2020 External Quality Review

TRILLIUM HEALTH RESOURCES

Submitted: May 7, 2021

Prepared on behalf of the
North Carolina Medicaid

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EXECUTIVE SUMMARY

The *Balanced Budget Act of 1997* requires State Medicaid Agencies that contract with Prepaid Inpatient Health Plans (PIHPs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358 (42 CFR § 438.358)*. This review determines the level of performance demonstrated by Trillium Health Resources (Trillium). This report contains a description of the process and the results of the 2020 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 the PIHP complies with service delivery as mandated by their *NC Medicaid Contract*
- Provide feedback for potential areas of further improvement
- Verify the delivery and determine the quality of contracted health care services

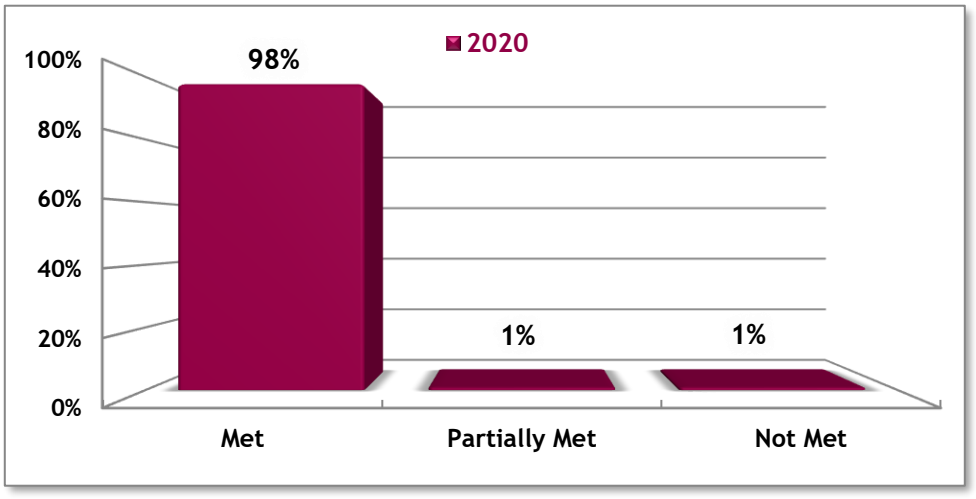
The process used for the EQR was based on the Centers for Medicare & Medicaid Services (CMS) protocols for EQR of Medicaid Managed Care Organizations (MCOs) and PIHPs. The review includes a Desk Review of documents, an Onsite visit, compliance review, validation of performance improvement projects (PIPs),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

Due to the COVID-19 pandemic, the 2020 EQR was delayed, and CCME implemented a focused review and the Onsite was conducted through a virtual platform.

A. Overall Score

The 2020 Annual EQR reflects that Trillium achieved a “Met” score for 98% of the standards reviewed. As Figure 1 indicates, 1% of the standards were scored as “Partially Met,” and 1% of the standards were scored as “Not Met”.

Figure 1: Annual EQR Results



B. Overall Findings

The following provides a global, or high-level, summary of the status of the Recommendations and Corrective Action items from the 2019 EQR and the findings of the 2020 EQR. Each section of this report details specific Recommendations and Corrective Actions.

Information Systems Capabilities Assessment (ISCA)

In the 2019 EQR, Trillium met 100% of the Administrative standards. Trillium received three Recommendations related to resubmission of the historical denied encounters, third-party payer encounter submissions, and Procedure code fields for lab, drug, and radiology services. Based on the findings in the 2020 EQR, it is recommended that Trillium continue to work with providers and the State to submit ICD-10 Procedure codes and DRG codes on Institutional encounter data extracts to NCTracks. It is also recommended that Trillium work with the State to resubmit the historical denied encounters.

Provider Services

In Trillium's 2019 EQR, there were two items requiring Corrective Action and four Recommendations in the Credentialing/Recredentialing section of Provider Services. Trillium addressed both Corrective Action items and the four Recommendations. In the current EQR, Trillium met 100% of the Credentialing/Recredentialing standards of Provider Services and received a Recommendation in both Credentialing and Recredentialing in the "Ownership Disclosure is addressed" standard. It is of note that Trillium has received either Corrective Action or a Recommendation regarding Ownership Disclosure in each EQR since 2016.

Quality Improvement

The Quality Improvement (QI) section included validation of Performance Measures (PMs) and Performance Improvement Projects (PIPs). The Performance Measure Query was accurate for (b) Waiver Measures. One (b) Waiver Measure had a substantial rate increase from last year, and there were no measures having rate decreases. All (c) Waiver Performance Measures were above benchmark rates. The five validated PIPs all scored in the High Confidence range, although three PIPs have Recommendations for improvement. There were two Recommendations within the PIPs for the 2019 EQR that were implemented and maintained, and all four PIPs scored in the High Confidence range. In this 2020 EQR, 100% of the QI standards were met.

Care Coordination

In the 2019 EQR, Trillium met 100% of Utilization Management (UM) standards for Care Coordination and Transition to Community Living programs. CCME issued one Recommendation for Trillium to add information about the Incedo Case Management platform to the *Care Coordination Program Description*. This recommendation was implemented.

For this EQR, CCME has issued five Recommendations. Three Recommendations target concerns regarding contact requirements by Intellectual/Developmental Disability (I/DD) Care Managers and late progress notes found in the Transition to Community Living (TCLI) files. The remaining Recommendations encourage Trillium to update its procedure for Complex Case Management to reflect the *NC Medicaid Contract* age requirements for Children with Complex Needs and to add details regarding internal performance measures to the *I/DD/MH/SUD/TCLI Care Management Monitoring Plans*.

Grievances and Appeals

In the 2019 EQR, Trillium met 100% of the Grievance and Appeal standards. Eleven Recommendations were given to add or correct language within Trillium's Grievance and Appeal procedures, *Trillium Provider Manual*, and *Trillium Health Resources Member and Family Handbook*, and Appeal and Grievance notifications. Only half of these Recommendations were addressed by Trillium. As a result, several of the areas of concern are repeated in this year's EQR.

In the 2020 EQR, Trillium met 90% of the Grievance and Appeal standards. In this year's EQR, CCME issued two Corrective Actions and five Recommendations. In the Grievance review, one Corrective Action was issued to address missing contractual and federal regulation language in the Grievance and Complaint procedures related to extensions to the Grievance resolution timeframe. One Recommendation related to the Grievance standards targets missing language in Trillium's Grievance and Complaint procedures

regarding how and when consultation with the Chief Medical Officer is captured within the Grievance file.

In the EQR of Appeal functions, one Corrective Action was issued to address the lack of documented processes Appeal staff must follow to be compliant with Trillium's Member Access to Protected Health Information procedure when releasing the Appeal record to enrollees or their representatives. Four Recommendations were issued targeting missing or incorrect contract language within the *Provider Manual*, *Member and Family Handbook*, and Appeal notifications.

Program Integrity

In the 2019 EQR, Trillium met 100% of the Program Integrity (PI) EQR standards, and three Recommendations were issued. Based on the 2019 PI file review, CCME recommended Trillium develop an executive summary to capture required and key elements within each PI file. The remaining two Recommendations in the 2019 PI EQR targeted missing information within Trillium's PI procedures related to *NC Medicaid Contract, Sections 14.3.4* and *14.3.5*. In the 2020 EQR, it was evident that Trillium did not implement any of the 2019 Recommendations. However, Trillium found alternative ways to address two of the three 2019 EQR findings. The 2019 PI Recommendation that targeted missing *NC Medicaid Contract, Section 14.3.5* language from Trillium procedures was not addressed. This 2019 Recommendation is particularly relevant to Trillium as the State reported previous issues with Trillium regarding the recovery of funds process. CCME again recommends that Trillium specify in a procedure the process and contractual requirements of Trillium related to *NC Medicaid Contract, Section 14.3.5*.

Encounter Data Validation

Based on the analysis of Trillium's encounter data, it was concluded that the data submitted to NC Medicaid is complete and accurate as defined by NC Medicaid standards. There is a minor issue with the Other Diagnosis codes that Trillium should review and perform outreach to provider who submit only the Primary Diagnosis codes. Overall, Trillium has corrected all other issues previously identified in the 2016, 2017, and 2018 encounter data validation reports and made significant strides in ensuring that they are submitting complete and accurate data to NC Medicaid.

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

METHODOLOGY

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

On November 2, 2020, 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 Trillium to participate in a pre-Onsite conference call with CCME and NC Medicaid to offer 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 on November 23, 2020 and reviewed by CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. The Desk Review included a review of credentialing, Grievance, program integrity, care coordination, and Appeal files.

The second segment of the EQR is typically a two-day Onsite review conducted at the PIHP's offices. However, due to COVID-19, this Onsite was conducted through a teleconference platform on April 5, 2021. This Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's Onsite activities included:

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

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

FINDINGS

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

A. Information Systems Capabilities Assessment (ISCA)

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

In the 2019 EQR, Trillium met 100% of the Administrative standards, which included the 2019 ISCA review, and received three Recommendations. Trillium addressed two of the three Recommendations and is awaiting notification from NC Medicaid on the submission of approximately 400,000 legacy claims to NCTracks.

Trillium uses the Trillium Business System (TBS) to process member enrollment and claims, submit encounters, and generate reports. Since 2018, Trillium has had full ownership of the TBS platform and it is maintained within Trillium's Information Technology (IT) and Business Systems Department. The ISCA tool and supporting documentation for enrollment systems loading processes clearly define the process for enrollment data updates in the TBS enrollment system. During the ISCA Onsite, Trillium demonstrated the TBS enrollment system. The system maintains a member's enrollment history, and the Global Eligibility File (GEF) file is imported daily into the TBS.

During the ISCA Onsite, Trillium stated that the enrollment records that are not loaded into TBS are exported to an exception report. Some of the errors encountered include records with address mismatches and invalid date of birth. Trillium stated that typically fewer than 50 records are exported to the exception report monthly.

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

During the Onsite system demonstration, staff displayed the enrollment information that is viewable and captured within TBS. The TBS system is able to capture demographic data like race, ethnicity, and language as well as coordination of benefit (COB) information. Trillium has experienced a small decrease in year-end enrollment numbers over the past three years.

Table 1: Enrollment Counts

2017	2018	2019
207,479	248,932	217,876

Trillium's claims and authorizations are processed in the TBS claims processing system. A review of Trillium's processes for collecting, adjudicating, and reporting claims was conducted through a review of its ISCA response and the supporting documentation provided. Trillium receives claims from three methods, 837 electronic file, provider web portal, and paper claims. During the Onsite, Trillium stated that they receive claims from emergency rooms and out-of-network providers on paper, accounting for less than 1% of claims. Table 2 details the percentage of 2019 claims received via the three methods.

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

Source	HIPAA File	Paper	Provider Web Portal
Institutional	86.80%	.10%	13.10%
Professional	84.70%	.02%	15.28%

Trillium stated that claims are approved, pended, or denied and paid within 7.18 days of claims receipt. If a required field is missing from a claim, the provider portal will not allow the claim to be submitted to Trillium. If the claim is being submitted electronically via an electronic 837 file and one or more required fields are missing, the provider will receive a HIPAA 999 response file advising the provider of the claim submission failure. If the claim is submitted, Trillium claims processors do not change any information on the claims. Trillium conducts daily, weekly, monthly, and quarterly audits of claims processed. Trillium staff conducts random audits of 3% of all claims processed daily.

For Professional claims, Trillium has the ability to receive and store as many as 12 ICD-10 Diagnosis codes on both the provider web portal and via HIPAA files. For Institutional claims, Trillium can capture as many as 41 ICD-10 Diagnosis codes if they are submitted on the claim via HIPAA files and as many as 25 ICD-10 Diagnosis codes if they are

submitted on the claim on the provider web portal. Trillium also has the ability to capture ICD-10 Procedure codes and Diagnosis Related Groups (DRGs) on both the provider web portal and via HIPAA files. During the Onsite, Trillium stated that though they have the ability to capture ICD-10 Procedure codes, Trillium does not receive ICD-10 Procedure codes on Institutional claims. Enrollment and claims history since April 2012 are maintained in the TBS. During the Onsite, Trillium indicated that the reporting database is backed up on a nightly basis.

Trillium has a defined process in place for their encounter data submission for approved claims, with 837 files submitted to NC Medicaid and 999 and 835 response files received back from NC Medicaid through the NCTracks system. The 835 file from NCTracks is used to review encounter denials. Extraction, submission, and reconciliation of encounter data are fully automated, but correcting denials and fixing issues related to incorrect provider information or member eligibility information are conducted manually. The breakdown of encounter data acceptance/denial rates by claim service detail counts was provided for encounters submitted in 2019. Table 3 provides a comparison of encounter data submitted in 2018 and 2019.

Table 3: Volume of 2018 and 2019 Submitted Encounter Data

2019	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	52,004	400	539	52,943
Professional	1,065,922	240	200	1,066,362
2018	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	47,787	296	1,481	49,564
Professional	872,120	16,601	10,740	899,461

Trillium has an approximate 99.9% acceptance rate for both Professional and Institutional encounters with dates of service in 2019. During the Onsite, Trillium advised the two top denial reason codes for encounters in 2019:

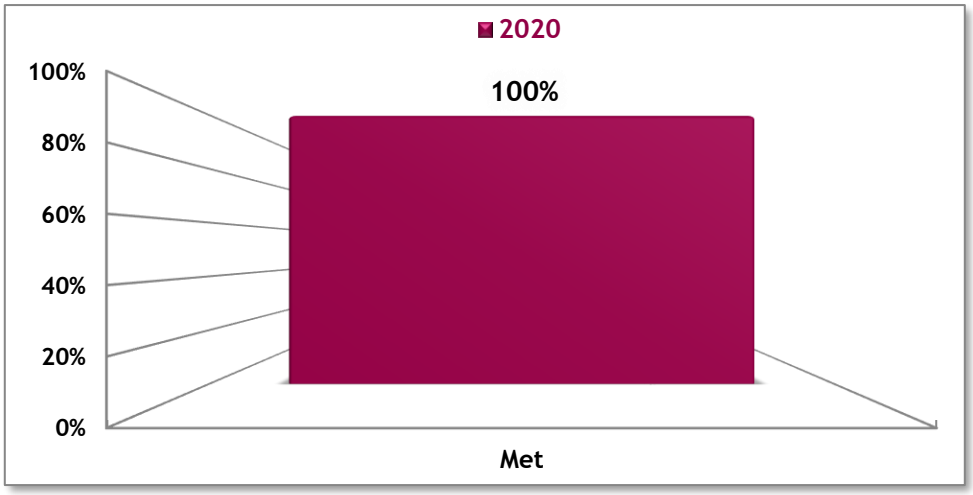
- Taxonomy code for attending provider missing or invalid
- Duplicate service or procedure

Trillium submits an encounter within an average of seven days from the time of adjudication to NCTracks. It takes Trillium approximately 68 days to correct and resubmit a denied encounter to NCTracks. Trillium uses the 835 response file to identify encounters that were denied. Trillium's IT Department categorizes the denied encounters based on the denial code and forwards the encounter to the appropriate functional area for correction and resubmission.

Trillium advised the number of ICD-10 Diagnosis codes submitted on Institutional and Professional encounters to NC Medicaid. Trillium is submitting all ICD-10 Diagnosis codes received for Professional and Institutional encounters. Trillium does not submit DRG received from the provider on Institutional encounters to NCTracks.

Figure 2 demonstrates that Trillium met all of the Standards in the 2020 ISCA EQR.

Figure 2: ISCA Findings



Strengths

- Trillium can capture as many as 41 Diagnosis codes on Institutional claims and 12 Diagnosis codes on Professional claims.
- Trillium can capture the DRG and ICD-10 Procedure codes on Institutional claims on the Provider Web Portal and via HIPAA files.
- Trillium has the ability to submit all ICD-10 Diagnosis codes submitted by the provider on the encounter data extracts to NCTracks.
- Trillium's current NCTracks encounter data acceptance rate is approximately 99.9% for the combined Professional and Institutional extracts.

Weaknesses

- Though Trillium has the ability to capture ICD-10 Procedure codes, they do not receive them on Institutional claims.
- Trillium does not have the ability to submit DRG codes on encounter data extracts to NCTracks.
- There are 418,439 denied encounters identified two years ago pending resubmission.

Recommendations

- Continue to work with providers to submit ICD-10 Procedure codes on Institutional claims, including on the 837 Institutional extract to NCTracks.
- Update Trillium's encounter data submission process to submit DRG codes on Institutional encounter data extracts to NCTracks.
- Continue to work with the State to resubmit all the historically denied encounters.

B. Provider Services

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

In Trillium's 2019 EQR of Credentialing/Recredentialing, there were two items requiring Corrective Action and four Recommendations. Trillium addressed both Corrective Action items and the four Recommendations.

The *Credentialing Committee By-Laws* and several policies and procedures, including the Credentialing and Re-Credentialing Process procedure, guide the credentialing and recredentialing processes. Trillium indicated they no longer use "a Credentialing Program Description as it relates to the Credentialing Committee. All relevant information related to the Credentialing process can be found in the procedures."

CCME's review of the credentialing and recredentialing files showed they were organized and contained appropriate information. Two of the four submitted practitioner credentialing files and two of the four submitted practitioner recredentialing files did not contain Ownership Disclosure information identifying the owner or managing employees. The Desk Review Materials list includes the reminder, "For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the

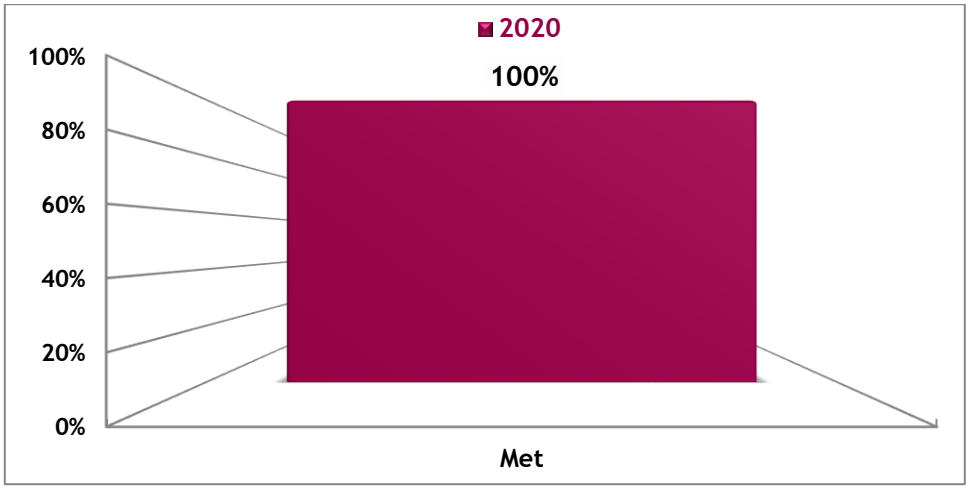
submitted practitioner file." In response to CCME's request on the Missing Desk Materials list, Trillium submitted the Ownership Disclosure from the files of the agencies the practitioners were joining. It is of note that Trillium has received either Corrective Action or a Recommendation regarding Ownership Disclosure in each EQR since the EQR for 2016.

Dr. Michael Smith, Chief Medical Officer (CMO) and a board-certified psychiatrist, chairs the Credentialing Committee. The voting membership listed on the submitted *Credentialing Committee Member List* includes seven provider representatives and three Trillium staff members, though the *Credentialing Committee By-Laws* stipulate the CMO only votes "in case of a tie, in which event he/she shall cast the deciding vote." The Credentialing and Re-credentialing Process procedure defines "Clean" and "Red-flagged" applications and notes the CMO "has authority as delegated by the Credentialing Committee to approve Clean Applications." Lists of "Clean" applications, approved by the CMO, are presented at the Credentialing Committee meetings. The reviewed Credentialing Committee meeting minutes reflect committee discussion of, and decisions about, "Red-flagged" applications. The *Credentialing Committee By-Laws* states, "A quorum at any regular or special meeting shall consist of the Committee Chair and 50 percent or more of the voting members, including at least 1 participating provider in person or via technology." A quorum was present at the Credentialing Committee meetings for which minutes were submitted for this EQR.

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

Under the COVID-19 flexibilities as outlined in *NC Medicaid Contract Amendment #9*, the annual *Network Adequacy and Accessibility Analysis* (Gaps Analysis) will be submitted "no later than ninety (90) calendar days after termination of the Amendment." The 2019 Gaps Analysis indicated Trillium did not meet all choice and location standards for seven Medicaid-funded services. Trillium filed, and NC Medicaid approved, *Exception Requests* for all seven services. During the Onsite review for this EQR, Trillium staff reported the PIHP has "made significant progress in closing those gaps", with program additions for Medicaid-funded Psychosocial Rehab (PSR), Partial Hospital, Substance Abuse Comprehensive Outpatient Treatment (SA-COT), and opioid treatment programs. As Figure 3 indicates, 100% of the standards in the Provider Services review were scored as "Met."

Figure 3: Provider Services Findings



Strengths

- There is a separate toll-free number for administrative and business matters.
- Credentialing and recredentialing files contain checklists to help guide the process.
- The Provider Learning Campus, with web-based training/education, is available to providers 24/7.
- In response to COVID-19, Trillium added a Coronavirus Information COVID-19 web page, with separate tabs for COVID-19 (general information about COVID-19), Members, Providers, and News/Resources.
- To keep providers informed and to ensure continued member access to care during COVID-19,Trillium instituted rate increases/enhancements to providers, issued daily Network Communication Bulletins, and posted a "Providers Q & A COVID-19" page and "Trillium COVID-19 Provider FAQ" document on the Trillium website.

Weaknesses

- Two of the four submitted practitioner credentialing files and two of the four submitted practitioner recredentialing files did not contain Ownership Disclosure information identifying the owner or managing employees. In response to CCME's request, Trillium submitted the Ownership Disclosure (from the contracted agency files) for the Licensed Practitioner (LP) files. Trillium has received either Corrective Action or a Recommendation regarding Ownership Disclosure in each EQR since the EQR for 2016.

Recommendations

- Ensure credentialing and recredentialing files include Ownership Disclosure information, in addition to the disclosure regarding ownership of "5% or more in the organizations that bill Medicaid for services." See *NC Medicaid Contract, Attachment O* and Section *1.13* and Section *1.14*. As noted on the Desk Review Materials list, "For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file."

C. Quality Improvement

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

In the 2019 EQR of PIPs there were no Corrective Actions and two Recommendations. Both Recommendations were implemented and evident in reports uploaded in the Desk Materials of this 2020 EQR. The 2019 EQR validation scores for (b) Waiver and (c) Waiver Performance Measures were fully compliant with an average validation score of 100%.

For the 2020 EQR, five PIPs were submitted and validated according to the CMS Protocol. During the Onsite, there were three PIPs discussed that have declines in measurement rates. All five PIPs scored in the High Confidence range. The 2020 EQR has no PIP Corrective Action items, although three PIPs have Recommendations for improvement.

For the 2020 EQR, Performance Measure Query was accurate for (b) Waiver Measures, and all measures were validated at 100%, "Fully Compliant." There was one (b) Waiver Measures with significant improvement over the past EQR and this was discussed during the Onsite. No measures had significant declines. The five (c) Waiver Performance Measures were at or above benchmark rates. The (c) Waiver Measure for The Percentage of Level 2 and 3 Incidents Reported Within Required Timeframes was below the State benchmark in the last measurement reported in the Desk Materials. The measurement taken after the Desk Materials were submitted and before the Onsite was at the benchmark and Trillium reported that at the Onsite interview and submitted the documentation to support that measurement. All (c) Waiver Measures were validated at 100% and "Fully Compliant" for this 2020 EQR.

Performance Measure Validation

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

Table 4: (b) Waiver Measures

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

Table 5: (c) Waiver Measures

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

CCME performed validations in compliance with the CMS-developed protocol, *EQR Protocol 2: Validation of Performance Measures 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 Reported Results

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

The change in rate from the previous review year to the current review was calculated and evaluated for substantial change, which is defined as change >10%. There was one measure with substantial improvement, the Follow Up after Hospitalization for Mental Illness in the FBC population for the 30-day follow-up. It improved from 65.5% to 80%, which is a 14.5% improvement. There were no measures that showed a substantial decline.

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

30-day Readmission Rates for Mental Health	2018	2019	Change
Inpatient (Community Hospital Only)	16.7%	16.4%	-0.30%
Inpatient (State Hospital Only)	6.3%	11.5%	5.20%
Inpatient (Community and State Hospital Combined)	16.6%	16.4%	-0.20%
Facility Based Crisis	18.2%	15.2%	-3.00%
Psychiatric Residential Treatment Facility (PRTF)	2.9%	10.2%	7.30%
Combined (includes crossovers between services)	16.2%	16.2%	0.00%

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

30-day Readmission Rates for Substance Abuse	2018	2019	Change
Inpatient (Community Hospital Only)	14.9%	19.1%	4.20%
Inpatient (State Hospital Only)	0.0%	0.0%	0.00%
Inpatient (Community and State Hospital Combined)	14.6%	19.1%	4.50%
Detox/Facility Based Crisis	10.6%	10.7%	0.10%
Combined (includes crossovers between services)	11.6%	12.9%	1.30%

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

Follow-up after Hospitalization for Mental Illness	2018	2019	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	35.9%	36.4%	0.50%
Percent Received Outpatient Visit Within 30 Days	57.2%	57.4%	0.20%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	65.5%	72.5%	7.00%
Percent Received Outpatient Visit Within 30 Days	65.5%	80.0%	14.50%
PRTF			
Percent Received Outpatient Visit Within 7 Days	16.5%	18.3%	1.80%
Percent Received Outpatient Visit Within 30 Days	46.2%	52.4%	6.20%
Combined (includes crossovers between services)			
Percent Received Outpatient Visit Within 7 Days	35.6%	36.3%	0.70%
Percent Received Outpatient Visit Within 30 Days	56.9%	57.5%	0.60%

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

Follow-up after Hospitalization for Substance Abuse	2018	2019	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	11.0%	14.1%	3.10%
Percent Received Outpatient Visit Within 30 Days	23.2%	20.4%	-2.80%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	53.6%	58.0%	4.40%
Percent Received Outpatient Visit Within 7 Days	58.6%	62.9%	4.30%
Percent Received Outpatient Visit Within 30 Days	64.7%	69.5%	4.80%
Combined (includes crossovers between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	47.2%	49.9%	2.70%
Percent Received Outpatient Visit Within 30 Days	54.6%	56.4%	1.80%

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2018	2019	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	44.3%	46.5%	2.20%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	21.3%	17.7%	-3.60%
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	37.8%	39.9%	2.10%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	23.6%	25.5%	1.90%
Ages 21–34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	49.0%	50.2%	1.20%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	33.2%	36.3%	3.10%
Ages 35–64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	44.5%	48.0%	3.50%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	30.9%	35.3%	4.40%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	40.8%	47.9%	7.10%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	36.0%	42.5%	6.50%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	45.4%	48.0%	2.60%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	30.6%	33.9%	3.30%

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

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		2018	2019	Change	2018	2019	Change
3-12	Male	0.3	0.2	-0.1	13.9	12.9	-1.0
	Female	0.2	0.2	0.0	13.7	9.9	-3.8
	Total	0.2	0.2	0.0	13.8	11.5	-2.3
13-17	Male	1.1	1.0	-0.1	15.1	11.3	-3.8
	Female	1.6	1.7	0.1	12.1	9.3	-2.8
	Total	1.3	1.3	0.0	13.4	10.0	-3.4
18-20	Male	1.7	2.1	0.4	10.3	7.6	-2.7
	Female	1.4	1.5	0.1	7.7	6.6	-1.1
	Total	1.5	1.8	0.3	9.0	7.2	-1.8
21-34	Male	4.7	5.3	0.6	7.9	8.6	0.7
	Female	1.4	1.5	0.1	6.9	7.9	1.0
	Total	2.1	2.4	0.3	7.4	8.3	0.9
35-64	Male	2.9	3.0	0.1	8.0	8.6	0.6
	Female	2.3	2.2	-0.1	7.8	9.0	1.2
	Total	2.5	2.5	0.0	7.9	8.8	0.9
65+	Male	0.4	0.5	0.1	14.5	15.0	0.5
	Female	0.3	0.3	0.0	16.7	22.5	5.8
	Total	0.3	0.4	0.1	15.9	19.5	3.6
Unknown	Male	0.0	0.0	0.0	0.0	0.0	0.0
	Female	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0
Total	**Male**	**1.3**	**1.4**	**0.1**	**9.9**	**9.3**	**-0.6**
	Female	**1.1**	**1.1**	**0.0**	**8.9**	**9.1**	**0.2**
	Total	**1.2**	**1.2**	**0.0**	**9.3**	**9.2**	**-0.1**

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

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
3-12	Male	10.49%	10.70%	0.21%	1.40%	1.81%	0.41%	0.12%	0.06%	-0.06%	10.36%	10.60%	0.24%
	Female	13.24%	13.34%	0.10%	1.40%	1.39%	-0.01%	0.03%	0.04%	0.01%	13.16%	13.19%	0.03%
	Total	11.98%	12.12%	0.14%	1.40%	1.58%	0.18%	0.07%	0.05%	-0.02%	11.88%	12.00%	0.12%
13-17	Male	23.10%	23.23%	0.13%	3.55%	3.81%	0.26%	0.19%	0.10%	-0.09%	22.98%	22.98%	0.00%
	Female	17.00%	17.61%	0.61%	1.26%	1.32%	0.06%	0.21%	0.24%	0.03%	16.90%	17.54%	0.64%
	Total	18.36%	18.92%	0.56%	1.77%	1.90%	0.13%	0.20%	0.21%	0.01%	18.26%	18.80%	0.54%
18-20	Male	18.61%	17.72%	-0.89%	2.33%	2.35%	0.02%	0.23%	0.22%	-0.01%	18.47%	17.55%	-0.92%
	Female	22.56%	21.96%	-0.60%	1.84%	1.64%	-0.20%	0.22%	0.18%	-0.04%	22.45%	21.88%	-0.57%
	Total	21.05%	20.32%	-0.73%	2.03%	1.92%	-0.11%	0.23%	0.19%	-0.04%	20.93%	20.21%	-0.72%
21-34	Male	6.36%	5.89%	-0.47%	0.43%	0.46%	0.03%	0.00%	0.00%	0.00%	6.23%	5.75%	-0.48%
	Female	7.15%	6.54%	-0.61%	0.30%	0.36%	0.06%	0.03%	0.00%	-0.03%	7.06%	6.50%	-0.56%
	Total	6.92%	6.34%	-0.58%	0.34%	0.39%	0.05%	0.02%	0.00%	-0.02%	6.82%	6.27%	-0.55%

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Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
35-64	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%
65+	Male	15.74%	15.18%	-0.56%	1.12%	1.16%	0.04%	0.30%	0.24%	-0.06%	15.65%	15.08%	-0.57%
	Female	14.82%	14.72%	-0.10%	1.00%	0.99%	-0.01%	0.13%	0.12%	-0.01%	14.74%	14.65%	-0.09%
	Total	15.21%	14.92%	-0.29%	1.05%	1.06%	0.01%	0.20%	0.17%	-0.03%	15.13%	14.84%	-0.29%
Unknown	Male	10.49%	10.70%	0.21%	1.40%	1.81%	0.41%	0.12%	0.06%	-0.06%	10.36%	10.60%	0.24%
	Female	13.24%	13.34%	0.10%	1.40%	1.39%	-0.01%	0.03%	0.04%	0.01%	13.16%	13.19%	0.03%
	Total	11.98%	12.12%	0.14%	1.40%	1.58%	0.18%	0.07%	0.05%	-0.02%	11.88%	12.00%	0.12%
Total	**Male**	**23.10%**	**23.23%**	**0.13%**	**3.55%**	**3.81%**	**0.26%**	**0.19%**	**0.10%**	**-0.09%**	**22.98%**	**22.98%**	**0.00%**
	Female	**17.00%**	**17.61%**	**0.61%**	**1.26%**	**1.32%**	**0.06%**	**0.21%**	**0.24%**	**0.03%**	**16.90%**	**17.54%**	**0.64%**
	Total	**18.36%**	**18.92%**	**0.56%**	**1.77%**	**1.90%**	**0.13%**	**0.20%**	**0.21%**	**0.01%**	**18.26%**	**18.80%**	**0.54%**

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

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
3–12	Male	0.03%	0.01%	-0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.01%	-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%	0.01%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.01%	-0.01%
13–17	Male	1.36%	1.29%	-0.07%	0.11%	0.13%	0.02%	0.17%	0.08%	-0.09%	1.23%	1.18%	-0.05%
	Female	0.99%	1.03%	0.04%	0.19%	0.13%	-0.06%	0.05%	0.05%	0.00%	0.86%	0.94%	0.08%
	Total	1.17%	1.16%	-0.01%	0.15%	0.13%	-0.02%	0.11%	0.07%	-0.04%	1.05%	1.06%	0.01%
18–20	Male	3.19%	3.38%	0.19%	0.40%	0.56%	0.16%	0.45%	0.42%	-0.03%	2.97%	3.09%	0.12%
	Female	2.69%	2.51%	-0.18%	0.17%	0.18%	0.01%	0.43%	0.37%	-0.06%	2.65%	2.33%	-0.32%
	Total	2.92%	2.91%	-0.01%	0.27%	0.35%	0.08%	0.44%	0.39%	-0.05%	2.80%	2.68%	-0.12%
21–34	Male	9.18%	8.72%	-0.46%	1.19%	1.24%	0.05%	1.75%	1.64%	-0.11%	8.61%	8.14%	-0.47%
	Female	7.39%	7.63%	0.24%	0.36%	0.35%	-0.01%	1.65%	1.87%	0.22%	7.12%	7.36%	0.24%
	Total	7.79%	7.89%	0.10%	0.54%	0.55%	0.01%	1.67%	1.81%	0.14%	7.45%	7.54%	0.09%

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Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
35–64	Male	8.43%	8.85%	0.42%	0.81%	0.96%	0.15%	1.73%	2.02%	0.29%	7.97%	8.20%	0.23%
	Female	6.19%	6.71%	0.52%	0.49%	0.47%	-0.02%	1.32%	1.58%	0.26%	5.87%	6.24%	0.37%
	Total	7.05%	7.54%	0.49%	0.61%	0.66%	0.05%	1.48%	1.75%	0.27%	6.67%	7.00%	0.33%
65+	Male	1.71%	1.77%	0.06%	0.11%	0.02%	-0.09%	0.36%	0.65%	0.29%	1.50%	1.42%	-0.08%
	Female	0.50%	0.62%	0.12%	0.02%	0.02%	0.00%	0.16%	0.21%	0.05%	0.40%	0.48%	0.08%
	Total	0.86%	0.97%	0.11%	0.05%	0.02%	-0.03%	0.22%	0.34%	0.12%	0.72%	0.77%	0.05%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**Male**	**2.76%**	**2.81%**	**0.05%**	**0.29%**	**0.32%**	**0.03%**	**0.52%**	**0.57%**	**0.05%**	**2.59%**	**2.59%**	**0.00%**
	Female	**3.00%**	**3.10%**	**0.10%**	**0.21%**	**0.19%**	**-0.02%**	**0.63%**	**0.71%**	**0.08%**	**2.85%**	**2.91%**	**0.06%**
	Total	**2.90%**	**2.98%**	**0.08%**	**0.24%**	**0.25%**	**0.01%**	**0.58%**	**0.65%**	**0.07%**	**2.74%**	**2.78%**	**0.04%**

Table 14: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	3-12			13-17			18-20			21-34		
Beaufort	0.05%	0.00%	-0.05%	1.57%	2.23%	0.66%	3.87%	4.25%	0.38%	10.42%	9.17%	-1.25%
Bertie	0.00%	0.00%	0.00%	1.08%	1.56%	0.48%	0.64%	0.63%	-0.01%	3.42%	3.05%	-0.37%
Brunswick	0.01%	0.00%	-0.01%	1.16%	1.25%	0.09%	4.03%	2.88%	-1.15%	7.81%	7.38%	-0.43%
Camden	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.52%	1.30%	-0.22%	4.73%	5.06%	0.33%
Carteret	0.05%	0.00%	-0.05%	1.10%	1.79%	0.69%	4.65%	2.84%	-1.81%	8.82%	8.49%	-0.33%
Chowan	0.00%	0.00%	0.00%	1.63%	0.96%	-0.67%	2.91%	2.26%	-0.65%	3.88%	3.59%	-0.29%
Columbus	0.00%	0.06%	0.06%	0.00%	0.91%	0.91%	0.00%	2.22%	2.22%	0.00%	6.83%	6.83%
Craven	0.00%	0.02%	0.02%	0.70%	0.90%	0.20%	2.57%	2.27%	-0.30%	7.66%	7.07%	-0.59%
Currituck	0.00%	0.00%	0.00%	0.91%	2.11%	1.20%	1.39%	1.43%	0.04%	4.66%	5.06%	0.40%
Dare	0.00%	0.00%	0.00%	1.57%	1.71%	0.14%	3.48%	1.72%	-1.76%	5.72%	6.25%	0.53%
Gates	0.00%	0.00%	0.00%	0.36%	0.36%	0.00%	2.61%	1.64%	-0.97%	5.62%	4.60%	-1.02%
Hertford	0.00%	0.00%	0.00%	0.94%	0.72%	-0.22%	1.53%	0.90%	-0.63%	3.91%	3.57%	-0.34%

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	3-12			13-17			18-20			21-34		
Hyde	0.00%	0.00%	0.00%	1.50%	0.78%	-0.72%	2.50%	2.56%	0.06%	4.86%	8.09%	3.23%
Jones	0.00%	0.00%	0.00%	0.33%	0.34%	0.01%	2.40%	3.33%	0.93%	6.00%	5.17%	-0.83%
Martin	0.00%	0.00%	0.00%	0.66%	1.31%	0.65%	2.56%	3.06%	0.50%	6.92%	6.95%	0.03%
Nash	0.01%	0.01%	0.00%	0.60%	0.67%	0.07%	1.58%	1.72%	0.14%	4.67%	3.85%	-0.82%
New Hanover	0.02%	0.01%	-0.01%	1.80%	1.60%	-0.20%	2.91%	3.57%	0.66%	7.29%	7.14%	-0.15%
Northampton	0.00%	0.00%	0.00%	0.71%	0.89%	0.18%	0.86%	0.56%	-0.30%	2.23%	2.82%	0.59%
Onslow	0.00%	0.01%	0.01%	0.68%	0.67%	-0.01%	2.34%	2.09%	-0.25%	4.84%	4.55%	-0.29%
Pamlico	0.00%	0.00%	0.00%	0.60%	0.00%	-0.60%	1.84%	2.47%	0.63%	10.43%	7.17%	-3.26%
Pasquotank	0.03%	0.00%	-0.03%	0.92%	0.34%	-0.58%	2.34%	1.92%	-0.42%	4.12%	3.33%	-0.79%
Pender	0.00%	0.00%	0.00%	1.29%	0.67%	-0.62%	1.67%	2.25%	0.58%	5.07%	6.27%	1.20%
Perquimans	0.00%	0.00%	0.00%	0.28%	0.30%	0.02%	3.07%	0.68%	-2.39%	3.63%	2.15%	-1.48%
Pitt	0.04%	0.03%	-0.01%	1.68%	1.53%	-0.15%	3.02%	3.22%	0.20%	5.39%	5.83%	0.44%
Tyrrell	0.00%	0.00%	0.00%	0.89%	0.00%	-0.89%	0.00%	0.00%	0.00%	3.70%	5.06%	1.36%
Washington	0.00%	0.00%	0.00%	0.64%	1.32%	0.68%	2.91%	3.68%	0.77%	5.33%	5.62%	0.29%

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	35-64			65+			Unknown			Total (Ages 3+)		
Beaufort	7.56%	7.11%	-0.45%	1.19%	1.10%	-0.09%	0.00%	0.00%	0.00%	3.62%	3.46%	-0.16%
Bertie	5.49%	5.22%	-0.27%	1.23%	0.96%	-0.27%	0.00%	0.00%	0.00%	2.15%	2.05%	-0.10%
Brunswick	5.74%	6.29%	0.55%	0.14%	0.34%	0.20%	0.00%	0.00%	0.00%	2.76%	2.73%	-0.03%
Camden	5.53%	4.57%	-0.96%	0.00%	2.30%	2.30%	0.00%	0.00%	0.00%	1.99%	1.96%	-0.03%
Carteret	6.88%	7.33%	0.45%	0.95%	1.11%	0.16%	0.00%	0.00%	0.00%	3.25%	3.24%	-0.01%
Chowan	6.70%	7.66%	0.96%	1.79%	1.26%	-0.53%	0.00%	0.00%	0.00%	2.62%	2.59%	-0.03%
Columbus	0.00%	4.86%	4.86%	0.00%	0.24%	0.24%	0.00%	0.00%	0.00%	0.00%	2.29%	2.29%
Craven	5.74%	6.00%	0.26%	0.36%	0.72%	0.36%	0.00%	0.00%	0.00%	2.60%	2.55%	-0.05%
Currituck	4.41%	4.73%	0.32%	0.00%	1.03%	1.03%	0.00%	0.00%	0.00%	1.73%	2.12%	0.39%
Dare	7.30%	7.41%	0.11%	1.02%	0.00%	-1.02%	0.00%	0.00%	0.00%	2.52%	2.41%	-0.11%
Gates	3.46%	3.73%	0.27%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.66%	1.52%	-0.14%
Hertford	5.94%	5.81%	-0.13%	1.02%	1.66%	0.64%	0.00%	0.00%	0.00%	2.18%	2.17%	-0.01%
Hyde	2.17%	2.98%	0.81%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.42%	1.89%	0.47%

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	35-64			65+			Unknown			Total (Ages 3+)		
Jones	4.47%	5.60%	1.13%	0.31%	0.00%	-0.31%	0.00%	0.00%	0.00%	1.98%	2.16%	0.18%
Martin	6.66%	7.53%	0.87%	1.44%	1.39%	-0.05%	0.00%	0.00%	0.00%	2.81%	3.03%	0.22%
Nash	4.44%	5.66%	1.22%	0.64%	1.03%	0.39%	0.00%	0.00%	0.00%	1.81%	1.98%	0.17%
New Hanover	8.17%	8.37%	0.20%	1.82%	1.64%	-0.18%	0.00%	0.00%	0.00%	3.33%	3.38%	0.05%
Northampton	4.34%	3.28%	-1.06%	1.32%	1.22%	-0.10%	0.00%	0.00%	0.00%	1.64%	1.47%	-0.17%
Onslow	5.17%	5.97%	0.80%	0.68%	0.84%	0.16%	0.00%	0.00%	0.00%	2.05%	2.09%	0.04%
Pamlico	7.01%	5.42%	-1.59%	0.00%	0.37%	0.37%	0.00%	0.00%	0.00%	3.14%	2.34%	-0.80%
Pasquotank	4.97%	3.54%	-1.43%	0.41%	0.27%	-0.14%	0.00%	0.00%	0.00%	1.91%	1.37%	-0.54%
Pender	5.68%	6.29%	0.61%	0.67%	0.79%	0.12%	0.00%	0.00%	0.00%	2.21%	2.42%	0.21%
Perquimans	4.67%	3.66%	-1.01%	0.35%	0.36%	0.01%	0.00%	0.00%	0.00%	1.81%	1.21%	-0.60%
Pitt	8.32%	8.43%	0.11%	1.12%	1.43%	0.31%	0.00%	0.00%	0.00%	2.94%	3.06%	0.12%
Tyrrell	5.26%	4.91%	-0.35%	2.96%	0.78%	-2.18%	0.00%	0.00%	0.00%	2.03%	1.54%	-0.49%
Washington	7.00%	6.81%	-0.19%	1.05%	1.27%	0.22%	0.00%	0.00%	0.00%	2.74%	2.88%	0.14%

Table 15: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	3-12			13-17			18-20			21-34		
Beaufort	13.76%	13.39%	-0.37%	17.05%	17.41%	0.36%	11.46%	11.57%	0.11%	22.68%	20.61%	-2.07%
Bertie	7.74%	6.87%	-0.87%	16.25%	15.42%	-0.83%	8.68%	6.27%	-2.41%	12.05%	10.37%	-1.68%
Brunswick	11.49%	11.16%	-0.33%	17.64%	16.25%	-1.39%	11.14%	11.95%	0.81%	14.69%	16.62%	1.93%
Camden	11.78%	9.37%	-2.41%	20.00%	20.83%	0.83%	16.67%	10.39%	-6.28%	11.24%	10.76%	-0.48%
Carteret	17.43%	16.62%	-0.81%	23.85%	24.50%	0.65%	16.28%	14.18%	-2.10%	19.87%	21.10%	1.23%
Chowan	8.24%	11.21%	2.97%	13.95%	16.83%	2.88%	9.30%	10.73%	1.43%	8.50%	9.74%	1.24%
Columbus	0.00%	10.14%	10.14%	0.00%	11.61%	11.61%	0.00%	7.39%	7.39%	0.00%	11.32%	11.32%
Craven	10.32%	11.86%	1.54%	17.63%	18.63%	1.00%	10.01%	10.39%	0.38%	16.37%	16.37%	0.00%
Currituck	10.91%	11.33%	0.42%	18.64%	18.97%	0.33%	11.81%	12.14%	0.33%	10.49%	12.18%	1.69%
Dare	8.78%	7.51%	-1.27%	14.49%	15.42%	0.93%	10.80%	7.93%	-2.87%	11.45%	13.79%	2.34%
Gates	5.09%	8.65%	3.56%	9.78%	13.67%	3.89%	11.30%	9.84%	-1.46%	13.86%	11.30%	-2.56%
Hertford	6.00%	6.01%	0.01%	9.56%	9.93%	0.37%	5.60%	4.94%	-0.66%	9.71%	8.81%	-0.90%

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	3-12			13-17			18-20			21-34		
Hyde	12.04%	11.84%	-0.20%	14.29%	16.41%	2.12%	2.50%	5.13%	2.63%	11.81%	16.18%	4.37%
Jones	9.41%	10.06%	0.65%	15.00%	17.29%	2.29%	12.00%	12.50%	0.50%	18.00%	22.07%	4.07%
Martin	11.08%	11.37%	0.29%	18.90%	17.61%	-1.29%	12.50%	12.23%	-0.27%	13.84%	15.37%	1.53%
Nash	5.46%	5.27%	-0.19%	8.65%	9.51%	0.86%	4.75%	6.66%	1.91%	8.85%	8.81%	-0.04%
New Hanover	13.84%	13.20%	-0.64%	20.38%	18.65%	-1.73%	13.48%	12.57%	-0.91%	16.63%	15.99%	-0.64%
Northampton	10.75%	8.47%	-2.28%	16.29%	12.87%	-3.42%	9.77%	8.40%	-1.37%	9.50%	9.35%	-0.15%
Onslow	11.55%	11.57%	0.02%	18.43%	19.41%	0.98%	13.25%	13.43%	0.18%	17.41%	16.47%	-0.94%
Pamlico	17.98%	21.52%	3.54%	28.23%	25.15%	-3.08%	12.27%	14.81%	2.54%	18.40%	17.92%	-0.48%
Pasquotank	9.27%	8.74%	-0.53%	15.08%	16.37%	1.29%	9.57%	11.97%	2.40%	12.08%	12.77%	0.69%
Pender	10.33%	10.28%	-0.05%	15.26%	15.60%	0.34%	7.51%	9.99%	2.48%	13.23%	16.21%	2.98%
Perquimans	9.34%	9.60%	0.26%	17.95%	16.96%	-0.99%	9.82%	11.64%	1.82%	10.41%	9.14%	-1.27%
Pitt	11.24%	10.71%	-0.53%	17.67%	17.90%	0.23%	11.05%	10.00%	-1.05%	14.02%	14.81%	0.79%
Tyrrell	8.94%	9.65%	0.71%	15.18%	19.49%	4.31%	5.41%	6.67%	1.26%	9.88%	10.13%	0.25%
Washington	8.58%	9.26%	0.68%	13.09%	12.97%	-0.12%	8.74%	7.89%	-0.85%	11.05%	10.15%	-0.90%

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	35-64			65+			Unknown			Total (Ages 3+)		
Beaufort	23.95%	24.02%	0.07%	8.51%	7.87%	-0.64%	0.00%	0.00%	0.00%	17.00%	16.60%	-0.40%
Bertie	14.93%	14.23%	-0.70%	5.61%	7.00%	1.39%	0.00%	0.00%	0.00%	10.90%	10.19%	-0.71%
Brunswick	17.67%	16.67%	-1.00%	5.54%	4.39%	-1.15%	0.00%	0.00%	0.00%	13.71%	13.39%	-0.32%
Camden	20.74%	18.72%	-2.02%	6.98%	8.05%	1.07%	0.00%	0.00%	0.00%	14.77%	13.25%	-1.52%
Carteret	23.26%	23.13%	-0.13%	6.23%	8.07%	1.84%	0.00%	0.00%	0.00%	18.89%	18.76%	-0.13%
Chowan	16.76%	16.03%	-0.73%	13.04%	10.55%	-2.49%	0.00%	0.00%	0.00%	11.63%	12.75%	1.12%
Columbus	0.00%	11.44%	11.44%	0.00%	3.33%	3.33%	0.00%	0.00%	0.00%	0.00%	9.88%	9.88%
Craven	19.96%	21.43%	1.47%	9.17%	9.38%	0.21%	0.00%	0.00%	0.00%	14.07%	15.08%	1.01%
Currituck	17.83%	20.00%	2.17%	3.05%	3.08%	0.03%	0.00%	0.00%	0.00%	12.83%	13.73%	0.90%
Dare	14.72%	15.68%	0.96%	6.78%	6.11%	-0.67%	0.00%	0.00%	0.00%	11.07%	10.89%	-0.18%
Gates	15.01%	16.08%	1.07%	5.31%	2.42%	-2.89%	0.00%	0.00%	0.00%	9.34%	10.72%	1.38%
Hertford	14.95%	14.22%	-0.73%	6.65%	5.75%	-0.90%	0.00%	0.00%	0.00%	8.99%	8.66%	-0.33%
Hyde	15.22%	15.74%	0.52%	7.59%	5.81%	-1.78%	0.00%	0.00%	0.00%	11.62%	12.41%	0.79%

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	35-64			65+			Unknown			Total (Ages 3+)		
Jones	18.25%	19.11%	0.86%	5.66%	5.05%	-0.61%	0.00%	0.00%	0.00%	12.83%	14.03%	1.20%
Martin	18.79%	17.81%	-0.98%	9.34%	8.91%	-0.43%	0.00%	0.00%	0.00%	14.03%	13.83%	-0.20%
Nash	12.40%	12.20%	-0.20%	6.02%	6.56%	0.54%	0.00%	0.00%	0.00%	7.79%	7.96%	0.17%
New Hanover	24.34%	21.44%	-2.90%	13.15%	10.76%	-2.39%	0.00%	0.00%	0.00%	17.27%	15.90%	-1.37%
Northampton	14.22%	14.49%	0.27%	6.89%	6.10%	-0.79%	0.00%	0.00%	0.00%	11.47%	10.20%	-1.27%
Onslow	23.25%	22.66%	-0.59%	11.20%	10.23%	-0.97%	0.00%	0.00%	0.00%	15.68%	15.46%	-0.22%
Pamlico	22.16%	22.29%	0.13%	14.02%	12.31%	-1.71%	0.00%	0.00%	0.00%	19.53%	20.18%	0.65%
Pasquotank	19.08%	18.16%	-0.92%	5.81%	6.16%	0.35%	0.00%	0.00%	0.00%	12.15%	12.22%	0.07%
Pender	17.87%	17.30%	-0.57%	10.32%	7.90%	-2.42%	0.00%	0.00%	0.00%	12.80%	13.07%	0.27%
Perquimans	16.88%	15.38%	-1.50%	4.21%	6.41%	2.20%	0.00%	0.00%	0.00%	11.71%	11.50%	-0.21%
Pitt	20.34%	20.29%	-0.05%	7.75%	8.76%	1.01%	0.00%	0.00%	0.00%	14.03%	13.99%	-0.04%
Tyrrell	13.45%	14.11%	0.66%	5.19%	3.91%	-1.28%	0.00%	0.00%	0.00%	10.02%	10.90%	0.88%
Washington	20.39%	19.42%	-0.97%	8.14%	9.37%	1.23%	0.00%	0.00%	0.00%	12.20%	12.18%	-0.02%

(b) Waiver Validation Results

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

Table 16: (b) Waiver Performance Measure Validation Scores

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

(c) Waiver Measures Reported Results

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

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

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	1715/1737 = 98.73%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	1715/1737 = 98.73%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	51/60 = 85.0%*	85%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	1252/1252 = 100.0%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	15/15 = 100.0%	85%

*The IW G2 rate was submitted after the onsite as the previous rate was below the benchmark and CCME requested the *updated* rate to determine if it had improved to the benchmark rate.

(c) Waiver Validation

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

Table 18: (c) Waiver Performance Measures Validation Scores

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

Performance Improvement Project (PIP) Validation

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

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

PIP Validation Results

Trillium submitted five projects for this 2020 EQR. All five projects in *Table 19, PIP Summary of Validation Scores*, were validated. Table 19 provides an overview and comparison of the 2019 and 2020 EQR validation scores.

Table 19: PIP Summary of Validation Scores

Project Type	Project	2019 Validation Score	2020 Validation Score
Clinical	Supermeasures SU	85/85=100% High Confidence in Reported Results	73/74=99% High Confidence in Reported Results
	Supermeasures MH	84/85=99% High Confidence in Reported Results	73/74=99% High Confidence in Reported Results
	ED Utilization	Not Submitted	79/79=100% High Confidence in Reported Results
	Utilization of MST	Not Submitted	73/74=99% High Confidence in Reported Results
Non-Clinical	Increasing Provider Satisfaction Related to the Appeals Process for Denial, Reduction, or Suspension of Service(s)	90/90=100% High Confidence in Reported Results	Not submitted
	Monitoring of In-Reach Contacts for TCLI	80/85=94% High Confidence in Reported Results	84/84=100% High Confidence in Reported Results

All 2020 EQR validated PIPs received a validation score within the High Confidence range and met the validation requirements. The five PIPs validated were: Supermeasures MH, Supermeasures SU, In Reach Contacts for TCLI, ED Utilization, and MST Utilization. The ED Utilization PIP had three measures, and all improved in the most recent remeasurements. The Supermeasures MH PIP showed improvement in rate for the NC Medicaid population, but the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH) population declined further and is at 19.0% for the most recent documented measurement. The Supermeasures SU PIP showed the NC Medicaid rate above goal (45%) for the last two remeasurements and the DMH declining, with the most recent rate at 32.2%. The In Reach Contacts for TCLI has sustained above goal rates (98%) for last several months and will be monitored for sustainment until mid-year 2021. MST Utilization has declined from 9.04% at baseline to 3.7% with a goal rate of 14.7%. New staff hires and educational and training interventions for care coordinators, schools, families, and DSS are in place to work toward improving the MST Utilization rate.

For the 2019 EQR, there were four PIPs validated: Provider Satisfaction, Supermeasures SU, and In Reach Contacts for TCLI. There were no Corrective Actions in the 2019 review; there were two Recommendations. There was a Recommendation for the Monitoring of

In-Reach Contacts for TCLI, to clarify the data analysis plan as weekly or monthly since the data analysis plan indicated weekly but rates were presented monthly. For the Supermeasures MH PIP, the NC Medicaid members were not showing improvement, and a refinement of interventions was recommended. Both Recommendations were implemented and evident in reports uploaded to the Desk Materials of this EQR.

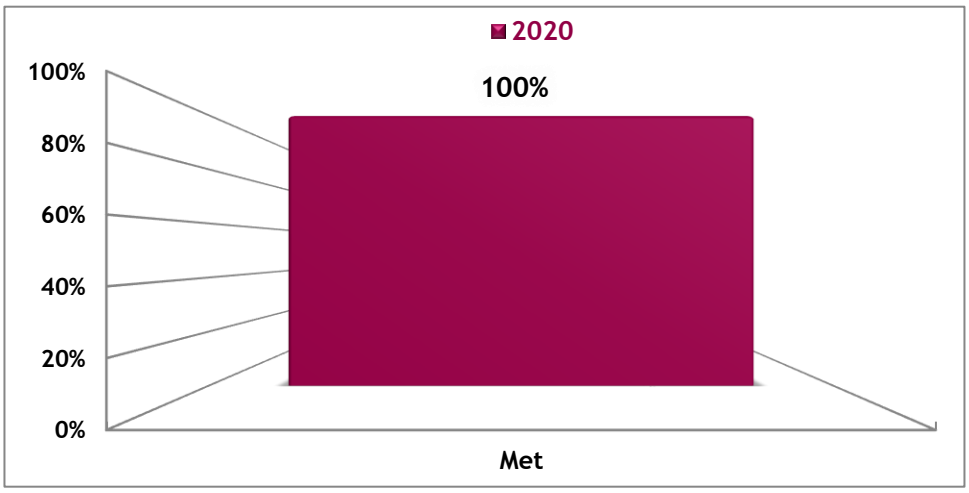
There were no Corrective Actions for the 2020 PIPs. There are three PIPs with one Recommendation each. These Recommendations are displayed in *Table 20: Performance Improvement Project Recommendations*.

Table 20: Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Supermeasures MH	Was there any documented, quantitative improvement in processes or outcomes of care?	For NC Medicaid, the follow up rate slightly declined in the last remeasurement, but it is still above the State goal of 40%; NC Medicaid is below the Trillium goal rate of 45% at 44.2%. The DMH rate also declined and remains below the State goal of 40%. The most DMH recent rate is 19.0%, a decrease from 27.2%.	Similar to the SU PIP, continue with current active interventions and examine rate after review of internal process and protocols for scheduling are completed; data analysis for dually covered members is recommended to assess impact on the measure.
Supermeasures SU	Was there any documented, quantitative improvement in processes or outcomes of care?	For NC Medicaid, the follow up rate slightly declined in the last remeasurement, but it is still above the Trillium goal of 45%. The DMH rate also declined and remains below the State goal of 40%. The most DMH recent rate is 32.2%, a decrease from 36.1%.	Continue with current active interventions and examine rate after review of internal process and protocols for scheduling are completed; data analysis for dually covered members is recommended to assess impact on the measure.
MST Utilization	Was there any documented, quantitative improvement in processes or outcomes of care?	Rate was 9.04% at baseline and declined to 3.7% at the latest measurement period.	Identify and implement a plan to determine if family refusal can be mitigated; continue working on improving access; continue interventions of childcare coordinator training and education for families, schools, and DSS.

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

Figure 4: Quality Improvement Findings



Strengths

- (b) and (c) Waiver Measures included all necessary documentation, and measures were reported according to specifications.
- All five validated PIPs were in the High Confidence range.
- 30-day Follow-up After Hospitalization for Mental Illness in the FBC Population improved substantially.

Weaknesses

- For the MST Utilization PIP, the rate was 9.04% at baseline and declined to 3.7% at the latest measurement period.
- For the Supermeasures MH PIP, the follow up rate slightly declined for NC Medicaid in the last remeasurement, but it is still above the State goal of 40%; NC Medicaid is below the Trillium goal rate of 45% at 44.2%. The DMH rate also declined and remains below the State goal of 40%. The most recent rate for DMH is 19.0%, a decrease from 27.2%.
- For the Supermeasures SU PIP, the follow up rate slightly declined for NC Medicaid in the last remeasurement, but it is still above the Trillium goal of 45%. The DMH rate also declined and remains below the State goal of 40%. The most DMH recent rate is 32.2%, a decrease from 36.1%.

Recommendations

- Identify and implement a plan to determine if family refusal can be mitigated; continue working on improving access; continue interventions of childcare coordinator training and education for families, schools, and DSS for the MST Utilization PIP.

- Continue with current active interventions and examine rate after review of internal process and protocols for scheduling are completed; data analysis for dually covered members is recommended to assess the impact on the measure for the Supermeasures MH PIP.

- Continue with current active interventions and examine rate after review of internal process and protocols for scheduling are completed; data analysis for dually covered members is recommended to assess the impact on the measure for the Supermeasures SU PIP.

D. Care Coordination

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

In the 2019 EQR, Trillium met 100% of Care Coordination and TCLI standards. CCME issued no Corrective Actions and one Recommendation. CCME recommended that Trillium add information about Incedo Case Management platform to the *Care Coordination Program Description*. The information recommended to be added included how the platform will be used to document Care Coordination activity, monitor interventions, and measure outcomes. This Recommendation was implemented.

For this EQR, CCME has issued five Recommendations. The review of Trillium's Complex Case Management procedure did not align with the *NC Medicaid Contract*. The procedure lists the age requirement for Children with Complex Needs as 0 to 21 years. However, *NC* Medicaid *Contract, Section 6.11.3.(c), Section g,* lists the age for Children with Complex Needs as 5 to 21. CCME recommends Trillium update the procedures for Complex Case Management to reflect the age requirements listed in the *NC Medicaid Contract*.

Trillium has a *Care Management Monitoring Plan* in place for I/DD/MH/SUD/TCLI that reviews the quality of services delivered by the Care Manager. The monitoring plans do not include internal benchmarks for Care Manager completion of tasks such as monitoring, Individual Support Plans (ISP's), and progress notes. During the Onsite, Trillium was unable to provide the percentage that Care Managers are expected to maintain when completing these tasks. CCME recommends that Trillium update the

I/DD/MH/SUD/TCLI Care Management Monitoring Plans to identify departmental benchmarks for Care Manager's task completion.

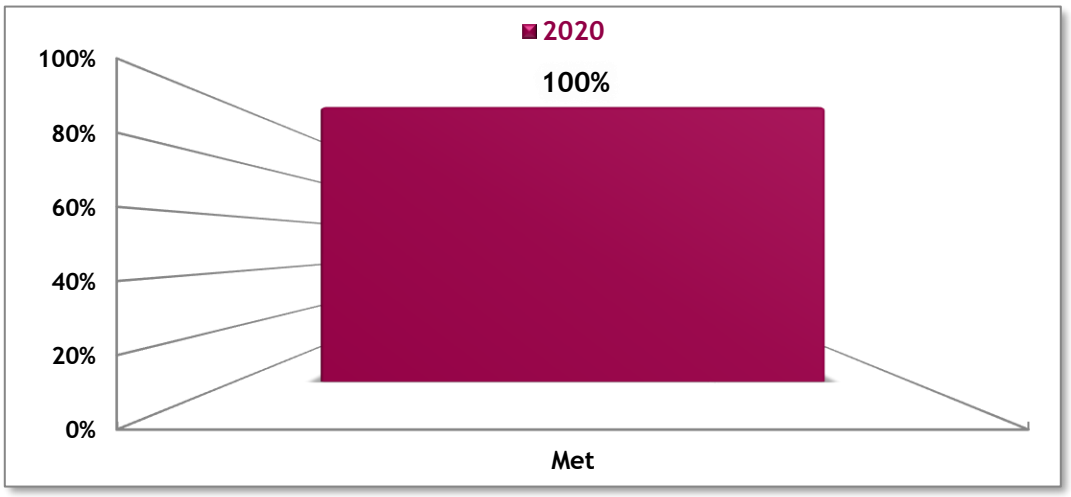
Moreover, the *I/DD Innovations Care Management Monitoring Plan* does not include the requirement that members participating in residential programs receive monthly face-to-face contacts by the Care Manager. *NC Medicaid Contract, Section 6.11.3 (h)* and *NC Clinical Coverage Policy 8P* require contacts to occur face-to-face on a monthly basis for members who live in residential programs. Additionally, the *I/DD Innovations Care Management Monitoring Plan* includes information that is inconsistent with *North Carolina Department of Health and Human Services (NCDHHS) Home and Community Based Services Final Rule Transition Plan*. Home and Community Based Services (HCBS) final rules also require face-to-face contact and documentation for members in residential programs to occur monthly. It is recommended that Trillium revise the *I/DD Innovations Care Management Monitoring Plan* to reflect the required monthly contact by the Care Managers as outlined in *NC Medicaid Contract, Section 6.11.3 (h)* and *NC Clinical Coverage Policy 8P*.

The review of I/DD files found noncompliance with *NC Medicaid Contract, Section 6.11.3 (h), NC Clinical Coverage Policy 8P*, and *the I/DD Innovations Care Management Monitoring Plan*. *NC Medicaid Contract, Section 6.11.3 (h)* and *NC Clinical Coverage Policy 8P*, require Care Coordination [Care Management] to make monthly face-to-face contact to members who receive residential supports. The review found that face-to-face contacts by the Care Manager occurred quarterly instead of monthly for two I/DD members who received residential supports. During the Onsite, Trillium provided additional dates to support monthly contacts, but did not include supporting documentation such as progress notes or *HCBS Monitoring Check Sheet*s to correspond with the dates. Additionally, the review found that the *HCBS Monitoring Check Sheet* did not meet the submission requirements of quarterly as outlined in *Trillium's I/DD Innovations Care Management Monitoring Plan*. The review found in one I/DD file that the *HCBS Monitoring Check Sheet* was completed every four months instead of quarterly. CCME recommends Trillium develop and implement a process that ensures I/DD Innovations members participating in residential supports receive monthly face-to-face contacts with Care Management staff. The process should also include a routine review of the *HCBS Monitoring Check Sheet*.

The review of TCLI files found that progress notes did not meet timely submission requirements. During the Onsite, Trillium stated that TCLI Care Managers have 72 hours to submit progress notes in the Incedo Case Management Platform. The review found seven percent (7%) of progress notes were submitted outside of the required timeframe. Some progress notes were more than 13 months late. CCME recommends that Trillium document and implement a process that routinely reviews TCLI staff progress notes to ensure documentation is compliant with the *TCLI Care Management Monitoring Plan*.

Figure 5 shows 100% of the Care Coordination standards were scored as "Met," and 4% were scored as "Partially Met."

Figure 5: Care Coordination Findings



Strengths

- Trillium provided ample supports to its members during the COVID-19 Stay at Home Order. Supports included resources and educational material about the pandemic and North Carolina's response, technological supports such as Alexa Echo Dots, TEMI Robots and cell phones, and personal protective equipment (PPE).
- The review of MH/SUD files for this EQR found that Care Managers are following Trillium's procedures regarding documentation expectations.
- Trillium has a process in place to ensure the continuous monitoring of members participating in TCLI, well after placement into independent housing.

Weaknesses

- Trillium's procedure for Complex Case Management lists the age for Children with Complex Needs as 0 to 21 years, while the *NC Medicaid Contract, Section 6.11.3.c.g.* cites the age as 5 to 21 years.
- The monitoring plans for I/DD/MH/SUD/TCLI lack internal benchmarks that measure the performance of Care Managers.
- The *I/DD Innovations Care Management Monitoring Plan* does not include the contact requirements for members participating in residential programs as outlined in *NC Medicaid Contract, Section 6.11.3 (h)* and *NC Clinical Coverage Policy 8P*.

- The review of I/DD files found noncompliance with *NC Medicaid Contract, Section 6.11.3 (h)* and *NC Clinical Coverage Policy 8P* requirement for monthly face-to-face contacts with members participating in residential services. The review also found in one I/DD file noncompliance with Trillium's *I/DD Innovations Care Management Monitoring Plan* that requires HCBS monitoring to occur quarterly. The review found that HCBS monitoring was occurring every 4 months.

- Trillium requires progress notes to be submitted within 72 hours of service delivery. The review of TCLI files found late progress notes, some more than 13 months old.

Recommendations

- Update the procedure for Complex Case Management to reflect the age requirement listed in *NC Medicaid Contract, Section 6.11.3 (c), g,* for Children with Complex Needs.

- Revise the current monitoring plans for I/DD/MH/SUD/TCLI to implement a data-driven process that identifies the frequency of Care Manager contacts, departmental benchmarks for compliance, and how and when outcomes of Care Management contacts are captured, reviewed, and reported.

- Document and implement a process that routinely reviews I/DD Care Managers' documentation of member contacts to ensure members participating in residential supports receive contacts as outlined in *NC Medicaid Contract, Section 6.11.3 (h)* and *NC Clinical Coverage Policy 8P*. Include in this process a routine review of the *HCBS Monitoring Check Sheet* for compliance with *NC Medicaid Contract* contact requirements.

- Revise the *I/DD Innovations Care Management Monitoring Plan* to reflect the contact requirements with enrollees in residential services as outlined *in NC Medicaid Contract, Section 6.11.3 (h)* and *NC Clinical Coverage Policy 8P*.

- Document and implement a process that routinely reviews TCLI staff progress notes to ensure documentation is compliant with the *TCLI Care Management Monitoring Plan*.

E. Grievances and Appeals

The Grievances and Appeals EQR for Trillium included a Desk Review of relevant policies and procedures, ten Grievance and ten Appeal files, the Grievances and Appeals Logs, the *Trillium Provider Manual Revised October 2020* (*Provider Manual*), *Trillium Health Resources Member and Family Handbook Revised January 2020* (*Member and Family Handbook*), the *Utilization Management Plan*, and information about Grievances and Appeals available on the Trillium website. An Onsite discussion with Grievance and Appeal staff occurred to further clarify Trillium's documentation and processes.

In the 2019 EQR, Trillium met 100% of the Grievance and Appeal standards. Eleven Recommendations were issued to add or correct language within Trillium's Grievance and Appeals procedures, *Provider Manual*, and *Member and Family Handbook,* and Grievance and Appeal notifications. Only half of these Recommendations were addressed by Trillium. As a result, several of the areas of concern are repeated in this year's EQR to the previous year's EQR. Trillium met 90% of the Grievance and Appeal standards in this 2020 EQR.

Grievances

In the 2019 EQR of Grievance functions, CCME provided four Recommendations. These Recommendations addressed opportunities for improvement in grievance procedure, *Provider Manual*, *Member and Family Handbook*, Grievance Resolution notifications and Grievance files. CCME also recommended that Trillium bolster the language within the Grievance Process and Scope procedure. In the 2020 EQR, the same and similar issues were again noted within the Grievance procedure, *Provider Manual*, *Member and Family Handbook*, Grievance Resolution notifications and Grievance files. As a result, CCME has issued one Corrective Action and one Recommendation in this year's EQR of Grievances.

NC Medicaid Contract, Attachment M requires that PIHPs resolve all Grievances and provide notice of resolution within 90 calendar days. This required timeframe for resolution of a Grievance is in Trillium's Grievance Process and Scope procedure but only regarding provider-related Grievances. Further, information within the procedure regarding extensions by Trillium to the Grievance resolution timeframe is also only under provider-related Grievances and does not include the notifications required by *42 CFR § 438.408 (c)*. The required notifications are:

- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
- Within two calendar days, give the enrollee written notice of the reason for the decision to extend the timeframe
- Inform the enrollee of the right to file a Grievance is he or she disagrees with that decision.

There is also no language in the Complaint Process and Scope procedure regarding extensions to the Complaint resolution timeframe. CCME has issued a Corrective Action to ensure *42 CFR § 438.408 (c)* language is captured within Trillium Grievance and Complaint procedures.

The Grievance Process and Scope procedure includes "if it is determined at the time of receipt of the Grievance that there is a potential health and safety component or significant clinical issue, then Trillium's Chief Medical Officer and other members of the Executive Team will be promptly notified by the person who received the Grievance. The

Chief Medical Officer will provide consultation and direction to the staff in how to proceed with the investigative process." There is, however, no guidance in the Grievance procedure regarding how and where these consultations and their outcomes are to be documented within the Grievance file. This was a Recommendation from the 2019 EQR and is again recommended in this 2020 EQR to ensure consultations are consistently captured within the Grievance files.

Appeals

In the 2019 EQR, CCME provided seven Recommendations targeting areas of improvement within the Appeals functions. Three Recommendations were aimed at adding language to the Trillium's Appeal procedure regarding expedited Appeals and providing the Appeal record to appellants. Two Recommendations were provided to improve upon Trillium's written notifications to appellants. All but one Appeal Recommendation was implemented by Trillium.

For this year's 2020 Appeals EQR, Trillium submitted the Appeals Log that captures all Appeals processed from October 2019 through September 2020. From that log, ten Appeal files were selected: two standard Appeals, six expedited Appeals, one invalid Appeal, and one withdrawn Appeal. Prior to the Onsite, additional expedited Appeal files were requested from Trillium. However, Trillium did not process any expedited Appeals during the timeframe following the Desk Materials upload and Trillium's Onsite.

In the 2020 EQR there were three areas of improvement that require updated Trillium documentation and one area that requires monitoring Appeal notifications. First, it was noted that the *Provider Manual* (on page 65) states, "to request Reconsideration, the member/guardian/authorized representative and/or the provider (acting with written consent) must complete and return the Trillium Reconsideration Review form…" This was also noted on page 85 and 86 of the *Member and Family Handbook*. This is more restrictive than language within the *NC Medicaid Contract*, Attachment *M*, and federal regulations. Secondly, on page 86 of the *Member and Family Handbook*, there are three places that state the enrollee has 30 days from the mailing date of the Adverse Benefit Determination notification to file an Appeal. As stated in the *NC Medicaid Contract, Attachment M, Section G.2, 42 CFR § 438.402 (c)ii,* the timeframe allowed for filing Appeals is 60 days from the mailing date of the Adverse Benefit Determination notification. The procedure, Medicaid Clinical Reconsideration Process, is correct and directs staff appropriately. Third, in neither the *Provider Manual* (page 66) nor the *Member and Family Handbook* (page 89) is it explained that Trillium is required to notify the enrollee of their right to file a Grievance if Trillium extends the Appeal resolution timeframe. Lastly, one of three denied expedited Appeal files did not include notification to the appellant of the right to file a Grievance if Trillium extends the Appeal resolution timeframe. Recommendations were made in this EQR to address these four issues.

In the 2019 EQR, CCME recommended Trillium detail in the Appeal procedure the process staff follow when releasing the Appeals record or reference the Member Access to Protected Health Information procedure in the Medicaid Clinical Reconsideration Process procedure. This Recommendation was to ensure the enrollee's protected health information (PHI) was released in accordance with Trillium's Member Access to Protected Health Information procedure. In the 2020 EQR, it was evident that Trillium did not implement this Recommendation as the Appeal procedure still provided no guidance to staff regarding the release of the Appeal record. Further, in the one file where the Appeal record was released there was no evidence staff took steps to protect the enrollee's PHI. For example, there was no documentation showing guardianship was confirmed, no evidence the request for PHI was forwarded to the Medical Record Specialist, and no evidence any consideration was given to ensure steps protecting PHI when releasing the Appeal record, as is required by Trillium's Member Access to Protected Health Information procedure. As the Appeal record contains PHI and there are several State and federal regulations that should be considered prior to releasing the Appeal record, CCME has issued a Corrective Action to ensure the Trillium documents a process by which the enrollee's Appeal record is released in accordance with Member Access to Protected Health Information.

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

Figure 6: Grievances and Appeals Findings

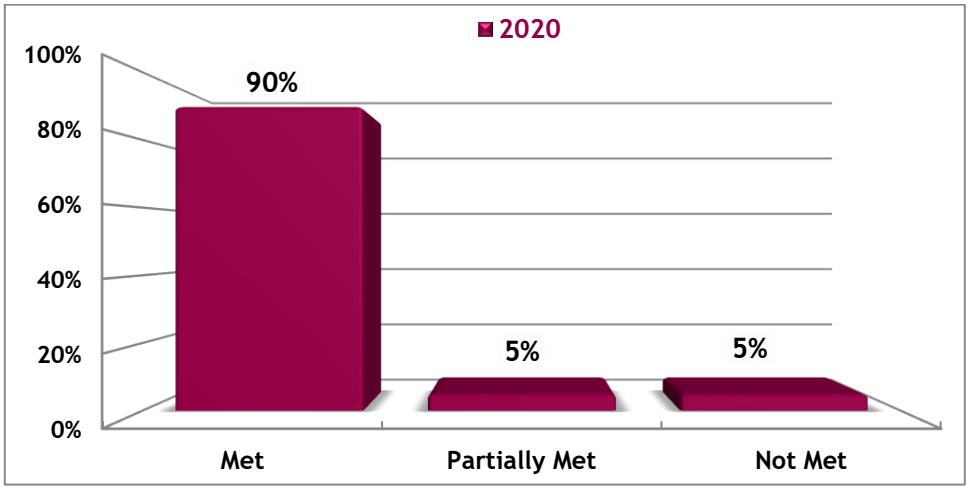


Table 21: Grievances and Appeals

Section	Standard	2020 Review
Grievances	Timeliness guidelines for resolution of the Grievance as specified in the contract;	Partially Met
Appeals	Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	Not Met

Strengths

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

Weaknesses

- The timeframe required for the resolution of a Grievance is in Trillium's Grievance Process and Scope procedure but only regarding provider-related Grievances.
- There is no language in the Grievance Process and Scope procedure regarding extensions to the Grievance resolution timeframe. This is required by *42 CFR § 438.408 (c)*.
- There is no language in the Complaint Process and Scope procedure regarding extensions to the Complaint resolution timeframe. This is required by *42 CFR § 438.408 (c)*.
- The Grievance Process and Scope procedure does not detail how and where consultations with the Chief Medical Officer, or any other Trillium Executive Team member, are captured within the Grievance file.
- On page 65 of the *Provider Manual* its stated, "To request Reconsideration, the member/guardian/authorized representative and/or the provider (acting with written consent) must complete and return the Trillium Reconsideration Review form." This was also noted on page 85 and 86 of the *Member and Family Handbook*. Requiring Trillium's Reconsideration Review form is more restrictive than language within the *NC Medicaid Contract, Attachment M* and *42 CFR § 438.406*.
- On page 86 of the *Member and Family Handbook*, it is stated in three places that the enrollee has 30 days from the mailing date of the Adverse Benefit Determination notification to file an Appeal. The timeframe allowed for filing Appeals is 60 days from

the mailing date of the Adverse Benefit Determination notification per *NC Medicaid Contract, Attachment M (G)(2) and 42 CFR § 438.402 (c)(2)ii*.

- In neither the *Provider Manual* nor the *Member and Family Handbook* is it explained that Trillium is required to notify the enrollee of their right to file a Grievance if Trillium extends the Appeal resolution timeframe.
- One of three denied expedited Appeal files did not include notification to the Appellant of the right to file a Grievance if Trillium extends the Appeal resolution timeframe.
- The Medicaid Clinical Reconsideration Process procedure does not provide guidance to Appeals staff regarding the steps taken before the Appeal record is released to protect PHI. This was a Recommendation in the 2019 EQR. Further, one Appeal file reviewed in the 2020 EQR had no evidence staff took steps to protect the enrollee's PHI.

Corrective Action

- Revise the Grievance Process and Scope procedure to ensure the 90-day Grievance resolution timeframe is applied to all types of Grievances, not just provider-related Grievances.
- Ensure the process required by *42 CFR § 438.408 (c)* is documented in the Grievance procedure to reflect all Grievances may be extended by Trillium.
- Ensure the process required by *42 CFR § 438.408 (c)* is documented in the Complaint procedure to reflect all complaints may be extended by Trillium.
- Detail in the Appeal procedure the process staff follow when releasing the Appeals record or reference the Member Access to Protected Health Information procedure in the Medicaid Clinical Reconsideration Process procedure.

Recommendations

- Include in the Grievance Process and Scope procedure how and where consultations with the Chief Medical Officer and other members of the Executive Team are captured within Grievance files.
- Revise the *Provider Manual* and the *Member and Family Handbook* to clarify that any written request can initiate the Appeal process.
- Revise the *Member and Family* Handbook to consistently state that enrollees have 60 days from the mailing date of the Adverse Benefit Determination notification to request an Appeal.

- Add to the *Provider Manual* and the *Member* and *Family Handbook* that Trillium is required to notify the enrollee of their right to file a Grievance if Trillium extends the Appeal resolution timeframe.

- Monitor all Appeal notifications to ensure required contractual language is not deleted through the automation process.

F. Program Integrity

The Program Integrity (PI) EQR involves an assessment of Trillium's compliance with federal and state regulations regarding PI functions. A Desk Review of Trillium's documentation was conducted and included review of Trillium's policies, procedures, training materials, Organizational Charts, job descriptions, committee meeting minutes and reports, provider agreements, enrollment application, PI workflows, *Provider Manual*, *Employee Handbook*, newsletters, conflict of interest forms, and Trillium's Compliance Plan. Additionally, 15 PI files were selected from the period of October 1, 2019 through September 30, 2020. The Onsite interviews were conducted to discuss the findings within the Desk Materials and PI files.

In the 2019 EQR, Trillium met 100% of the PI EQR standards, and three Recommendations were issued. Based on the 2019 PI file review, it was recommended Trillium develop an executive summary to capture required and key elements within each PI file. This executive summary would capture 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 with practical knowledge of the working of the relevant programs, and an estimated or actual dollar value of funds exposed. The remaining two Recommendations in the 2019 PI EQR targeted missing information within Trillium's PI procedures related to *NC Medicaid Contract*, *Sections 14.3.4* and *14.3.5*.

In the 2020 EQR, it was evident that Trillium did not implement any of the 2019 Recommendations. However, Trillium did find alternative ways to address two of the three 2019 EQR findings. Fifteen PI files were thoroughly reviewed to ensure Trillium investigates all allegations of fraud and provides NC Medicaid's Investigations Unit with required information for credible allegations of fraud on a NC Medicaid-approved template. While Trillium did not develop an executive summary to accompany each file, the file review showed all 15 PI files met all applicable requirements, including the issues identified in the 2019 EQR.

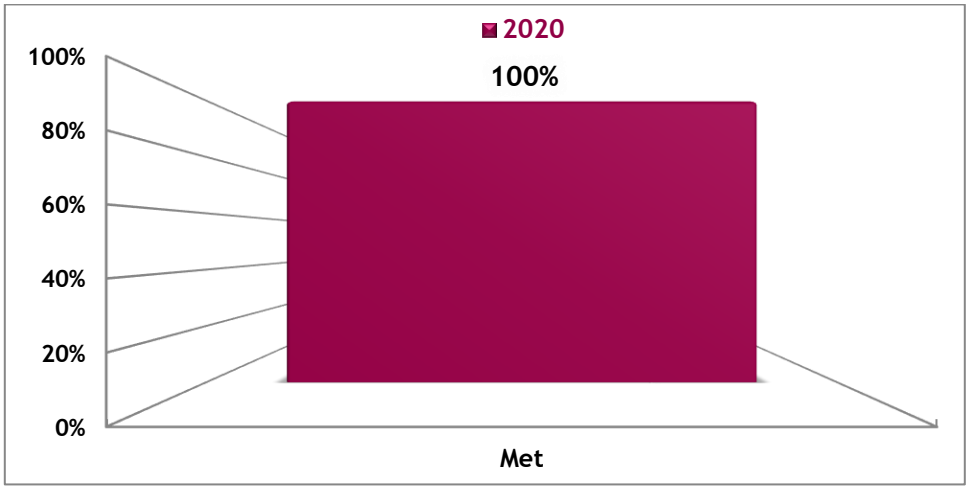
While the 2019 PI Recommendation that targeted missing *NC Medicaid Contract, Section 14.3.4* language from Trillium procedures was not addressed, Trillium did add language to a desktop manual. The prohibited actions and requirement of written approval from NC Medicaid regarding provider sanctions is outlined in the *Desktop Protocol Investigations of FWA*.

The third 2019 PI Recommendation that targeted missing *NC Medicaid Contract, Section 14.3.5* language from Trillium procedures was not addressed. Further, no alternative Trillium documentation captures the contractual requirement. *NC Medicaid Contract, Sections 14.3.5* 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 *NCGS 108C-5*, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery."

This 2019 Recommendation is particularly relevant to Trillium as the State reported previous issues with Trillium regarding the recovery of funds process. CCME again recommends that Trillium specify in a procedure the process and contractual requirements of Trillium related to *NC Medicaid Contract, Section 14.3.5.*

Figure 7 demonstrates that Trillium met all of the Program Integrity standards in this year's EQR.

Figure 7: Program Integrity Findings



Strengths

- Trillium's Annual Compliance Plan includes detailed metrics on the prior year PI activities.
- Trillium was able to support its Provider Network Team while carrying out Special Investigative Unit (SIU) functions during the COVID-19 interruption.

Weaknesses

- There is no policy or procedure in place to address *NC Medicaid Contract, Section 14.3.5,* and the State reported previous issues with Trillium regarding the recovery of funds process.

Recommendations

- Add specific language to procedures describing the collection of provider funds process, when instructed in writing by NC Medicaid. See *NC Medicaid contract, Section 14.3.5.*

G. Encounter Data Validation

The scope of the Encounter Data Validation is guided by the CMS Encounter Data Validation Protocol and focused on measuring the data quality and completeness of claims paid by Trillium for the period of January 2019 through December 2019. North Carolina Senate Bill 371 requires that each LME/MCO 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 LME/MCO capitation rates, measuring the quality of services managed by LME/MCOs, assuring compliance with State and federal regulations, and for oversight and audit functions." All claims paid by Trillium should be submitted and accepted as a valid encounter to NC Medicaid. The approach to the review included:

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

Results and Recommendations

Issue: Additional Diagnosis Codes

Other Diagnosis codes were populated less than 17% of the time for Professional claims. This is a slight improvement compared to 13% that was seen on 2018 dates of service. The absence of Other Diagnosis codes does not appear to be a mapping issue within Trillium, but likely driven by some providers' not coding beyond the Primary Diagnosis code. This value is not required by Trillium when adjudicating the claim, therefore, certain providers may not be submitting Other Diagnosis codes even in cases where they are present when submitting claims via Provider Web Portal or 837P.

Recommendation

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, it was concluded that the data submitted to NC Medicaid is complete and accurate as defined by NC Medicaid standards.

There is a minor issue with the Other Diagnosis codes that Trillium should review and perform outreach to provider who submit only the Primary Diagnosis codes. Overall, Trillium has corrected all other issues previously identified in the 2016, 2017, and 2018 encounter data validation reports and made significant strides in ensuring that they are submitting complete and accurate data to NC Medicaid.

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

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: 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

November 2, 2020

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

Dear Ms. Wainwright,

At the request of the North Carolina Medicaid (NC Medicaid) this letter serves as notification that the 2020 External Quality Review (EQR) of Trillium Health Resources (Trillium) is being initiated. The review will be conducted by us, The Carolinas Center for Medical Excellence (CCME), and is a contractual requirement. The review will include both a Desk Review (at CCME) and a one-day, virtual Onsite that will address contractually required services.

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

The CMS EQR protocols can be found at:

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

Due to COVID-19 and the issuance of the contractual flexibilities issued by the State outlined in Contract Amendment #9, the 2020 EQR will be a focused review. The focus of this review will be on the Corrective Actions from the previous EQR and Trillium functions that impact enrollee health and safety. Similarly, for the 2020 EQR, the two day Onsite previously performed at PIHP offices will conducted during a one day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **April 8, 2021**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

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

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

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

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 5

Cc: Kim Huneycutt, PIHP Contract Manager
Tasha Griffin, NC Medicaid Contract Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager
Hope Newsome, NC Medicaid Quality Management Specialist

Focused External Quality Review 2020

MATERIALS REQUESTED FOR DESK REVIEW

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

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

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

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

16. Information regarding the following selected Performance Measures:

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

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

Required information includes the following for each measure:

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

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

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

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

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

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

        B. Other:
            1. All PSVs conducted during the current process, including current supervision contracts for all LPAs and all provisionally-licensed practitioners (*i.e.*, LCAS-A, LCSW-A).
            2. Ownership disclosure information/form (For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file).

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

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

A. Insurance:

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

B. Other:

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

19. a. By November 6, 2020, submit a copy of the complete listing of Program Integrity case files active during October 2019 through September 2020. On this list, provide the following for each case file:
    i. Date case opened
    ii. Source of referral
    iii. Category of case (enrollee, provider, subcontractor)
    iv. Current status of the case (opened, closed)
    b. Program Integrity Plan and/or Compliance Plan.
    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.
    e. All 'Attachment Y' reports collected during the review period.
    f. All 'Attachment Z' reports collected during the review period.
    g. Provider Manual and Provider Application.
    h. Enrollee Handbook
    i. Subcontractor Agreement/Contract Template.
    j. Training and educational materials for the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
    k. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse.

l. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors, and employees.
m. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other State or Federal agency.
n. Code of Ethics and Business Conduct.
o. Internal and/or external monitoring and auditing materials.
p. Materials pertaining to how the PIHP captures and tracks complaints.
q. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
    i. NC Medicaid approved reporting templates.
r. Sample Data Mining Reports.
s. NC Medicaid Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
t. Monthly reports of NCID holders/FAMS-users in PIHP.
u. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
v. Corrective action plans including any relevant follow-up documentation.
w. Policies/Procedures for:
    i. Program Integrity
    ii. HIPAA and Compliance
    iii. Internal and external monitoring and auditing
    iv. Annual ownership and financial disclosures
    v. Investigative Process
    vi. Detecting and preventing fraud
    vii. Employee Training
    viii. Collecting overpayments
    ix. Corrective Actions
    x. Reporting Requirements
    xi. Credentialing and Recredentialing Policies
    xii. Disciplinary Guidelines

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

Section	Question Number	Attachment
Enrollment Systems	1b	Enrollment system loading process
Enrollment Systems	1f	Enrollment loading error process reports
Enrollment Systems	1g	Enrollment loading completeness reports
Enrollment Systems	2c	Enrollment reporting system load process

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

c. A copy of the IT Disaster Recovery Plan.

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

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

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

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

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

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

B. Attachment 2: EQR Validation Worksheets

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

- Innovations (c Waiver) Performance Measures Validation Worksheet
  - Proportion of beneficiaries reporting their Care Coordinator helps them to know what Waiver services are available
  - Proportion of beneficiaries reporting they have a choice between providers
  - Percentage of Level 2 and 3 incidents reported within required timeframes
  - Percentage of beneficiaries who received appropriate medication
  - Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required

- Performance Improvement Project Validation Worksheet
  - Supermeasures SU
  - Supermeasures MH
  - ED Utilization
  - Utilization of MST
  - Monitoring of In-Reach Contacts for TCLI

CCME EQR PM Validation Worksheet

PIHP Name:	**Trillium**
Name of PM:	**Readmission Rates for Mental Health**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Trillium**
Name of PM:	**Readmission Rates for Substance Abuse**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Trillium**
Name of PM:	**Follow-up After Hospitalization for Mental Illness**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Trillium**
Name of PM:	**Follow-up After Hospitalization for Substance Abuse**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Trillium**
Name of PM:	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Trillium**
Name of PM:	**Mental Health Utilization- Inpatient Discharged and Average Length of Stay**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Trillium**
Name of PM:	**Mental Health Utilization**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Trillium**
Name of PM:	**Identification of Alcohol and Other Drug Services**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Trillium**
Name of PM:	**Substance Abuse Penetration Rate**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Trillium**
Name of PM:	**Mental Health Penetration Rate**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

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

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Trillium**
Name of PIP:	**SUPERMEASURES SU**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	For NC Medicaid, the follow up rate slightly declined in the last remeasurement, but it is still above the Trillium goal of 45%. The DMH rate also declined and remains below the State goal of 40%. The most recent DMH rate is 32.2%, a decrease from 36.1%. ***Recommendation: Continue with current active interventions and examine rate after review of internal process and protocols for scheduling are completed; data analysis for dually covered members is recommended to assess impact on the measure.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement in rate.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Trillium**
Name of PIP:	**SUPERMEASURES MH**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	For NC Medicaid, the follow up rate slightly declined in the last remeasurement, but it still above the State goal of 40%; NC Medicaid is below the Trillium goal rate of 45% at 44.2%. The DMH rate also declined and remains below the State goal of 40%. The most recent DMH rate is 19.0%, a decrease from 27.2%. ***Recommendation: Similar to the SU PIP, continue with current active interventions and examine rate after review of internal process and protocols for scheduling are completed; data analysis for dually covered members is recommended to assess impact on the measure.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement in rate.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Trillium**
Name of PIP:	**ED UTILIZATION**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	For measure #1, rate decreased from .69 to .59, which is improvement; measure #2 improved from 77.42 to 77.46, which is improvement; measure #3 declined from 9.47 to 7.28, which is improvement.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be result of interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Trillium**
Name of PIP:	**MST UTILIZATION**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Rate was 9.04% at baseline and declined to 3.7% at the latest measurement period. ***Recommendation: Identify and implement a plan to determine if family refusal can be mitigated; continue working on improving access; continue interventions of childcare coordinator training and education for families, schools, and DSS.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement in rate.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Trillium**
Name of PIP:	**MONITORING OF IN-REACH CONTACTS FOR TCLI – TCLI 90-DAY CONTACT**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Monthly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several months.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Goal is 98%. The last 3 remeasurements have met the goal rate, at 98.47%, 98.83%, and 98.58% for September 2020, which is the last documented rate.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to interventions as rate improved and remained above the goal rate.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**MET**	Goal rate has been sustained for the last 3 remeasurement periods. Only June 2020's rate was below the goal since April 2020.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**84**
Project Possible Score	**84**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

C. Attachment 3: Tabular Spreadsheet

CCME PIHP Data Collection Tool

PIHP Name:	Trillium Health Resources
Collection Date:	2020

I. Information Systems Capabilities Assessment (ISCA)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I A. Management Information Systems						
1. Enrollment Systems						
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Trillium has standard processes in place for enrollment data updates and uploads the daily and quarterly Global Eligibility File (GEF) files to the Trillium Business System (TBS) enrollment system. Trillium uses the monthly 820 capitation file to reconcile the Medicaid eligibility with payment received every month. Trillium also uses the 820 file to determine member months in their financial reporting to the State. Demographic data is captured in the TBS system, and patients' IDs are unique to members. Historical enrollment information is captured and maintained for all members.
1.2 The MCO is able to identify and review any errors identified during, or as a result, of the State enrollment file load process.	X					Trillium produces an enrollment exception report to verify the completeness of the GEF load.
1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.	X					During the Onsite, Trillium demonstrated the TBS enrollment screens and their capability to store the demographic information. All historical data for members is stored and merged under one member ID.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Claims System						
2.1 The MCO processes provider claims in an accurate and timely fashion.	X					For 2019, approximately 98.81% of the Institutional and 99.83% of Professional claims are auto-adjudicated. All Trillium claims are processed through TBS' claims adjudication system. On an average, Trillium claims are adjudicated to determine if the claim is approved, pended, or denied and paid within 7.18 days of approval. If a required field is missing from a claim, the provider portal will not allow the claim to be submitted to Trillium. If the claim is being submitted electronically via an electronic 837 file and one or more required fields are missing, the provider will receive a HIPAA 999 response file advising the provider of the claim submission failure. Trillium claims processors do not change any information on the claims.
2.2 The MCO has processes and procedures in place to monitor review and audit claims staff.	X					Trillium conducts daily, weekly, monthly, and quarterly audits of claims processed. Trillium audits a random sample 3% of all claims adjudicated daily.
2.3 The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	X					Trillium indicated in their ISCA response that 41 Institutional ICD-10 Diagnosis codes and 12 ICD-10 Diagnosis codes are captured for Professional claims on the provider web portal. ICD-10 Procedure codes and Diagnosis Related Group (DRG) codes received from the provider can be captured. However, currently Trillium does not receive ICD-10 Procedure codes on claims from providers. ***Recommendation: Work with the providers to increase the number of ICD-10 Procedure codes submitted on a claim.***
2.4 The MCO's claim system screens store and track claim information and claim adjudication/payment information.	X					Onsite review of the claims system screens identified the capture of adjudication/payment information for the claims.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Reporting						
3.1 The MCO's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Trillium captures all necessary data elements required for enrollment and claims reporting.
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. Trillium copies the full backup file to a repository where backup files for the past 30 days are archived for protection against accidental deletion and ransomware attacks.
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's encounter data submission process allows all ICD-10 Diagnosis codes for Institutional and Professional encounters to be submitted to NCTracks. Trillium's encounter data submission process allows for the ICD-10 Procedure codes received on an Institutional claim to be submitted to NCTracks. DRG codes are captured in the TBS system but are not included for encounter data submissions. ***Recommendation: Update Trillium's encounter data submission process to submit DRG codes on Institutional encounter data extracts to NCTracks.***
4.2 The MCO has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					Trillium uses the 835 encounter response file to identify and reconcile encounter data denials. Denied encounters are worked on by the appropriate department for investigation and correction.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.3 MCO has policies and procedures in place to reconcile and resubmit encounter data denied by NC Medicaid.	X					Trillium's IT Department categorizes the denied encounters based on the denial code and forwards the denied encounter to the appropriate functional area for correction and resubmission. Trillium has an encounter data acceptance rate of 99.9%. There are approximately 418,439 encounters that have not yet been submitted to NCTracks. In a follow-up after the Onsite, Trillium confirmed that this issue has not yet been resolved. This was a Recommendation from the past two audit years. ***Recommendation: Work with NC Medicaid to submit the historical encounters.***
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					Communication has been established between the various departments to address the encounter denials, correct the issues, and resubmit the encounter to NCTracks.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II A. Credentialing and Recredentialing						
1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					The *Credentialing Committee By-Laws* and several policies and procedures, including the Credentialing and Re-credentialing Process procedure, guide the credentialing and recredentialing processes.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	X					The *Credentialing Committee By-Laws* define the responsibilities of the Credentialing Committee. The Credentialing and Re-credentialing Process procedure states the "Credentialing Committee is a peer-review body comprised of a diverse group of providers/practitioners that range in multiple specialties across the provider network." The procedure delegates to the Chief Medical Officer the authority for approval of "clean" applications and defines "red-flagged" applications, which are to be reviewed by the Credentialing Committee. The Credentialing Committee meeting minutes indicate which members are "voting" members, which members are present, and the outcome of votes cast. The meeting notes contain evidence of the committee discussion and decision-making.
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Credentialing files reviewed for the EQR were organized and contained appropriate information. CCME identified the following issues in the file review:
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
3.1.3 Valid DEA certificate; and/or CDS certificate	X					
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.8 Query of the National Practitioner Data Bank (NPDB) ;	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); and query of the State Exclusion List;	X					
3.1.10 Query for the System for Awards Management (SAM);	X					
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	X					
3.1.14 Names of hospitals at which the physician has admitting privileges, if any	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.15 Ownership Disclosure is addressed.	X					Two of the four submitted practitioner credentialing files did not contain Ownership Disclosure information identifying the owner or managing employees. Upon request, Trillium submitted this information, taken from the agency files. ***Recommendation: Ensure credentialing files include Ownership Disclosure information, in addition to the disclosure regarding ownership of "5% or more in the organizations that bill Medicaid for services." See NC Medicaid Contract, Attachment O and Section 1.13 and Section 1.14. As noted on the Desk Review Materials list, "For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file."***
3.1.16 Criminal background Check	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files reviewed for the EQR were organized and contained appropriate information. CCME identified the following issues in the file review:
4.1 Recredentialing every three years;	X					The Trillium Credentialing and Re-credentialing Process procedure states, "Trillium will work with practitioners and providers to be re-credentialed within 3 years of the date of the approval of initial credentialing or the most recent re- credentialing date."
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
4.2.3 Valid DEA certificate; and/or CDS certificate	X					
4.2.4 Board certification if claimed by the applicant;	X					
4.2.5 Malpractice claims since the previous credentialing event;	X					
4.2.6 Practitioner attestation statement;	X					
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event; and query of the State Exclusion List;	X					
4.2.9 Requery of the SAM.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (OIG LEIE);	X					
4.2.11 Requery of the Social Security Administration's Death Master File	X					
4.2.12 Requery of the NPPES;	X					
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					
4.2.14 Ownership Disclosure is addressed.	X					Two of the four submitted practitioner recredentialing files did not contain Ownership Disclosure information identifying the owner or managing employees. Upon request, Trillium submitted this information, taken from the agency files. ***Recommendation: Ensure recredentialing files include Ownership Disclosure information, in addition to the disclosure regarding ownership of "5% or more in the organizations that bill Medicaid for services." See NC Medicaid Contract, Attachment O and Section 1.13 and Section 1.14. As noted on the Desk Review Materials list, "For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file."***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					Trillium uses their *Verification of Provider Standing* (*VPS*) form to document provider performance for consideration at recredentialing. *VPS* forms were mentioned regarding at least one file in each of the submitted Credentialing Committee meeting minutes, and completed *VPS* forms were in all submitted re-credentialing files.
5. The PIHP formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the PIHP for serious quality of care or service issues.	X					The *Credentialing and Re-credentialing Process* procedure states "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).
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					

III. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III. Quality Improvement						
III. A Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					
III. B Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					A total of five PIPs were submitted and all five were validated according to the CMS Protocol.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					The five validated PIPs scored in the High Confidence range, although three PIPs had errors, and CCME provided Recommendations for improvement. The errors and Recommendations all were in the area of documented, quantitative improvement in processes or outcomes of care, and included: The rate was 9.04% at baseline and declined to 3.7% at the latest measurement period for the MST Utilization PIP. ***Recommendation: Identify and implement a plan to determine if family refusal can be mitigated; continue working on improving access; continue interventions of childcare coordinator training and education for families, schools, and DSS for the MST Utilization PIP.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						For the Supermeasures MH PIP, the follow up rate slightly declined for NC Medicaid in the last remeasurement, but it is still above the State goal of 40%; NC Medicaid is below the Trillium goal rate of 45% at 44.2%. The DMH rate also declined and remains below the State goal of 40%. The most recent rate for DMH is 19.0%, a decrease from 27.2%. ***Recommendation: Continue with current active interventions and examine rate after review of internal process and protocols for scheduling are completed; data analysis for dually covered members is recommended to assess the impact on the measure for the Supermeasures MH PIP.*** For the Supermeasures SU PIP, the follow up rate slightly declined for NC Medicaid in the last remeasurement, but it is still above the Trillium goal of 45%. The DMH rate also declined and remains below the State goal of 40%. The most recent DMH rate is 32.2%, a decrease from 36.1%. ***Recommendation: Continue with current active interventions and examine rate after review of internal process and protocols for scheduling are completed; data analysis for dually covered members is recommended to assess the impact on the measure for the Supermeasures SU PIP.***

VI. Care Coordination

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. A Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					During the last EQR, it was recommended that Trillium add information regarding the implementation of the Care Management platform Incedo. This recommendation was implemented.
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					Trillium has a procedure in place for Complex Case Management that outlines the program's eligibility requirements. The procedure lists the age for Children with Complex Needs as 0-21 years. However, *NC Medicaid Contract, Section 6.11.3 (c), g,* lists the age for Children with MH, I/DD and other Complex Needs as 5 and under 21 years. ***Recommendation: Update the procedure for Complex Case Management to reflect the age requirement listed in NC Medicaid Contract, Section 6.11.3 (c), g, for Children with Complex Needs.***
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.5 Quality monitoring and continuous quality improvement;	X					Trillium has a Care Management monitoring plan in place for I/DD/MH/SUD/TCLI that reviews the quality of support delivered by the Care Manager. A process is in place to provide supervision at scheduled intervals to each Care Manager. During supervision, the completeness of tasks and documentation are reviewed within the Incedo platform. Reports derived from Incedo are used during supervision to show the Care Manager what their progress is regarding task completion. The monitoring plans do not include internal performance measures for core tasks completed by the Care Managers. During the Onsite, Trillium was unable to provide percentages used for benchmarks that measure Care Managers' completion of tasks such as member contacts, ISPs development, and progress notes submission. ***Recommendation: Revise the current monitoring plans for I/DD/MH/SUD/TCLI to implement a data-driven process that identifies the frequency of Care Manager contacts, departmental benchmarks for compliance, and how and when outcomes of member contacts are captured, reviewed, and reported.***
2.6 Determination of which Behavioral Health Services are medically necessary;	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					
2.8 Coordinate care with each Enrollee's provider;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.9 Provide follow-up activities for Enrollees;	X					
2.10 Ensure privacy for each Enrollee is protected.	X					
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					The *I/DD Innovations Care Management Monitoring Plan* does not include the requirement that members participating in residential programs receive monthly face-to-face contact with the Care Manager. *NC Medicaid Contract, Section 6.11.3 (h)* and *NC Clinical Coverage Policy 8P* requires monthly face-to-face contact with the Care Manager for members who receive residential supports. Furthermore, the PIHP states that Home and Community Based Services (HCBS), including residential services, occur quarterly. This is not in compliance with *North Carolina Department of Health and Human Services (NCDHHS) Home and Community Based Services Final Rule Transition Plan,* which denotes face-to-face contact and documentation of residential monitoring to occur monthly. ***Recommendation: Revise the I/DD Monitoring Plan to reflect the service delivery monitoring requirements for residential services as outlined in NC Medicaid Contract, Section 6.11.3 (h) and NC Clinical Coverage Policy 8P.***
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					The review of MH/SUD Care Coordination files shows that Trillium's Care Management policies and procedures are being followed regarding documentation expectations. The review of I/DD files found non-compliance in the monitoring of HCBS for two members who received residential supports. *NC*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Medicaid Contract, Section 6.11.3 (h) and *NC Clinical Coverage Policy 8P* require monthly face-to-face contact by Care management staff for members who receive residential supports. The review found a pattern of quarterly contacts instead of monthly. Likewise, this finding was further supported by review of the *HCBS Monitoring Check Sheet*. The review of *HCBS Monitoring Check Sheet* confirmed quarterly monitoring of I/DD members who received residential supports. *The North Carolina Department of Health and Human Services (NCDHHS) Home and Community Based Services Final Rule Transition Plan,* requires face-to-face contact and documentation of residential monitoring to occur monthly instead of quarterly. ***Recommendation: Document and implement a process that routinely reviews I/DD Care Manager contacts to ensure members participating in residential supports receive monthly, face-to-face contacts. Include in this process a routine review of the HCBS Monitoring Check Sheets for compliance with NC Medicaid Contract, Section 6.11.3.h., NC Clinical Coverage Policy 8P and NCDHHS HCBS Final Rule Transition Plan.***
IV. B Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.1 Care Coordination activities occur, as required.	X					
2.2 Person Centered Plans are developed as required.	X					
2.3 Assertive Community Treatment, Peer Support, Supported Employment, Community Support Team, Psychosocial Rehabilitation, and other services as set forth in the DOJ Settlement are included in the individual's transition, if applicable.	X					
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					Trillium has a mechanism in place to provide one-time transitional support.
2.5 QOL Surveys are administered timely.	X					
3. Transition, diversion and discharge processes are in place for TCLI members as outlined in the DOJ Settlement and *DHHS Contract*.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.	X					
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					Trillium's website contains relevant information regarding the TCLI Communications Plan.
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					The review of TCLI files found 7% of progress notes were submitted outside of Trillium's required 72-hour timeframe. Some progress notes were more than 13 months late. ***Recommendation: Document and implement a process that routinely reviews TCLI Care Managers' progress notes to ensure this documentation is in compliance with the TCLI Care Management Monitoring Plan.***

VI. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee Grievances in a manner consistent with contract requirements, including, but not limited to:	X					The Grievance Process and Scope procedure is the primary procedure that guides staff through the Grievance functions and requirements. The Complaint Process and Scope procedure is the primary procedure that guides staff through the Complaint functions and requirements.
1.1 Definition of a Grievance and who may file a Grievance;	X					Trillium defines a Grievance as, "any expression(s) of dissatisfaction about any matter other than an Adverse Benefit Determination filed by a member or by an individual who has been authorized in writing to file on behalf of a member." Trillium defines a Complaint as, "any expression of dissatisfaction this organization or a provider when communicated by an external provider, stakeholder/organization, or family member who does not have written consent to file a Grievance on a member's behalf. Concerns filed about Trillium Health Resources by a member, guardian, or a member's authorized representative (with written authorization) do not fall within the scope of this procedure (Reference Grievance Process and Scope Procedure)."
1.2 The procedure for filing and handling a Grievance;	X					
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract;		X				In the 2019 EQR, CCME recommended that Trillium bolster the language within the Grievance Process and Scope procedure. Specifically, there was need for additional language around the resolution timeframe for Grievances and the required notifications when Trillium extends the Grievance resolution timeframe. Trillium did not address these Recommendations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						NC Medicaid Contract, Attachment M, Section C requires that PIHPs resolve all Grievances and provide notice of resolution within 90 calendar days. The timeliness guideline for resolution of a Grievance is in Trillium's Grievance Process and Scope procedure but only regarding provider-related Grievances. Further, information within the procedure regarding extensions by Trillium to the Grievance resolution timeframe is also only under provider-related Grievances and does not include the notifications required by *42 CFR § 438.408 (c)*. The required notifications are: • Make reasonable efforts to give the enrollee prompt oral notice of the delay. • Within two calendar days give the enrollee written notice of the reason for the decision to extend the timeframe • Inform the enrollee of the right to file a Grievance if he or she disagrees with that decision. Additionally, there is no language in the Complaint Process and Scope procedure regarding extensions to the Complaint resolution timeframe. The extension process is required by *42 CFR § 438.408 (c)*. ***Corrective Action: Revise the Grievance Process and Scope procedure to ensure the 90 day Grievance resolution timeframe required by NC Medicaid Contract, Attachment M, Section C, is applied to all types of Grievances, not just provider Grievances.*** ***Ensure the process required by 42 CFR § 438.408 (c) is documented in the Grievance procedure to reflect all Grievances may be extended by Trillium. Revise the procedure to include the required notifications when Trillium extends the Grievance resolution timeframe:*** • ***Make reasonable efforts to give the enrollee prompt oral notice of the delay.*** • ***Within two calendar days give the enrollee written notice of the reason for the decision to extend the timeframe.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						• *Inform the enrollee of the right to file a Grievance if he or she disagrees with that decision.* *Revise the Complaint Process and Scope procedure to define the process by which Trillium extends the Complaint resolution timeframe, as required by 42 CFR § 438.408 (c), including that Trillium may extend the complaint resolution timeframe up to 14 calendar days if:* • *The enrollee requests the extension.* • *Trillium shows (to the satisfaction of NC Medicaid, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.* • *Trillium extends the complaint resolution timeframes, Trillium will:* ○ *Make reasonable efforts to give the enrollee prompt oral notice of the delay.* ○ *Within two calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if he or she disagrees with that decision.*
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 "if it is determined at the time of receipt of the Grievance that there is a potential health and safety component or significant clinical issue, then Trillium's Chief Medical Officer and other members of the Executive Team will be promptly notified by the person who received the Grievance. The Chief Medical Officer will provide consultation and direction to the staff in how to proceed with the investigative process." There is, however, no guidance in the Grievance procedure regarding how and where these consultations and their outcomes are to be documented within the Grievance file. This was a Recommendation from the 2019 EQR and is again

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						recommended in this 2020 EQR to ensure consultations are consistently captured within the Grievance files. ***Recommendation: Include in the Grievance Process and Scope procedure how and where consultations with the Chief Medical Officer and other members of the Executive Team are 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					Trillium's Grievance Process and Scope procedure states, "Trillium must provide for the retention of Grievance records for 10 years following a final decision", which exceeds the five-year timeframe required by the *NC Medicaid Contract, Attachment M, Section B.2.*
2. The PIHP applies the Grievance policy and procedure as formulated.	X					In the 2020 EQR, it was noted that Trillium resolved all Grievances within the 90-day timeframe required by *NC Medicaid Contract*, *Attachment M* and *42 CFR § 438.408 (b)(1).* In the 2019 EQR, a Recommendation was issued to ensure Grievance Resolution notifications provide detailed and concise information to demonstrate to grievants their concerns were adequately considered and thoroughly resolved. In the 2020 EQR Grievance file review, the Grievance Resolution notifications provided to Grievants include adequate details of the resolution process and resolution.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider Appeals of an Adverse Benefit Determination by the PIHP in a manner consistent with contract requirements, including:	X					Trillium's procedure, Medicaid Clinical Reconsideration Process, is the primary procedure governing the Appeal process.
1.1 The definitions an Appeal and who may file an Appeal;	X					
1.2 The procedure for filing an Appeal;	X					In the 2019 EQR, it was recommended that Trillium add to the *Trillium Provider Manual* under the *Medicaid Services Appeal - Level 1* section, that Trillium sends an acknowledgement letter whenever an Appeal is received. This Recommendation was implemented by Trillium and is now evident in the current *Provider Manual Revised October 2020 (Provider Manual)*. It was also noted in the 2020 EQR that the *Provider Manual* (on page 65) states, "to request Reconsideration, the member/guardian/authorized representative and/or the provider (acting with written consent) must complete and return the Trillium Reconsideration Review form." This was also noted on page 85 and 86 of the *Member and Family Handbook Revised January 2020 (Member and Family Handbook)*. This is more restrictive than language within the *NC Medicaid Contract, Attachment M,* and federal regulations. ***Recommendation: Revise the Provider Manual and the Member and Family Handbook to clarify that any written request can initiate the Appeal process.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						On page 86 of the *Member and Family Handbook*, it states in three places that the enrollee has 30 days from the mailing date of the Adverse Benefit Determination notification to file an Appeal. The timeframe allowed for filing Appeals is 60 days from the date of the Adverse Benefit Determination notification. The procedure, Medicaid Clinical Reconsideration Process, is correct and directs staff appropriately. This timeframe is outlined in the *NC Medicaid Contract, Attachment M, Section G.2, 42 CFR § 438.402 (c)ii,* and Trillium's procedures. This was a Recommendation issued in the 2019 EQR that was not addressed. ***Recommendation: Revise the Member and Family Handbook to clearly state that enrollees have 60 days from the mailing date of the Adverse Benefit Determination notification to request an Appeal.***
1.3 Review of any Appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited Appeal where the life or health of the enrollee would be jeopardized by delay;	X					In the 2019 EQR, CCME recommended Trillium add to the procedure, Medicaid Clinical Reconsideration Process, the requirement of Trillium to inform enrollees of their right to file a Grievance if Trillium denies a request to expedite an Appeal. This is required by *42 CFR § 438.410 (c)*. Trillium implemented this 2019 Recommendation, and this information is located on page 3 of the Appeal procedure.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.5 Timeliness guidelines for resolution of the Appeal as specified in the contract;	X					Neither the *Provider Manual* (page 66) nor the *Member and Family Handbook* (page 89) explains that Trillium is required to notify the enrollee of their right to file a Grievance if Trillium extends the Appeal resolution timeframe. This was a Recommendation from the 2019 EQR that was not addressed. ***Recommendation: Add to the Provider Manual and the Member and Family Handbook that Trillium is required to notify the enrollee of their right to file a Grievance if Trillium extends the Appeal resolution timeframe.***
1.6 Written notice of the Appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The PIHP applies the Appeal policies and procedures as formulated.	X					In the 2019 EQR of the Appeal files, it was noted that acknowledgement notifications of expedited Appeals were unclear regarding the timeframe for resolution of expedited Appeals. Trillium implemented this Recommendation, and the expedited Appeal acknowledgment notification now clearly states the Appeal will be resolved in 72 hours. Also, in the 2019 EQR of the Appeal files, CCME recommended Trillium ensure that enrollees are notified of their right to file a Grievance when Trillium denied a request to expedite an Appeal.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						In the 2020 EQR of the Appeal files, there was evidence in two of the three Appeal files where Trillium denied the expedited that the enrollee was notified of their right to file a Grievance regarding Trillium's denial. In the two files where the enrollee was notified of their right to file a Grievance, notification was provided in the written acknowledgement. During the Onsite, staff explained the template was revised and formally approved before January 2020, and the one denied expedited Appeal file did not include notification to the appellant of the right to file a Grievance within the written acknowledgement letter. Staff reported this was due to some language deleted from the letter with automation efforts at Trillium. Recent expedited Appeal files were requested, but none were available beyond the three files reviewed during the Desk Review. ***Recommendation: Monitor all Appeal notifications to ensure required contractual language is not deleted through the automation process.***
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					The 2019 EQR had a Recommendation to analyze the Appeals data and present this data to the QI Committee for review and discussion. CCME recommended Trillium look for meaningful data that could identify potential quality improvement opportunities. Trillium explained at the Onsite they have implemented the Recommendation with monthly meetings to discuss Appeals data and are implementing an automated Appeals system to make it easier to connect the Adverse Benefit Determination notifications with the Appeal data. This data is reported to the Quality Improvement Committee. They plan to analyze trends over time but need to collect more data over a longer period.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.			X			In the 2019 EQR, CCME recommended Trillium detail in the Appeal procedure the process staff follow when releasing the Appeal record or reference the Member Access to Protected Health Information procedure in the Medicaid Clinical Reconsideration Process procedure. This was to ensure the enrollee's protected health information (PHI) was released in accordance with Trillium's Member Access to Protected Health Information procedure. In the 2020 EQR, it was evident that Trillium did not implement this Recommendation as the Appeal procedure still provided no guidance to staff regarding the release of the Appeal record. Further, in the one file where the Appeal record was released there was no evidence staff took steps to protect the enrollee's PHI. For example, there was no documentation showing guardianship was confirmed, no evidence the request for PHI was forwarded to the Medical Record Specialist, and no evidence any consideration was given to ensure steps protecting PHI when releasing the Appeal record, as is required by Trillium's Member Access to Protected Health Information procedure. As the Appeal record contains PHI and there are several State and federal regulations that should be considered prior to releasing the Appeal record, CCME has issued a Corrective Action to ensure the Trillium documents a process by which the enrollee's Appeal record is released in accordance with Member Access to Protected Health Information. ***Corrective Action: Detail in the Appeal procedure the process staff follow when releasing the Appeals record or reference the Member Access to Protected Health Information procedure in the Medicaid Clinical Reconsideration Process procedure.***

VI. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI A. General Requirements						
1. PIHP shall be familiar and comply with *Section 1902 (a)(68)* of the *Social Security Act*, *42 CFR § 438.455* and *1000* through *1008*, as applicable, including proper payments to providers and methods for detection of fraud and abuse.	X					Trillium's Compliance Plan addresses multiple federal regulation and *NC Medicaid Contract* requirements, including required content of Provider Agreements, investigations of allegations of fraud, waste, and abuse, proper provider payments, etc.
2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents', and subcontractors,' compliance with the requirements of this *Section 14* of the *NC Medicaid Contract*.	X					
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					
4. PIHP shall investigate all Grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with *42 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					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. PIHP shall establish and implement a special investigations or program integrity unit, however named, that is responsible for PIHP program integrity activities, including identification, detection, and prevention of fraud, waste, and abuse in the PIHP Closed Provider Network. PIHP shall identify an appropriately qualified contact for Program Integrity and Regulatory Compliance issues as mutually agreed upon by PIHP and NC Medicaid. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator. In addition, PIHP shall identify a primary point of contact within the Special Investigations Unit to receive and respond to data requests from MFCU/MID. The MFCU/ MID will copy the PIHP Contract Administrator on all such requests.	X					The establishment of an SIU and all of its functions as well as a designated contact is addressed in the Investigation of Suspected Fraud, Waste and/or Abuse procedure. There were no changes in key personnel within Trillium's Program Integrity (PI) Department.
4. PIHP shall participate in quarterly Program Integrity meetings with NC Medicaid Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. PIHP shall send staff to participate in monthly meetings with NC Medicaid Program Integrity staff either telephonically or in person, at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.	X					
6. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information	X					
7. Within seven (7) business days of a request by the Division, PIHP shall also make portions of the PIHP's Regulatory Compliance and Program Integrity minutes relating to Program Integrity issues available for review, but the PIHP may, redact other portions of the minutes not relating to Regulatory Compliance or Program Integrity issues.	X					Trillium sends un-redacted committee minutes to the State every month.
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	X					

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

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

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.3 In accordance with Attachment Y - Audits/Self-Audits/investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					Trillium's Claims Adjudication, Adjustments, Paybacks and Exceptions procedure outlines the process for Provider self-reporting.
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					
10.5 Process for handling self-audits and challenge audits.	X					
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. FAMS is cited as a source on multiple cases in the PI log.
10.7 Process for informing PIHP employees, subcontractors, and providers regarding the *False Claims Act.*	X					Trillium provided provider, employee, and community newsletters that discuss Fraud, Waste, and Abuse reporting.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.8 If PIHP makes or receives annual payments of at least $5,000,000, PIHP shall establish and maintain written policies for all employees, contractors, or agents that detail information about the *False Claims Act* and other federal and state laws as described in the *Social Security Act 1902(a)(66)*, including information about rights of employees to be protected as whistleblowers.	X					The process related to the False Claims Act and whistleblower protections is found in Trillium's Compliance Plan.
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					The use of EOBs for verification of services is found in Trillium's Member Explanation of Benefits: Detection of Fraud, Waste, and Abuse procedure. Trillium also provided a sample post-payment review tool.
10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available database or other search mechanism.	X					The process for obtaining provider financial information is found in the Trillium's Credentialing and Re-credentialing procedure.

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					The process for identifying overpayments and dispute resolutions is addressed in Trillium's Provider Sanctions procedure.
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					
13. In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						Based on the 2019 PI file review, it was recommended Trillium develop an executive summary to capture required and key elements within each PI file. This executive summary would capture 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 with practical knowledge of the working of the relevant programs, and an estimated or actual dollar value of funds exposed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						In the 2020 EQR, it was evident that Trillium did not implement any of the 2019 Recommendations. However, Trillium did find alternative ways to address two of the three 2019 EQR findings. Fifteen PI files were thoroughly reviewed to ensure Trillium investigates all allegations of fraud and provides NC Medicaid's Investigations Unit with required information for credible allegations of fraud on a NC Medicaid approved template. While Trillium did not develop an executive summary to accompany each file, the file review showed all 15 PI files met all applicable requirements, including the issues identified in the 2019 EQR.
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					
13.2 Source/origin of complaint;	X					
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					
13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated; and dates of suspected intentional misconduct;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					
13.6 All communications between PIHP and the Provider concerning the conduct at issue, when available.	X					
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					
13.8 Total Sample Amount of Funds Investigated per Service Type	X					
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 reviewed for this 2020 PI EQR. However, review of Trillium's procedures related to enrollee fraud showed adequate processes are in place.
14.1 The Enrollee's name, birth date, and Medicaid number;	X					
14.2 The source of the allegation;	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.11 Information on Biller/Owner;	X					
14.12 Additional Provider Locations that are related to the allegations;	X					
14.13 Legal and Administrative Status of Case.	X					
15. PIHP and NC Medicaid shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of State and Federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.	X					
16. PIHP shall use the NC Medicaid Fraud and Abuse Management System (FAMS) or a NC Medicaid approved alternative data mining technology solution to detect and prevent fraud, waste, and abuse in managed care.	X					Trillium is using FAMS and new data mining initiatives include identifying billing greater than 24 hours in a day. Trillium is exploring adding a report to identify billed services that are mutually excluded.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
18. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month or the next business day if the 10th day is a non-business day (i.e., weekend or State or PIHP holiday). In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to NC Medicaid Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59 p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to NC Medicaid Program Integrity all Network Provider contract terminations	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.						
VI C. Provider Payment Suspensions and Overpayments						
1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, NC Medicaid Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If NC Medicaid determines that a full investigation is warranted, NC Medicaid shall make a referral within five (5) business days of such determination to the MFCU/ MID and will suspend payments in accordance with *42 CFR § 455.23*. At least monthly, NC Medicaid shall provide written notification to PIHP of the status of each such referral. If MFCU/ MID indicates that suspension will not impact their investigation, NC Medicaid may send a payment suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates						All aspects of the Payment Suspension process are found in Trillium's Internal Communication about Provider Payment Suspension from DHB procedure.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						
1.1 In the circumstances described in *Section 14.3 (c)* above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.	X					
2. Upon receipt of a payment suspension notice from NC Medicaid Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of NC Medicaid Program Integrity's suspension and lasting until PIHP is notified by NC Medicaid Program Integrity in writing that the suspension has been lifted.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					The requirement to provide access and support to NC Medicaid regarding investigations is found in Trillium's Referral of Suspected Provider and Beneficiary Fraud to Division of Health Benefits procedure.
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid Program Integrity due to allegations of suspected fraud without prior written approval from NC Medicaid Program Integrity or the MFCU/MID. If PIHP takes administrative action, including issuing a Notice of Overpayment based on such fraud that precedes the submission date of a Division referral, the State will adjust the PIHP capitated payment in the amount of the original overpayment identified or One Thousand Dollars ($1,000) per case, whichever amount is greater.	X					While the 2019 PI Recommendation that targeted missing *NC Medicaid Contract, Section 14.3.4* language from Trillium procedures was not addressed, Trillium did add language to a desktop manual. The prohibited actions and requirement of written approval from NC Medicaid regarding provider Sanctions is outlined in the Desktop Protocol Investigations of FWA.

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with *NCGS 108C-5*, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.	X					In the 2020 EQR, it was noted a 2019 PI Recommendation targeted missing *NC Medicaid Contract, Section 14.3.5* language from Trillium procedures was not addressed. Further, no alternative Trillium documentation captures the contractual requirement. This 2019 Recommendation is particularly relevant to Trillium as the State reported previous issues with Trillium regarding the recovery of funds process. CCME again recommends that Trillium specify in a procedure the process and contractual requirements of Trillium related to *NC Medicaid Contract, Section 14.3.5*. ***Recommendation: Add specific language to procedures describing the collection of provider funds process, when instructed in writing by NC Medicaid. See NC Medicaid contract, Section 14.3.5.***

D. Attachment 4: Encounter Data Validation Report

Trillium Health Resources

Encounter Data Validation Report

performed on behalf of

North Carolina Medicaid

April 21, 2021

Prepared By:

hms

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

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Background

Health Management Systems (HMS) has completed a review of the encounter data submitted by Trillium Health Resources (Trillium) to North Carolina Medicaid (NC Medicaid) as specified in The Carolinas Center for Medical Excellence (CCME) agreement with NC Medicaid. CCME contracted with HMS to perform encounter data validation for each LME/MCO. North Carolina Senate Bill 371 requires that each LME/MCO 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 LME/MCO capitation rates, measuring the quality of services managed by LME/MCOs, assuring compliance with State and federal regulations, and for oversight and audit functions."

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

Overview

The scope of the review, guided by the CMS Encounter Data Validation Protocol, focused on measuring the data quality and completeness of claims paid and submitted to NC Medicaid by Trillium for the period of January 2019 through December 2019. All claims paid by Trillium are expected to be submitted and accepted as valid encounters by NC Medicaid. Our approach to the review included:

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

Review of Trillium's ISCA response

The review of Trillium’s ISCA response was focused on section V. Encounter Data Submission. NC Medicaid requires each LME/MCO 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 LME/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 LME/MCO.
The LME/MCO is required to resubmit encounters for claims that may be rejected due to compliance errors or NC Medicaid edits marked as "DENY" in Appendix 1.

Looking at claims with dates of service in 2019, Trillium submitted 1,119,305 unique encounters to the State. To date, 0.07% of all encounters submitted in 2019 have not been corrected and accepted by NC Medicaid. This figure represents an improvement in comparison to the 1.29% denial rate seen in 2018.

2019	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
Institutional	52,943	52,004	400	539	1.02%
Professional	1,066,362	1,065,922	240	200	0.02%
Total	1,119,305	1,117,926	640	739	0.07%

Each year, Trillium has made significant improvements to their encounter submission process, increasing their acceptance rate and quality of encounter data year over year. The table below reflects the increase in acceptance rate from 92% to 99.93% between 2017 and 2019, well above NC Medicaid's expectations. Trillium's very high acceptance rate in 2019 is even more notable when factoring in the increase in number of encounters over the past few years.

Year of Service	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
2017	874,434	735,008	70,931	68,495	7.83%
2018	949,025	919,907	16,897	12,221	1.29%
2019	1,119,305	1,117,926	640	739	0.07%

During the latest audit, Trillium provided an overview of the protocols they follow to submit encounter data and following up on the denials. Over the past few years, Trillium has implemented a highly efficient process for reviewing the denials and making the necessary changes to various parts of their information systems to prevent future encounter submissions from denying for the same denial reason. As the 2019 figures show, Trillium enacts such changes very rapidly and we believe much of that success is owed to the Trillium staff who coordinate well and act swiftly to review the denials, identify root cause issues, and implement changes to stem the issues that are flagged by NCTracks.

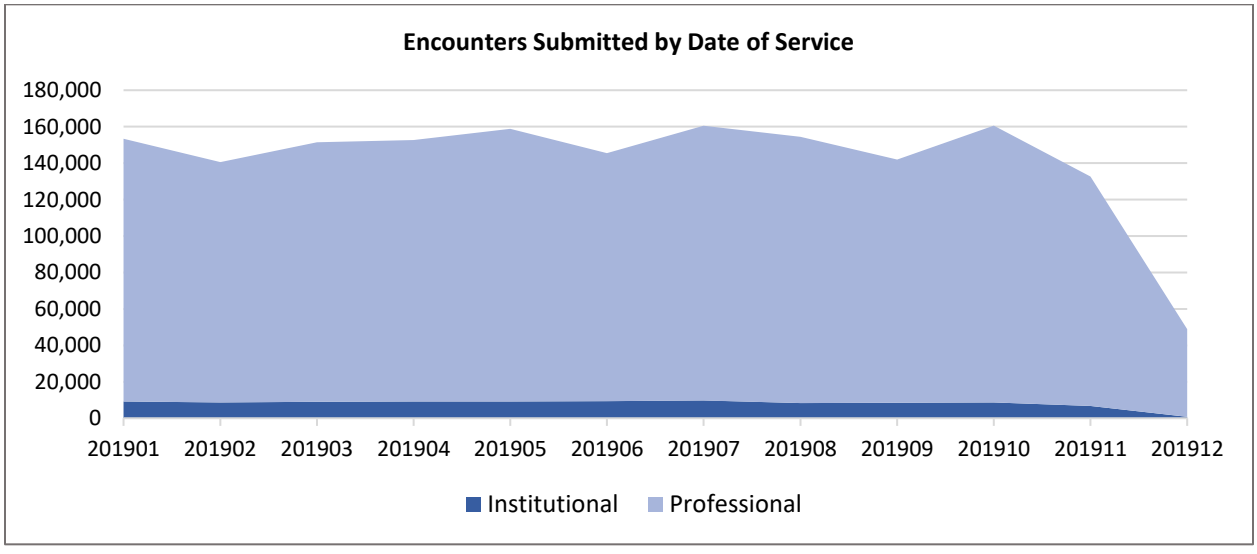
According to Trillium's response and the evaluation of the submitted encounter data, most of the outstanding and ongoing denials are related to invalid Taxonomy codes. In order to reduce the number of

denied encounters going forward, they are continuing to apply the following strategy laid out in prior reviews.

- Automate process for resending marked claims ready for resubmission
- Reviewing the denials and denial reasons to determine root cause issues
- Update claim edits to synchronize with NCTracks
- Enhance process to compare provider records based on Global Provider File (GPF) received from NC Medicaid to identify system differences
- Trillium Provider Network staff will review differences with Provider
- Update CIE contract(s) and/or NCTracks via PUF or MCR submitted by Provider accordingly
- Limit eligible Provider Taxonomy codes on Claim Forms (CIE Data)
- Develop reconciliation process for claims based on workflow developed
- Develop first level adjudication at service to Taxonomy code level
- Educate providers and staff

Analysis of Encounters

The analysis of encounter data evaluated whether Trillium submitted complete, accurate, and valid data to NC Medicaid for all claims paid between January 1, 2019 through December 31, 2019. 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 1.7 Million Professional and 113,630 Institutional claim lines. The files submitted during 2019 also contained resubmissions of old dates of service and line level details, therefore these figures are expected to differ from Trillium's ISCA responses – which summarizes at the claim header level. The graph below represents the dates of services of all claims submitted to NC Medicaid in 2019.



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

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

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

Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% nonmissing and valid on physician or other applicable provider type claims (e.g., other practitioners)
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid codes (using International Statistical Classifications of Diseases, Ninth Revision, Clinical Modification [ICD-9-CM] lookup tables) for practitioner providers (not including transportation, lab, and other ancillary providers)
Other Diagnosis	This is not expected to be coded on all claims even with applicable provider types, but should be coded with a fairly high frequency.	90% valid when present
Dates of Service	Dates should be evenly distributed across time.	If looking at a full year of data, 5%–7% of the records should be distributed across each month.
Unit of Service (Quantity)	The number should be routinely coded.	98% nonzero <70% should have one if Current Procedural Terminology (CPT) code is in 99200–99215 or 99241–99291 range.
Procedure Code	Critical Data Element	99% present (not zero, blank, or 8- or 9-filled). 100% should be valid, State-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.
Procedure Code Modifier	Important to separate out surgical procedures/ anesthesia/assistant surgeon, not applicable for all Procedure codes.	> 20% non-missing. Expect a variety of modifiers both numeric (CPT) and Alpha (Healthcare Common Procedure Coding System [HCPCS]).
Patient Discharge Status Code (Hospital)	Should be valid codes for inpatient claims, with the most common code being “Discharged to Home.” For outpatient claims, the code can be “not applicable.”	For inpatient claims, expect >90% “Discharged to Home.” Expect 1%–5% for all other values (except “not applicable” or “unknown”).
Revenue Code	If the facility uses a UB04 claim form, this should always be present	100% valid

Encounter Accuracy and Completeness

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

Table: Evaluation of Key Fields

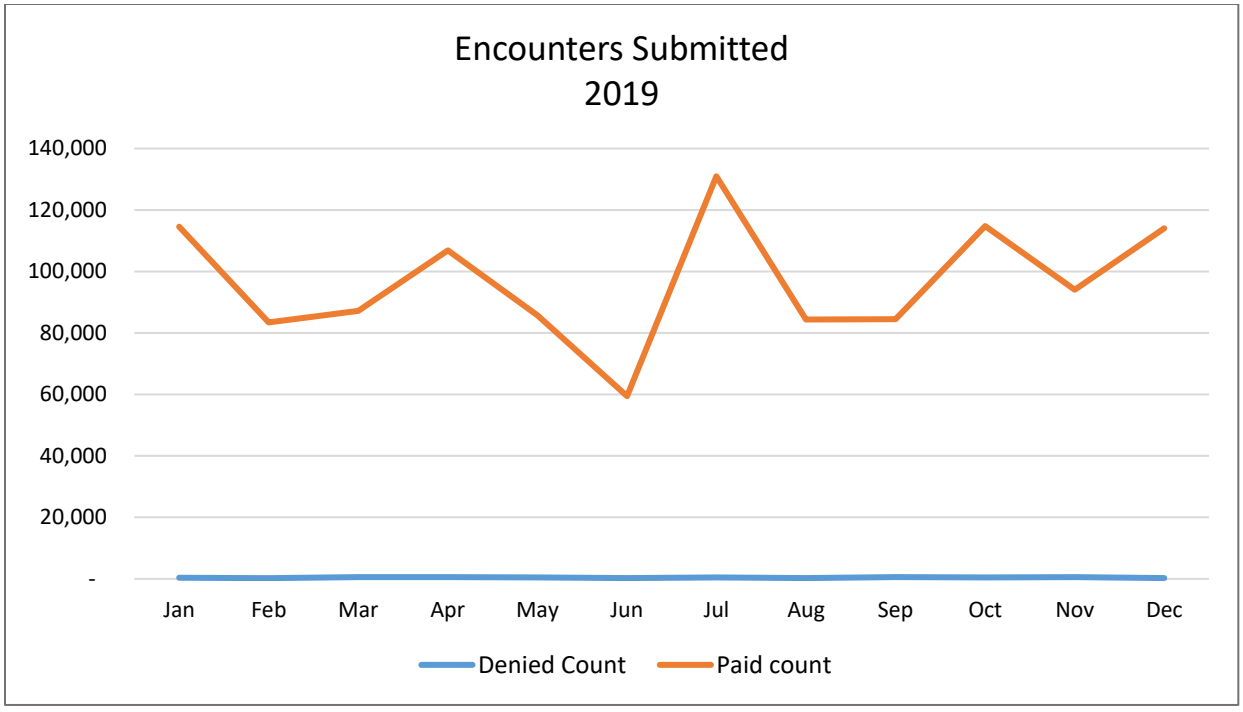
Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%
Recipient Name	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%
Recipient Date of Birth	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%
MCO/PIHP ID	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%
Provider ID	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%
Attending/Rendering Provider ID	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%
Provider Location	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%
Place of Service	1,864,325	100.00%	1,864,325	100.00%	1,864,325	100.00%	1,864,325	100.00%
Specialty Code / Taxonomy - Billing	1,864,325	100.00%	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%
Specialty Code / Taxonomy - Rendering / Attending	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%
Principal Diagnosis	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%
Other Diagnosis	353,068	18.94%	353,068	18.94%	353,068	18.94%	353,068	18.94%
Dates of Service	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%	1,864,326	100.00%
Unit of Service (Quantity)	1,864,322	100.00%	1,864,322	100.00%	1,864,322	100.00%	1,864,322	100.00%
Procedure Code	1,844,289	98.93%	1,844,289	98.93%	1,844,289	98.93%	1,844,289	98.93%
Procedure Code Modifier	813,397	43.63%	813,397	43.63%	813,397	43.63%	813,397	43.63%
Patient Discharge Status Code Inpatient	113,630	100.00%	113,630	100.00%	113,630	100.00%	113,630	100.00%
Revenue Code	113,630	100.00%	113,630	100.00%	113,630	100.00%	113,630	100.00%

Overall, the inconsistencies in the data pointed back to the same encounter submission and denial issues that were highlighted in Trillium's ISCA response and NC Medicaid's encounter acceptance report. Institutional claims contained complete and valid data in 18 of the 18 key fields (100%). The Procedure code field was populated consistently and with expected values. This represents an improvement compared to 2017 and 2018 when some Procedure codes provided were labeled as "Line Level Procedure Code", but contained mixed values of CPT/HCPCS and Revenue codes.

Professional encounter claims submitted contained complete and valid data in 15 of the 15 key Professional fields (100%). Minor issues were noted with Other Diagnosis codes, but did not exceed the validation threshold as defined in Data Quality Standards for Evaluation of Submitted Encounter Data Fields table above.

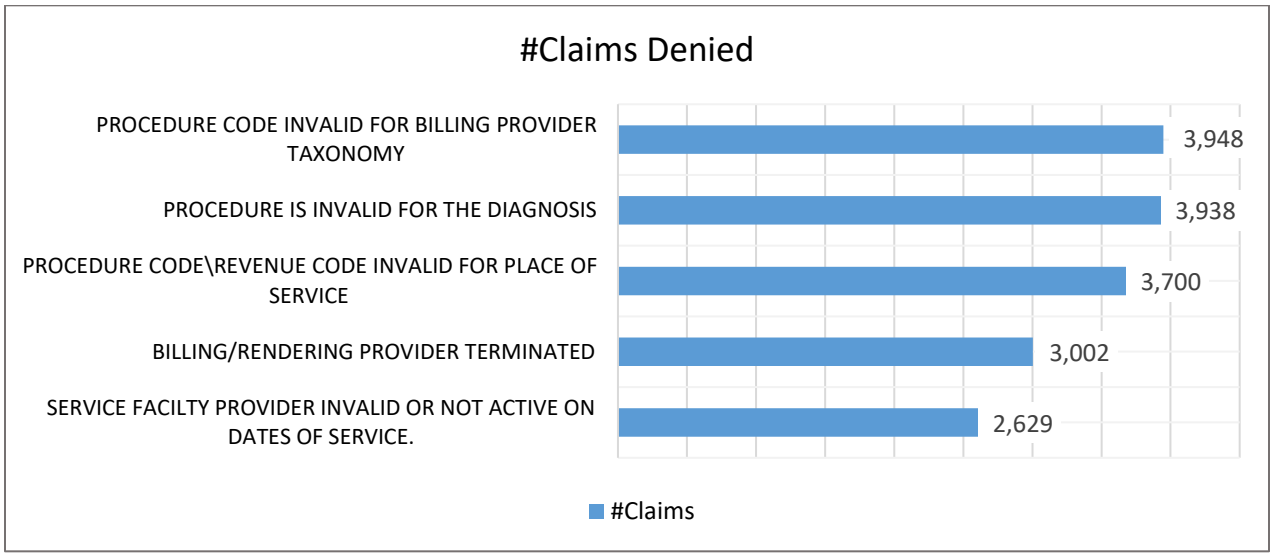
Encounter Acceptance Report

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 LME/MCO. The report is tracked by check write which makes it difficult to tie back to the ISCA response as some of the submissions were for dates of services prior to 2019. Additionally, the converted encounter 837 files we receive from LME/MCOs contain claim line level details, which increases the number of records compared to ISCA responses and some NC Medicaid reports which report results at the claim header level. During the 2019 weekly check write schedule, Trillium submitted a total of 1,159,746 encounters to NC Medicaid. Overall, 0.43% of all encounters submitted were denied.

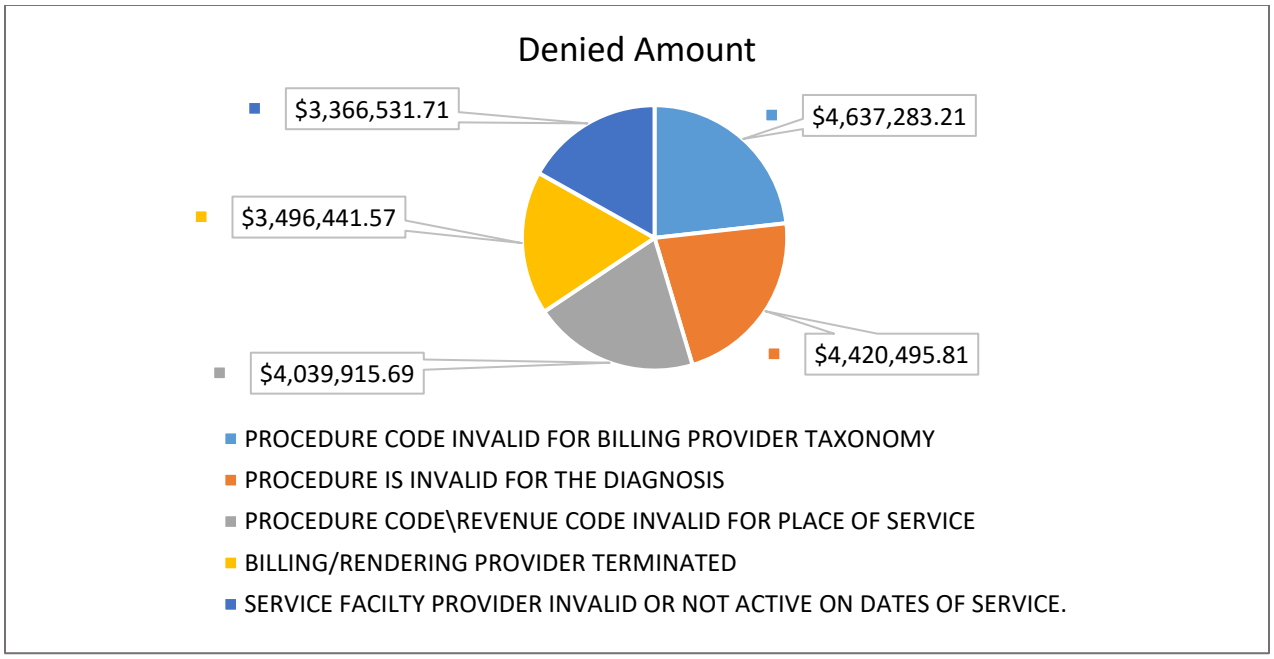


Evaluation of the top denials for Trillium encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis above. Encounters were denied primarily for:

- Procedure code invalid for billing provider taxonomy
- Procedure is invalid for the diagnosis
- Procedure code/Revenue code invalid for place of service
- Billing/Rendering provider terminated
- Service facility provider invalid or not active on dates of services



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



Results and Recommendations

Issue: Additional Diagnosis Codes

Other Diagnosis codes were populated less than 17% of the time for Professional claims. This is a slight improvement compared to 13% that was seen on 2018 dates of service. The absence of Other Diagnosis codes does not appear to be a mapping issue within Trillium, but likely driven by some providers' not coding beyond the Primary Diagnosis code. This value is not required by Trillium when adjudicating the claim, therefore, certain providers may not be submitting Other Diagnosis codes even in cases where they are present when submitting claims via Provider Web Portal or 837P.

Recommendation:

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, it was concluded that the data submitted to NC Medicaid is complete and accurate as defined by NC Medicaid standards.

There is a minor issue with the Other Diagnosis codes that Trillium should review and perform outreach to provider who submit only the Primary Diagnosis codes. Overall, Trillium has corrected all other issues previously identified in the 2016, 2017, and 2018 encounter data validation reports and made significant strides in ensuring that they are submitting complete and accurate data to NC Medicaid.

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