action Plan.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 The MCO's claim system screens store and track claim information and claim adjudication/payment information.	X					Onsite review of the CIE system confirms this is satisfied.
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 diagnosis codes and is capable of capturing additional procedure, DRG, and revenue codes for submitted claims. Trillium is also capable of submitting the captured elements on encounter data submissions to NC Medicaid.
3.2 The MCO has processes in place to back up the enrollment and claims data repositories.	X					Trillium's claims database is backed up nightly to a repository where up to 30 days' worth of copied data is archived. A vendor provides nightly restore points of their data repository, a cloud hosted server allows the PIHP to go back several weeks in time to access data from weeks prior. Regular disaster recovery tests are conducted to ensure critical processes are not disrupted in the event of disasters or system issues. Disaster recovery processes were discussed Onsite and Trillium indicated no disruption to services in the audited year.
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 captures all required secondary diagnosis codes for institutional and professional encounters, and has addressed last year's Corrective Action Plan. ICD-10 procedure and DRG codes are captured in the CIE system and are also included for encounter data submissions. Discussions on including procedure codes for certain lab, drug, or radiology services, as well as identifying third party payers on encounter data submissions occurred during the Onsite. ***Recommendation: Leave procedure codes blank if the HCPCS code provided does not map to the revenue code for a lab, drug, or radiology service encounter.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						For encounters associated with third-party payers and are submitted to NC Medicaid, fill in the appropriate payer ID field to ensure these encounters are identified for coordination of benefits.
4.2 The MCO has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					The 835 denial report is utilized by Trillium to help reconcile denied encounters. Denied encounters are grouped by a denial code, matched against a tracking log database, and assigned to the appropriate department for investigation and correction.
4.3 MCO has policies and procedures in place to reconcile and resubmit encounter data denied by NC Medicaid.	X					Encounter denial reports were provided and ISCA documentation shows flow charts and procedures for encounter data submissions to NC Medicaid.
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					Since bringing the CIE system in-house, Trillium created a new business unit with a staff of 18 employees to oversee and maintain the CIE system. The encounter data process has improved significantly and staff is able to speak to encounter data submissions, reconciliations, and data system backups.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II. A. Credentialing and Recredentialing						
1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					The *Credentialing Program Description*, the *Credentialing Committee By-laws,* and policies and procedures, including the *Credentialing and Re-credentialing Process* procedure, guide the credentialing and recredentialing processes.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	X					The *Credentialing Committee Bylaws* define the responsibilities of the Credentialing Committee. The *Credentialing Committee Bylaws , the Credentialing Program Description,* and the *Credentialing and Re-credentialing Process* procedure delegate to the Chief Medical Officer the authority for approval of "clean" applications. However, none of these documents define "flagged"/"red-flagged" applications, which are to be reviewed by the Credentialing Committee. The *Credentialing and Re-credentialing Process* procedure states, "Red-flagged file is a complete application that must be reviewed by the Credentialing Committee. The file has gone through the PSV and conduct check process and has had significant adverse reports (hits) found. A red-flag summary will be developed to include any additional information the staff can gather from the applicant." There is no definition or example of what an adverse "hit" is. The Credentialing Committee meeting minutes clearly reflect committee discussion and decisions for "flagged" applications. The Credentialing Committee meetings are held in a variety of ways: Face to Face, Webex, Telepresence. The committee met 11 times

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						from April 2018 through March 2019 (the September meeting was cancelled due to Hurricane Florence), with a quorum present for all meetings. Individual member attendance at the meetings from April 2018 through February 2019 ranged from 10% (one provider member) to 100% (four members) of the meetings at which they were a member. An additional five members attended between 50% and 75% of the meetings at which they were a member. ***Recommendation: In the Credentialing and Recredentialing Process procedure, provide a definition or examples of items that are considered an (adverse) "hit" or "flag" that would result in a file being reviewed by the Credentialing Committee.***
1. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Initial credentialing files reviewed were organized and contained appropriate information. Issues regarding the initial credentialing process are discussed in the standards that follow.
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					The PSVs of the DEA certificates in the submitted files do not include the URL of the website nor the date of the query. The date of the query is documented on the *Credentialing Checklist*. During the Onsite visit, Trillium staff determined that a change in software

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						resulted in these items no longer being in the footer of the PSV printout. ***Recommendation: Include the URL of the accreditation website and the date of the query when printing the PSV.***
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					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Credentialing files include screenshots of the query of the *State Exclusion List*. The date of the query is visible on all except 1 of the screenshots for practitioners. The evidence of the queries for the organizational providers is less consistent, with screenshots for 3 of the 4 initial credentialing files, and a download of the actual *State Exclusion List* spreadsheet for one of the providers. One of the screenshots has no date displayed. One of the screenshots does not list the name of the agency for which the search was conducted (it has the Excel message stating, "We couldn't find what you were looking for. Click Options for more ways to search".). One screenshot has all needed elements (the name on which the search was conducted; the date of the query, the date of the State Exclusion List). The date of the query is documented on the Credentialing Checklists. ***Recommendation: Standardize the query process, to include the details of how the query should be conducted and saved for purposes of the PSV.***
3.1.10 Query for the System for Awards Management (SAM);	X					
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	X					The PSVs of the NPPES in the submitted files do not include the URL of the website nor the date of the query. The date of the query is documented on the Credentialing Checklist. During the Onsite visit, Trillium staff determined that a change in software resulted in these items (website URL and date of query) no longer being in the footer of the PSV printouts. ***Recommendation: Include the URL of the accreditation website and the date of the query when printing the PSV.***
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					
2. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files reviewed were organized and contained appropriate information. Issues regarding the recredentialing process are discussed in the standards that follow.
4.1 Recredentialing every three years;	X					At the last EQR, 7 of the 12 providers were not re-credentialed within three years, with recredentialing ranging from a day to about 8 weeks late. In some files, it appeared that Trillium was counting the time since credentialing or the prior recredentialing based on the date the approval letter was sent, versus the date of the prior approval. At the last Onsite, Trillium staff acknowledged this was a problem in the past but reported it is now resolved.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Corrective Action was required for this Standard at the last EQR. All of the providers whose files were submitted for the current EQR were recredentialed within 3 years.
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					The *Credentialing Checklist* in 3 Licensed Independent Practitioner files, and in 5 Licensed Practitioner files list items relevant to an agency (i.e. accreditation verification, Articles of Incorporation, facility license), but do not include PSV of the practitioner's clinical license. The practitioner clinical license PSVs are in the files. ***Recommendation:* Revise the *Supplemental & LIP Re-Credentialing Checklist* used for practitioners to include the PSV of required items, such as the practitioner clinical license and document the date the PSV is conducted.**
4.2.3 Valid DEA certificate; and/or CDS certificate	X					The PSVs of the DEA certificates in the submitted files do not include the URL of the website nor the date of the query. The date of the query is documented on the *Credentialing Checklist*. During the Onsite visit, Trillium staff determined that a change in software resulted in these items (URL and date of query) no longer being in the footer of the PSV printout. ***Recommendation: Include the URL of the accreditation website and the date of the query when printing the PSV.***
4.2.4 Board certification if claimed by the applicant;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.5 Malpractice claims since the previous credentialing event;	X					
4.2.6 Practitioner attestation statement;	X					
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event; and query of the State Exclusion List;	X					Practitioner recredentialing files include screenshots of the query of the *State Exclusion List*. The evidence of the queries for the organizational providers is less consistent, with screenshots for two of the four agency recredentialing files, and a download of the actual State Exclusion List spreadsheet for the other two agency providers. One of the agency recredentialing files has a screenshot with the query for one of the owners, but no evidence of a query for the agency itself. The date of the query is documented on the Re-Credentialing Checklists. ***Recommendation: Standardize the query process, to include the details of how the query should be conducted and saved for purposes of the PSV.***
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.11 Query of the Social Security Administration's Death Master File	X					
4.2.12 Query of the NPPES;	X					The PSVs of the NPPES in the submitted files do not include the URL of the website nor the date of the query. The date of the query is documented on the *Credentialing Checklist*. During the Onsite visit, Trillium staff determined that a change in software resulted in these items (website URL and date of query) no longer being in the footer of the PSV printouts. ***Recommendation: Include the URL of the accreditation website and the date of the query when printing the PSV.***
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					
4.2.14 Ownership Disclosure is addressed.		X				With their Desk Materials, Trillium submitted recredentialing files for 6 Licensed Independent Practitioners (LIPs), 6 Licensed Practitioners (LPs) who were joining agencies, and 4 organizational (agency) files. The 6 LIP files contained the question of "Do you have ownership or control interest of 5% or more in other organizations that bill Medicaid for services?", but did not contain actual Ownership Disclosure for the practitioners. When asked about it at the Onsite visit, Trillium provided the Part D Ownership Disclosures, but they did not appear to be from the current recredentialing applications. Trillium staff confirmed the provided PSVs were from the initial credentialing process and the Part D Ownership Disclosure was not obtained as part of the recredentialing process for the LIPs.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The *NC Medicaid Contract, Attachment O,* requires applicants to identify "all persons with an ownership or control interest" and "all managing employees". *NC Medicaid Contract, Section 1.13* requires disclosure of criminal convictions and requires criminal background checks of "Provider and Persons with Controlling Interest". *NC Medicaid Contract, Section 1.14* requires the PIHP to check the exclusion status of "the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider…" ***Corrective Action: 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" and PSV of the required exclusion checks. See NC Medicaid Contract, Attachment O and Section 1.13 and Section 1.14.***
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 and the *Credentialing Program Description* state, "Staff will collect information regarding the provider's performance within the network via the Verification of Provider Standing (VPS) form. This form is utilized and completed to obtain information regarding Program Integrity, Complaints and Grievances, as well the Network Monitoring." The *Recredentialing Checksheet* has this statement, "Verification of Provider Standing: (Only Program Integrity Needed for "Supplementals")." The files of the 6 LPs/"Supplementals" being recredentialed for contracted agencies did not have the Complaints & Grievances or Network sections of the form completed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Compliance with Trillium's *Credentialing and Re-Credentialing Process* procedure's requirements regarding consideration of the provider's performance within the network" was also an issue at the previous 2 EQRs. At the last EQR, Trillium submitted a Corrective Action Plan that stated, "Trillium has updated our *Agency, and Supplemental & LIP Recredentialing Checklists* (attached) to specifically note that we have received *VPS* forms from Program Integrity, Network, and Compliance and that they have been placed in the practitioner's file." ***Corrective Action: As indicated in the Corrective Action for the last EQR, to comply with Trillium's Credentialing and Recredentialing Process procedure and NC Medicaid Contract, Section 7.6, ensure provider performance is taken into consideration at recredentialing. If Trillium is using the Verification of Provider Standing (VPS) forms for this process, confirm all completed forms have been received prior to submitting the recredentialing application packet for approval by the Chief Medical Officer or the Credentialing Committee.***
1. The PIHP formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the PIHP for serious quality of care or service issues.	X					The *Credentialing Program Description* addresses quality of care issues, including the responsibilities of the Credentialing Committee when quality of care issues are identified. The *Credentialing and Re-credentialing Process* procedure states "Practitioners or facilities may be provisionally credentialed when justified by continuity or quality of care issues." The *Provider Sanctions* procedure outlines the process of investigating violations or significant performance problems, and imposing sanctions, up to and including, termination of contract(s).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					Several of the printouts of the PSVs for accreditation do not include the URL of the accreditation agency website, nor the date of the query/printout. ***Recommendation: Include the URL of the accreditation website and the date of the query when printing the PSV.***
II B. Adequacy of the Provider Network						
1. The PIHP maintains a network of providers that is sufficient to meet the health care needs of enrollees and is consistent with contract requirements.	X					Trillium identified challenges including the rural nature and sparse population of much of its 26-county catchment area. During the Onsite visit, staff reported that, despite posting RFPs in the past to try to meet gaps, they were unable to add providers to fill the gaps. RFPs are currently posted on the Trillium website for Young Adult Transitional Housing, Community Support Treatment, Assertive Community Treatment, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Program. Trillium staff reported they are pursuing "a couple of Alternative Service Definitions" in an attempt to address gaps and needs. This year, a new methadone clinic opened in Elizabeth City, with several others "close to opening," including clinics in Dare and Carteret Counties. These clinics will reduce travel time for members seeking opioid treatment.
1.1 Enrollees have a Provider location within a 30 – mile distance of 30 minutes' drive time of their residence. Rural areas are 45 miles and 45 minutes. Longer distances as approved by NC Medicaid are allowed for facility based or specialty providers.	X					Trillium's *2017 Network Adequacy & Accessibility Analysis (Finalized 2018)* lists nine services that did not meet choice/access standards. Trillium submitted, and NC Medicaid approved, Exception Requests for those services. RFPs for several services are posted on the Trillium website. Details are provided on pages 52 and 56 of the *Member and Family Handbook*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 Enrollees have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the enrollee may utilize an out-of-network specialist with no benefit penalty.	X					The *Out of Network Client Specific Agreements* procedure addresses the usage of out-of-network services, including as needed for specialty services. The *Member and Family Handbook* addresses medical necessity in several places, with page 62 providing detailed information. The handbook references out-of-network providers in several places, but conveys mixed messages regarding medically necessary services when an in-network provider is not available. The handbook does not clearly communicate that, if medically necessary treatment is required, but specialty services are not available in-network, the member may use an out-of-network specialist with no benefit penalty. Page 56 of the *Member and Family Handbook* states, "If you have contacted a provider for services who is not part of the Trillium provider network and wish to continue to be seen by this provider, you will need to make arrangements with this provider to pay out of pocket for services.", and, "You are responsible for payment of services if you go to an out-of-network provider for non-emergency services that are not pre-authorized by Trillium". Page 64 of the handbook states, "If you have Medicaid, we will try to find an in-network provider for your care. If no in-network provider is available, we will work hard to find an out-of-network provider. It is our job to make sure providers are available for you." ***Recommendation: Revise the Member and Family Handbook to clearly indicate that, if a network specialist is not available, the member may use an out-of-network specialist with no benefit penalty. See 42 CFR § 438.206 and NC Medicaid Contract Attachment B, Section 6.4.5.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 The sufficiency of the provider network in meeting enrollee demand is formally assessed at least annually.	X					Trillium's *Gaps Analysis* reports various efforts to increase member/family and stakeholder input into the gaps and needs process, with a reported 39.76% increase in stakeholder survey responses and a 102% increase in member & family survey responses. The current *Gaps Analysis* lists nine Medicaid-funded services for which Trillium did not meet choice/access standards. Eight of these were the same services for which Trillium did not meet choice/access standards in the last *Gaps Analysis* process. One gap (I/DD Facility-Based Respite) from the previous *Gaps Analysis* met choice/access standards in the current process. A gap in Child Mental Health Out-of-Home Respite was newly identified in the *2017 Network Adequacy & Accessibility Analysis (Finalized 2018)*. *Exception Requests* for those services were submitted to and approved by NC Medicaid.
1.4 Providers are available who can serve enrollees with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					The Trillium *Cultural Competency Plan* is posted on the Trillium website. *Trillium Network Communication Bulletin #40* dated March 22, 2019 provides details of the PIHP, including informing providers that it is posted on the Trillium website. The *Trillium Provider Manual* includes a link to the *Cultural Competency Plan* on the Trillium website; however, the link goes to "Page not found". A "Search" of the website for the *Cultural Competency Plan* provides three results, but none link directly to the *Cultural Competency Plan*. Trillium has contracts with providers who use sign language, and with Fluent Language, which includes Braille. ***Recommendation: Correct the link in the Provider Manual to the Cultural Competency Plan. Have a staff member periodically check links to ensure they work. Enable a direct link on the website from a "Search" to the Cultural Competency Plan.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.5 The PIHP demonstrates significant efforts to increase the provider network when it is identified as not meeting enrollee demand.	X					Trillium uses Client Specific Agreements to obtain needed services when an in-network provider is not available. Trillium has issued Request for Proposals (RFPs) and used targeted provider recruitment to try to address gaps and needs. Several RFPs are currently posted on the Trillium website.
2. Provider Accessibility						
2.1 The PIHP formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					
II C. Provider Education						
1. The PIHP formulates and acts within policies and procedures related to initial education of providers.	X					The *Training* procedure states "The Training Unit is tasked with identifying the training needs of the provider network and Trillium staff. The Training Unit is responsible for the coordination of all provider network and internal staff trainings through collaboration with various external Trillium committees, including the Clinical Advisory Committee (CAC), Consumer and Family Advisory Committee (CFAC), Provider Network Council (PNC) and the provider network." The procedure goes on to outline the orientation that takes place with providers "upon establishment of a contract."
2. Initial provider education includes:						New providers are notified about orientation materials and requirements via a letter from the Contracts Department.
2.1 PIHP purpose and mission;	X					
2.2 Clinical Practice Standards;	X					Page 26 of the Trillium *Provider Manual* includes a link to the Clinical Practice Guidelines on the Trillium website; however, when

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						the link is clicked, it inserts the URL into the "To" section of a new email message. It does not go to the Clinical Practice Guidelines. The Clinical Practice Guidelines are posted on the "For Providers" section of the Trillium website. ***Recommendation: Correct the link in the Provider Manual to the Clinical Practice Guidelines. Have a staff member periodically check links to ensure they work.***
2.3 Provider responsibilities;	X					
2.4 PIHP closed network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability.	X					
2.5 Access standards related to both appointments and wait times;	X					The *Provider Manual* provides the correct access standards for both appointments and wait times. As indicated at the last two EQRs, the *Trillium Call Center Training for New Providers* has correct timeframes for Access Standards, but does not contain any information regarding appointment wait times. ***Recommendation: Include appointment wait times in the Trillium Call Center Training for New Providers.***
2.6 Authorization, utilization review, and care management requirements;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.7 Care Coordination and discharge planning requirements;	X					
2.8 PIHP dispute resolution process;	X					
2.9 Complaint investigation and resolution procedures;	X					
2.10 Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements;	X					
2.11 Enrollee rights and responsibilities	X					
2.12 Provider program integrity requirements that include how to report suspected fraud, waste and abuse, training requirements as outlined in the False Claims Act, and other State and Federal requirements.	X					
3. The PIHP provides ongoing education to providers regarding changes and/or additions to its programs, practices, enrollee benefits, standards, policies and procedures.	X					The Trillium website gives providers access to newsletters and notifies them about available training events. Trillium has an extensive training plan, which includes provider trainings on the Provider Portal.
II D. Clinical Practice Guidelines for Behavioral Health Management						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1. The PIHP develops clinical practice guidelines for behavioral health management of its enrollees that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					During the Onsite visit, Trillium staff confirmed the Clinical Advisory Committee (CAC) annually (or whenever there is a change), reviews and approves the Clinical Practice Guidelines. The *Clinical Advisory Committee* procedure states, "The CAC develops or adopts clinical practice guidelines for the common behavioral health diagnoses and treatment modalities found in the population of the Trillium member community." Trillium staff reported the CAC will review and approve the Clinical Practice Guidelines on June 7, 2019.
2. The PIHP communicates the clinical practice guidelines for behavioral health management and the expectation that they will be followed for PIHP enrollees to providers.	X					Clinical Practice Guidelines are posted on the Trillium website. Page 26 of the *Provider Manual* includes a link to the Clinical Practice Guidelines page on the Trillium website, but clicking on the link opens a new email message and inserts the link in the "To" field. ***Recommendation: Correct the link in the Provider Manual to the Clinical Practice Guidelines. Have a staff member periodically check links to ensure they work.***
II E. Continuity of Care						
1. The PIHP monitors continuity and coordination of care between providers.	X					Trillium staff reported continuity and coordination of care are monitored through routine monitoring, or monitoring if there is a provider concern.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II F. Practitioner Medical Records						
1. The PIHP formulates policies and procedures outlining standards for acceptable documentation in the Enrollee medical records maintained by providers.	X					The *Medical Records Provider Requirements* procedure and the *Provider Manual* include regulations for medical records compliance, including references to *Administrative Procedural Service Manual (APSM) 45-2*, *APSM 30-1*, and the *NCTracks Provider Claims and Billing Assistance Guide*.
2. The PIHP monitors compliance with medical record documentation standards through formal periodic medical record audit and addresses any deficiencies with the providers.	X					Medical record monitoring is conducted as a part of the NC DHHS provider monitoring program. Trillium staff monitor medical record documentation through Desk Reviews, Onsite reviews and routine monitoring, and in response to Complaints, Grievances and provider Concerns.
3. The PIHP has a process for handling abandoned records, as required by the contract.	X					The "Abandoned Records" section of the *Management and Assumption of Medical Records* procedure includes all steps required by *NC Medicaid Contract 8.2, Clinical Records*.

III. ENROLLEE SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III A. Enrollee Rights and Responsibilities						
1. The PIHP formulates policies outlining enrollee rights and procedures for informing enrollees of these rights.	X					Procedure titled *Member Rights and Responsibilities* includes both member rights and the procedure for informing enrollees of these rights.
2. Enrollee rights include, but are not limited to, the right:	X					The following rights are documented in the *Member and Family Handbook* on page 68, unless otherwise noted. They are also

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						documented in the procedure titled *Member Rights and Responsibilities*.
2.1 To be treated with respect and due consideration of dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;						
2.3 To participate in decisions regarding health care;						
2.4 To refuse treatment;						
2.5 To be free from any form of restraint of seclusion used as a means of coercion, discipline, convenience or retaliation;						
2.6 To request and receive a copy of his or her medical record, except as set forth in 45 C.F.R. §164.524 and in N.C.G.S. § 122C-53(d), and to request that the medical record be amended or corrected in accordance with 45 CFR Part 164.						
2.7 Of enrollees who live in Adult Care Homes to report any suspected violation of their enrollee rights, to the appropriate regulatory authority as outlined in NCGS§ 131-D21.						Documented on page 3 of Procedure, *Member Rights and Responsibilities*. Documented in the *Member and Family Handbook* on page 74.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III B. Enrollee PIHP Program Education						
1. Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid waiver managed care program which they are contractually entitled, including:	X					Procedure, *Member Rights and Responsibilities, includes* "Notifying new members, within 14 days of enrollment, of the *Notice of Privacy Practices* and of the availability of the Trillium *Member and Family Handbook*, which is posted on the Trillium website at www.Trilliumhealthresources.org and how to request a printed copy of the handbook if needed." The Communications Department is responsible for this notification. *The New Member Form Letter 2018* is sent to members with 14 days and explains how to access the website at www.TrilliumHealthResources.org for information including: Trillium *Member and Family Handbook, Rights and Responsibilities, Benefit Plan Information and Service Definitions, a Welcome to Trillium Presentation, Provider Network Directory,* and Educational Opportunities. The Access to Care phone number is provided for members 24 hours a day, 365 days a year.
1.1 A description of the benefits and services provided by the PIHP and of any limitations or exclusions applicable to covered services. These descriptions must have sufficient detail to ensure the Enrollees understand the benefits to which they are entitled and may include a web link to the PIHP Benefit Plan. This includes a descriptions of all Innovations Waiver services and supports;						On pages 17-21 of the *Member and Family Handbook*, benefits and services are explained in Section 2: What is the Medicaid Waiver.
1.2 Benefits include access to a 2nd opinion from a qualified health care professional within the network, or arranges for the enrollees to obtain						On page 68 of the *Member and Family Handbook*, the right to a second opinion is explained for members.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
one outside the network, at no cost to the enrollee;						
1.3 Updates regarding program changes;						Changes in services and programs are explained on page 41 of the *Member and Family Handbook*.
1.4 A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;						EPSDT benefits are explained on page 42 of the *Member and Family Handbook.*
1.5 An explanation of the Enrollee's responsibilities and rights and protection as set forth in *42 CFR § 438.100*;						Explained on pages 52-53 of the *Member and Family Handbook*.
1.6 An explanation of the Enrollee's rights to select and change Network Providers						Explained on page 53 of the *Member and Family Handbook*.
1.7 The restrictions, if any, on the enrollee's right to select and change Network Providers						Explained on pages 52-53 of the *Member and Family Handbook*.
1.8 The procedure for selecting and changing Network Providers						Explained on pages 52-53 of the *Member and Family Handbook*.
1.9 Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request);						The *Network Provider Directory* is searchable online and contains all required information. A complete copy can be requested from the Call Center and mailed to members. Members can print online search results from the online *Network Provider Directory* with a new feature located on the "Print Search Results" link. This will export the search results, printing only what the member is searching for.
1.10 The non-English languages, if any, spoken by each Network Provider;						2019 Review: Updates to the online provider directory in "advanced search" has a language drop-down, but very little (or nothing) comes up when each of these languages are chosen. There are languages and translation options in this drop-down selection field.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The printed provider directory has a section for Languages. How is the field populated? (Some note "Translator-English" or are blank).
1.11 The extent to which, and how, after-hours and emergency coverage are provided, including:						The *Trillium Accessing Care* brochure explains all the access avenues offered.
1.11.1 What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services in accordance with *42 CFR § 438.114* and EMTALA;						Emergency and Post Stabilization Services are discussed in the *Member and Family Handbook* on pages 27 and 32. This was added in response to the CAP process during last year's EQR .
1.11.2 The fact that prior authorization is not required for emergency services;						
1.11.3 The process and procedures for obtaining Emergency Services, the use of 911 telephone services or the equivalent;						
1.11.4 The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract;						In the *Network Provider Directory* search online, there is a filter for Service Category. The category "Emergency Department" brings up a list of 238 locations for Emergency Departments. Onsite interview confirmed that the 238 locations includes walk-in clinics as well. Post Stabilization services is missing from the search. ***Recommendation: In the online Network Provider Directory, add Post Stabilization services as a Service Category search criteria, in addition to Emergency Services. The search for both Emergency and Post Stabilization services needs to return only those providers that offer both services.***
1.11.5 A statement that, subject to the provisions of the *NC Medicaid Contrac*t, the Enrollee has a						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
right to use any hospital or other setting for Emergency care;						
1.12 The PIHP's policy on referrals for Specialty Care to include cost sharing, if any, and how to access Medicaid benefits that are not covered under the *NC Medicaid Contract;*						On page 21, the *Member and Family Handbook* states, "Trillium does not allow co-payment, deductibles, or other forms of cost-sharing for Medicaid members for Medicaid services per the contract…"
1.13 Any limitations that may apply to services obtained from Out-of Network Providers, including disclosures of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of Network Providers, and the procedures for obtaining authorization for such services.						Page 56 of the *Member and Family Handbook* provides members a detailed explanation of out-of-network services that is easy to understand.
1.14 How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost-sharing;						
1.15 Procedures for obtaining out-of-area or out-of-state coverage of services, if special procedures exist;						Out-of-area coverage is discussed and easy to understand in the *Member and Family Handbook*. Although, there is no explanation of out-of-state coverage. ***Recommendation: In the Member and Family Handbook, add member procedures for obtaining out-of-state coverage of services in addition to out-of-area services.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.16 Information about medically necessary transportation services by the department of Social Services in each country;						This is discussed in the *Member and Family Handbook* on page 57.
1.17 Identification and explanation of State laws and rules Policies regarding the treatment of minors;						Page 70 in the *Member and Family Handbook* explains the rights of minors.
1.18 The enrollee's right to recommend changes in the PIHP's policies and procedures						Page 70 in the *Member and Family Handbook* explains the right to make "recommendations regarding changes to Trillium policies, procedures, and services."
1.19 The procedure for recommending changes in the PIHP's policies and services;						If members would like to make recommendations for changes, page 70 of the *Member and Family Handbook* directs members to contract Trillium by phone or in writing. Phone number and address is provided.
1.20 The Enrollee's right to formulate Advance Directives;						This is explained on pages 75-76 of the *Member and Family Handbook*.
1.21 The Enrollee's right to file a Grievance concerning non-actions, and the Enrollee's right to file an Appeal if PIHP takes an action against an Enrollee;						This member right is explained in the *Member and Family Handbook* on pages 84-86.
1.22 The accommodations made for non-English speakers, as specified in *42 CFR § 438.10(c)(5);*						Oral translation is available in any language and written translation is available in Spanish, the prevalent non-English language. Services for hearing impaired and vision impaired members is available.
1.23 Written information shall be made available in the non-English languages prevalent in the PIHP's services area.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.24 The availability of oral interpretation service for non-English languages and how to access the service;						Oral translation is available in any language.
1.25 The availability of interpretation of written information in prevalent languages and how to access those services						Written translation is available in Spanish, the prevalent non-English language. Trillium can also translate any written material into other languages by Language Line.
1.26 Information on how to report fraud and abuse; and						Information on how to report fraud and abuse is on page 101 of the *Member and Family Handbook*.
1.27 Upon an Enrollee's request, the PIHP shall provide information on the structure and operation of the agency and any physician incentive plans.						Staff guide members to the "About Us" section of the website for information on the structure and operation of Trillium. On page 53 of the *Member and Family Handbook,* it states, "Trillium does not offer any physician incentive plans to members of its provider network."
1.28 Information on Grievance, Appeal and fair hearing procedures and information specified in CFR §438.10 (g).						Trillium covers information on Grievance, Appeal, and fair hearing procedures in the *Member and Family Handbook*.
2. Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.	X					The A*nnual Letter* is approved by the Leadership Team. A report of members who received service in the past 12 months is pulled and sent to an external vendor to complete this mailing. The letter instructs members to access the website to view privacy practices, *Member and Family Handbook*, benefit plan, rights and responsibilities, *Provider Network Directory*, and educational opportunities. Trillium reports the week following the annual letter is the highest call volume of the year.
3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in CFR 438.10 (f) (61) and 438.10 (g) at least 30 days	X					Members are notified in writing of any significant changes. There were no significant changes during the review period.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
before calendar days before the intended effective date of the change; and (2) . termination of their provider within fifteen (15) calendar days after PIHP receives notice that NC Medicaid or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.						5 providers who were terminating (2 involuntary/ 3 voluntary) were reviewed for dates the provider or Trillium sent notification of the termination and the dates the enrollees were notified by Trillium of the termination and need to transition to a new provider. Enrollees for 1 provider were notified 9 days outside the required 15 calendars days. This constitutes a good faith effort. Trillium also implemented a tracking process January 2019 that logs all member letters to track Continuity of Care Letters.
4. Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation of prevalent non-English languages as required by the contract.	X					Page 26 of the *Member and Family Handbook* explains that Trillium can translate the handbook, forms, and brochures into other languages in addition to English and Spanish by requesting it from the Access to Care line. Page 2 of the *Member and Family Handbook* states, the handbook "is available in Spanish and in alternate formats (braille, large-print, audio). If you need an alternate version or have limited reading ability, call our Customer Services Department…". This statement is repeated in Spanish. This information is printed in large font. This satisfies *NC Medicaid Contract, Section 6.9.2 and CFR 438.10 (d).* The recommendations from last EQR to "create enrollee material in large font and have a plan to print when requested" and "Add a notice to the website and in the *Member and Family Handbook*, in 18 point font or greater, that states all enrollee materials can be printed in large print and mailed if needed" have been implemented. Trillium confirmed this process during the Onsite interview and creates large print material in-house, when requested.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. The PIHP maintains and informs Enrollees of how to access a toll-free vehicle for 24-hours Enrollee access to coverage information from the PIHP, including the availability of free oral translation services for all languages and care management services such as crisis interventions.	X					
III C. Behavioral Health and Chronic Disease Management Education						
1. The PIHP enables each enrollee to choose a Provider upon enrollment and provides assistance as needed.	X					Page 19 the *Member and Family Handbook* offers help to members in choosing a provider.
2. The PIHP informs enrollees about the behavioral health education services that are available to them and encourages them to utilize these benefits.	X					The *Member and Family Handbook* refers members to the Trillium website and Access to Care phone number for member education. The website has events posted including: Child Community Collaborative in different counties, mental health first aid- Veterans (2 dates). Between now and December, there are no other types of education offered on the website event timeline. Onsite interview explained that events will be added closer to the scheduled date of the event. On the website, member orientation videos are available, Eat the Rainbow education, Safe schools, and Trillium access to care information. The New Member Orientation and Community Training Survey link on the Trillium website resulted in a “page not found” message. ***Recommendation: Correct the New Member Orientation and Community Training Survey link on the Trillium website to display the correct information.***
3. The PIHP tracks the participation of enrollees in the behavioral health education services.	X					All live events use a sign-in sheet. Web events are tracked, electronically, by user registration.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III D. Call Center						
1. The PIHP provides customer services that are responsible to the needs of the Enrollees and their families. Services include:	X					Call performance statistics for the period of April 2018 through March 2019: Average speed of answer is between 4-6 seconds. Call abandonment rate all less than 3 seconds. Call volume is between 1642 and 2371 calls per month.
1.1 Respond appropriately to inquiries by enrollees and their family members (including those with limited English proficiency);	X					The Call Center uses the Language Line service to determine the correct language of a member with translation services provided after needs are assessed. Most callers will tell the Call Center staff what language they speak.
1.2 Connect enrollees, family members and stakeholders to crisis services when clinically appropriate;	X					Clinical triage questions are used to determine the level of urgency. Clinician utilizes mobile crisis if needed. They can dispatch mobile crisis, law enforcement, or EMS, as needed. They ask for a CIT-trained law enforcement officer and dispatch mobile crisis with law enforcement frequently. Call Center staff stay on the line with the caller until services arrive.
1.3 Provide information to enrollees and their family members on where and how to access behavioral health services;	X					
1.4 Train its staff to recognize third-party insurance issues, recipient Appeals, and Grievances and to route these issues to the appropriate individual;	X					
1.5 Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.6 Process referrals twenty-four (24) hours per day, seven (7) days per week; 365 days per year; and	X					
1.7 Process Call Center linkage and referral requests for services twenty-four (24) hours per day, seven (7) days per week, 365 days per year.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV A. The Quality Improvement (QI) Program						
1. The PIHP formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to enrollees.	X					*The 2018-2019 Quality Management Plan* documents Trillium's goals, structure, scope, and methodology of their Quality Improvement Program.
2. The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.	X					As explained in the *2018-2019 Quality Management Plan*, Trillium reviews, selects, and disseminates clinical practice guidelines relevant to its members based on literature review, and input from the Clinical Advisory Committee (CAC) and the Trillium Chief Medical Officer. The Chief Medical Officer and CAC will review monitoring of practitioner adherence of selected elements of the guidelines on an annual basis and provide feedback and assistance to the provider agencies as needed. Monitoring on the following Clinical Practice Guidelines was completed in August 2018:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						1. Use of rating scales to monitor treatment effectiveness and outcomes in the treatment of major depression. 2. Adherence to metabolic monitoring guidelines for members being treated with antipsychotic medication, with specific focus on lipid panels and serum glucose/Hemoglobin A1C. New Clinical Practice Guidelines will be monitored as a result of CAC voting to discontinue the previous process. The new process began around April 2019 and will involve HEDIS measures that relate to the newly targeted Clinical Practice Guidelines.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					The procedure, *Detecting Over and Under Utilization,* is in place for detecting over and under utilization. This procedure includes reviewing utilization patterns using claims data to examine trends regarding multiple services, inpatient readmissions, outpatient visits, and other measures. The Executive Dashboard for February 2019 contained monthly service costs for Medicaid B3 services, Child Residential services including PRTF, BH Long-Term Level III, and Foster Care. The report also reported Intermediate Care Facility costs, Inpatient services, and other service type costs. CAC Meeting minutes for April 2018 contained discussion of monitoring of underutilization of services and medications for Alcohol Use Disorder, Clozapine, and Multisystemic Therapy. As well, the Governing Board Report offered documentation on claims reviews regarding utilization, and action steps to improve member engagement with services and adherence to treatment recommendations. The *QM 2018-2019 Work Plan* demonstrated steps to monitor under and over utilization, steps taken or tasks to address issues, and completion status.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.		X				April 2018 QIC minutes reported the 2017 *Experience of Care in Health Outcomes (ECHO) Survey* results for Adult and Child surveys and compares measures to last year. The *2018-2019 Quality Management Plan* explains how surveys are administered, results reviewed and analyzed by QIC, results compared to previous annual survey data, discussed in committees, and conclusions documented in meeting minutes. All of these steps were followed. Although, conclusions do not include plans to improve items that were identified as low scoring. Low scoring items identified in the Adult survey include, "treatment and information about plans, perceived improvement and getting treatment quickly." In the Child survey, "Care Coordination showed a decrease from 82.4% to 70.4% with the state average at 76.8%." The conclusion by QIC is, "As a result of this survey it was determined to change the percentage in the Annual QM Work Plan goal from 80% satisfaction to the state average of 70%.". A report was prepared by Trillium analyzing results of the 2017 and 2018 *ECHO Surveys*. None of the lower scoring survey results have been identified for quality improvement. ***Corrective Action: Implement interventions to improve lower scoring areas of the Adult and Child ECHO surveys. Discuss the intervention progress with QIC throughout the year and adjust as needed.*** ***Recommendation: Adjust the ECHO Survey goal percentage for "overall satisfaction" to a fixed target and work to achieve that target. Currently the goal is set for the "state average" which will be different each year.***
5. The PIHP reports the results of the enrollee satisfaction survey to providers.	X					The 2017 and 2018 Child and Adult *ECHO Survey* results analysis reports are posted on the Trillium website. The *May 22, 2018 QIC Minutes* have a section that notes reports given on all the different committee's last meetings. The GQIC section

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						notes that member and provider survey results were presented to the GQIC. The *May 8, 2018 GQIC Minutes* include the report to the committee on *ECHO Survey* results.
6. The PIHP reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					*ECHO Survey* results were reported to QIC in April 2018.
7. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, time frame for implementation and completion, and the person(s) responsible for the project(s).	X					The *QM Work Plan* includes Activity, Start Date, Due Date, Assigned To, % Complete, Status, and Comments. The *QM Work Plan* is updated quarterly. GQIC has an annual work plan which is updated quarterly or as needed. It includes Activity, Objectives, Tasks, Responsible Person, Monitoring Frequency, and Review/Update Status, and Comments.
V B. Quality Improvement Committee						
1. The PIHP has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Improvement Committee (QIC) is the formal committee overseeing the QI Program and provides on-going reporting the Board of Directors. The Global Quality Improvement Committee (GQIC) is the committee representing the provider network to discuss and explore ideas related to quality improvement issues.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The QIC consists of a cross functional team including members from various departments across the organization, including the Trillium Health Resources Chief Medical Officer. The Chief Medical Officer and the Senior Director of Quality Management co-chair the committee. GQIC has provider representatives, Regional Consumer, and Family Advisory Committee members, and Trillium staff. Trillium staff do not have voting privileges. Recruiting was completed for vacant

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						positions of GQIC, except for a network physician, and a possible candidate has been identified.
3. The QI Committee meets at regular intervals.	X					The QIC meets monthly. If a quorum is not present at the meeting, voting is conducted electronically. GQIC meets quarterly. If a quorum is not present at the meeting, voting is conducted electronically.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are documented for every QIC and GQIC meeting.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					***Recommendations:*** ***Please refer to Table 22 and Table 23 for specific recommendations related to PIPs.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV E. Provider Participation in Quality Improvement Activities						
1. The PIHP requires its providers to actively participate in QI activities.	X					On page 85 in the *Provider Manual*, "Trillium recommends providers complete quality improvement projects that demonstrate evidence of performance improvement related to some aspect of organizational processes/structure, member outcomes, or other provider improvement activities."
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Provider Performance Reports are created by the QM Data Unit. They are sent to providers quarterly to offer providers information on how they are performing in certain areas compared to other similar providers. This data is informational and can assist providers with internal improvements such as validating data or possible development of QIPs. Trillium provides a blinded peer review opportunity for network providers, primarily for QIP review of network provider's individual QIPS. Trillium has decided to discontinue monitoring of all provider QIPs, but is considering a random sampling review in the future.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					*The Annual Quality Management Program Evaluation Fiscal Year 2017-2018* document contains an Executive Summary, 2017-2018 highlights, 17 QM Program "Compliance Elements", and a Summary. The "Compliance Elements" each have goals, outcome analysis, Met/Not Met scores, and next steps. The Compliance Elements are a complete representation of the Trillium QM program. The QIP compliance element could be enhanced by including information documented in the QIP Annual Report. This details goals, barriers, interventions, measurement period, and grafting over time. ***Recommendation: Include the QIP Annual Report within the Annual Quality Management Program Evaluation, embedded or as an appendix.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The annual report of the QI program is submitted to the QI Committee and to the PIHP Board of Directors.	X					As documented in the *2018-2019 Quality Management Plan*, "the QM Evaluation is presented to the QIC and Governing Board annually." The Governing Board receives the evaluation via email and hard copy at the Board Meeting.

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. The Utilization Management (UM) Program						
1. The PIHP formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					
1.1 structure of the program;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 consideration of new technology;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.6 the Appeal process, including a mechanism for expedited Appeal;	X					
1.7 the absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					
1.8 mechanisms to detect underutilization and overutilization of services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Dr. Michael Smith became Chief Medical Officer (CMO) in July 2018. Trillium documentation showed Dr. Smith was fully integrated into the UM program and providing clinical and supervisor oversight.
3. The UM program design is reevaluated annually, including Provider input on medical necessity determination guidelines and Grievances and/or Appeals related to medical necessity and coverage decisions.	X					The *Utilization Management (UM) Plan* is reviewed annually and supported by the policies and procedures that are in place.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.		X				The *NC Medicaid Contract Section 7.4.2*, requires that "for children ages 3 through 6, PIHP must use one of the *following options to determine medical necessity reviews: a. the Early Childhood Services Intensity Instrument (ECSII) …b. the Children and Adolescent Needs and Strength (CANS) or c. Another validated assessment…"* There was no reference to this type of assessment in any UM documentation and, during the Onsite, UM staff struggled to identify which assessment is required for this age group. Trillium eventually clarified that the ECSII was required to be completed by providers when providing services for this population. Trillium needs to ensure providers are trained in the use of the ECSII and include this required

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						assessment for children ages three to six in their procedures, *UM Plan*, and *Provider Manual*. ***Corrective Action: Include in procedures, the UM Plan, and Provider Manual that Trillium requires providers to utilize the Early Childhood Services Intensity Instrument (ECSII) when assessing children ages three to six for services.***
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
4. Utilization management standards/criteria are consistently applied to all enrollees across all reviewers.	X					
5. Emergency and post stabilization care is provided in a manner consistent with contract and federal regulations.	X					
6. Utilization management standards/criteria are available for Providers.	X					
7. Utilization management decisions are made by appropriately trained reviewers	X					
8. Initial utilization decisions are made promptly after all necessary information is received	X					The files for this EQR showed all were made timely.
9. Denials						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.1 A reasonable effort that is not burdensome on the enrollee or the provider is made to obtain all pertinent information prior to making the decisions to deny services	X					Trillium's *Lack of Information* procedure details the process that occurs when required materials are not available for the review process. The Onsite discussion indicated this procedure has helped to set reasonable expectations on providers for proving required documentation and has helped streamline this process.
9.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Trillium's process for entering Treatment Authorization denial decisions into their UM platform includes steps in which the UM Care Manager attaches a hard copy of the full denial decision to the Treatment Authorization portal. This hard copy includes the name and credentials of the physician or psychologist rendering the denial decision. The Care Manager then copies and pastes the Peer Reviewer denial decision into the electronic Treatment Authorization section of the platform. The narrative copied does not include the name or credentials of the Peer Reviewer and gives the appearance that denial decisions are made by the Care Manager. ***Recommendations: As denial decisions are required to be made by physicians or psychologists, CCME recommends the name and credentials of these Peer Reviewers are captured within the electronic Treatment Authorization section of the UM platform.***
9.3 Denial decisions are promptly communicated to the provider and enrollee and include the basis for the denials of service and the procedure for Appeal.	X					
V C. Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	x					The *Care Coordination Program Description* provided an overview of the Care Coordination Program but does not include information regarding Incedo. This platform captures Care Coordination progress notes, assessments, and other essential activities, as well as provides

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						a monitoring and data component that measures outcomes of Care Coordination. ***Recommendations: Add information about Incedo in the Care Coordination Program Description. Include details regarding how this platform is used to document Care Coordination activities, monitor interventions, and measure outcomes.***
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					
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					
2.5 Quality monitoring and continuous quality improvement;	X					The data generated from the Incedo Care Coordination platform is used to develop data dash boards used for supervision, monitoring services and service delivery, and monitoring outcome measures.
2.6 Determination of which Behavioral Health Services are medically necessary;	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions	X					Care Coordinators are assigned to specified hospitals and are involved in the admission and discharging processes that is defined in the *Coordination of Services Following Discharge* procedure.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
and discharges, including discharge planning;						
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					
2.10 Ensure privacy for each Enrollee is protected.	X					
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					The Incedo platform includes algorithms that provide reminders to the care coordinators, such as when quarterly monitoring and Individual Support Plans are due. The Incedo data is used to create dash boards that are used for supervision to ensure compliance with the HCBS standards.
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					The Care Coordination files showed the policies and procedures are followed. During the Onsite interview, a demonstration of the Incedo platform was provided. Through the demonstration, it was evident that the use of the Incedo modules provided guidance and support to care coordinators.
V. D Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					Transition to Community Living (TCLI) functions are performed by appropriately trained staff, as reviewed in the PIHP's TCLI Job Descriptions.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Recovery International is contracted to provide In-Reach services. Peer Support and Supported Employment are provided by network providers. Due to the ruralness of the region, Assertive Community Treatment (ACT) services are provided as unbundled services. Services were included in all Transition Plans and Person-Centered Plans reviewed.
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					There is a mechanism in place to provide and monitor all information related to one-time Transitional Funds. This is a cross function process with related information maintained in a folder that is shared by TCLI and financial staff.
2.5 QOL Surveys are administered timely.	X					QOL surveys were present in files, where appropriate.
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	X					The Onsite interview confirmed training continues to be provided to community members and stakeholders and PIHP staff as changes are made regarding TCLI. In addition, a TCLI brochure and a Housing Factsheet are available for internal and external stakeholders.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
hotline and services for enrollees with limited English proficiency.						
6. A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures and processes, as required by NC Medicaid, and developed by the PIHP.	X					

VI. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee Grievances in a manner consistent with contract requirements, including, but not limited to:	X					The Trillium Grievances process is located within the Call Center. All staff at Trillium are trained to take in and document Grievances within the Grievance module. Call Center staff receive additional training related to clarification of a Grievance and the resolution process. When a Grievance is entered in the PIHP's Grievance module it triggers a notification to the Customer Services Manager who then assigns the Grievance.
1.1 Definition of a Grievance and who may file a Grievance;	X					
1.2 The procedure for filing and handling a Grievance;	X					The procedure, *Grievance Process and Scope*, and the *Provider Manual* include the procedure for filing and handling a Grievance.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract;	X					In the *Grievance Process and Scope* procedure, details around the required timeframe for processing Grievances is only under the section describing Grievances against providers. Additionally, required timeframes for resolving Grievances are incongruent across this procedure, *Provider Manual*, and *Member and Family Handbook*. ***Recommendation: Revise procedure, Grievance Process and Scope, to reflect the timeliness guideline for all Grievances, not just Grievances against providers. Additionally, ensure that the timeframe guideline is consistent across the procedure, Provider Manual, and Member and Family Handbook.*** There are details missing from the *Grievance Process and Scope* procedure related to the notifications required from Trillium, if Trillium extends the Grievance resolution timeframe. ***Recommendations: Add to procedure, Grievance Process and Scope, the missing details regarding an extension by Trillium to the Grievance resolution timeframe. These details need to include:*** ***i. Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and,*** ***ii. Inform the enrollee of the right to file a Grievance if she/he disagrees with the decision.***
1.4 Review of all Grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					*The Grievance Process and Scope procedure includes the "Chief Medical Officer will provide consultation and direction to the staff in how to proceed with the investigative process." However, the procedure does not address how or where this consultation and direction will be documented.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendations: Include in the Grievance Process and Scope procedure how and where CMO consultation is captured within Grievance files
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					An upgrade of the Grievance module platform included the ability to separate Grievances from Complaints with improved analytical abilities.
2. The PIHP applies the Grievance policy and procedure as formulated.	X					In nine of the 11 Grievance files reviewed, the Grievance resolution notification sent to the Grievant provided minimal information about the steps Trillium took to resolve the Grievance and the outcome of the Grievance. This was true even when multiple allegations had been made within the Grievance. ***Recommendations: Ensure Grievance Resolution notifications provide detailed and concise information to demonstrate to Grievants their concerns were adequately considered and thoroughly resolved. This is particularly true for Grievances that include multiple allegations.***
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider Appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					
1.1 The definitions an Appeal and who may file an Appeal;	X					
1.2 The procedure for filing an Appeal;	X					In the previous two EQRs, CCME recommended Trillium add to the Provider Manual that an acknowledgement letter is sent to the enrollee by Trillium when an Appeal is received. This letter may be the only evidence available to providers, who may continue to provide services during the pendency of the Appeal, that an Appeal is being processed. In the previous year, Trillium did add this information to the Provider Manual. However, it was added only to the Non-Medicaid Service Reconsideration Process section of the manual. Additionally, the acknowledgement notification information added to the manual states, "Trillium acknowledges receipt of the Appeal in writing via a letter to the appellant dated the next working day." This timeframe is not supported by Trillium's Appeal procedure, Medicaid Clinical Reconsideration Process which does not give a timeframe for sending acknowledgment letters. ***Recommendation: Add to the Provider Manual, under the Medicaid Services Appeal - Level 1 section, that Trillium sends an acknowledgement letter whenever an Appeal is received. Ensure the manual reflects the same timeframe for sending an acknowledgment letter is the same as outlined in the Appeal procedure, Medicaid Clinical Reconsideration Process.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	X					The procedure, *Medicaid Clinical Reconsideration Process*, does not include the right of an enrollee or authorized appellant to file a Grievance if Trillium denies a request to expedite an Appeal. This is required by *42 CFR § 438.410 (c)*. ***Recommendation/Corrective Action: Add the right of an enrollee to file a Grievance when a request for an expedited Appeal is denied by Trillium to the procedure, Medicaid Clinical Reconsideration Process.***
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					
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					Five expedited files were reviewed. In the two files where Trillium agreed to expedite the Appeal, the acknowledgment letter states the Appeal may take "up to 30 days" to resolve. This timeframe is inaccurate, as expedited Appeals must be resolved and notification given within 72 hours of receipt of the Appeal, per *DMA Contract, Attachment M, H.5*. This timeframe can be extended for an additional 14 days but should never take "up to 30 days", as is outlined in Trillium's expedited acknowledgment letter.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendations: Ensure notifications to appellants reflect the correct timeframe Trillium follows for resolving and providing notice of the outcome of an expedited Appeal. In the three files where Trillium did not agree to expedite the resolution of the Appeal, an acknowledgement letter was sent informing the appellant of Trillium's decision. This acknowledgement letter did not inform the appellant of their right to file a Grievance against Trillium for denying the request to expedite an Appeal, nor did staff inform the appellant of this right when providing oral notification of the denial of their request to expedite the Appeal. ***Recommendations: When Trillium does not agree to expedite the resolution of the Appeal, ensure the appellant is informed of their right to file a Grievance against Trillium for the denial of the request to expedite the resolution and notification of an Appeal. Ensure the Medicaid Clinical Reconsideration Process, procedure also reflects that appellants are informed of their right to file a Grievance when a request to expedite an Appeal has been denied by Trillium.***
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					Trillium collects appeal data monthly. This data collected includes the number of each type of appeal (i.e., MH/SU versus I/DD, clinical versus administrative, and standard versus expedited) and the number of appeal outcomes for each month over the previous two years. These numbers are submitted to the QI Committee, however, there is no analysis of the data nor any evidence of review or discussion by the committee. An analysis of appeal data (e.g., rates of appeals as compared to UM denials, percentage of appeals by service, seasonal spikes in expedited appeal requests, appeal outcomes by Peer Reviewer, etc.) along with review and discussion by committee. Improving this process would make this data more

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						meaningful and help identify potential quality improvement opportunities. ***Recommendation: Analyze the appeals data and present to the QI Committee for review and discussion. Look for meaningful data that can identify potential quality improvement opportunities.***
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					Trillium's Appeal procedure states, "Upon request, Trillium will provide the appellant/ authorized representative with the case/Reconsideration file, including medical records, and any other documents and records." This procedure does not describe steps staff follow to protect enrollee PHI when releasing the Appeal record. The procedure, *Member Access to Protected Health Information,* does delineate the steps required by Trillium when releasing PHI. ***Recommendation: Either include a process in the Appeal procedure that spells out the steps taken when releasing the Appeals record or reference the procedure, Member Access to Protected Health Information, in the Appeals procedure, Medicaid Clinical Reconsideration Process.*** There was some evidence that Appeals staff confirm guardianship and/or secure releases of information when the appellant is someone other than the enrollee. However, there was no consistent documentation by staff that showed the steps they took to protect the enrollee's PHI. ***Recommendation: Ensure any steps taken by staff to release PHI, secure guardianship documentation and/or a release of information, etc. are documented within the enrollee's Appeal record.***

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. Delegation						
1. The PIHP has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					
2. The PIHP conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the PIHP if the PIHP were directly performing the delegated functions.	X					

VIII. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII A. General Requirements						
1. PIHP shall be familiar and comply with Section 1902(a)(68) of the Social Security Act, *42 CFR § 438,455* and *1000* through *1008*, as applicable, including proper payments to Providers and methods for detection of fraud and abuse.	X					This requirement is addressed in the *2018-2019 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					This requirement is addressed in the *2018-2019 Compliance Plan.*
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					This requirement is addressed in the *2018-2019 Compliance Plan.*
4. PIHP shall investigate all Grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					This requirement is addressed in the *2018-2019 Compliance Plan.*
VIII 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					This requirement is addressed in the *2018-2019 Compliance Plan.*

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					This requirement is addressed in the *2018-2019 Compliance Plan.* Training curriculum was provided.
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	X					This requirement is addressed in the *Investigation of Suspected Fraud, Waste and/or Abuse* procedure.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						
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					NC Medicaid confirms that Trillium participated in all quarterly meetings.
5. PIHP shall send staff to participate in monthly meetings with Division Program Integrity staff, either telephonically or in person at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.						
6. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information.	X					
7. The Division recognizes that the scope of the PIHP's Regulatory Compliance Committee includes issues beyond those related to Program Integrity. Within seven (7) business days of a request by the	X					Trillium sends un-redacted committee minutes every month.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						
8. PIHP's written Compliance Plan shall, at a minimum include:						
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(66) of the Social Security Act;	X					This requirement is addressed in the *2018-2019 Compliance Plan*.
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing and development of corrective action initiatives;	X					This requirement is addressed in the *2018-2019 Compliance Plan*.
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					This requirement is addressed in the *2018-2019 Compliance Plan*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including NC Medicaid or MFCU/MID, and including promptly supplying all data in a uniform format provided by DHB and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by Division as provided in Section 13.2 – Monetary Penalties.	X					This requirement is addressed in the *2018-2019 Compliance Plan*.
9. In accordance with *42 CFR § 436.606(a)(vii)*, PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under *NC Medicaid Contract*, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under *NC Medicaid Contract*; and making documentation of investigations and	X					This requirement is addressed in the *2018-2019 Compliance Plan*. Trillium provided monthly *Attachment Y* reports from the review period.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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						
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					This requirement is addressed in the procedure *Investigation of Suspected Fraud, Waste and/or Abuse*.
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse;	X					This requirement is addressed in the procedure *Investigation of Suspected Fraud, Waste and/or Abuse*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure. This process shall include procedures for logging the complaint, determining if the complaint is valid, assigning the complaint, investigating, appeal, recoupment, and closure. The detailed workflow needs to differentiate the steps taken for fraud versus abuse; PIHP shall establish and implement policies for treatment of recoveries of all overpayments from PIHP to Providers and contracted agencies, specifically including retention policies for treatment of recoveries of overpayments due to fraud, waste, or abuse. The retention policies shall include processes, timeframes, and required documentation for payment of recoveries of overpayments to the State in situations where PIHP is not permitted to retain some or all of the recoveries of overpayments. This provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.	X					This requirement is addressed in the procedure *Investigation of Suspected Fraud, Waste and/or Abuse*, as well as in the detailed Program Integrity workflows.
10.3 In accordance with *Attachment Y* – Audits/Self-Audits/Investigations PIHP shall establish and implement	X					This requirement is addressed in the procedure, *Claims Adjudication, Adjustments, Paybacks and Exceptions.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						
10.4 Process for tracking overpayments and collections, based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on *Attachment Y* – Audits/Self-Audits/Investigations;	X					Trillium submitted provider monitoring tool templates. Trillium provided *Attachment Y* reports for the months April 2018 – March 2019. 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 NC Medicaid.
10.5 Process for handling self-audits and challenge audits;	X					This requirement is addressed in the *Internal Communication Process for Provider Self-Audit Requests* procedure.
10.6 Process for using data mining to determine leads;	X					Trillium provided several examples of data mining reports from FAMs and from internal data mining efforts.
10.7 Process for informing PIHP employees, subcontractors and providers regarding the False Claims Act;	X					Trillium submitted 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	X					This requirement is addressed in the *2018-2019 Compliance Plan*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid-standardized elements or a NC Medicaid-approved template;	X					This requirement is addressed in the procedure *Member Explanation of Benefits: Detection of Fraud, Waste, and Abuse*. Trillium also provided a sample letter and post payment review data.
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					This requirement is addressed in the procedure *Credentialing and Re-credentialing*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.	X					This requirement is addressed in the procedure *Provider Sanctions*.
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					This requirement is addressed in the procedure *Investigation of Suspected Fraud, Waste and/or Abuse*.
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:						This requirement is addressed in the procedure, *Investigation of Suspected Fraud, Waste and/or Abuse*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					This review showed that 14 of 15 files contained the requirement information, but one file was missing the NPI of the provider. An executive summary would provide a quick reference of key elements of the investigation and provide a cross check process that ensures all required elements are within each PI file. ***Recommendation: Develop an executive summary for each file that captures key elements of the investigation including subject (name, Medicaid provider ID, address, provider type), source/origin of complaint, date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation, contact information for PIHP staff persons with practical knowledge of the working of the relevant programs, and an estimated or actual dollar value of funds exposed.***
13.2 Source/origin of complaint;	X					Fifteen of 15 files reviewed contained this required element.
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					Fifteen of 15 files reviewed contained this required element.
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					Fifteen of 15 files reviewed contained this required element.
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					Five of 15 files reviewed were found to be not applicable. Ten of the remaining ten files reviewed contained the required documentation

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.6 All communications between PIHP and the Provider concerning the conduct at issues, when available.	X					Fifteen of 15 files reviewed contained this required element.
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					Fifteen of 15 files reviewed contained this required element.
13.8 Total Sample Amount of Funds Investigated per Service Type.	X					Fifteen of 15 files reviewed contained this required element.
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 were presented for IPRO to review.
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		

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and				X		
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		
14.11 Information on Biller/Owner;				X		
14.12 Additional Provider Locations that are related to the allegations;						
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	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
are consistent with the forms, tools and letters utilized by other PIHPs.						
16. PIHP shall use the NC Medicaid Fraud and Abuse Management System (FAMS) or a NC Medicaid-approved alternative data mining technology solution to detect and prevent fraud, waste and abuse in managed care.	X					
17. If PIHP uses FAMS, PIHP shall work with the NC Medicaid designated Administrator to submit appropriate claims data to load into the NC Medicaid Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	X					This requirement is addressed in the procedure *Investigation of Suspected Fraud, Waste and/or Abuse*. Trillium also provided evidence that claims data was uploaded to the NC Medicaid secure site, per the requirements.

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.						
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						

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.	X					This requirement is addressed in the *Internal Communication about Provider Payment Suspension from DHB* procedure.
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					This requirement is addressed in the *Internal Communication about Provider Payment Suspension from DHB* procedure.
3. PIHP shall provide to NC Medicaid all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					This requirement is addressed in the procedure *Referral of Suspected Provider and Beneficiary Fraud to Division of Health Benefits.*
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	X					Trillium procedure wording is in alignment with *NC Medicaid Contract, Section 14.3.4,* that requires Trillium to receive written authority to take administrative action against a provider suspected of fraud. ***Recommendation: Add specific language to procedures that address the requirement that Trillium "shall not take***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						***administrative action against a 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." See NC Medicaid Contract, Section 14.3.4.***
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					This requirement is addressed in the procedure *Provider Sanctions*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.	X					Procedure wording is not in alignment with *NC Medicaid Contract, Section 14.3.6*, that require Trillium to remit funds owed by providers to the State when instructed to do so by NC Medicaid. ***Recommendation: Add specific language to procedures that require Trillium to remit funds owed by providers to the State when instructed to do so by NC Medicaid. See NC Medicaid contract, Section 14.3.5, which states, "In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery."***
7. Recovery Audit Contactors (RACs) for the Medicaid program may audit Providers in the PIHP Network and may work collaboratively with PIHP on identification of overpayments. NC Medicaid shall require RACs to give PIHP prior written notice of such audits and the results of any audits as permitted by law.						
8. The MFCU/MID reserves the right to prosecute or seek civil damages regardless of payments made by the Provider to PIHP. The Parties shall work						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
collaboratively to develop a plan for the disbursement of the share of monies that are recovered and returned to the state by the MFCU/MID for fraudulent claims paid by PIHP. NC Medicaid will examine options to refund returned funds to PIHP and/or to appropriately account for these recoveries in the rate setting process.						

IX. FINANCIAL SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IX. Financial						
1. The PIHP has policies and systems in-place for submitting and reporting financial data.	X					Trillium detailed the submission of their monthly Medicaid reports at the Onsite interview, including staff entries in the Excel workbook. Trillium reviews and updates, as necessary, all policies and procedures on an annual basis. All finance policies and procedures CCME reviewed reflect an annual review date of March 2019. ***Recommendation: Update policies and procedures to add details regarding who is responsible for duties and citing contract requirements.***
2. The PIHP has and adheres to a cost allocation plan that meets the requirements of *42 CFR § 433.34*.	X					The administrative cost allocation plan is documented in Trillium's *Expenditures and Purchases* procedure, which was last updated in March 2019. The FY 2018-2019 plan was provided as part of Trillium's Desk Materials. NC Medicaid funds absorb 87.5% of the administrative costs (prior fiscal year was 85%)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. PIHP maintains detailed records of the administrative costs and expenses incurred as required by the *NC Medicaid Contract*.	X					Trillium provided a copy of their chart of accounts, which included a tab for Administrative and Services charge codes. All account combinations begin with 01- for Trillium, followed by the four digit Department number, the four digit for the natural expense, and then two digits for the funding source.
4. Maintains an accounting system in accordance with *42 CFR § 433.32 (a).*	X					Trillium uses Great Plains Accounting System and claims are processed using CIE.
5. The PIHP follows a record retention policy of retaining records for ten years. (*NC Medicaid Contract, Section 8.3.2* and *Amendment 4, Section 31).*	X					Trillium's *Financial Record Retention* procedure addresses compliance with NC Medicaid requirements for record retention for all financial records. This procedure had been updated to reflect the ten-year retention required by *NC Medicaid Contract, Section 8.3.2*.
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution in accordance with *NC Medicaid Contract*.	X					Trillium maintains their Medicaid restricted risk reserve accounts with Southern Bank and provided bank statements in their Desk Materials for February and March 2019. The balance as of March 31, 2019 was $46,504,747.
7. The required minimum balance of the Risk Reserve Account meets the requirements of the *NC Medicaid Contract*.	X					Trillium has met 10.7% of their capitation payments. They are required to contribute 2% of each monthly payment, until they reach 15% of their payments. ***Recommendation: Add to the Financial Risk Management procedure the required timeframe for making the risk reserve payment. NC Medicaid Contract, Section 1-General Provisions 1.8 requires, "Deposits shall be made within five (5) business days of receiving the monthly capitation payment."***
8. All funds received by PIHP are accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as required by the *NC Medicaid Contract*.	X					Funds are segregated by funding source. The chart of accounts was provided in the Desk Materials. All reports and systems separate Medicaid funds.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9. The Medical Loss Ratio (MLR) meets the requirements of *42 CFR § 438.8* and the *NC Medicaid Contract*.			X			The Medicaid report schedule O demonstrates the Medical Loss Ratio. The MLR is required to be 85% after adding in HCQI activities, but the year-to-date percentage was 83.2% as of March 31, 2019. ***Corrective Action: Trillium needs to implement a corrective action plan to improve the medical loss ratio of 83.9% as of April 2019 including:*** • ***Determining the level of spending to increase the MLR to 85%*** • ***Determining if any prior spending is allowed as Quality Improvement Activities for calculating the Medical Loss Ratio*** • ***Planning to spend for allowed Quality Improvement Activities such as those improving health outcomes, preventing hospital readmissions, improving patient safety, and wellness and health promotion activities as appropriate*** • ***Maintaining documentation for all QIA expenses*** • ***Improving the MLR ratio to 85% within three months*** • ***Communicating progress on raising the ratio with the State Medicaid office***

E. Attachment 5: Encounter Data Validation Report

Trillium Health Resources

Encounter Data Validation Report

performed on behalf of

North Carolina Medicaid

June 26, 2019

Prepared By:

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

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Background

Health Management Systems (HMS) has completed a review of the encounter data submitted by 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 certify the data complete and accurate.

Overview

The scope of our review, guided by the CMS Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid and submitted to NC Medicaid by Trillium for the period of January 2018 through December 2018. All claims paid by Trillium should be submitted and accepted as a valid encounter to 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 converted 837 encounter files
- 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 MCO 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 2018, Trillium submitted 949,025 unique encounters to the State. To date, 1% of all 2018 encounters submitted have not been corrected and accepted by NC Medicaid.

2018	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
Institutional	49,564	47,787	296	1,481	3%
Professional	899,461	872,120	16,601	10,740	1%
Total	949,025	919,907	16,897	12,221	1%

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 73% to 99%, well above NC Medicaid's expectations.

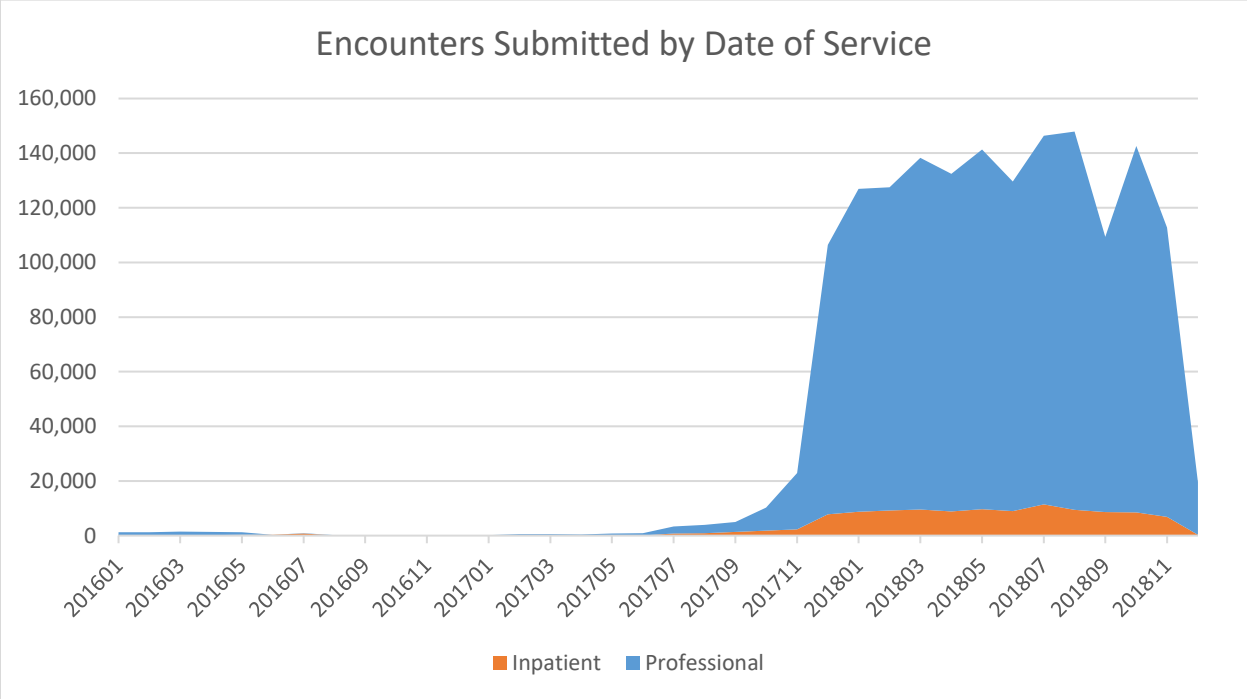
Year of Service	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
2016	987,620	653,787	63,805	270,028	27%
2017	874,434	735,008	70,931	68,495	8%
2018	949,025	919,907	16,897	12,221	1%

According to Trillium's response and the evaluation of the submitted encounter data, most of the outstanding and ongoing denials are related to invalid taxonomy codes for the Billing Provider Id. In order to reduce the number of denied encounters going forward, they are continuing to apply the following strategy laid out in the 2016 and 2017 review.

- Automate process for resending marked claims ready for resubmission
- 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, 2018 through December 31, 2018. 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 SFTP. This included more than 1.5 Million Professional claims and 115,618 Institutional claims. The files submitted contained resubmissions of old dates of service as well as new claims. The graph below represents the dates of services of all claims submitted to NC Medicaid in 2018.



In order to evaluate the data, HMS ingested and combined all 574 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.	100% valid

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

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

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% nonmissing and valid on physician or other applicable provider type claims (e.g., other practitioners)
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid codes (using International Statistical Classifications of Diseases, Ninth Revision, Clinical Modification [ICD-9-CM] lookup tables) for practitioner providers (not including transportation, lab, and other ancillary providers)
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

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
		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.

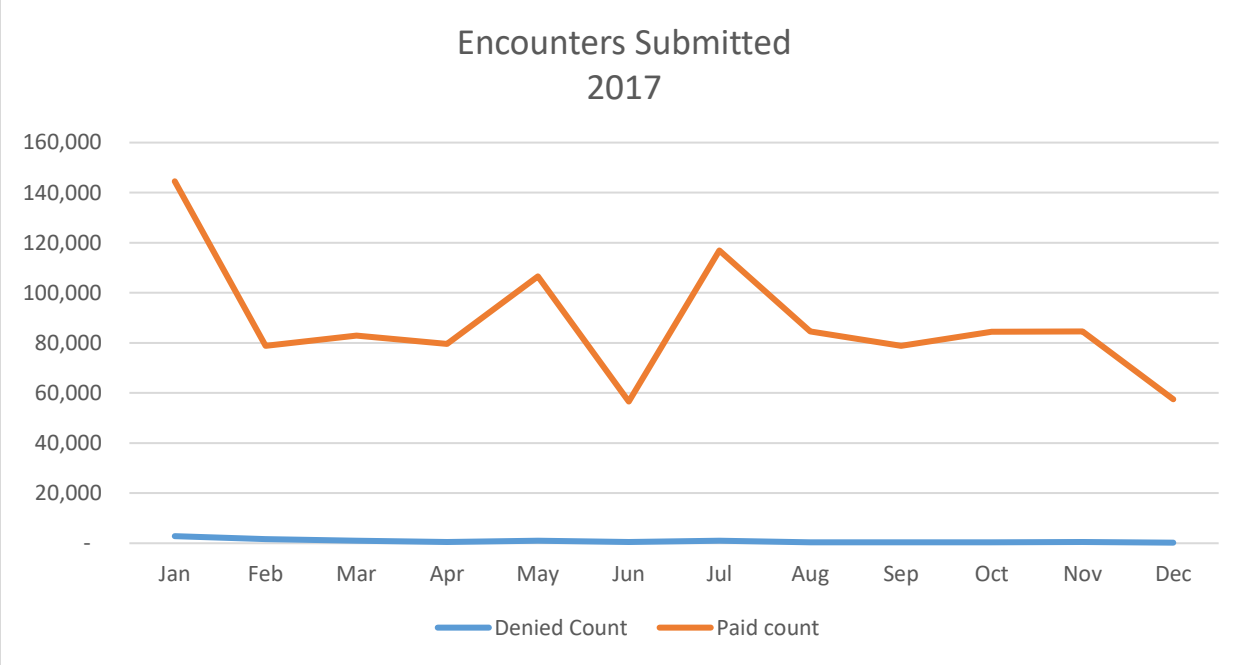
Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%
Recipient Name	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%
Recipient Date of Birth	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%
MCO/PIHP ID	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%
Provider ID	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%
Attending/Renderring Provider ID	1,641,359	99.92%	1,641,359	99.92%	1,641,359	99.92%	1,641,359	99.92%
Provider Location	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%
Place of Service	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%
Specialty Code / Taxonomy - Billing	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%
Specialty Code / Taxonomy - Rendering / Attending	1,641,359	99.92%	1,641,359	99.92%	1,641,359	99.92%	1,641,359	99.92%
Principal Diagnosis	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%
Other Diagnosis	331,793	20.20%	331,793	20.20%	331,793	20.20%	331,793	20.20%
Dates of Service	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%
Unit of Service (Quantity)	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%	1,642,739	100.00%
Procedure Code	1,584,295	96.44%	1,584,295	96.44%	1,583,816	96.41%	1,583,816	96.41%
Procedure Code Modifier	717,003	43.65%	717,003	43.65%	717,003	43.65%	717,003	43.65%
Patient Discharge Status Code Inpatient	115,618	100.00%	115,618	100.00%	115,618	100.00%	115,618	100.00%
Revenue Code	115,618	100.00%	115,618	100.00%	115,618	100.00%	115,618	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, but not with expected values. Procedure codes provided were labeled as "Line Level Procedure Code", but contained mixed values of HCPCS and revenue codes. The same issue was present in our 2017 claims review as well; however, the procedure code was populated more accurately in the 2018 claims reviewed.

Professional encounter claims submitted contained complete and valid data in 15 of the 15 key Professional fields (100%). Issues identified in the 2017 report, Rendering Provider Id and Specialty/Taxonomy values, were resolved. Minor issues were noted with Other Diagnosis values and procedure code, but did not exceed the validation threshold as defined in Data Quality Standards for Evaluation of Submitted Encounter Data Fields table above.

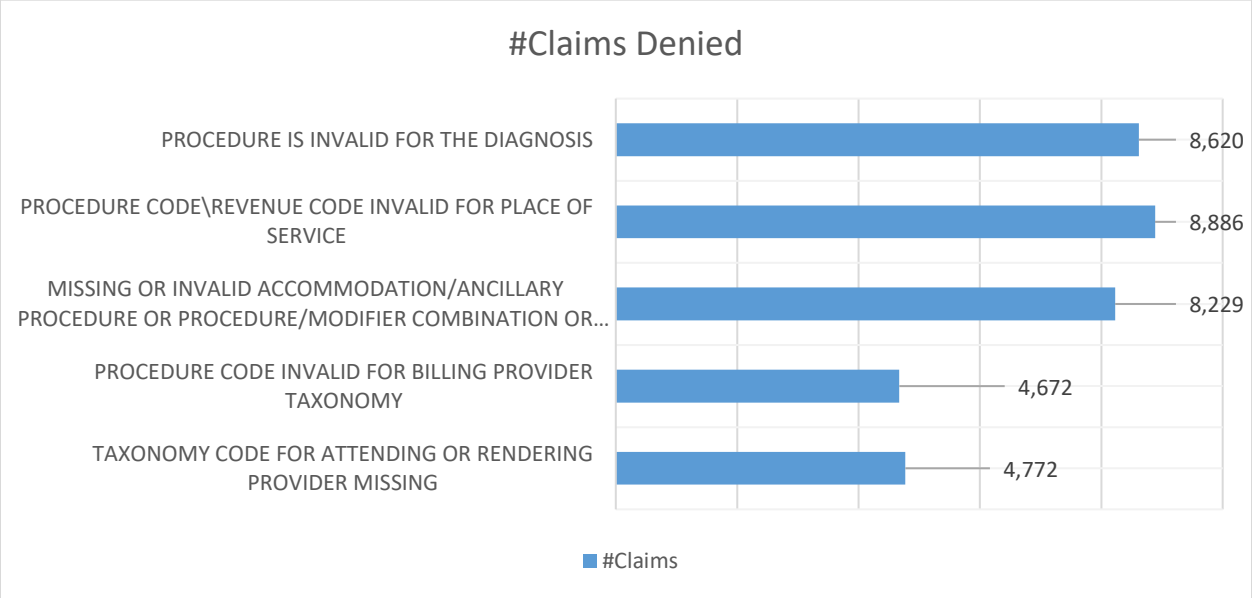
Encounter Acceptance Report

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 made it difficult to tie back to the ISCA response and converted encounter files since only the Date of Service for each is available. During the 2018 weekly check write schedule, Trillium submitted a total of 1,055,767 encounters to NC Medicaid. On average, 1% of all encounters submitted were denied.

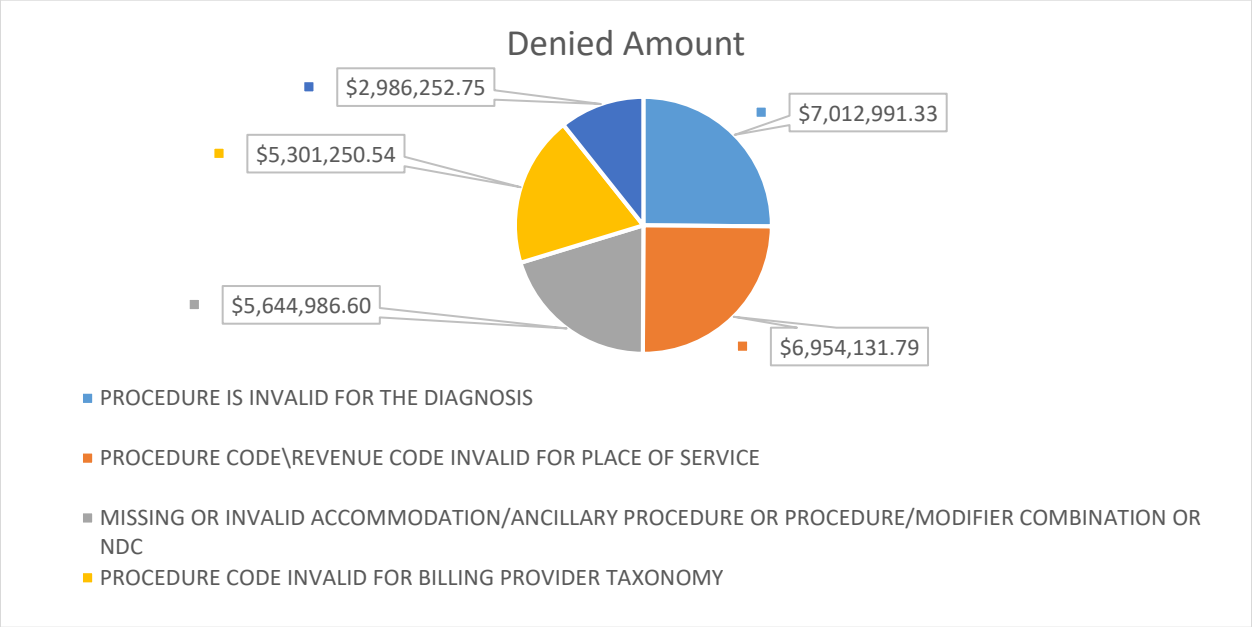


Evaluation of the top denials for Trillium encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis above. Encounters were denied primarily for:

- Procedure is invalid for the diagnosis
- Procedure code / Revenue code invalid for place of service
- Missing or invalid accommodation/ancillary procedure or procedure/modifier combination
- Taxonomy code for attending or rendering provider missing



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



Results and Recommendations

Issue: Procedure Code

The procedure code should be populated 99% of the time with valid values. In the encounter files provided, HMS found that the procedure code was populated within the 99% threshold. However, for both Institutional and Professional claims, the procedure code was populated with a mix of valid procedure codes and revenue codes. Revenue codes should never be received or populated in the procedure code field.

Resolution:

During the Onsite ISCA review, sample claims reviewed within their claims processing system showed that their provider portal allows the submission of invalid values. Trillium should ensure that the appropriate data validation checks are in place in their provider portal to prevent revenue codes from being submitted in the procedure code fields. Trillium should also update the 837 mapping to avoid submitting invalid values in the procedure code field.

Issue: Additional Diagnosis Codes

Additional diagnosis codes were populated less than 13% for Professional claims. The missing diagnosis codes did not appear to be a mapping issue on Trillium's behalf, but likely driven by what providers are submitting. This value is not required by Trillium when adjudicating the claim, therefore, not a requirement of the provider when submitting via Provider Portal or 837.

Resolution:

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 are minor issues with the procedure code value in both the Professional and Institutional encounters that Trillium should review and revise in their 837 mapping. Overall, Trillium has corrected all issues previously identified in the 2016 and 2017 encounter data validation reports and made significant strides ensuring they are submitting complete and accurate data 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