2018 Revised External Quality Review

PARTNERS BEHAVIORAL HEALTH

Submitted: November 9, 2018
Revised: January 18, 2019

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

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EXECUTIVE SUMMARY

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

The goals of the review include:

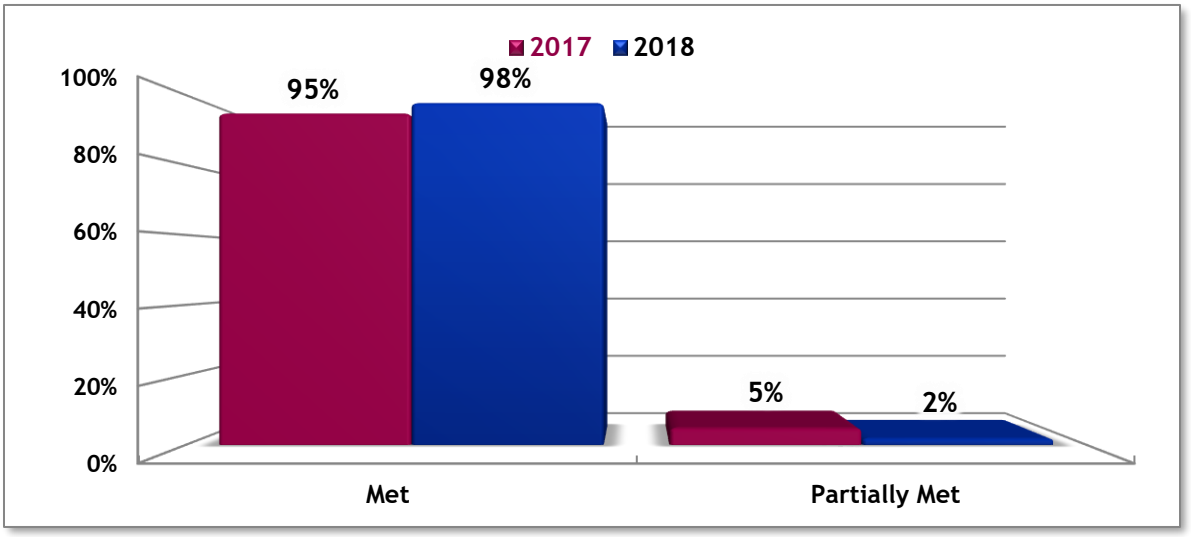
- Determining if Partners complies with service delivery as mandated by its *DMA Contract* with NC Medicaid
- Providing feedback for potential areas of improvement
- Verifying the delivery and determining the quality of contracted health care services

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

A. Overall Findings

The 2018 Annual EQR reflects that Partners achieved a "Met" score for 98% of the standards reviewed. As Figure 1 indicates, 2% of the standards scored as "Partially Met," and 0% of the standards scored as "Not Met." It should be noted that the "Not Met" score calculated to .39% and is represented as 0% as decimals are omitted. Figure 1 provides a comparison of Partners' 2017 review results to 2018 results.

Figure 1: Annual EQR Review Results



B. Overall Recommendations

CCME identified the following global recommendations for improvement and recommends implementing these changes in conjunction with the detailed recommendations defined in each respectively labeled section.

Administration

CCME did not identify any concerns with Partners' policies and procedures and confidentiality practices in the 2018 EQR. Partners is adequately staffed, with the exception of the Associate Medical Director position. This position has been vacant since October 2017 and, until recently, Partners has not sought to fill it. CCME identified and raised concerns about the amount of oversight and involvement for which the Chief Medical Officer is currently responsible. Partners is encouraged to work aggressively to fill the Associate Medical Director position.

Partners has a comprehensive enrollment system and claims processing system in place. Staff are able to speak to processes and provided a demonstration of the enrollment and claims data captured in AlphaMCS.

Partners has implemented processes to address encounter submission denials attributed to provider taxonomy discrepancies, and is working with NC Medicaid to resolve outstanding issues. Partners' encounter data acceptance rate is 98-100%. Partners provided a comprehensive discussion about how it has addressed backlogged encounters and how it has reduced denials attributed to provider taxonomy codes.

Currently, Partners' claim processing system is capable of capturing up to 25 ICD-10 diagnosis codes for institutional claims and up to 12 ICD-10 diagnosis codes for professional claims. The provider web portal for Institutional claims mirrors the UB04 Claim Form and allows for up to 18 ICD-10 diagnosis codes. Even though Partners captures all the secondary ICD-10 diagnosis codes in NCTracks, Partners is only submitting up to two diagnosis codes to NCTracks on the encounter data files. As discussed Onsite, NCTracks is capable of capturing up to 25 diagnosis codes for institutional claims and 12 diagnosis codes for professional encounters.

Provider Services

The Provider Services review includes Network Adequacy and Credentialing and Recredentialing. The "Partially Met" item for this review is due to the lack of a policy or procedure that addresses the *DMA Contract Attachment B, Section 8.2.1* requirements for abandoned records. Several files do not contain Primary Source Verifications (PSVs) or other items needed for the EQR, or the PSVs are illegible or do not contain the date of the query. In response to CCME's request, Partners provided additional documents. CCME recommends verifying credentialing and recredentialing files contain all required items as outlined in the Recommendations section of the EQR report. CCME also recommends Partners add to a policy or procedure the "Abandoned Records" steps identified in *DMA Contract Attachment B, Section 8.2.1.*

Enrollee Services

The Enrollee Services review focuses on enrollee rights and responsibilities, enrollee PIHP program education, behavioral health and chronic disease management education, and the Call Center. Partners' Call Center meets all metrics and has Overflow Call Procedures for its call overflow delegate to use when training staff on its process. The Communications and Marketing Department informs enrollees of additional training offered by Partners through the *Behavioral Health Focus* bi-monthly community newsletter, social media, and the Partners website. Partners can improve enrollee services by providing the new enrollee with written information about three specific sub-standards within 14 business days. One, the printed *Provider Directory* has a field for "Languages supported" which is unclear if this refers to interpreted language or languages spoken by the provider. The second is the field for "provider accepting new patients," which is missing from the printed and online Provider Directories. Third, Partners provides no explanation about the location where post stabilization services are furnished.

Quality Improvement

Partners' PIPs are all in the High Confidence range. The B and C waiver measures include all necessary documentation and measures are reported according to specifications. Partners has improved attendance at the Quality Improvement Committee (QIC) meetings

and the documentation in the *Quality Assurance / Quality Improvement Program Evaluation 2016-17* by separating results and analysis throughout the document. The greatest area for improvement is Clinical Practice Guideline monitoring. CCME's Onsite interview revealed that Partners is only holding providers accountable for Clinical Practice Guidelines when addressing a Quality of Care Concern. There is not a proactive process for routinely monitoring that all providers are following specific Clinical Practice Guidelines. This was a recommendation during last EQR not implemented.

Utilization Management

The EQR of Utilization Management (UM) includes review of the UM, Care Coordination, and Transition to Community Living (TCLI) departments and functions. Partners meets all standards, and CCME recommends the three following improvements:

1. Consider increasing the complexity of cases used for the Inter-Rater Reliability (IRR) process and/or increasing the bench mark rate;

2. The TCLI procedure describes the availability of the Transition Year Fund; however, the mechanism to access the fund is not indicated. Include where the mechanism for Transition Year Fund is in the TLCI policy and procedure.

3. The TCLI file review includes all the required documents; however, three Transition Plans do not have required signatures. Develop a monitoring process to verify that transition plans are signed by members or their legal representative, guardian, and provider.

Grievances and Appeals

Partners' *Grievance Management* policy and procedure includes the use of the terms "Grievance" and "Complaints." This policy and procedure initially clarifies that a "Grievance" is filed by Medicaid enrollees and a "Complaint" is filed by non-Medicaid members, but then uses the terms interchangeably throughout the rest of the police and procedures. CCME recommends either consistently separating the grievance process from the complaint process in the *Grievance Management Policy* or consistently using one term (e.g., grievance/complaint) to prevent confusion by staff.

While Partners' appeal policy and procedure addresses extensions to the appeal resolution timeframe by stating, "a written notice will be mailed to the consumer explaining the reason for the delay." There is a need to add that the written notice is mailed to consumer within two (2) days per *42 CFR § 438.402*.

During the Onsite visit CCME found that staff understand and are well-versed in the appeals process. Appeal staff provides significant support to verify appellants are informed about the appeals process and have opportunities to provide additional information to peer reviewers. Partners' staff described clinical involvement from the

Chief Medical Officer, Dr. Stanton. Overall, Partners processes appeals within the appeal federal regulations and contractual requirements; however, CCME noted minor issues within the appeals policy, procedure, and *Provider Operations Manual*. Key elements are missing from the appeal records CCME reviewed that, with the help of routine monitoring, can be promptly identified and corrected.

Delegation

Partners reported three delegated entities. During the Onsite visit, CCME discovered that there is a fourth delegation (Peer Review delegated to Dr Houser-Betti). The submitted delegate files include contracts, with Business Associate Agreements (BAA) for all four delegates, as they have access to Protected Health Information (PHI). Partners submitted evidence of annual monitoring of all four delegates. No items require corrective Action. CCME recommends that Partners revise the language in the *Delegation Program Description* to comply with the language regarding monitoring in the *DMA Contract Attachment B, Section 11.1.2*.

Program Integrity

Partners has a high-level *Regulatory Compliance Program Description/Plan*. This policy and procedure, as well as others, point to the *DMA Contract* for detailed requirements; however, policies and procedures do not detail all the timeliness standards DMA contract requires.

Partners is thoroughly implementing the contractual requirements and actively monitoring the requirement implementation using internal checks and audits. Partners has processes in place to verify services received by members and, if issues are identified, investigates them through their Program Integrity (PI) complaint investigation process.

The PI cases are complete and include, where applicable, a thorough report of all relevant information, such as allegations, contact information of involved parties, interviews, communications, dollar amounts involved, findings, any resulting tentative notices of overpayment, and next steps. Partners has very few enrollee fraud cases, and none are in the random file sample for review.

Financial Services

Partners received all “Met” scores for the 2018 Financial Services EQR review. Two policy and/or procedure enhancements are identified. CCME recommends Partners add the five-business day transfer requirement to policy and procedure *3.14, Management of Risk Reserve*. CCME also recommends that Partners revise policy and procedure *4.11, Record Retention and Disposition* to refer to the 10-year requirement of financial records required by *DMA Contract, Section 8.3.2*.

Encounter Data Validation

Based on the analysis of Partners' encounter data, it was concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues were noted with both institutional and professional encounters. Based on Partners' ISCA response, overview of the AlphaMCS system, and limited number of data anomalies, HMS believes that the errors are associated with the creation of the 837 rather than the data received and maintained. Corrective actions are needed to resolve the issues identified with Recipient Id, Dates of Service, and diagnosis codes.

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 Partners. The goal is to ensure that Partners 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 PMs, and validation of PIPs, as well as optional activity in the area of Encounter Data Validation, conducted by CCME's subcontractor, HMS. Additionally, as required by CCME's contract with NC DHHS, an ISCA Audit and Medicaid program integrity (PI) review of the health plan was conducted by CCME's subcontractor, IPRO.

On August 22, 2018, CCME sent notification to Partners that the annual EQR was being initiated (see *Attachment 1*). This notification included:

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

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

The review consisted of two segments. The first was a desk review of materials and documents received from Partners on September 12, 2018 and reviewed in the offices of CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, care coordination, case management, and appeal files.

The second segment was a two-day, onsite review conducted on October 10, 2018 and October 11, 2018, at Partners' corporate office in Gastonia, North Carolina. CCME's onsite visit focused on areas not covered in the desk review and areas needing clarification. For a list of items requested for the onsite visit, see *Attachment 2*. CCME's onsite activities included:

- Entrance and Exit Conferences
- Interviews with Partners' Administration and Staff

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

FINDINGS

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

A. Administration

The Administration review focuses on the PIHP's policies, procedures, staffing, compliance and confidentiality, information system, and encounter data capture and reporting.

Policies & Procedures

Partners has 204 policies and procedures in place to guide the quality of care provided to members. Partners uses established procedures to confirm documentation is organized, clearly written, reviewed annually, and approved by the organization's leadership team. Procedures are maintained and reviewed annually by department heads, and policies are reviewed annually by Partners' Board of Directors. Program Descriptions and plans are maintained by departmental heads and reviewed annually. It is evident through revision history documentation that procedures are revised regularly. Partners' policy and procedure set is organized and all policies and procedures accounted for per the *Policies/Procedures Master Listing*.

Organizational Staffing/ Management

Partners' leadership team is led by Mr. Rhett Melton, Chief Executive Officer (CEO). Mr. Melton provides leadership and day-to-day oversight of Partners' business activities. Per Partners' Organizational Chart, 17 positions (or 4%) of Partners' current workforce is currently vacant. No department appears affected by these vacancies except the Medical Department. Dr. Stanton serves began serving as Chief Medical Officer (CMO) in September of 2017, but the Associate Medical Director (AMD) position has been vacant since October 2017. During the Onsite interview, Partners stated active recruiting for the AMD position began in the last few months. While Partners is meeting their contractual requirements and there is evidence that Dr. Stanton is managing the workload, there is a risk that the workload is not sustainable.

Committee minutes reflect Dr. Stanton chairs the Clinical Advisory, Credentialing, Quality Improvement Projects, Quality of Concern, and Utilization Management/Review committees. She also participates actively in the Network Management and Quality Improvement committees. While her clinical oversight is reflected in her job description, committee minutes, and during the Onsite interview, this oversight is not reflected in the Organizational Chart.

The Organizational Chart reflects staff credentials, licensure, certifications, etc., and demonstrates staff is appropriately trained for respective positions.

Confidentiality

As a covered entity under the Health Insurance Portability and Accountability Act (HIPAA), CCME reviewed Partners' policies and procedures regarding management and protection of enrollee confidentiality. CCME found evidence of procedural development specific to HIPAA privacy compliance, HIPAA oversight, confidentiality of information, access to and amendments of Protected Health Information (PHI), HIPAA Breach Notification, and release of information with and without client consent.

Procedure 2.15U, Employee Training and Support indicates that Partners provides "initial orientation and training for all employees before assuming assigned roles and responsibilities," and that this initial orientation includes training on confidentiality and other regulatory compliance topics. During the Onsite visit, CCME verified that this training occurs in the first two days of new staff employment.

Information Systems Capabilities Assessment (ISCA)

Island Peer Review Organization (IPRO), in contract with CCME and as recommended by the CMS' Encounter Data Validation protocol, conducted the yearly review of Partners' Information Systems Capabilities Assessment (ISCA).

Partners, like many other behavioral health managed care organizations in North Carolina, uses the AlphaMCS transactional system, a hosted system environment produced by Mediware. Mediware modifies the user interface and conducts backend programming updates to the system.

Prior to the Onsite visit, Partners completed the 2018 ISCA tool and submitted supporting documentation, workflow, and procedures. IPRO reviewed all submitted materials and responses, and re-reviewed materials submitted for last year's audit. Partners' staff was prepared to speak about existing processes and reports during the Onsite discussion. Questions regarding the ISCA tool and follow-up on last year's audit findings were discussed with the PIHP. Even with a power outage, Partners' staff was prepared to do live demonstrations and display enrollment and claims data elements in the AlphaMCS system at Partners' office location in Gastonia, North Carolina, on October 11th, 2018.

Enrollment Systems

Partners has experienced slight changes in enrollment over the past three years. The year-end enrollment figures for 2015 to 2017 are 154,351 in 2015, 156,553 in 2016, and 153,341 in 2017.

The ISCA tool and supporting documentation for enrollment systems loading processes define the process for enrollment data updates in AlphaMCS clearly. Partners receives and loads the daily global eligibility file (GEF) with a one day lag. The GEF file contains new Medicaid member records and information about members who have updates or edits since the previous file; Partners also processes and loads the daily GEF into a local Data Warehouse (DW) to support reporting needs. The GEF data loaded into the local DW allows for summary reports and comparisons to total records and identification of discrepancies. Every month Partners uses the 820 capitation file to compare enrollment in AlphaMCS and identify discrepancies.

Historical data is stored within the AlphaMCS system. All eligibility data (start and end dates) for members are maintained and updated; no information is deleted. The AlphaMCS system maintains enrollment history from Partners' inception date. During the Onsite visit, Partners' staff identified a limitation with the daily GEF file; the GEF only includes up to 100 of the most recent historical records for a member, typically seen with members enrolled in NC Innovations Waiver. Partners developed an Orphan Claims report to assist in the identification of any member records dropped due to the 100 record limitation of the GEF.

The AlphaMCS system assigns unique member identification numbers (Unique ClientID) and stores the Medicaid identification number received on the GEF. Partners' eligibility is able to merge multiple member records and link patient historical claims. During the Onsite visit, Partners' staff demonstrated the AlphaMCS screens that have the capability to store up to seven Medicaid IDs.

Claims Systems

Partners' claims are processed in the AlphaMCS claim system. CCME conducted a thorough review of Partners' ISCA response and supporting documentation as part of its review of processes for collecting, adjudicating and reporting claims. Partners conducted a demonstration of its AlphaMCS system and provider web portal during the Onsite review.

The majority of institutional and professional claims received are electronic (HIPAA or Provider Web portal, see Table 1) and the only paper claims received are by providers who do not have access to the AlphaMCS system. If required fields are missing from a claim, the provider web portal does not allow the claim to be finalized and processed,

and for other electronically submitted claims, providers receive a 999 transaction file which advises them of the missing or invalid data elements submitted on the claim(s).

Table 1: Percent of claims with 2017 dates of service received via Electronic (HIPAA, Provider Web Portal) or paper forms.

Claim Type	HIPAA File	Paper	Provider Web Portal
Institutional	77.7%	0.4%	21.9%
Professional	81.3%	0.0%	18.7%

During the Onsite visit, Partners' staff demonstrated how claims information is captured in the AlphaMCS, provider web portal entry screens for claims submissions, and claims denial reports. AlphaMCS is capable of capturing up to 25 ICD-10 diagnosis codes for institutional claims and up to 12 ICD-10 diagnosis codes for professional claims. The provider web portal for institutional claims mirrors the UB04 Claim Form and allows for up to 18 ICD-10 diagnosis codes.

In 2018, Partners updated the AlphaMCS system to capture and store the ICD-10 procedure code and the DRG codes received by providers; Partners did not provide a date of when the update occurred.

Partners reports an auto-adjudication percentage of 87.7% of institutional claims and 98.9% for professional claims. In addition, the following claims submitted to Partners are pending: claims billed with an emergency department Bill Type of 013X or claims in excess of $5,000. A pending report is generated daily for a claims processor to review and manually approve or deny the claim.

Partners has a policy and procedure provided prior to the Onsite regarding the auditing of claims. Audit reports are produced and reviewed daily and quarterly, and claims are regularly reviewed for accuracy and appropriate adjudication and denial; Partners' goal is lowering the number of claim denials.

Reporting

Partners' data repository captures and stores all the enrollment and claims information from February 2013 for Medicaid eligibility data and July 2012 for state claims data. All eligibility data is loaded into the AlphaMCS system and Mediware also maintains a backup at an offsite storage facility. AlphaMCS stores data in a Microsoft SQL Server database. The local reporting copy of the system is populated by a scheduled full and daily incremental SQL database copies. Control checks compare the daily DW a.m. build to AlphaMCS.

Partners provided a disaster recovery plan for review prior to the Onsite audit. During the Onsite visit, an unplanned weather related event and a power outage occurred; however, Partners was able to display the AlphaMCS enrollment and claim screens, the provider web portal, and available reports without disruptions.

As per the ISCA, Partners' reporting is generated on demand based on user supplied run parameters. Prior to generating reports, validation and testing steps are performed and results reviewed by a cross departmental team. Run dates and run parameters are included on the output of all reports to validate current versions and ranges are being submitted and submitting staff can catalog results for future access. During the Onsite visit, Partners stated there are approximately 250 reports available for users to produce with various run parameters.

Encounter Data Submissions

Partners has a defined process in place for its encounter data submission, with 837 files submitted to NC Medicaid, and 835 files received back from NC Medicaid through the NCTracks system. The 835 file from NCTracks is used to review denials. Partners can track claims from the adjudication process to their encounter submissions status.

Partners parses the outgoing 837 professional and 837 institutional encounter files and the inbound 835 files, and stores the detailed records in a SQL database; it performs a reconciliation matching the returned 835 information against the 837P and 837I encounter sent files. Records in the database are linked to paid claims in AlphaMCS to enable Partners to identify the adjudicated claims not yet been submitted to NCTracks.

For comparison purposes, Table 2 shows encounter data acceptance/denial rates for 2016 and 2017 provided by Partners.

Table 2: Volume of 2016 and 2017 Submitted Encounter Data

2017	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	64,951	56	358	65,365
Professional	1,232,678	44,972	4,289	1,281,939
2016	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	63,466	324	117	63,907
Professional	1,281,668	76,838	2,287	1,360,793

Currently, Partners does not submit all the secondary diagnosis codes to NCTracks. For institutional encounters, Partners submits the admitting and principal diagnosis codes on the 837I. For professional encounters, Partners submits the principal and the first secondary diagnosis codes on the 837P. NCTracks is capable of receiving up to 25 diagnosis codes for institutional claims and 12 diagnosis codes for professional claims.

In 2018, Partners updated the encounter data submission process and the ICD-10 procedure code, and the DRG codes received from the provider are submitted to NCTracks. Partners did not provide a date in the process for the update.

During the Onsite visit, Partners stated it is not submitting any physical health secondary diagnosis codes to NCTracks; documentation provided from NC Medicaid indicates that NCTracks would not deny any valid secondary ICD-10 diagnosis codes.

In prior years, the majority of encounter data issues were related to a provider taxonomy issue. In the past two years, Partners has worked on resolving the provider taxonomy issues and incorporated various checks in their claim adjudication and encounter data submission process. Partners' encounter data reconciliation process has focused on the identification and correction provider taxonomy mismatches, which was the primary denial reason. During the Onsite visit, Partners stated it is in the process of resubmitting the historically denied encounters for provider taxonomy.

In the past year, Partners focused its encounter data reconciliation process on the identification and correction of the provider taxonomy mismatches which was its primary reason for denial. Currently, 98% to 100% encounters submitted to NCTracks are accepted. During the Onsite visit, Partners stated that the top current reason for denial is duplicate encounters.

Figure 2 provides an overview of the Administrative 2017 scores compared to 2018 scores.

Figure 2: Administration Comparative Findings

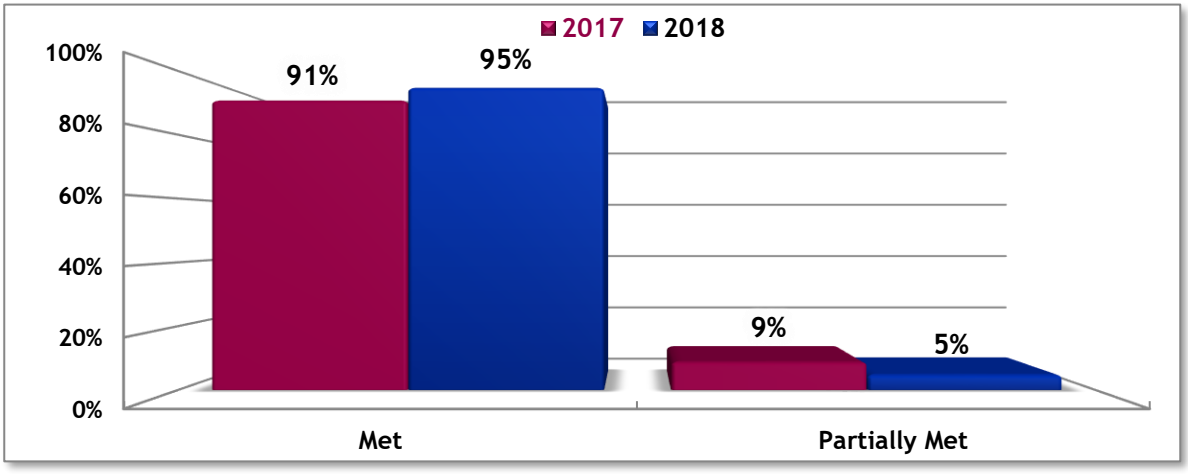


Table 3: Administration

Section	Standard	2018 Review
Management Information Systems	4.1 The MCO has the capabilities in place to submit the State required data elements to DMA on the encounter data submission.	**Partially Met**

Strengths

- Partners' policy and procedure set is organized with evidence of annual review and regular revision.
- It is evident that Dr. Stanton has thorough knowledge of Partners' clinical operations.
- Partners' Organizational Chart reflects staff credentials, licensure, certifications, etc. and demonstrates staff is appropriately trained for each position.
- Partners ensures new staff are trained on confidentiality "before assuming assigned roles and responsibilities."
- The PIHP has a comprehensive enrollment and claims processing system.
- Partners has a suite of enrollment, claim, and encounter data reconciliation reports using AlphaMCS and its data warehouse.
- The PIHP made significant improvements in the rate of denied encounter submissions to the state and meets the state standard for encounter acceptance rates on a monthly basis.
- Claims and encounter and IT staff are knowledgeable about processes and are dedicated to improving encounter data submissions, reducing the number of encounter data denials, and the reducing resubmission of denied encounters.

Weaknesses

- While Partners is meeting their contractual requirements and there is evidence that Dr. Stanton is managing the workload, there is a risk that the workload is not sustainable.
- Partners' Organizational Chart does not accurately reflect the CMO's involvement and oversight of UM, QI, Credentialing, and other clinical functions.
- Partners indicates that they are currently only submitting up to two diagnosis codes for encounter data submissions.

Corrective Action

- Update Partners' encounter data submission process to allow for all ICD-10 CM diagnosis codes submitted on an institutional and professional 837 HIPAA file submitted to NCTracks. Twenty-five ICD-10 diagnosis codes are the maximum number of diagnosis codes that can be submitted on an 837I, and the maximum number that is captured by NCTracks. NCTracks is capable of capturing up to 12 diagnosis codes for professional claims.

Recommendations

- Continue recruiting for the Associate Medical Director position.
- Align Partners' Organizational Chart to reflect the clinical oversight outlined in Partners' CMO job description and *DMA Contract, Section 6.7.6 and 7.1.3*.
- During the Onsite visit, Partners advised its denial rate may increase if it were to submit all the secondary ICD-10 diagnosis codes and any physical health related secondary diagnosis codes to NCTracks. CCME recommends that Partners discuss the denial criteria applied to secondary ICD-10 diagnosis codes by NCTracks with NC Medicaid.

B. Provider Services

Partners' Provider Services EQR is comprised of Credentialing and Recredentialing, and Network Adequacy (including Provider Accessibility, Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, and Practitioner Medical Records). CCME reviewed relevant policies and procedures, the *Credentialing Program Description*, the *Credentialing Committee Charter*, credentialing/ recredentialing files, provider training and educational materials (including the *Provider Orientation Toolkit*, Provider Knowledge Base, and Partners' Training Academy), the *Provider Operations Manual (Revised December 2017)*, Credentialing Committee meeting minutes, provider network information, Clinical Practice Guidelines, the *2017 Community Behavioral Health Provider and Service Gap Analysis Report (Gaps Analysis),* and the Partners' website.

The *Credentialing Program Description* provides information about the scope and processes of the credentialing program and includes several pages about the Credentialing Committee. Dr. J. Octavio Salazar, the previous Chief Medical Officer (CMO), chaired Credentialing Committee meetings through September 28, 2017. Dr. Elizabeth Stanton, a board-certified psychiatrist, became the CMO after Dr. Salazar retired. Dr. Stanton started chairing the Credentialing Committee with the October 26, 2017 meeting. The Credentialing Committee includes Partners' employees and network providers representing various specialties. The Associate Medical Director position is vacant, and the Credentialing Committee has no alternate chairperson. During the Onsite discussion, Dr. Stanton indicated she does not schedule vacation when Credentialing

Committee meetings are scheduled, and she has held the meeting via teleconference when she was sick.

The *Credentialing Committee Charter* states, "The Committee has a quorum if greater than ½ of the filled positions of the voting membership are present. All members are voting members unless identified as non-voting or designee. A designee only votes in the absence of the voting member." The Credentialing Committee meets at least quarterly, with meeting minutes showing 12 committee meetings with a quorum present at 11 of the meetings from July 2017 through June 2018. There was no quorum of voting members present at the August 24, 2017 meeting, but the minutes state that Dr. Salazar (CMO/Credentialing Committee Chair at the time) "acknowledged a quorum," and the committee conducted business, including votes on "flagged" applications. During the timeframe for this EQR, the attendance of provider representatives (or their designees) ranged from 38% (one member, with no designee) to 100%, with three provider representatives or their designee attending from 42% to 75% of meetings at which they were a member. Attendance of Partners' employees who were members ranged from 36% to 100% of meetings at which they were a member.

The *Credentialing Program Description* notes, "While the approval of applications with clean verifications and backgrounds may be delegated to the MCO's CMO, the Credentialing Committee reviews applications with clean verifications and backgrounds presented by the CMO as part of its regular meeting [N-CR 3(d)(ii)]. The CMO's decisions will be reviewed in the Credentialing Committee and reflected in the committee minutes. [N-CR 4(i)]." The Credentialing Committee meeting minutes include lists of credentialing and recredentialing applications that were "Approved by Medical Director." Credentialing Committee meeting minutes reflect discussion and votes on the credentialing and recredentialing applications "flagged" for committee review.

The credentialing and recredentialing files submitted for Desk Review did not contain any Primary Source Verifications (PSVs). The PSVs were submitted upon the request of CCME. The file review showed the files are organized and contained appropriate information; however, several items were not located in either the initially-submitted desk materials or the materials submitted in response to CCME's request. Most items were provided in response to the Onsite Request List or during the Onsite visit.

Providers with "Associate" licensure (such as LPC-A or LCSW-A) and providers who are Licensed Psychological Associates (LPAs) are required by the respective licensing boards to have supervision. Therefore, the PIHP should obtain the current supervision contract as part of the credentialing/recredentialing process. No supervision contract was found in the files of these providers.

Partners' *Credentialing Program Description* defines a "Complete Application" as "an application that includes a signed attestation and all required information and

documentation in order for the credentialing verification to be completed." The *Credentialing Program Description* several times lists the requirement for an attestation that the application is complete and accurate.

The submitted applications of practitioners joining agencies have attestations signed by agency personnel, rather than the application attestation signed by the actual applicant (the practitioner). Partners submitted a representative sample of the practitioner application attestations in response to CCME's Onsite Request List. Partners' staff confirmed they obtain attestations from applicants. Per the *Credentialing Program Description*, Partners should verify all credentialing files include attestations signed by the applicant (not the agency personnel).

An area of discussion during the Onsite visit was a site visit report that indicates the review was conducted via Face Time, with no Partners' staff member going onsite. Details regarding these items are contained in the Tabular Spreadsheet (Attachment 4). For future reviews, ensure all requested items, including the full credentialing and recredentialing files with PSVs, are included in the files uploaded for Desk Review.

The *2017 Community Behavioral Health Provider and Service Gap Analysis* identified choice and access gaps for Opioid Treatment and for Substance Abuse Comprehensive Outpatient Treatment Programs (SA-COTs). Partners filed an Exception Request with North Carolina Medicaid for these two services. During Onsite discussion, Partners' staff reported that data collected for the *2018 Gaps Analysis* indicated the gap for Opioid Treatment Providers was eliminated. The gap for SA-COT continues, and Partners has filed an Exception Request for SA-COT. Geo-access maps are created annually as part of the Gaps Analysis and are also created as needed to monitor network access and choice for identified services. Vanessa Anderson, Provider Network Specialist, works with the subcommittee charged with developing services, and Ms. Anderson provides reports to the Network Management Committee. Requests for Proposals (RFPs) are issued as needed. Geo-Access maps are typically run before the RFP is issued, after the RFP closes, and as progress is made on the project.

When in-network providers are not available to provide medically necessary services, Partners uses Out of Network Consumer Specific Agreements (CSA) to obtain the services. Care Coordination and Call Center staff can submit requests for out-of-network providers, including specialty services, based on identified service need. Network providers sometimes bring an identified need to the attention of Partners' staff. Out-of-network requests and authorizations are tracked and reported each month to the Quality Improvement Committee (QIC). Providers may be offered a full contract, based on identified need.

The *DMA Contract Attachment B*, Section *8.2.1* includes requirements of the Prepaid Inpatient Health Plan (PIHP) regarding abandoned records. During Onsite discussion,

Partners' staff reported they follow the steps outlined in the contract, but the required steps are not included in any policy or procedure.

Figure 3 shows 99% of the standards in the Provider Services section were scored as "Met." The "Partially Met" score is due to the failure to include in any policy or procedure the steps regarding "Abandoned Records" as outlined in *DMA Contract Attachment B, Section 8.2.1.*

Figure 3: Provider Services Findings

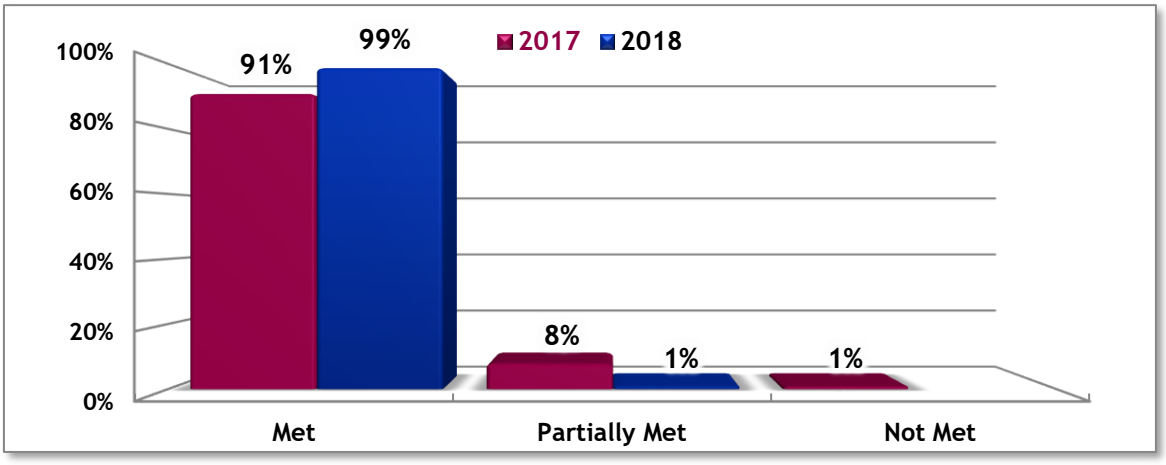


Table 4: Provider Services

Section	Standard	2018 Review
Practitioner Medical Records	The PIHP has a process for handling abandoned records, as required by the contract.	**Partially Met**

Strengths

- Partners provides a toll-free number for providers to reach relevant departments Utilization Management (UM); Provider Network, including Enrollment/Credentialing; Finance/Claims/Contracting; Information Technology (IT)}.
- The Partners' website has numerous resources for providers, including the Provider Knowledge Base and Partners' Training Academy.
- Credentialing and recredentialing files are well-organized and contain appropriate documentation.
- Provider Forums are offered quarterly via webinar to minimize loss of billable time for providers.

- Training sessions are offered via webinar. Partners offers a large annual training event for providers in a central location.
- *Communication Bulletins* and *Provider Alerts* communicate important information to providers.

Weaknesses

- Issues related to some of the submitted credentialing/recredentialing files include:
  - missing items, including, for example:
    - current Primary Source Verifications (PSVs) of licensure; DEA certificate
    - proof of some types of insurance; Ownership Disclosure information
  - Illegible PSVs or PSVs that did not include the date of the query.
- CCME could not find evidence of a query of *The North Carolina Medicaid Provider Termination and Exclusion list* (known as the *State Exclusion List*) in any practitioner credentialing or recredentialing files submitted for desk review.
- The review date on the "*DHHS Unlicensed Site Review Tool*" completed for one of the practitioner initial credentialing file states the "site visit" was completed "6/14/2018 via face time." During the Onsite visit, staff confirmed the review was completed via the FaceTime app and no Partners' staff were onsite. Partners' staff confirmed this practice is not in any policy or procedure and has not been discussed with or approved by North Carolina Medicaid.
- No policy or procedure addresses the 2018 *DMA Contract Attachment B*, section *8.2.1* requirements for abandoned medical records.

Corrective Action

- Add to a policy or procedure to address the "Abandoned Records" steps identified in *DMA Contract Attachment B*, section *8.2.1*.

Recommendations

- Verify credentialing and recredentialing files contain all required information and PSVs, as outlined in the DMA Contract. Specific Recommendations are included in Attachment 4, the Tabular Spreadsheet.

  Note: If Partners does not keep a copy of the relevant information in the individual credentialing or recredentialing files, retrieve or print copies from the relevant files or from Cactus (software program) and upload as part of the credentialing/ recredentialing files for the EQR desk review. Verify PSV copies submitted for the EQR are legible and include the date of the query.
- Discuss with NC Medicaid the practice of conducting a site visit via the FaceTime app, rather than staff conducting the site visit onsite. If approved by North Carolina

Medicaid, retain documentation of the approval, and capture the practice in a Partners' policy or procedure.

C. Enrollee Services

CCME reviewed Partners' Member Services, including relevant policies and procedures, the *Consumer/Enrollee Handbook*, Call Center scripts, orientation materials, new member correspondence and documentation, enrollee continuing education offerings, and website.

Melissa Cline, Member Services Director, oversees Eligibility & Enrollment, Consumer Relations, and Access to Care Departments. Ms. Cline has three Access to Care supervisors reporting to her from the Call Center. The Consumer Relations Director and the Eligibility & Enrollment Supervisor also report directly to Ms. Cline. Rachel Porter is the Senior Director of Marketing & Communications, and her team is responsible for enrollee written material, including the *Consumer/Enrollee Handbook, Services Guides, New Enrollee Letters, Annual Enrollee Letters,* and the *Behavioral Health Focus* bi-monthly publication.

Within 14 days of the initial request for services, Partners provides new enrollees with a *Welcome Letter* and a copy of the *Notice of Privacy Practices*. The letter directs members to the PIHP website for information about eligible services, privacy, rights and responsibilities, committee enrollees can join, and other resources like housing and employment. The letter includes the 24-hour Access to Care phone number and the TTY phone number. The letter directs enrollees to the website for access to the *Consumer/Enrollee Handbook* in English or Spanish and instructions to call the Access to Care phone number if a printed copy is needed, or if the document is needed in Braille or another language.

The printed and online *Provider Directory* is missing the field for "provider accepting new patients." The printed *Provider Directory* has a field for "Languages supported" which is unclear if this refers to interpreted language or languages spoken by the provider. The *Provider Directory* is available to print or download from the website. Partners is updating the *Provider Directory* to add and improve functionality and features.

In review of the written materials provided to enrollees, Partners provides no explanation about the location where Post Stabilization services are furnished. The most logical place to add a list of example locations for post stabilization services is in the *Consumer/Enrollee Handbook*.

The Marketing and Communications Department informs enrollees of educational offerings by posting them in the *Behavioral Focus* publication, on the website, on social media (Facebook), and some offerings are released to the press. Partners tracks and documents enrollee attendance.

Partners has a reciprocal contract with VayaHealth, another Prepaid Inpatient Health Plan (PIHP), for overflow call coverage. Partners has a detailed document entitled *Overflow Call Procedures* for VayaHealth to use when answering Partners' overflow calls. Partners meets all Call Center metrics, including calls answered by VayaHealth.

The following chart indicates Partners received a score of "Met" for 94% of the standards during the Enrollee Services review. Standards with scores of "Partially Met" and "Not Met" are detailed in Table 5.

Figure 4: Enrollee Services Findings

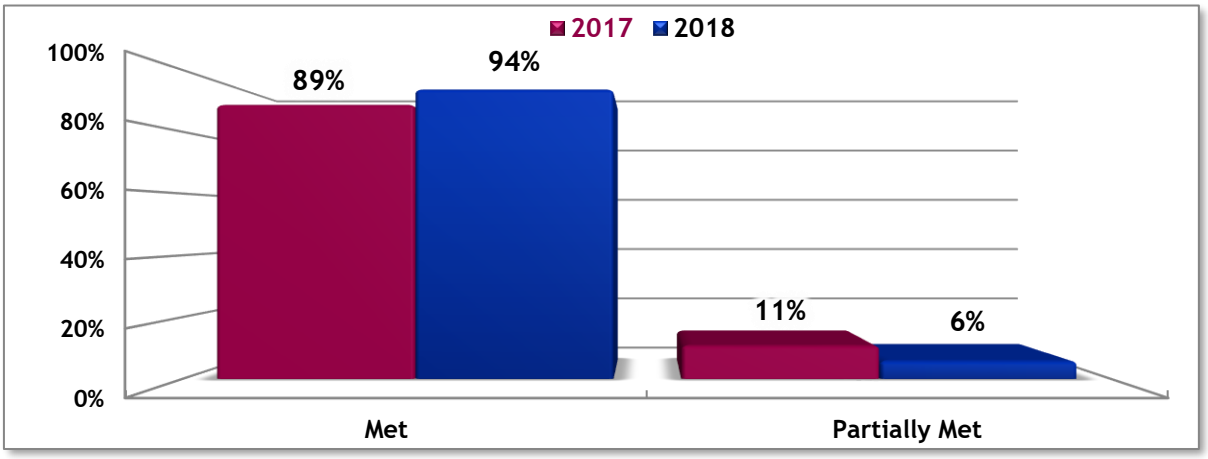


Table 5: Enrollee Services

Section	Standard	2018 Review
Enrollee PIHP Program Education	Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid waiver managed care program which they are contractually entitled, including: • Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request); • The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract;	**Partially Met**

Strengths

- Partners has a detailed document called *Overflow Call Procedures* for VayaHealth to use when answering Partners' overflow calls.

- All terminated provider files meet criteria for the review, and the process in place is being followed that allows enrollees to be notified promptly when their provider is terminated from the network.
- The *Behavioral Health Focus* is a bi-monthly (every 2 weeks) community resource produced by the Communications and Marketing Department. The publication has a section entitled "In the Community" that lists available training and support functions for members.

Weaknesses

- The field for "provider accepting new patients" is missing from the printed and online *Provider Directory*.
- The printed *Provider Directory* has a field for "Languages supported;" it is unclear if this refers to interpreted language or languages spoken by the provider. The *Credentialing Initiation Form* has a question for "Languages other than English which you are able to communicate fluently." This is clear it is the provider's spoken languages.
- In review of the written materials provided to enrollees, there is no explanation given about the location at which post stabilization services are furnished.
- General enrollee written materials and large print materials are not prepared with a minimum size requirement. Font and size are not referenced in a policy or procedure.

Corrective Action

- Add the field for "provider accepting new patients" to the printed and online *Provider* Directory.
- Add locations where post stabilization services are furnished to the enrollee written materials.

Recommendations

- Rename the field "Languages supported" in the printed *Provider Directory* to indicate if that is the provider spoken language or interpretation services available. Provider spoken language is required in the *Provider Directory*.
- Enrollee written materials require a font size no smaller than 12 point, per *42 CFR § 438.10 (D(6) (ii)*, and large print is no smaller than 18 point, per *42 CFR § 438.10(d)(3)*. Include this reference in a marketing and communications policy and procedure for enrollee written materials and verify the policy and procedure are implemented.

D. Quality Improvement

Partners' *2018-19 Quality Assurance (QA)/Quality Improvement (QI) Plan and Program Description* outlines how the program measures and improves the care and services received by enrollees and providers. Partners' Board of Directors (BOD) has ultimate authority and responsibility for the QA/QI Program. The BOD delegates these responsibilities to the Quality Improvement Committee (QIC) through the Chief Executive Officer. Quality Management (QM) Director, William Rankin, is responsible for the day-to-day operational responsibility of the QA/QI Program. Dr. Elizabeth Stanton, Chief Medical Officer (CMO), co-chairs the QIC with Mr. Rankin. *The QA/QI Plan and Program Description* outlines the CMO's responsibilities within the QM Program.

Partners' *Provider Operations Manual* and *Quality Assurance/Quality Improvement Plan and Program Description* explain several ways Clinical Practice Guidelines are monitored. During the Onsite discussion, staff could not describe or provide evidence of this monitoring. Monitoring provider compliance with Clinical Practice Guidelines is an EQR standard and was a best practice recommendation from last year's EQR.

Partners reported all provider and enrollee survey results to multiple committees, including the QIC. Partners analyzed the Experience of Care & Health Outcomes (ECHO) survey to identify improvement areas and began implementing improvements. Results are shared with providers via the Provider Forum and Provider Council.

The *QM Work Plan* is a living document of QM activities and is updated at least quarterly. The work plan displays activities, tasks, responsible person or department, target date, and status.

The QIC meets monthly and had a quorum present at each of the reviewed meetings. The QIC is comprised of Partners' staff, CFAC members, and provider members. Attendance by CFAC and provider members was less than 50% during the last EQR. Partners has worked to improve attendance over the past year.

Partners' providers lead the Global Continuous Quality Improvement Committee (GCQIC). This committee is composed of providers, Consumer Family Advisory Committee (CFAC) members, and stakeholder members in collaboration with Partners' staff. Key Partners' staff who attend the GCQIC meetings also attend QIC meetings, allowing information to flow from the providers to the QIC meeting attendees. GQIC promotes improvement and processes within provider agencies. Based on onsite interviews, providers involved in GQIC are actively participating in individual QI activities; although, Partners is not monitoring providers on individual QIPs. The State Contract 18-19 Template document on page 14, number 10, states, "Providers shall demonstrate a Continuous Quality Improvement (CQI) process by identifying a minimum of 3 improvement projects acted upon per year. Projects and results will be reported to the LME-MCO in any quarter of completion." CCME recommends Partners develop and implement a program and process

that implements, monitors, and offers technical assistance for all providers wherein they submit three improvement projects each year.

Partners prepares the *Quality Assurance /Quality Improvement Program Evaluation* annually. It is a narrative document providing an analysis of progress toward QM Department goals for the fiscal year. It contains a summary of the QA/QI Program, findings, a complete evaluation of progress to date for each QIP, and progress with projects within each department monitored by the QA/QI Department. Partners' leadership presented the *2017-18 Quality Assurance/Quality Improvement Program Evaluation* to both the QIC and the BOD. Partners separated results and analysis throughout the document, following recommendations from the 2017 EQR. Analysis determines if further interventions are needed. Partners provides a documented determination when additional data collection is needed and if the item will be carried into the new program year.

Performance Measure Validation

As part of the EQR, CCME conducted the independent validation of NC Medicaid-selected B and C Waiver performance measures.

Table 6: B Waiver Measures

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

Table 7: C Waiver Measures

C WAIVER MEASURES	
Number and percentage of new waiver enrollees who have a LOC prior to receipt of services	Proportion of PCPs that are completed in accordance with DMA (NC Medicaid) requirements
Proportion of providers that meet licensure, certification, and/or other standards prior to their furnishing waiver services	Proportion of records that contain a signed Freedom of Choice Statement
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Proportion of participants reporting their Care Coordinator helps them understand which waiver services are available to them

C WAIVER MEASURES	
Proportion of providers reviewed according to PIHP monitoring schedule to determine continuing compliance with licensing, certification, and contract and waiver standards	Proportion of participants reporting they have a choice between providers
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	Proportion of claims paid by the PIHP for Innovations waiver services that have been authorized in the service plan

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

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

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

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

B Waiver Measures

The 30-day follow-up after hospitalization for mental illness in the Facility Based Crisis FBC population and inpatient group show substantial decline in rate. Initiation of Alcohol & Other Drug Dependence Treatment for 13 to 17-year olds improved, but decreased for 65+ age group, reflecting a need to improve the rate for that population.

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

30-day Readmission Rates for Mental Health	2016	2017	Change
Inpatient (Community Hospital Only)	8.8%	6.7%	-2.1%
Inpatient (State Hospital Only)	0.0%	0.0%	0.0%
Inpatient (Community and State Hospital Combined)	9.0%	6.7%	-2.3%

30-day Readmission Rates for Mental Health	2016	2017	Change
Facility Based Crisis	12.6%	11.8%	-0.8%
Psychiatric Residential Treatment Facility (PRTF)	18.8%	16.1%	-2.7%
Combined (includes cross-overs between services)	12.6%	9.5%	-3.1%

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

30-day Readmission Rates for Substance Abuse	2016	2017	Change
Inpatient (Community Hospital Only)	10.2%	7.8%	-2.4%
Inpatient (State Hospital Only)	0.0%	0.0%	0.0%
Inpatient (Community and State Hospital Combined)	10.1%	7.7%	-2.4%
Detox/Facility Based Crisis	7.5%	6.9%	-0.6%
Combined (includes cross-overs between services)	11.9%	8.5%	-3.4%

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

Follow-up after Hospitalization for Mental Illness	2016	2017	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	41.9%	46.5%	4.6%
Percent Received Outpatient Visit Within 30 Days	63.6%	64.2%	0.6%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	23.1%	26.1%	3.0%
Percent Received Outpatient Visit Within 30 Days	46.2%	34.8%	-11.4%
PRTF			
Percent Received Outpatient Visit Within 7 Days	38.6%	32.9%	-5.7%
Percent Received Outpatient Visit Within 30 Days	57.1%	62.0%	4.9%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	41.4%	23.9%	-17.5%

Follow-up after Hospitalization for Mental Illness	2016	2017	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 30 Days	63.1%	45.5%	-17.6%

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

Follow-up after Hospitalization for Substance Abuse	2016	2017	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	24.9%	26.6%	1.7%
Percent Received Outpatient Visit Within 30 Days	31.6%	40.3%	8.7%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	19.0%	11.5%	-7.5%
Percent Received Outpatient Visit Within 7 Days	22.9%	16.4%	-6.5%
Percent Received Outpatient Visit Within 30 Days	35.2%	37.7%	2.5%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	24.3%	14.6%	-9.7%
Percent Received Outpatient Visit Within 30 Days	32.7%	29.9%	-2.8%

*NR = Denominator is equal to zero.

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2016	2017	Change
Ages 13-17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	37.7%	51.9%	14.2%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	24.0 %	33.2%	9.2%

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2016	2017	Change
Ages 18-20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	56.6%	50.5%	-6.1%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	28.6%	26.9%	-1.7%
Ages 21-34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	59.2%	57.5%	-1.7%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	45.3%	43.4%	-1.9%
Ages 35-64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	48.5%	50.0%	1.5%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	29.6%	31.1%	1.5%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	46.0%	34.9%	-11.1%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	12.0%	12.7%	0.7%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	52.5%	52.6%	0.1%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	35.1%	35.2%	0.1%

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

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		2016	2017	Change	2016	2017	Change
3-12	Male	0.3	0.3	0	24.9	34.1	9.2
	Female	0.2	0.2	0	25.3	14.7	-10.6
	Total	0.3	0.2	-0.1	25.0	27.1	2.1
13-17	Male	1.7	1.5	-0.2	39.2	44.3	5.1
	Female	2.6	2.6	0	20.0	21.2	1.2
	Total	2.1	2.0	-0.1	27.7	29.7	2
18-20	Male	2.1	1.5	-0.6	9.5	7.3	-2.2
	Female	1.8	1.5	-0.3	11.4	7.1	-4.3
	Total	2.0	1.5	-0.5	10.4	7.2	-3.2
21-34	Male	4.2	4.5	0.3	8.6	7.6	-1
	Female	1.9	1.7	-0.2	7.2	6.5	-0.7
	Total	2.5	2.3	-0.2	7.7	7.0	-0.7
35-64	Male	3.3	3.8	0.5	8.1	9.1	1
	Female	2.8	2.7	-0.1	7.5	7.8	0.3
	Total	3.0	3.1	0.1	7.7	8.4	0.7
65+	Male	0.5	0.6	0.1	14.3	63.5	49.2
	Female	0.4	0.3	-0.1	16.2	15.9	-0.3
	Total	0.5	0.4	-0.1	15.6	35.4	19.8
Unknown	Male	0.0	0.0	0	0.0	0.0	0
	Female	0.0	0.0	0	0.0	0.0	0
	Total	0.0	0.0	0	0.0	0.0	0
Total	Male	1.6	1.5	-0.1	16.4	18.0	1.6
	Female	1.5	1.4	-0.1	11.6	11.2	-0.4
	Total	1.5	1.5	0	13.6	14.3	0.7

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

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
3-12	Male	13.95%	12.84%	-1.11%	0.26%	0.19%	-0.07%	0.66%	0.54%	-0.12%	13.90%	12.80%	-1.10%
	Female	10.32%	9.37%	-0.95%	0.17%	0.13%	-0.04%	0.24%	0.14%	-0.10%	10.28%	9.34%	-0.94%
	Total	12.17%	11.14%	-1.03%	0.21%	0.16%	-0.05%	0.45%	0.34%	-0.11%	12.12%	11.10%	-1.02%
13-17	Male	17.54%	15.24%	-2.30%	1.36%	1.25%	-0.11%	1.13%	0.96%	-0.17%	17.23%	15.06%	-2.17%
	Female	19.68%	18.18%	-1.50%	1.75%	1.84%	0.09%	0.57%	0.53%	-0.04%	19.53%	18.00%	-1.53%
	Total	18.59%	16.68%	-1.91%	1.55%	1.54%	-0.01%	0.85%	0.75%	-0.10%	18.36%	16.50%	-1.86%
18-20	Male	10.78%	8.61%	-2.17%	1.34%	0.96%	-0.38%	0.13%	0.12%	-0.01%	10.67%	8.47%	-2.20%
	Female	12.53%	11.60%	-0.93%	1.27%	0.98%	-0.29%	0.21%	0.15%	-0.06%	12.30%	11.42%	-0.88%
	Total	11.72%	10.19%	-1.53%	1.31%	0.97%	-0.34%	0.17%	0.14%	-0.03%	11.54%	10.03%	-1.51%
21-34	Male	27.63%	24.67%	-2.96%	2.85%	3.11%	0.26%	0.18%	0.09%	-0.09%	27.49%	24.44%	-3.05%
	Female	23.94%	21.24%	-2.70%	1.23%	1.23%	0.00%	0.17%	0.07%	-0.10%	23.86%	21.16%	-2.70%
	Total	24.80%	22.03%	-2.77%	1.61%	1.66%	0.05%	0.17%	0.07%	-0.10%	24.71%	21.91%	-2.80%

2018 External Quality Review

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
35-64	Male	25.04%	23.69%	-1.35%	2.28%	2.42%	0.14%	0.08%	0.15%	0.07%	24.85%	23.44%	-1.41%
	Female	29.19%	26.99%	-2.20%	2.04%	1.88%	-0.16%	0.12%	0.17%	0.05%	28.99%	26.86%	-2.13%
	Total	27.61%	25.75%	-1.86%	2.13%	2.08%	-0.05%	0.11%	0.16%	0.05%	27.42%	25.57%	-1.85%
65+	Male	7.25%	9.08%	1.83%	0.44%	0.49%	0.05%	0.00%	0.00%	0.00%	7.11%	8.99%	1.88%
	Female	7.02%	7.73%	0.71%	0.43%	0.31%	-0.12%	0.02%	0.02%	0.00%	6.86%	7.67%	0.81%
	Total	7.08%	8.12%	1.04%	0.44%	0.36%	-0.08%	0.02%	0.01%	-0.01%	6.93%	8.05%	1.12%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	Male	17.04%	15.56%	-1.48%	1.11%	1.08%	-0.03%	0.53%	0.45%	-0.08%	16.90%	15.43%	-1.47%
	Female	17.85%	16.46%	-1.39%	1.06%	1.01%	-0.05%	0.22%	0.17%	-0.05%	17.74%	16.37%	-1.37%
	Total	17.51%	16.08%	-1.43%	1.08%	1.04%	-0.04%	0.35%	0.29%	-0.06%	17.38%	15.97%	-1.41%

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

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
3-12	Male	0.02%	0.03%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.03%	0.01%
	Female	0.01%	0.00%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	-0.01%
	Total	0.02%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.02%	0.00%
13-17	Male	1.55%	1.64%	0.09%	0.06%	0.08%	0.02%	0.37%	0.41%	0.04%	1.38%	1.44%	0.06%
	Female	0.78%	0.81%	0.03%	0.03%	0.12%	0.09%	0.09%	0.12%	0.03%	0.75%	0.70%	-0.05%
	Total	1.17%	1.24%	0.07%	0.04%	0.10%	0.06%	0.23%	0.27%	0.04%	1.07%	1.08%	0.01%
18-20	Male	2.64%	2.32%	-0.32%	0.37%	0.31%	-0.06%	0.48%	0.36%	-0.12%	2.47%	2.20%	-0.27%
	Female	2.34%	1.85%	-0.49%	0.36%	0.23%	-0.13%	0.30%	0.21%	-0.09%	2.19%	1.79%	-0.40%
	Total	2.48%	2.08%	-0.40%	0.37%	0.27%	-0.10%	0.39%	0.28%	-0.11%	2.32%	1.99%	-0.33%
21-34	Male	11.41%	9.98%	-1.43%	1.62%	1.28%	-0.34%	1.31%	0.99%	-0.32%	10.94%	9.78%	-1.16%
	Female	10.29%	9.07%	-1.22%	1.12%	1.01%	-0.11%	1.29%	1.18%	-0.11%	10.06%	8.94%	-1.12%
	Total	10.55%	9.28%	-1.27%	1.23%	1.07%	-0.16%	1.30%	1.13%	-0.17%	10.27%	9.14%	-1.13%

2018 External Quality Review

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
35-64	Male	8.42%	8.04%	-0.38%	1.49%	1.54%	0.05%	0.74%	0.57%	-0.17%	7.97%	7.69%	-0.28%
	Female	6.02%	5.82%	-0.20%	0.78%	0.69%	-0.09%	0.56%	0.43%	-0.13%	5.76%	5.63%	-0.13%
	Total	6.93%	6.66%	-0.27%	1.05%	1.01%	-0.04%	0.63%	0.48%	-0.15%	6.60%	6.41%	-0.19%
65+	Male	0.80%	1.12%	0.32%	0.11%	0.36%	0.25%	0.03%	0.04%	0.01%	0.77%	0.92%	0.15%
	Female	0.29%	0.30%	0.01%	0.04%	0.04%	0.00%	0.01%	0.00%	-0.01%	0.28%	0.28%	0.00%
	Total	0.43%	0.53%	0.10%	0.06%	0.13%	0.07%	0.02%	0.01%	-0.01%	0.41%	0.46%	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**	**2.90%**	**2.74%**	**-0.16%**	**0.43%**	**0.43%**	**0.00%**	**0.34%**	**0.28%**	**-0.06%**	**2.74%**	**2.60%**	**-0.14%**
	Female	**3.45%**	**3.16%**	**-0.29%**	**0.40%**	**0.37%**	**-0.03%**	**0.39%**	**0.34%**	**-0.05%**	**3.34%**	**3.08%**	**-0.26%**
	Total	**3.22%**	**2.98%**	**-0.24%**	**0.42%**	**0.39%**	**-0.03%**	**0.37%**	**0.31%**	**-0.06%**	**3.09%**	**2.88%**	**-0.21%**

Table 16: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Burke	0.00%	0.03%	0.03%	1.59%	1.47%	-0.12%	3.01%	1.84%	-1.17%	17.53%	10.64%	-6.89%
Catawba	0.01%	0.00%	-0.01%	0.74%	1.25%	0.51%	2.38%	1.95%	-0.43%	13.80%	7.83%	-5.97%
Cleveland	0.00%	0.00%	0.00%	0.66%	1.03%	0.37%	1.62%	1.73%	0.11%	9.69%	6.27%	-3.42%
Gaston	0.02%	0.01%	-0.01%	1.19%	1.30%	0.11%	3.04%	2.32%	-0.72%	14.60%	7.20%	-7.40%
Iredell	0.01%	0.00%	-0.01%	0.72%	1.00%	0.28%	2.39%	1.90%	-0.49%	12.10%	6.57%	-5.53%
Lincoln	0.00%	0.04%	0.04%	0.92%	1.68%	0.76%	1.91%	2.55%	0.64%	12.75%	9.40%	-3.35%
Surry	0.02%	0.00%	-0.02%	0.48%	0.78%	0.30%	1.56%	2.40%	0.84%	12.92%	7.46%	-5.46%
Yadkin	0.04%	0.00%	-0.04%	0.53%	0.77%	0.24%	2.49%	2.01%	-0.48%	12.60%	7.08%	-5.52%
	35-64			65+			Unknown			Total		
Burke	10.77%	8.95%	-1.82%	0.34%	0.59%	0.25%	0.00%	0.00%	0.00%	5.32%	3.88%	-1.44%
Catawba	11.43%	8.59%	-2.84%	0.57%	1.03%	0.46%	0.00%	0.00%	0.00%	4.47%	3.10%	-1.37%
Cleveland	7.46%	5.81%	-1.65%	0.48%	1.03%	0.55%	0.00%	0.00%	0.00%	3.45%	2.63%	-0.82%
Gaston	12.31%	7.04%	-5.27%	0.42%	0.72%	0.30%	0.00%	0.00%	0.00%	5.39%	3.01%	-2.38%
Iredell	9.44%	6.06%	-3.38%	0.60%	0.44%	-0.16%	0.00%	0.00%	0.00%	3.96%	2.46%	-1.50%
Lincoln	7.81%	7.12%	-0.69%	0.70%	0.63%	-0.07%	0.00%	0.00%	0.00%	3.90%	3.42%	-0.48%
Surry	7.08%	5.96%	-1.12%	0.23%	0.34%	0.11%	0.00%	0.00%	0.00%	3.36%	2.55%	-0.81%
Yadkin	8.56%	7.15%	-1.41%	0.00%	0.14%	0.14%	0.00%	0.00%	0.00%	3.51%	2.47%	-1.04%

Table 17: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Burke	10.34%	9.85%	-0.49%	15.43%	15.05%	-0.38%	9.99%	9.15%	-0.84%	20.87%	14.17%	-6.70%
Catawba	9.03%	8.83%	-0.20%	16.28%	16.22%	-0.06%	9.91%	10.29%	0.38%	19.45%	13.65%	-5.80%
Cleveland	9.98%	9.61%	-0.37%	17.00%	16.99%	-0.01%	11.15%	10.13%	-1.02%	20.60%	13.41%	-7.19%
Gaston	12.38%	11.74%	-0.64%	21.26%	20.25%	-1.01%	13.52%	12.53%	-0.99%	27.15%	15.75%	-11.40%
Iredell	9.22%	8.73%	-0.49%	16.52%	16.37%	-0.15%	9.90%	8.90%	-1.00%	15.42%	11.54%	-3.88%
Lincoln	10.84%	10.15%	-0.69%	18.11%	19.02%	0.91%	9.44%	11.16%	1.72%	23.78%	16.01%	-7.77%
Surry	8.60%	8.84%	0.24%	14.07%	13.32%	-0.75%	7.45%	9.41%	1.96%	18.59%	13.19%	-5.40%
Yadkin	7.42%	7.06%	-0.36%	12.63%	14.04%	1.41%	6.88%	7.50%	0.62%	13.67%	10.04%	-3.63%
	35-64			65+			Unknown			Total		
Burke	32.14%	24.73%	-7.41%	8.59%	9.56%	0.97%	0.00%	0.00%	0.00%	16.77%	14.16%	-2.61%
Catawba	32.73%	23.81%	-8.92%	10.66%	12.73%	2.07%	0.00%	0.00%	0.00%	16.10%	13.72%	-2.38%
Cleveland	30.05%	23.04%	-7.01%	12.12%	13.73%	1.61%	0.00%	0.00%	0.00%	17.25%	14.49%	-2.76%
Gaston	38.47%	27.44%	-11.03%	9.56%	12.82%	3.26%	0.00%	0.00%	0.00%	21.36%	16.97%	-4.39%
Iredell	22.69%	16.83%	-5.86%	8.87%	10.41%	1.54%	0.00%	0.00%	0.00%	13.75%	11.92%	-1.83%
Lincoln	31.59%	24.57%	-7.02%	6.84%	16.11%	9.27%	0.00%	0.00%	0.00%	17.72%	15.84%	-1.88%
Surry	22.85%	18.66%	-4.19%	3.05%	8.68%	5.63%	0.00%	0.00%	0.00%	12.97%	12.14%	-0.83%
Yadkin	22.71%	16.50%	-6.21%	2.49%	5.40%	2.91%	0.00%	0.00%	0.00%	11.24%	10.11%	-1.13%

B Waiver Validation Results

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

Table 18: B Waiver Performance Measure Validation Scores 2017

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

C Waiver Measures

Changes made to the measures are validated for review of 2016-2017 C Waiver measures. Partners selected eight new measures and retained two previously validated measures. Partners includes documentation for all ten C Waiver measures. Partners reported rates are displayed in the following table.

Table 19: C Waiver Measures Validation Results

Performance measure	Data Collection	July 1, 2016-June 30, 2017
Proportion of Level of Care evaluations completed at least annually for enrolled participants	Semi Annually	699/699 = 100%
Proportion of Level of Care evaluations completed using approved processes and instrument	Semi Annually	699/699 = 100%
Proportion of New Level of Care evaluations completed using approved processes and instrument	Semi Annually	32/32 = 100%
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Annually	0/0 = NA
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	Annually	40/42 = 95.24%
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	Annually	1067/1067 = 100%
Proportion of Individual Support Plans that address identified health and safety risk factors	Semi Annually	709/709 = 100%
Percentage of participants reporting that their Individual Support Plan has the services that they need	Annually	1067/1067 = 100%
Proportion of individuals for whom an annual ISP and/or needed updates took place	Annually	1067/1067 = 100%
Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval	Quarterly	4/4 = 100%

*NA= Denominator is equal to zero.

Validation scores are fully compliant with an average validation score of 100% across the 10 measures. The validation scores are shown in Table 20, C Waiver Performance Measure Validation Scores *2017*. The validation worksheets offer detailed information on point deduction when validating each C Waiver measure.

Table 20: C Waiver Performance Measure Validation Scores 2017

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

Performance Improvement Project (PIP) Validation

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

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

In 2017, Partners had three PIPS validated including Primary Care Physician (PCP) referrals to behavioral health, TCLI supported employment, and Call Center services. The issues in the 2017 review cycle are lack of improvement in rates, clear presentation of results, and accurate documentation of data collection cycle. The identified issues were corrected in 2018. For the 2018 review, four new projects were validated: TCLI Transitioned in 90 days, Promoting follow up within 7 days for mental health treatment, Promoting follow up within 7days for SUD treatment, and PCP referrals to Behavioral Health. The PCP referrals to behavioral health methodology changed and a new baseline for this new methodology was established. The primary issues with the PIP documentation are the baseline goal and benchmark rates and presentation of the results.

The following table is a summary of the validation scores for each project for current and previous review cycles.

Table 21: Performance Improvement Project Validation Scores

Project Type	Project	2018 Validation Score	2017 Validation Score
Clinical	Promoting follow up within 7 days for mental health treatment	86/91=95% High Confidence in Reported Results	Not Validated
	Promoting follow up within 7 days for SUD treatment	91/91=100% High Confidence in Reported Results	Not Validated
Non-Clinical	TCLI Transitioned in 90 days	86/91=95% High Confidence in Reported Results	Not Validated
	PCP referrals to Behavioral Health	84/84=100% High Confidence in Reported Results	Not Validated

The tables that follow list the specific errors by project and include recommendations to correct the errors.

Table 22: TCLI Transitioned in 90 days-Non-Clinical

Section	Reasoning	Recommendation
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	The benchmark is listed as the comparison goal in the results Table, instead of the comparison benchmark.	Comparison goal should be the same as the "baseline goal" and the comparison benchmark should be the documented benchmark rate from Table B.

Table 23: Promoting Follow Up within 7 Days for Mental Health Treatment- Clinical

Section	Reasoning	Recommendation
Did the study use objective, clearly defined, measurable indicators?	Measures are defined, but baseline goal is higher than benchmark for measure #2.	Revise report to indicate the benchmark rate as best practice rate, and baseline goal as short-term goal.

Figure 5, Quality Improvement Findings, provides a comparison of Partners' current EQR Quality Improvement results to the 2017 review results.

Figure 5: Quality Improvement Findings

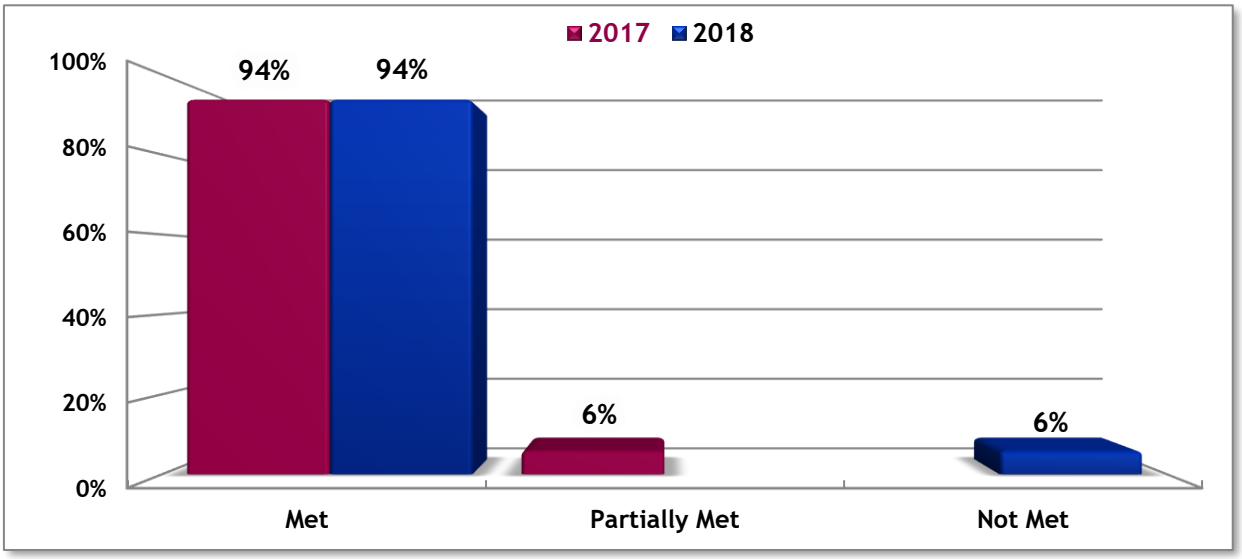


Table 24: Quality Improvement

Section	Standard	2018 Review
The Quality Improvement (QI) Program	The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.	Not Met

Strengths

- B and C waiver measures include all necessary documentation and measures are reported according to specifications.

- There is a policy and procedure for the detection of over and underutilization; services are monitored and analyzed.
- All PIPs are in the High Confidence range.
- Partners improved attendance at QIC meetings over the past year.
- Partners addressed recommendations from last EQR within the *Quality Assurance / Quality Improvement Program Evaluation 2016-17* and separated results and analysis throughout the document. Analysis is completed to determine if further interventions are needed. There is a documented determination when additional data collection is needed and if the item will be carried into the new program year.

Weaknesses

- Partners' *Provider Operations Manual* and *Quality Assurance/Quality Improvement Plan and Program Description* explain several ways Clinical Practice Guidelines are monitored. During the Onsite discussion, staff could not describe or provide evidence of this monitoring. Monitoring provider compliance with Clinical Practice Guidelines is an EQR standard and was a best practice recommendation from last year's EQR.
- The *Quality Assurance / Quality Improvement Program Evaluation 2016-17* documents reflect no improvement is needed for enrollee satisfaction survey measures, although, no discussion is detailed in committee minutes that arrives at this decision.
- CCME found during onsite interviews that providers involved in GQIC are actively participating in individual QI activities, but Partners is not monitoring the completion of QIPs. The *State Contract 18-19 Template* document on page 14, number 10, states, "Providers shall demonstrate a Continuous Quality Improvement (CQI) process by identifying a minimum of 3 improvement projects acted upon per year. Projects and results will be reported to the LME-MCO in any quarter of completion."

Corrective Action

- Initiate a process to proactively and routinely monitor provider adherence to Clinical Practice Guidelines throughout the provider network. Offer technical assistance when needed.

Recommendation:

- Create a process for committee discussion regarding lower scoring Enrollee survey measures for the purpose of identifying steps to improve these measures. Capture discussion and next steps within QIC minutes.
- Implement and document a process that monitors the submission of provider QIPs to Partners.

E. Utilization Management

The EQR of Partners' Utilization Management (UM) Program includes review of the UM Plan, policies and procedures, and UM approval and denial decisions files. An Onsite discussion with staff provided additional information. Partners' Board of Directors provides overall governance and oversight, including the UM Program and its implementation. The Chief Medical Officer (CMO), Dr. Elizabeth Stanton, MD, oversees medical decision-making and provides clinical supervision and guidance to the UM Program. Jane Harris, MSW, LCSW, is Chief Clinical Officer (CCO), and directly supervises clinical operations, including UM and Care Coordination. Charity Bridges, MA, LPA, is UM Director and oversees three Mental Health (MH)/Substance Use (SU) UM Supervisors and an Intellectual Developmental Disability (I/DD) UM Manager.

The *Utilization Management Plan* describes the UM Program purpose, scope, structure, components, and staffing qualifications. It provides an overview of the authorization processes and includes criteria used in the review process. The lines of responsibility and accountability are illustrated in the organizational chart.

The policies are thorough and are updated annually through a defined procedure. The *UM Plan* is evaluated at least annually, and includes the original goals, results, analysis, identified barriers, and strategies for the succeeding year's plan.

Development and adoption of UM criteria is a process shared by the CMO, CCO, Clinical Director, UM Director, Quality Management Team, and the UM Team, with annual review and approval by the Clinical Advisory Committee. Processes for inter-rater reliability (IRR) testing are in place to ensure consistency in criteria application by UM staff and delegated peer reviewers. IRR results are reported to the Quality Improvement Committee, Clinical Advisory Committee, and Utilization Review/Utilization Management Committee and are used to develop or enhance staff training and criteria development.

Review of UM approval and denial files confirms that requirements for review and authorization determination of service requests are met. Appropriate criteria are used; attempts were made to obtain additional clinical information, when necessary, and decisions are made within required timeframes. Authorization determination timeliness is monitored using a daily reporting process.

The *Mental Health /Substance Abuse Use Care Coordination Program Description* and the *Intellectual/ Developmental Disabilities Program Description* describe Partners' Care Coordination Program. The Clinical Directors for the Care Coordination Program are Lynne Grey, MA LPC, LCAS for MH/SU, and Tammy Gilmore, MEd for I/DD. Members are identified for Care Coordination through data monitoring, referrals, and clinical alerts from other departments. Members with complex health needs and high-risk health conditions are identified to address clinical needs, facilitate linkages to services, and ensure appropriate Person Center Plans and Individual Support Plans development.

Care Coordinators use decision making tools to assess the clinical needs and services for members. Care Coordination staff participate in Child and Family team/treatment team meetings to ensure the *System of Care* principles are implemented, advocate for the member, and provide education and information on benefits, resources, and services. Care coordinators verify that activity follow-up is provided; they also monitor outreach activities. Care Coordination files reflect thorough documentation and indicate appropriate processes are followed for MH/SU and I/DD enrollees.

Jeffery Sanders, LCSW, is the Transition to Community Living Initiative (TCLI) Program Manager, with two supervisors and a Lead Transition Coordinator. Partners has one overarching policy and procedure, *9.08, Mental Health and Substance Use (MHSU) Care Coordination -Transition to Community Living and U.S. Department of Justice (TCL-DOJ) Initiative*. This policy and procedure references the *TCLI How to Manual* for specific information. The requirements for staff qualifications and their role and responsibilities in the TCLI Program are clearly outlined in the *TCLI How To Manual*. The manual includes the *Transition to Community Living Checklist* with detailed information for completion. The *Transition to Community Living Checklist* references the availability of Transition Year Funds to support TCLI enrollees, but this availability and how to access these funds is not described in the TCLI policy and procedure.

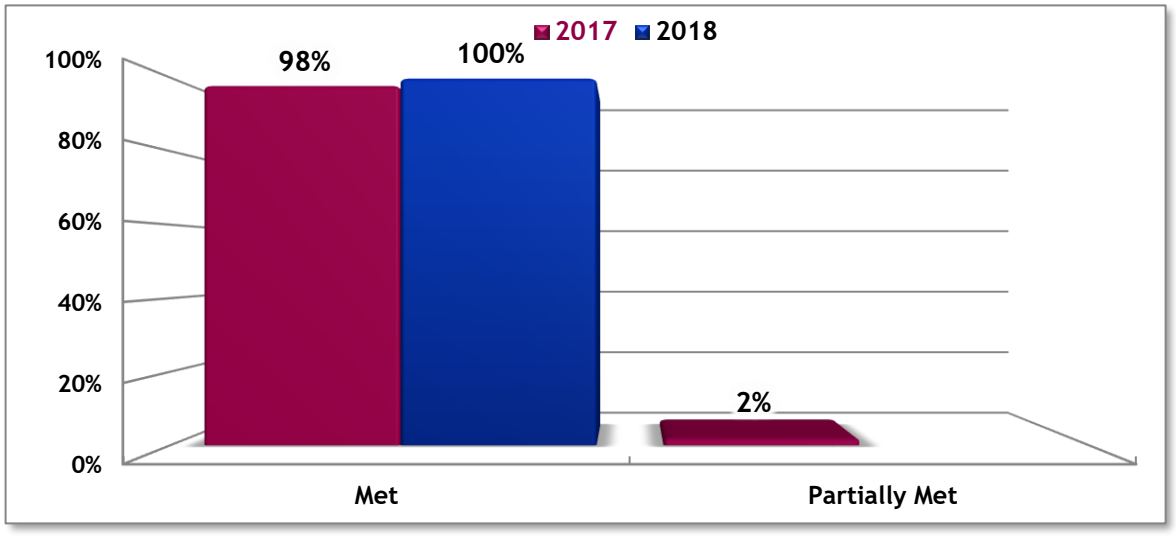
Assertive Community Treatment, Peer Support Services, and Supportive Employment Services are offered to members, when appropriate. During the Onsite interview, CCME and Partners discussed the loss of providers who meet fidelity measures for Supportive Employment (SE) services, resulting in a decrease of availability of this service during the year under review. Partners is recruiting additional providers who meet Supportive Employment fidelity to increase the availability of this service over the next year.

The *Quality of Life (QOL) Surveys* are present in the files, when appropriate. The *Transition to Community Living (TCLI) Checklist* identifies the timing for *QOL Survey* timely completion. In the review of the *TCLI Dashboard*, CCME noted a significant improvement in QOL survey administration; during SFY 2016-17 the completion Summary was 48.9% and during SFY 2017 -18 the completion Summary is 87.7 % - a substantial improvement. In addition, the file review indicates that members had transition plans; however, three of the transition plans are not signed. Monitoring the Transition Plans to ensure that they have all the required signatures will ensure completion.

The TCLI Program Manager and supervisors validate required TCLI reporting is submitted to NC Medicaid via the state's TCLI Database.

As illustrated in Figure 6, Utilization Management Comparative Findings, Partners achieved scores of "Met" for 100% of the standards for the Utilization Management section of the review.

Figure 6: Utilization Management Findings



Strengths

- The Utilization Management (UM) Plan describes the UM Program. The document defines the UM Management Program purpose, scope, structure, components, and staffing qualifications.
- During the Onsite review, Partners provided evidence that Dr. Elisabeth Stanton was involved and had oversight of many aspects of the UM Programs.
- Partners has a set of UM standards to determine medical necessity. These predetermined standards are available on the Partners' Website for all providers.
- I/DD, Care Coordination Monitoring of Plan Completion, clarifies the process to ensure that the requirements are meet for the I/DD members' ISP.
- MH/SU Care Coordination, clarifies the role of the MH/SU care coordinator in monitoring and ensuring that the Person-Centered Plan is complete.
- A significant improvement in Quality of Life survey administration is noted with the 2016-17 Summary having 48.9% completion and the 2017 -18 Summary having 87.7 % completion.

Weaknesses

- Partners has a mechanism to provide one-time transitional support; however, the mechanism is not referenced or described in policy and procedure *9.08, Mental Health and Substance Use (MHSU) Care Coordination -Transition to Community Living and U.S. Department of Justice (TCL-DOJ) Initiative.*
- Transition plans were completed but three Transition Plans do not have the required signatures.

Recommendations

- Add into policy and procedure 9.08, Mental Health and Substance Use (MHSU) Care Coordination -Transition to Community Living and U.S. Department of Justice (TCL-DOJ) Initiative information about the availability of Transition Year Funds. In policy and procedure 9.08, either describe how to access these funds or reference an existing policy and procedure that has this detail.

- Ensure TCLI transition plans contain the appropriate signatures.

F. Grievances and Appeals

Grievances

The EQR of Partners' grievance processes includes review of the *Grievance Management Policy*, grievance files, the *Grievance Data Log* and an Onsite interview. The Grievance Program is overseen by the Legal Department. Andrew Walsh, JD, MBA, is the Legal Officer, and April Cash is the Grievance Coordinator. Ms. Cash reviews each grievance that Partners receives. During the Onsite interview CCME noted that the organizational change of moving Grievances to the Legal Department is effective and a reduction of first and second level reviews is noted.

Partners has one overarching grievance policy and procedure, *6.00U, Grievance Management Policy*, that defines a grievance consistent with the *DMA Contract Attachments H and M*. Within the policy portion of this document, it is that grievances and complaints have similar procedures and, therefore, are "defined by Procedure, but substantially synonymous." Subsequently, the procedure portion of this document then uses these terms interchangeably. CCME recommends either the grievance and complaint processes are separated within the procedure or that these terms are consistently represented as synonymous (i.e., "grievance/complaint") throughout the policy and procedure. This will prevent confusion of staff that may quickly reference the procedure and not the policy.

Policy and procedure *6.00U, Grievance Management Policy* defines a system of registering and responding to grievances. The policy and procedure indicates that when a grievance is extended by Partners, a *Notice of Extension* letter is sent; however, it does not include the timeframe. Per *42 CFR § 438.402*, this notification must be sent within two (2) days.

Partners tracks the timeliness of grievance resolutions, along with the number and outcome of grievance decisions that progress to higher levels of review. The PIHP also looks at patterns, trends, and analysis of the trends. This data is reported in the Quality Improvement, the Quality of Care, the Consumer and Family Advisory, and the Human Rights Committees.

CCME's review of grievance files indicates that the grievance policy and procedure is followed, and the grievance process was completed within 13 days for the files reviewed, and 14 days for grievances processed during the year in review.

Appeals

The EQR process involved the review of 20 appeals files submitted as part of the EQR desk review, policy and procedure *13.04U, Clinical Utilization Management Appeals,* the *Consumer/Member Handbook*, the *Provider Operations Manual*, and appeal information on Partners' website. CCME completed interviews with Partners' staff and Partners provided additional appeal information during these discussions. CCME requested additional appeal files and documents prior to and during the onsite visit as the files originally uploaded for the desk review were incomplete.

The Appeals Department is housed within the Utilization Management (UM) Department. Sheree Raymon, MA, LPC, has oversight of the appeals process and supervises two Appeal Specialists, an Appeals Clinician, and a Processing Assistant. Ms. Raymon reports to the Utilization Manager, Jennifer Moore, MA, LPC.

Appeal data is reviewed and discussed at the quarterly Utilization Management/Utilization Review Committee. Information presented to this committee includes the number of appeals, appeal rates, appeal outcomes, and updates on second level appeal cases.

Discussion with appeals staff during the Onsite review revealed Dr. Stanton is involved with the appeals process through her UM committee participation and overall availability for case staffing, including consultation of expedited appeals. During this discussion it was evident that staff is well versed on the contractual and procedural requirements of the appeal process.

Partners' appeal process is guided by policy and procedure *13.04U, Clinical Utilization Management Appeals*. This policy and procedure is missing several elements required by *DMA Contract* and federal regulations;

- Per *DMA Contract Attachment M, G.6* and *42 CFR § 438.408(c)(2)(ii)*.
  - when Partners extends the appeal resolution timeframe, within 2 calendar days a written notification of the extension must be sent to the appellant.
  - Reasonable efforts must also be made by Partners to give the enrollee prompt oral notice of the delay.
  - the enrollee is informed of the right to file a grievance
- Per *DMA Contract Attachment M, H.8* and *42 CFR § 438.10(b)*, Partner's shall ensure staff will not take punitive action against providers assisting enrollees with the appeal process. This assurance is also not explained in the *Provider Operations Manual*.

- Per *DMA Contract Attachment M, A.1* Partners must acknowledge each appeal. There is no information in Partners' appeal policy describing how Partners' acknowledges invalid appeals.

Partners uses the *Consumer Contact Log* to capture the date and time an appeal is received and all communications and notifications with appellants. These logs are the only source of documentation that captures dates of oral appeal requests and oral resolution notifications. There were no *Consumer Contract Logs* initially submitted with the appeal records requested for the Desk Review. CCME recommends that Partners ensure *Consumer Contact Logs* are submitted for any EQR or audit as they are clearly part of the appeal record.

CCME requested these logs during the Onsite and confirmed that the 28 of the 30 appeal files were processed within the required processes and timeframes. In the remaining two files:

- One appeal file showed an acknowledgment notice was sent outside of the one business day timeframe established in Partners' policy and procedure.
- One expedited appeal file showed staff required a written appeal request from the appellant. A written request is not required to follow an oral, expedited request, per Partners' policy and procedure, and the *DMA Contract*.

Developing a monitoring process of appeal records will ensure appeals are being processed within the *DMA Contract* requirements and that appeal records, including *Consumer Contact Logs*, are complete, consistent, and legible. Monitoring will also provide early detection of steps taken by appeal staff that are outside what is required by Partners' policies and procedures.

The *Consumer Contact Logs* show appeal staff consistently contacted appellants, Utilization Management staff, and Care Coordinators in an effort to obtain additional, up-to-date information and assist the appellant through the appeal process. During the Onsite discussion, Partners' staff confirmed they reach out to each appellant by phone. Partners also provided evidence within the files that, in the course of this outreach, staff ensure protection of the enrollee's confidentiality by obtaining appropriate documentation (e.g., guardianship documentation).

There is no provision within the DMA Contract for PIHPs to require a specific form from appellants to initiate the appeal process. However, Partners' *Provider Operations Manual* (pg. 109) states appellants "must complete and return the Partners' Reconsideration Review Request." Similarly, page 18 of the *Consumer/Member Handbook* references completion of "the form" and "the Reconsideration Review Request Form" as the only option for submitting a written appeal. Correcting these documents will clarify that appeal rights exist regardless of the format of the appeal request.

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

Figure 7: Grievances and Appeals Comparative Findings

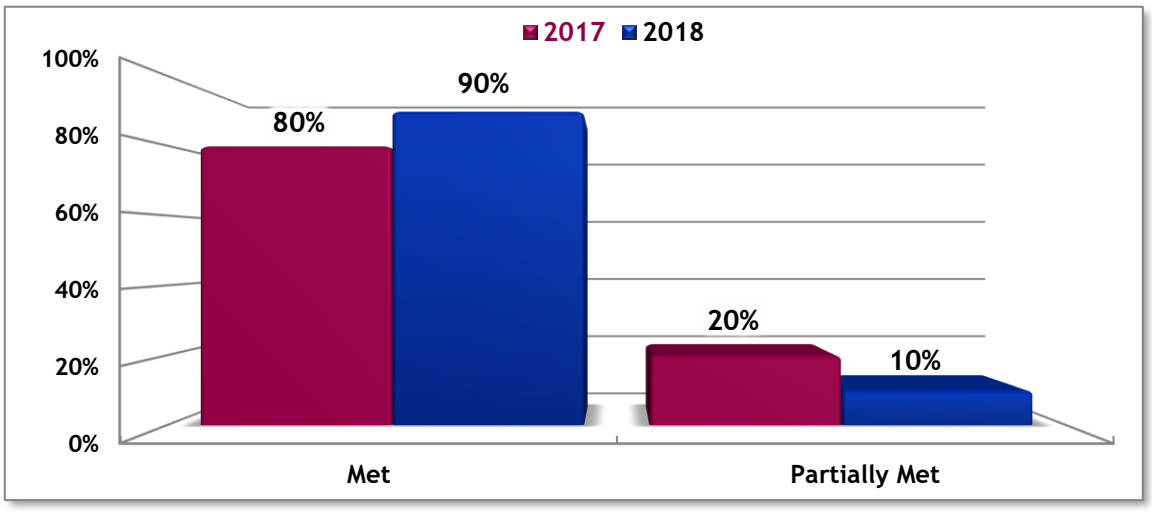


Table 25: Grievances and Appeals

Section	Standard	2018 Review
Appeals	The procedure for filing an appeal	Partially Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met

Strengths

- Staff reported that the organizational transition, moving grievances to the Legal Department, resulted in a reduction of second level grievances.
- Grievance patterns, trends and resolution compliance were reported in the Quality Improvement, Quality of Care, Consumer and Family Advisory, and Human Rights Committees.
- The Grievances are managed in accordance to the policies and procedures.
- Partners provides evidence that the CMO is involved in the clinical aspects of appeals.
- The appeal staff is well-versed in the requirements of the appeals process.

- During the Onsite discussion, Partners' staff reported they attempt to call each appellant to offer information and assistance.
- Within each file, coordination with Utilization Management and Care Coordination is consistently noted.
- Appeal data is reviewed and discussed in the UM Committee.
- Partners provides evidence within of appeals staff obtaining appropriate documentation to protect enrollee's confidentiality the files.

Weaknesses

- Within the policy portion of 6.00U, it is clarified that complaints and grievances are "defined by procedure, but substantially synonymous." However, the procedure uses the terms "complaint" and "grievance" interchangeably. This may be confusing to staff that quickly reference the procedure.
- Policy and procedure *6.00U, Grievance Management Policy* defines the standard and expedited grievance resolution timeframes consistent with the *DMA Contract*. On page four, item J, this policy and procedure explains the process followed if Partners or the consumer request an extension. Item 2. b. states: "a written notice will be mailed to the consumer explaining the reason for the delay." The timeframe for sending this notification is missing.
- Policy and procedure *13.04U, Clinical Utilization Management Appeals* does not include the requirement that, when Partners extends the appeal resolution timeframe, reasonable efforts must be made by Partners to give the enrollee prompt oral notice of the delay and a written notice of the extension must be mailed to the appellant within two calendar days. This policy also doesn't include that the enrollee will be notified of their right to file a grievance if they disagree with Partners' extension.
- Policy and procedure *13.04U, Clinical Utilization Management Appeals* does not clarify Partners ensures that punitive action will not be taken against providers that file or assist with an appeal.
- The *Provider Operations Manual* does not clarify that Partners ensures punitive action will not be taken against providers that file or assist with an appeal.
- One appeal file reviewed was identified as an invalid appeal request. Partners disclosed that, for a period of time and prior to January of 2018, appeal staff did not send invalid notifications to appellants when appropriate. Acknowledging every appeal is required by *DMA Contract*, including those that are invalid.
- Partners does not consider the *Consumer Contact Log* to be a part of the appeal file, but many of the required appeal elements such as date and time of appeal receipt, oral notifications of expedited appeals, etc. are only found in these logs.

- The *Provider Operations Manual* and the *Consumer/Member Handbook* do not provide clear information to potential appellants that any written request for appeal can initiate the appeal process and that the Partners' *Reconsideration Request Review Form* is not required.

Corrective Actions

- Revise policy and procedure *13.04, Clinical Utilization Management Appeals*, to include the requirement that, when Partners extends the appeal resolution timeframe, reasonable efforts must be made by Partners to give the enrollee prompt oral notice of the delay and a written notice of the extension must be mailed to the appellant within two calendar days. Also include in this policy and procedure that the enrollee is notified of their right to file a grievance if they disagree with Partner's extension to the resolution timeframe. See *DMA Contract Attachment M, G.6* and *42 CFR § 438.408(c)(2)(ii)*.

- Include the right of an appellant to file a grievance if they disagree with Partners' decision to extend the appeal resolution timeframe in policy and procedure *13.04U*.

- Revise policy and procedure *13.04U* to reflect that Partners shall ensure punitive action is not taken against a provider who requests or supports an enrollee's appeal.

Recommendations

- Either separate out, within the procedure portion of 6.00U, the procedures for "grievances" and "complaints" or consistently reference these terms as synonymous by using "grievance/complaint" throughout the policy and procedure.

- Add information to the *Provider Operations Manual* that Partners ensures punitive action is not taken against a provider who requests or supports an enrollee's appeal.

- Clarify in policy and procedure *13.04, Clinical Utilization Management* the steps for processing an invalid appeal, including acknowledging to the appellant the receipt of an invalid appeal.

- Enhance the appeal record monitoring process to ensure appeals are being processed within the *DMA Contract* requirements and that appeal records, including *Consumer Contact Logs*, are complete, consistent, and legible.

- Ensure complete appeal files are submitted for any audit or review, including all communication and notifications between Partners' staff and appellants.

- Clarify in the *Provider Operations Manual* and *Consumer/Enrollee Handbook* that any version of a written request for appeal initiates the appeal process and that the Partners' *Request for Reconsideration Review Form* is not required.

G. Delegation

CCME's review of Delegation functions includes a review of the *Delegation Program Description*, the submitted *Delegate List*, Delegation Contracts, and Delegation Monitoring materials.

Partners reported three delegated entities (BHM, Prest & Associates, and VayaHealth), as evidenced in Table 26. Since the last EQR, Partners added the contract with Prest & Associates. During the Onsite visit, CCME determined that there is a delegation for Peer Review to Dr. Houser-Betti.

Partners' contract with BHM was effective July 1, 2012, and a Business Associates Agreement (BAA) was added effective July 1, 2015. The latest contract and BAA with VayaHealth were effective July 1, 2017. The contract and BAA with Prest & Associates were effective November 1, 2017. Partners does not currently have any delegated credentialing. The current contract and BAA with Dr. Houser-Betti was effective July 1, 2018, but Partners' staff report there has been a contract with Dr. Houser-Betti for several years.

The *Delegation Program Description* indicates Partners conducts an annual assessment that "includes a review of the Delegate's applicable written Policies and Procedures and other documents of activities related to delegated functions to confirm continued compliance with applicable URAC standards, and any applicable laws and regulations. If the Delegate is URAC accredited and maintains that accreditation the annual assessment is not required." In contrast, the *DMA Contract Attachment B,* section *11.1.2 d* states that subcontracts shall "provide that PIHP shall monitor the subcontractor's performance on an ongoing basis, at least annually, and subject it to formal review according to a periodic schedule consistent with industry standards."

Partners submitted evidence of annual reviews and monitoring its delegates.

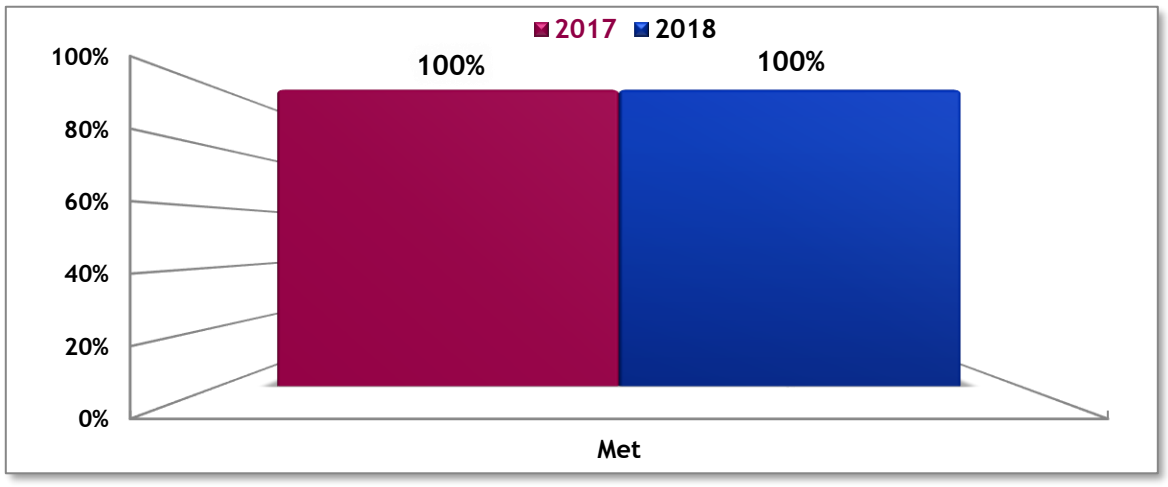
Table 26 lists the current delegated services.

Table 26: Delegated Entities

Delegated Entities	Service
BHM Healthcare Solutions	Peer Review
Prest & Associates	Physician Advisor/Peer Review
VayaHealth	Call Coverage (Overflow and Non-Overflow)
Angela Houser-Betti, Psy.D., PLLC	Peer Review

Partners had no corrective actions or recommendations from the 2017 EQR. Figure 8 provides a comparison of the 2017 scores versus the 2018 scores.

Figure 8: Delegation Comparative Findings



Strengths

- Partners has current delegation contracts and Business Associate Agreements (BAAs) with the four named delegates.
- Partners meets and communicates regularly with its delegates and conducts regular monitoring.

Weaknesses

- The *Delegation Program Description* indicates Partners conducts an annual assessment that "includes a review of the Delegate's applicable written Policies and Procedures and other documents of activities related to delegated functions to confirm continued compliance with applicable URAC standards, and any applicable laws and regulations. If the Delegate is URAC accredited and maintains that accreditation the annual assessment is not required." In contrast, the *DMA Contract Attachment B,* section *11.1.2 d* states that subcontracts shall "provide that PIHP shall monitor the subcontractor's performance on an ongoing basis, at least annually, and subject it to formal review according to a periodic schedule consistent with industry standards."

Recommendations

- Revise the *Delegation Program Description* to comply with *DMA Contract Attachment B*, section *11.1.2* language regarding monitoring "the subcontractor's performance on an ongoing basis, at least annually…"

H. Program Integrity

As required by its contract with CCME, IPRO is tasked with assessing PIHP compliance with federal and state regulations regarding Program Integrity (PI) functions. It should be noted that while standards reference "DMA", this current title for this division is "NC Medicaid".

IPRO's review of Partners began in September 2018 with an offsite review of Partners' PI files and documentation. IPRO analyzed files and documentation and conducted onsite interviews on October 11, 2018, with the PI director and PI Department staff to review the offsite documentation and file review findings.

File Review

IPRO requested the universe of PI files from Partners for the review period of October 2017 through September 2018 and selected a random sample of 15 files with a two file oversample, for a total of 17 files. None of the 15 files reviewed were referred to NC Medicaid (formerly DMA).

Contract Requirement Section VIII B.12

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

Findings:
Fifteen of 15 files CCME reviewed document the initiation of an investigation within 10 business days. Of these, five cases warranted a report to NC Medicaid (formerly DMA); all five cases included a report to NC Medicaid within five business days of the final determination.

Contract Requirement Section VIII B.13

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

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

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

Findings:

During the Onsite visit, Partners reported that in the past year it had a total of four NC Medicaid referrals, none of which were accepted by NC Medicaid. Partners stated that it does not have many cases with credible allegations of fraud and did not consider the four referrals to be unusual. None of these referred cases are included in the random file review sample of 15 cases.

Fifteen of 15 files CCME reviewed contain the subject, source, date reported, description, and contact information included in this requirement.

Six of 15 cases involve a dollar amount in the allegation/investigation and all six have the amount paid and sample/exposed dollar amount.

Eight the 15 cases warranted communications between Partners and the provider, and all eight include documentation of relevant communications.

Contract Requirement Section VIII B.14

In each case of suspected enrollee fraud, the PIHP shall provide DMA program integrity with:

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

Findings:

No cases under review involve suspected enrollee fraud. During the Onsite visit, Partners indicated that there is one case of enrollee fraud (card sharing in an inpatient unit) last year. This case was referred to NC Medicaid. Partners stated that it was very unusual to have credible complaints of enrollee fraud, waste, and abuse.

Documentation

IPRO conducted an offsite review of Partners' documentation to assess the PIHP's compliance with federal and state regulations and its contract with NC Medicaid. The documentation review includes Partners' policies, procedures, training materials, job descriptions, committee meeting minutes and reports, provider agreements, enrollment application, workflows, the *Provider Operations Manual*, *Consumer/Enrollee Handbook*, newsletters, conflict of interest forms, and the *Regulatory Compliance Program Description/Plan*. IPRO reviewed information under three topic areas: General Requirements, Fraud and Abuse, and Provider Payment Suspensions and Overpayments. CCME conducted onsite interviews on October 11, 2018 with the PI director and PI staff to review the offsite documentation and file review findings.

General Requirements

Findings:

Section VIII A. General Requirements is addressed in Partners' submitted documentation.

Fraud and Abuse

Contract Requirement Section VIII B.12

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

Findings:

This requirement is not addressed in any policy or procedure submitted by Partners. However, Partners has the timeliness aspects of this requirement clearly stated in the *MCO/DMA Process Flow Chart* (Work Flow 2017).

Fifteen of 15files CCME reviewed document the initiation of an investigation within 10 business days. Of these, five cases warranted a report to NC Medicaid; all five cases include a report to NC Medicaid within five business days of the final determination.

Upon request and after the onsite visit, Partners provided a *Program Integrity Quality Assurance Review Worksheet* that includes the two timeliness aspects of this requirement

and further evidence that Partners actively monitors the implementation of this requirement.

Contract Requirements Section VIII B. 13.1–13.8

The contract language for these requirements is detailed under the File Review section.

Findings:

The findings for this requirement are detailed under the File Review section. All 15 files reviewed meet the subpart requirements of Section VIII B.13, when applicable; however, neither this requirement nor any of its subparts are addressed in any of the policy or procedures submitted by Partners.

Contract Requirements VIII B. 14.1–14.7

The contract language for these requirements is detailed under the File Review section.

Findings:

The findings for this requirement are detailed under the File Review section. No cases under review involve suspected enrollee fraud.

Contract Requirement VIII B. 17

If PIHP uses FAMS, PIHP shall work with the DMA designated Administrator to submit appropriate claims data to load into the DMA Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the DMA designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.

Findings:

This requirement is not addressed in any policy or procedure submitted by Partners. After the onsite visit, Partners provided evidence of communication regarding removal of two FAMS users to NC Medicaid (formerly DMA); however, it is not possible to determine if these requests were timely, as per this requirement (i.e., within 48 hours).

Partners is actively monitoring and reporting its FAMS users and requesting access removals from NC Medicaid.

Contract Requirement VIII B. 18

PIHP shall submit to the DMA Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month. Section 9.8 Fraud and Abuse Reports. In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to DMA Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59p.m. on the tenth (10th) of each month in the

format as identified in Attachment Y. PIHP shall also report to DMA Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.

Findings:

This requirement was not addressed in any policy or procedure submitted Partners. However, Partners presented the following evidence that this requirement is being implemented:

Partners submitted eight monthly FAMS user reports for the period from July 2017 to June 2018 and eight NCID holder reports from September 2017 to June 2018. Partners submitted the following written explanation for missing reports: "We are missing the FAMS users reports for the months of October through December 2017 and January 2018. During the period October or November, we added one user, William Owens. No other changes took place among PBHM's FAMS users until February when Craig Witkowski's access was removed."

"We are missing NC TRACKS NCID user reports for the months of August 2017 and October through November 2017." During the onsite review, Partners explained that the individual handling these FAMS user reports is no longer employed by Partners, and though normally in such a case the reports would be found in the ex-employee's email account or files, in this case, the PIHP was unable to locate the missing FAMS user reports. After the onsite review, Partners provided email messages to NC Medicaid acknowledging that it submitted the FAMS user and NCID holder reports and NC Medicaid acknowledgement of the submissions. Partners then submitted four new FAMS user reports for October 2017 to January 2018, though these documents were submitted past the allowed deadline.

Partners also submitted Attachment Y reports for the review period evidencing monthly reporting of suspected and confirmed fraud and abuse cases by the 10th of the month.

Upon request, Partners also submitted Attachment Z reports for the review period evidencing monthly reporting of terminated providers or non-renewal of providers after the onsite review. These reports are timely, as per the requirement.

Provider Payment Suspensions

Contract Requirement VIII B. 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.

Findings:

This requirement is not addressed in any policy or procedure submitted Partners. However, after the onsite review, Partners provided evidence that none of the providers NC Medicaid sent suspension notices for were in their network; therefore, none had any payments suspended. Partners submitted evidence of confirmation of this fact from the Finance Department, as well.

Contract Requirement VIII B. 2

Upon receipt of a payment suspension notice from DMA Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of DMA Program Integrity's suspension and lasting until PIHP is notified by DMA Program Integrity in writing that the suspension has been lifted.

Findings:

This requirement is not addressed in any policy or procedure submitted by Partners. However, after the onsite review, Partners provided evidence that none of the providers NC Medicaid sent suspension notices for were in its network; therefore, none had any payments suspended. Partners submitted evidence of confirmation of this fact from the Finance Department, as well.

Contract Requirement VIII B. 4

PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to DMA Program Integrity due to allegations of suspected fraud without prior written approval from DMA Program Integrity or the MFCU/MID.

Findings:

This requirement is not addressed in any policy or procedure submitted by Partners. During the onsite review, Partners confirmed that it does not have this requirement in any policy or procedure, though its practice is aligned with this requirement.

After the onsite review, Partners submitted evidence for the four cases that had suspension notices from NC Medicaid, that Partners took administrative action after receiving the notice, which provides evidence of implementing this requirement.

Contract Requirement VIII B. 5

Notwithstanding the foregoing, nothing herein shall be construed as prohibiting PIHP from taking any action against a Network Provider in accordance with the terms and conditions of any written agreement with a Network Provider, including but not limited to prepayment review, identification and collection of overpayments, suspension of referrals, de-credentialing, contract nonrenewal, suspension or termination or other

sanction, remedial or preventive efforts necessary to ensure continuous, quality care to Enrollees, regardless of any ongoing investigation being conducted by DMA, MFCU/MID or other oversight agency, to the extent that such action shall not interfere with Enrollee access to care or with any such ongoing investigation being conducted by DMA, MFCU/MID or other oversight agency.

Findings:

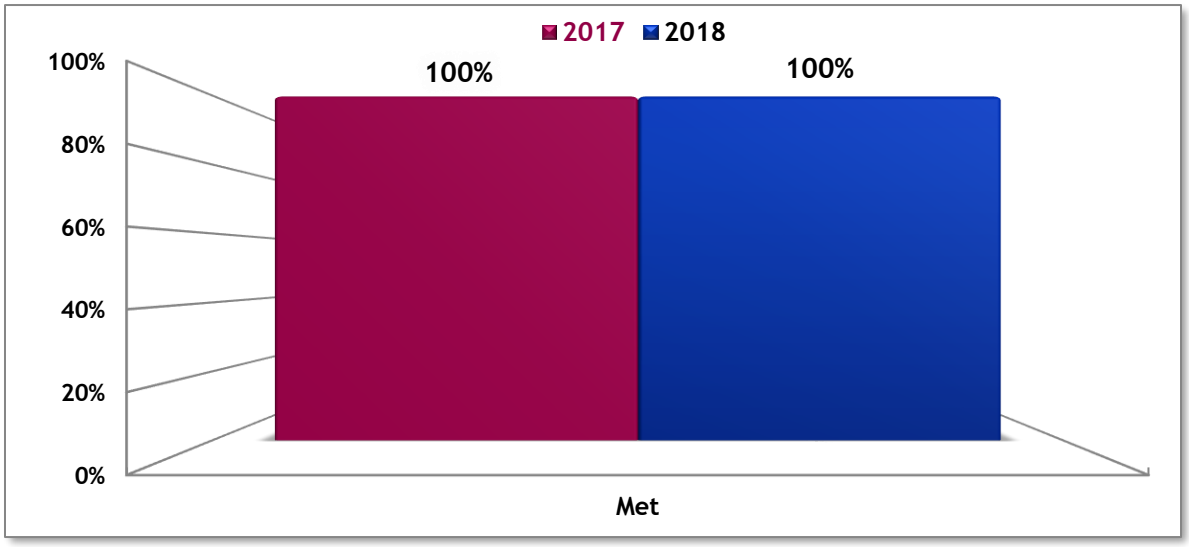
This requirement is partially addressed in the *Provider Monitoring Policy*; however, the premise that "such action shall not interfere with enrollee access to care" is not addressed in any policy or procedure.

The *Consumer/Enrollee Handbook* encourages enrollees to report fraud, waste, and abuse; however, it does not indicate that such an action will not interfere with enrollee's access to care.

During the onsite review, Partners explained that it has included information about protection of rights of those who report fraud, waste, and abuse (i.e., whistleblower rights and protection), but it does not have an explicit statement for enrollees about continuity of access to care.

As illustrated in Figure 9, Program Integrity Findings, Partners achieved scores of "Met" for 100% of the standards.

Figure 9: Program Integrity Comparative Findings



Strengths

- Partners has ongoing processes in place to monitor the implementation of PI requirements.

- The PI Department staff exhibits a fundamental understanding of Partners' contract with NC Medicaid, as well as with the relevant regulatory requirements.

Weaknesses

- Policies and procedures lack some of the timeliness elements that are part of the contractual requirements. Partners provides evidence of the implementation of these elements.
- Policies and procedures lack the required information needed when referring cases to NC Medicaid (formerly DMA) or do not cite the *LME/MCO Suspected Provider Fraud* or *Abuse DMA Program Integrity Referral* template.
- Policies and procedures lack sufficient language regarding processes of payment suspension. Specifically, policy or procedure does not state payment suspension must be lifted within three business days upon notification, and that payment suspension must last from the beginning of suspension period indicated in the suspension notice until written notification from NC Medicaid.
- Policy and procedures do not include that the PIHP will not take administrative action regarding allegations of suspected fraud on any Providers referred to the NC Medicaid Program Integrity Department due to allegations of suspected fraud without prior written approval from the NC Medicaid Program Integrity Department or the MFCU/MID.
- Policies and procedures lack any language that ensures that reporting fraud, waste, and abuse does not interfere with enrollee access to care.

Recommendations

- Include the timeframe for notifying NC Medicaid when there are changes in FAMS-users in a policy and procedure, clearly stating the timeliness requirement. Include the date of change/termination of employment in the FAMS user removal request email to provide clear evidence that it is meeting the 48-hour requirement.
- Include in a policy and procedure language clearly stating the timeliness requirements for lifting the payment suspension.
- Include in a policy and procedure, language clearly stating the timeliness requirements that payment suspension must last from beginning of suspension indicated in the suspension notice until written notification from NC Medicaid (i.e., from effective date to receipt of written notification from NC Medicaid).
- Include a statement that reporting fraud, waste, and abuse does not affect or interfere with enrollee's access to care.
- Include timeframe requirements for initiating a preliminary investigation in a policy and/or procedure, clearly stating the timeliness requirements. Partners can choose to

cite the existing flow chart and worksheet and attach it to an existing policy and/or procedure, as these documents list the timeliness elements. Partners can also make the flow chart an official procedure document and list it in the master list of policies and procedures, or include the requirement explicitly in relevant policies and procedures.

- Either include all the required information needed when referring a case to NC Medicaid in a policy and/or procedure or cite the *LME/MCO Suspected Provider Fraud* and *Abuse DMA Program Integrity Referral* template and attach it to relevant policies and procedures.
- Include language clearly stating the timeliness requirements for reporting all current NCID holders/FAMS-users in a policy and/or procedure.
- Include in a policy and/or procedure that the PIHP will not take administrative action regarding allegations of suspected fraud against any Providers referred to the NC Medicaid Program Integrity Department due to allegations of suspected fraud without prior written approval from the NC Medicaid Program Integrity Department or the MFCU/MID.

I. Financial Services

CCME's review of Partners' financial services identified enhancements to Partners' policies and procedures. CCME recommends Partners add the five-business day transfer requirement after capitation payment to policy and procedure *3.14, Management of Risk Reserve*. Partners must also revise policy and procedure *4.11, Record Retention and Disposition* to reference the 10-year requirement of financial records required by *DMA Contract, Section 8.3.2*.

CCME reviewed the following Partners' desk review materials prior to the onsite visit:

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

After reviewing Partners' desk materials, an onsite visit and interview was held at Partners' office on October 11, 2018. In reviewing Partners' financial operations, CCME utilized a standardized EQR finance desk review and onsite administrative interview guide. Recommendations from prior EQRs were also reviewed to determine whether they were implemented. In addition to the standardized desk review inquiries, CCME asked additional interview questions in the following areas:

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

Although Partners demonstrates ongoing financial stability, it is currently operating at a net loss for both Medicaid and non-Medicaid services. This loss is due to funding decreases by the NC General Assembly. The Medicaid loss has caused a decrease in funding for reinvestment projects since the prior fiscal year. Partners' audit report dated June 30, 2017, received an unqualified opinion, and there are no findings on the report regarding internal control over financial reporting and compliance. During fiscal year 2017, Partners' total net position decreased by $15,537,278.

Partners exceeded the contract benchmarks for current ratio, defensive interval, and medical loss ratio. Partners' Medicaid current ratio is 4.06 with a total current ratio of 3.25 for May 2018. The Medicaid current ratio is 3.85 with a total current ratio of 3.23 for June 2018 (benchmark is 1.00). Partners' Medicaid medical loss ratio is 90.4% fiscal year-to-date (benchmark is 85%). Partners' Medicaid total assets on May 31, 2018, are $101,848,261 and overall total assets are $133,317,921. As of June 30, 2018, Medicaid total assets are $99,196,655 and overall total assets are $127,134,163.

Partners meets standard *42 CFR § 433.32(a)* for maintaining an appropriate accounting system (Great Plains). The Great Plains modules Partners uses are general ledger, accounts payable, fixed assets, cash management, and payroll. Partners uses AlphaMCS for claims processing. Partners is outsourcing its payroll processing.

Partners meets the minimum record retention of 10 years required by *DMA Contract, Section 8.3.2*. Financial records are maintained for 10 years total, with eight years offsite at a HIPAA compliant storage facility, and two years onsite. Within Great Plains, records

are not purged and remain accessible through an archived database. Records are kept longer if any unresolved audit findings exist. In Partners' claims system, every claim line is moved from AlphaMCS to Great Plains, maintaining claims detail. CCME suggests that Partners add the 10-year contract requirement for financial records to policy and procedure *4.11, Records Retention and Disposition*.

Partners' policies and procedures are reviewed annually, or as needed. All finance policies and procedures reviewed by CCME reflect an annual board approval date of November 6, 2017. All policies are maintained on a SharePoint site. Policy and procedural changes are disseminated to staff by a standing agenda item at staff meetings. New hires are provided policies and procedures during orientation, and supervisors review policies with new staff members individually. During the onsite interview, Partners stated that several staff members are completing the NC Medicaid reports, and the Chief Business Officer reviews them.

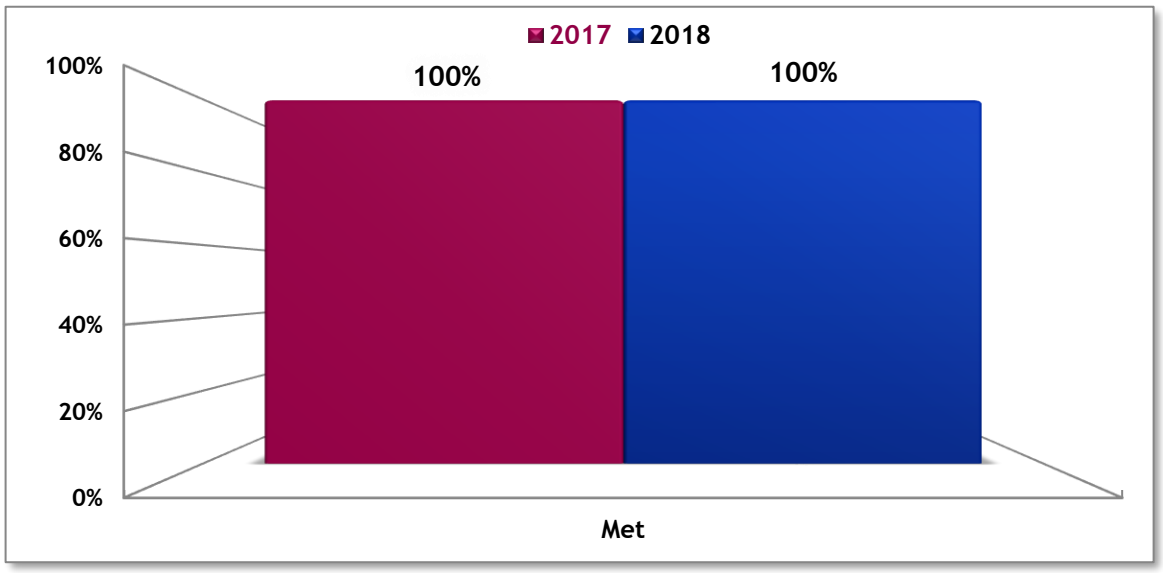
Partners' cost allocation plan meets the requirements for allocating the administrative costs between federal, state, and local entities based on revenue as required by *42 CFR § 433.34*. The audit report does not list any disallowed costs, nor were any identified during the onsite review. Annually, Partners submits a cost allocation plan to NC Medicaid to determine the percentage of Medicaid's share of administrative costs. Currently, this percentage is 86%, and there is little fluctuation. The administrative expenses are recorded by expense type in the general ledger and are then allocated to the different funding sources based on a percentage of total revenues received (minus county funding). The cost allocation is calculated monthly by the Finance Director. Partners' Medicaid funds are properly segregated through the chart of accounts in the Great Plains general ledger.

Partners' Medicaid Risk Reserve account meets the minimum requirement of 2% of the capitation payment per month required by *DMA Contract, Section 1.9*. Partners reached 10.7% of their required percentage of annualized capitation maximum (15%) by June 30, 2018, with a Medicaid Risk Reserve balance of $29,527,064. Once the capitation payment is received from NC Medicaid, the Finance Director calculates the risk reserve payment and pays the risk reserve contribution electronically within five business days to the risk reserve account at NC Capital Management Trust. All deposits are timely, and CCME found no evidence of unauthorized withdrawals. The Chief Financial Officer (CFO) reviews the bank reconciliation for this account as part of the monthly financial statement close. Partners provided CCME with bank statements demonstrating the risk reserve deposit and balance.

The prior EQR recommends Partners consider developing a policy and/or procedure documenting the submission of monthly NC Medicaid financial reports. This was added to the *Management of Financial Risk* policy and procedure.

Figure 10 shows 100% of the standards in the Finance section were scored as "Met" in both the 2017 and 2018 reviews.

Figure 10: Financial Findings



Strengths

- Partners has a strong financial position, as demonstrated by its key Medicaid financial ratios.
- Medicaid reports are filed timely with no disallowed costs to Medicaid.
- All risk reserve payments are timely.
- Partners met the record retention requirement of keeping records for a minimum of 10 years.
- Partners uses an extensive financial dashboard to inform the Finance Committee (a subcommittee of their Board of Directors and Executive Leadership team) of current financial and operation status.

Recommendations

- CCME recommends Partners add the five-business day transfer requirement after capitation payment to policy and procedure *3.14, Management of Risk Reserve*.
- Revise policy and procedure *4.11, Record Retention and Disposition* to refer to the 10-year requirement of financial records required by *DMA Contract, Section 8.3.2*.

J. Encounter Data Validation

To utilize the encounter data as intended and provide proper oversight, NC Medicaid must be able to deem the data complete and accurate. CCME's subcontractor, HMS, has completed a review of the encounter data submitted by Partners to NC Medicaid, as specified in the CCME agreement with NC Medicaid.

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

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

Results and Recommendations

Issue: Recipient ID

The Recipient Id was not consistently populated with valid data for professional or institutional claims. This information is key for passing the front end edits put in place by the State and to effectively price the claim. All Recipient Ids should be a ten byte, alpha numeric field. The value was always populated, however, not always with the correct length or expected format.

Resolution

Partners should check their claims processing system and data warehouse to ensure the Recipient Id is being captured appropriately. Claims submitted through the portal or an 837 would be denied by Partners. Partners should double check their 837 encounter creation process and encounter data extract process to make sure data was not lost or manipulated during transformation.

Issue: Dates of Service

A valid date of service is required in order to properly adjudicate a claim. This issue only occurred in the institutional claims data provided.

Resolution

Dates of service are a required field. Partners should be unable to pay institutional claims without this information. The MCO should check their claims processing system and data warehouse to ensure the field is required and being captured appropriately. If captured correctly, Partners should double check their 837 encounter creation process and encounter data extract process to make sure data was not lost during transformation.

Issue: Diagnosis Code

Two items need to be addressed as it relates to diagnosis codes. The principal diagnosis was not populated for 100% of the claims. Typically, the claim would be denied by Partner's when adjudicating claim as well as denied by NC Medicaid when submitted as an encounter record. Also, there are never more than 2 diagnosis codes provided/submitted in the encounter data for professional or institutional claims.

Resolution

The missing principal diagnosis code is not large enough to exceed the threshold outlined in the Data Quality Standards table above (>90%), however, Partner's should review the data being captured and submitted to ensure that claims are never submitted without a principal diagnosis. The second part noted above will require action by Partner's and NC Medicaid. NC Medicaid will need to work with the plans and CSRA to determine what additional non-behavioral health diagnosis codes should be submitted and accepted when available. Currently, NCTracks will deny any encounter with a non behavioral health diagnosis regardless of the position of the diagnosis code value (i.e. primary, secondary, tertiary, etc.). There are behavioral health services provided by the plans that require medical services and medical diagnosis codes. Partners will need to work collaboratively with the state and Alpha to ensure they can capture and report all diagnosis codes once NCTracks has been updated to accept.

Conclusion

Based on the analysis of Partners' encounter data, we have concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues were noted with both institutional and professional encounters. Based on Partners' ISCA response, overview of the Alpha system, and limited number of data anomalies, HMS believes that the errors are associated with the creation of the 837 rather than the data received and maintained. Partners should take corrective action to resolve the issues identified with Recipient Id, Dates of Service, and diagnosis codes.

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 Partners The goal is to ensure that Partners is reporting all paid claims as encounters to NC Medicaid.

The complete Encounter Data Validation Report can be found as Attachment 5.

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

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

August 22, 2018

Mr. Rhett Melton
Chief Executive Officer
Partners Behavioral Health
901 South New Hope Road
Gastonia, North Carolina 28054

Dear Mr. Melton,

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

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

The CMS EQR protocols can be found at:

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

The CCME EQR review team plans to conduct the onsite visit at Partners on **October 10, 2018** through **October 11, 2018**. For your convenience, a tentative agenda for the two-day review is enclosed.

In preparation for the desk review, the items on the enclosed **Materials Requested for Desk Review** list are to be submitted electronically and are due no later than **September 12, 2018**. As indicated in item 42 of the review list, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted by the aforementioned deadline.

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

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

The location for the file transfer site is:

https://eqro.thecarolinascenter.org

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

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

An opportunity for a pre-onsite conference call with your management staff, in conjunction with the DHB, 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: Jackie Copeland, Partners' Contract Manager
Greg Daniels, DHB Contract Manager
Renee Rader, DHB Quality Manager
Deb Goda, DHB Behavioral Health Unit Manager

A. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2018

MATERIALS REQUESTED FOR DESK REVIEW

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

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

3. Current Medical Director, medical staff job descriptions.

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

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

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

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

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

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

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

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

12. A current provider manual and provider directory.

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

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

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

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

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

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

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

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

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

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

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

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

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

25. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

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

27. Practice guidelines developed for use by practitioners, including references used in their development, when they were last updated and how they are disseminated. Also, policies and procedures for researching, selecting, adopting, reviewing, updating, and disseminating practice guidelines.

28. All information supplied as orientation to new providers, including a copy of the provider handbook or manual.

29. A copy of the provider contract/application.

30. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the PIHP, and any reports of activities submitted by the subcontractor to the PIHP. Also, completed evaluations of entities conducted before delegation is granted.

31. Contracts for all delegated entities.

32. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used. Include annual evaluation, if applicable.

33. Please provide an excel spreadsheet with a list of enrollees that have been placed in care coordination since April 2015. Please indicate the disability type (MH/SA, I/DD).

34. Please provide an excel spreadsheet with a list of enrollees that have been place in the TCLI program since April 2015. Please include the following: number of individuals transitioned to the community, number of individuals currently receiving Care Coordination, number of individuals connected to services and list of services receiving, number of individuals choosing to remain in ACH connected to services and list of services receiving.

35. Information regarding the following selected Performance Measures:

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

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

36. Required information includes the following <u>for each measure</u>:

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.

37. 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.)
38. Summary description of quality oversight of the Transition to Community Living Initiative, including monitoring activities, performance metrics, and results.
39. Data and/or reports for the Transition to Community Living Initiative (e.g., numbers of in-reach completed, housing slots filled, completed transitions, numbers of enrollees in supported employment, numbers of enrollees assigned to assertive community treatment [ACT], etc.) for the period July 2017 – June 2018.
40. Call performance statistics for the period of July 2017 – June 2018, including average speed of answer, abandoned calls, and average call/handle time for customer service representatives (CSRs).
41. Provide electronic copies of the following files:
    a. Credentialing files for 12 most recently credentialed practitioners (should include 6 licensed practitioners who work at agencies and 6 Licensed Independent Practitioners, include at least two physicians). Please also include four files for network provider agencies and/or hospitals and/or psychiatric facilities, in any combination. The credentialing files should include all of the following:

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

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

The recredentialing files should include all of the following:

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

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

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

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

42. Provide the following for Program Integrity:
    a. File Review: Please produce a listing of all active files during the review period (July 2017 – June 2018) including:
        i. Date case opened
        ii. Source of referral
        iii. Category of case (enrollee, provider, subcontractor)
        iv. Current status of the case (opened, closed)
    b. Program Integrity Plan and/or Compliance Plan.
    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.
    e. All 'Attachment Y' reports collected during the review period.
    f. Provider Manual and Provider Application.
    g. Enrollee Handbook.
    h. Subcontractor Agreement/Contract Template.
    i. Training and educational materials for the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
    j. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse.

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

l. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to DMA/DHB or any other State or Federal agency.

m. Code of Ethics and Business Conduct.

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

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

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

    i. DMA/DHB approved reporting templates.

q. Sample Data Mining Reports.

r. DMA/DHB Monthly Meeting Minutes for entire review period, including agendas and attendance lists.

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

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

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

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

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

a. A completed ISCA.

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

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

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

k. PIHP approved annual budget for fiscal year in review.

l. P&Ps regarding program integrity (fraud, waste, and abuse) including a copy of PIHP's compliance plan and work plan for the last twelve months.

m. Copy of the last two program integrity reports sent to DMA/DHB's Program Integrity Department.

n. An Excel spreadsheet listing all of the internal and external fraud, waste, and abuse referrals, referral agent, case activity, case status, case outcome (such as provider education, termination, recoupment and recoupment amount, recoupment reason) for the last twelve months.

o. A copy of PIHP's Special Investigation Unit or Program Integrity Unit Organization chart, each staff member's role, and each staff member's credentials.

p. List of the internal and external program integrity trainings delivered by PIHP in the past year.

q. Description and procedures used to allocate direct and overhead expenses to Medicaid and State funded programs, if changed during the review period.

r. Claims still pending after 30 days.

s. Bank statements for the restricted reserve account for the most recent two months.

t. A copy of the most recent cost allocation plan.

u. A copy of the PIHP's accounting manual.

v. A copy of the PIHP's general ledger chart of accounts.

w. Any finance Corrective Action Plan

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

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

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

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

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

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

B. Attachment 3: EQR Validation Worksheets

- Performance Improvement Project Validation Worksheet
  - Behavioral Health-TCLI Transition 90 days
  - Behavioral Health-MH follow up 7 days
  - Behavioral Health-PCP Referrals to BH
  - Behavioral Health-SUD follow up 7 days

- Mental Health 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

- Innovations Measures Validation Worksheet
  - Innovations Measure: Level of Care Initial Evaluation
  - Innovations Measure: Level of Care Evaluations Completed Using Approved Processes and Instruments
  - Innovations Measure: New Level of Care Evaluations Completed Using Approved Processes and Instruments
  - Innovations Measure: Proportion of Providers That Implemented an Approved Corrective Action Plan
  - Innovations Measure: Proportion of Providers Wherein All Staff Completed Mandated Training
  - Innovations Measure: Proportion of ISPs in which Services and Supports Reflect Participant Assessed Needs and Life Goals
  - Innovations Measure: ISPs Address Identified Health and Safety Risk Factors
  - Innovations Measure: Participants Reporting That ISP Has Services They Need
  - Innovations Measure: Individuals for Whom an Annual ISP and/or Needed Updates Took Place
  - Innovations Measure: New Waiver Participants are Receiving Services According to ISP within 45 Days of Approval

CCME EQR PIP Validation Worksheet

Plan Name:	**PARTNERS**
Name of PIP:	**TCLI TRANSITIONED IN 90 DAYS – NON-CLINICAL**
Reporting Year:	**2017**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	The DOJ settlement requirement is 80% for TCLI individuals, and the current rate for Partners is below the target rate.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	Partners addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is stated in the report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures are clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions to address lack of transportation, fear of loss of benefits, and communication are listed in Section IV of the report.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses were performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Partially Met**	The benchmark is listed as the comparison goal in the results Table, instead of the comparison benchmark. ***Recommendation: Comparison goal should be the same as the "baseline goal" and the comparison benchmark should be the documented benchmark rate from Table B.***
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	There are two measurements: baseline and remeasurement 1.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis of data is provided and follow up interventions are documented.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology was the same at both measurement periods.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	The rate improved from baseline to remeasurement 1.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement appears to be a result of the interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not calculated as sampling is not being utilized.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge with only two measurements.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	86
Project Possible Score	91
Validation Findings	95%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**PARTNERS**
Name of PIP:	**PROMOTING FOLLOW-UP WITHIN 7 DAYS OF DISCHARGE FROM A COMMUNITY HOSPITAL, STATE PSYCHIATRIC HOSPITAL, AND FACILITY BASED CRISIS SERVICE FOR MENTAL HEALTH TREATMENT**
Reporting Year:	**2017**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	The current rate is below 40% target rate for mental health follow-up within 7 days.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	Partners addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is stated in the report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Partially Met**	Measures are defined, but baseline goal is higher than benchmark for measure #2. ***Recommendation: Revise report to indicate the benchmark rate as the best practice rate, and the baseline goal/rate as the short-term goal.***
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.

STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and interim monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions to address barriers are listed in Section IV.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses were performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly and accurately.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	There are two measurements: baseline and remeasurement 1.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis of data is provided and follow up interventions are documented.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology was the same at both measurement periods.

9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	The rate improved from baseline to remeasurement 1.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement appears to be a result of the interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not calculated as sampling is not being utilized.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge with only two measurements.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	**86**
Project Possible Score	**91**
Validation Findings	**95%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**PARTNERS**
Name of PIP:	**PHYSICAL HEALTH/PRIMARY CARE PHYSICIAN (PCP) REFERRALS TO BEHAVIORAL HEALTH- NON-CLINICAL**
Reporting Year:	**2017**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	The current rate of PCP referrals is 12% which is below the goal of 15%.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	Partners addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is stated in the report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measure is related to processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions to address barriers are listed in Section IV.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses were performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly and accurately.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	There is only baseline measurement due to change in methodology.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis of data is provided and follow up interventions are documented.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology was revised, and baseline data for new methodology has been established.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline data only.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Baseline data only.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not calculated as sampling is not being utilized.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	84
Project Possible Score	84
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**PARTNERS**
Name of PIP:	**PROMOTING FOLLOW-UP WITHIN 7 DAYS OF DISCHARGE FROM A COMMUNITY HOSPITAL, STATE PSYCHIATRIC HOSPITAL, STATE ADACTS, AND DETOX/FACILITY BASED CRISIS SERVICES FOR SUD TREATMENT**
Reporting Year:	**2017**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	The current rate is below 40% target rate for SUD follow-up within 7 days.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	Partners addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is stated in the report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures are defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and interim monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions to address barriers are listed in Section IV.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses were performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly and accurately.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	There are two measurements: baseline and remeasurement 1.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis of data is provided and follow up interventions are documented.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology was the same at both measurement periods.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	The rates improved from baseline to remeasurement 1.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement appears to be a result of the interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not calculated as sampling is not being utilized.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge with only two measurements.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	91
Project Possible Score	91
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS**
Name of PM:	**READMISSION RATES FOR MENTAL HEALTH**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS**
Name of PM:	**READMISSION RATES FOR SUBSTANCE ABUSE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR SUBSTANCE ABUSE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS**
Name of PM:	**INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS**
Name of PM:	**MENTAL HEALTH UTILIZATION- INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS**
Name of PM:	**MENTAL HEALTH UTILIZATION**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS**
Name of PM:	**IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS**
Name of PM:	**SUBSTANCE ABUSE PENETRATION RATE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS**
Name of PM:	**MENTAL HEALTH PENETRATION RATE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**PARTNERS**
Name of PM	**INNOVATIONS MEASURE: LEVEL OF CARE EVALUATION**
Reporting Year	**2017**
Review Performed	**10/18**

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N7. Numerator	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N8. 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**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R4. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**PARTNERS**
Name of PM	**INNOVATIONS MEASURE: LEVEL OF CARE EVALUATIONS COMPLETED USING APPROVED PROCESSES AND INSTRUMENTS**
Reporting Year	**2017**
Review Performed	**10/18**

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N9. Numerator	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N10. 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**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R5. Reporting	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R6. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

	PARTNERS
Name of PM	**INNOVATIONS MEASURE: NEW LEVEL OF CARE EVALUATIONS COMPLETED USING APPROVED PROCESSES AND INSTRUMENTS**
Reporting Year	**2017**
Review Performed	**10/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G6. Documentation	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G7. Data Reliability	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D7. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D8. 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**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N11. Numerator	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N12. 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**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R7. Reporting	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R8. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**PARTNERS**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF PROVIDERS THAT IMPLEMENTED AN APPROVED CORRECTIVE ACTION PLAN**
Reporting Year	**2017**
Review Performed	**10/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G8. Documentation	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G9. Data Reliability	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D9. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D10. 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**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N13. Numerator	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N14. 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**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R9. Reporting	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R10. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**PARTNERS**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF PROVIDERS WHEREIN ALL STAFF COMPLETED MANDATED TRAINING**
Reporting Year	**2017**
Review Performed	**10/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G10. Documentation	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G11. Data Reliability	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D11. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D12. 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**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N15. Numerator	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N16. 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**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R11. Reporting	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R12. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**PARTNERS**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF ISPS IN WHICH SERVICES AND SUPPORTS REFLECT PARTICIPANT ASSESSED NEEDS AND LIFE GOALS**
Reporting Year	**2017**
Review Performed	**10/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G12. Documentation	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G13. Data Reliability	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D13. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D14. 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**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N17. Numerator	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N18. 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**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R13. Reporting	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R14. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**PARTNERS**
Name of PM	**INNOVATIONS MEASURE: ISPS ADDRESS IDENTIFIED HEALTH AND SAFETY RISK FACTORS**
Reporting Year	**2017**
Review Performed	**10/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G14. Documentation	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G15. Data Reliability	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D15. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D16. 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**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N19. Numerator	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N20. 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**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R15. Reporting	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R16. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**Partners Behavioral Health**
Name of PM	**INNOVATIONS MEASURE: PARTICIPANTS REPORTING THAT ISP HAS SERVICES THEY NEED**
Reporting Year	**2017**
Review Performed	**10/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G16. Documentation	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G17. Data Reliability	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D17. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D18. 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**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N21. Numerator	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N22. 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**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R17. Reporting	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R18. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**PARTNERS**
Name of PM	**INNOVATIONS MEASURE: INDIVIDUALS FOR WHOM AN ANNUAL ISP AND OR NEEDED UPDATES TOOK PLACE**
Reporting Year	**2017**
Review Performed	**10/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G18. Documentation	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G19. Data Reliability	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D19. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D20. 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**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N23. Numerator	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N24. 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**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R19. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R20. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**PARTNERS**
Name of PM	**INNOVATIONS MEASURE: NEW WAIVER PARTICIPANTS ARE RECEIVING SERCICES ACCORDING TO ISP WITHIN 45 DAYS OF APPROVAL**
Reporting Year	**2017**
Review Performed	**10/18**

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G20. Documentation	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G21. Data Reliability	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D21. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D22. 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**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N25. Numerator	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N26. 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**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R21. Reporting	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R22. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

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

AVERAGE VALIDATION PERCENTAGE & AUDIT DESIGNATION
100% FULLY COMPLIANT

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

C. Attachment 4: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

CCME PIHP Data Collection Tool

Plan Name:	PARTNERS
Collection Date:	2018

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A. General Approach to Policies and Procedures						
1. The PIHP has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Partners' policy and procedure set is organized with evidence of annual review and regular revisions. All policies and procedures were accounted for per the *Policies/Procedures Master Listing*.
I. B. Organizational Chart / Staffing						
1. The PIHP's resources are sufficient to ensure that all health care products and services required by the State of North Carolina are provided to enrollees. At a minimum, this includes designated staff performing in the following roles:						
1.1 A full time administrator of day-to-day business activities;	X					Rhett Melton continues in his role as Chief Executive Officer.
1.2 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical	X					Dr. Stanton has served as Chief Medical Officer (CMO) since October 2017, and substantial oversight of the medical aspects of the operation are evident in her job description and committee participation. While Dr. Stanton demonstrated thorough knowledge of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
aspects of operation, including quality assurance activities.						Partners' clinical operations, CCME expresses concerns over the amount of CMO and Associate Medical Director functions and responsibilities for which she is responsible. ***Recommendation: Continue to recruit for the AMD position.***
2. Operational relationships of PIHP staff are clearly delineated.	X					Partner Organizational Chart does not accurately show the Chief Medical Officer's (CMO) involvement and oversight of UM, QI, Credentialing, and other clinical functions. ***Recommendation: Align Partners' Organizational Chart to reflect the clinical oversight outlined in Partners' Chief Medical Officer job description and DMA Contract, Section 6.7.6 and 7.1.3.***
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all PIHP staff positions, including those that are required by DMA contract.	X					Partners' Organizational Chart reflects staff credentials, licensure, certifications, etc. and demonstrates staff is trained appropriately for their positions.
I. C. Confidentiality						
1. The PIHP formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					CCME found evidence of procedural development specific to HIPAA privacy compliance, HIPAA oversight, confidentiality of information, access to and amendments of Protected Health Information (PHI), HIPAA Breach Notification, and release of information with and without client consent.
2. The PIHP provides HIPAA/confidentiality training to new employees and existing staff.	X					Partners verifies new staff is trained on confidentiality "before assuming assigned roles and responsibilities." Staff reported during the Onsite interview this training occurs on day one of their employment.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I D. Management Information Systems						
1. Enrollment Systems						
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Partners has defined processes for enrollment data updates. AlphaMCS handles enrollment data updates using daily GEF. Partners uses the monthly capitation file to reconcile the enrollment information in AlphaMCS.
1.2 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Demographic data is captured in the AlphaMCS system, and patient IDs are unique to members.
1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.	X					Historical enrollment information is captured for all members in the AlphaMCS system.
2. Claims System						
2.1 The MCO processes provider claims in an accurate and timely fashion.	X					Approximately 89.7% of Institutional claims and 98.9% of Professional claims are auto-adjudicated. The following claims are pending: claims billed with an emergency department Bill Type of 013X or claims in excess of $5,000.00. A pending report is generated daily for a claims processor to review and manually approve or deny the claim.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.2 The MCO has processes and procedures in place to monitor review and audit claims staff.	X					Partners provided a policy and procedure document with details regarding the auditing of claims on a daily and quarterly basis.
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					Checks and internal audits in place to lower the number of claim denials.
2.4 The MCO's claim system screens store and track claim information and claim adjudication/payment information.	X					Claim system captures up to 25 ICD-10 diagnosis codes for institutional claims and up to 12 ICD-10 diagnosis codes for professional claims.
3. Reporting						
3.1 The MCO's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Partners captures all necessary data elements required for enrollment and claims reporting. Historical data is stored in the system from the inception of the PIHP.
3.2 The MCO has processes in place to back up the enrollment and claims data repositories.	X					This was discussed Onsite and Partners provided a disaster recovery policy and procedure along with the ISCA tool.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Encounter Data Submission						
4.1 The MCO has the capabilities in place to submit the State required data elements to DMA on the encounter data submission.		X				Update encounter data submission process to allow for all ICD-10 CM secondary diagnosis codes submitted on an institutional and professional 837 HIPAA file submitted to NCTracks. Twenty-five ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837I and the maximum number that is captured by NCTracks. NCTracks is capable of capturing up to 12 diagnosis codes for professional claims. ***Corrective Action: Update encounter data submission process to allow for all ICD-10 CM diagnosis codes submitted on an institutional and professional 837 HIPAA file submitted to NCTracks. Twenty-five ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837I and the maximum number that is captured by NCTracks. NCTracks is capable of capturing up to 12 diagnosis codes for professional claims.***
4.2 The MCO has the capability to identify, reconcile and track the encounter data submitted to DMA.	X					Encounter data reconciliation tracks the submission of the encounter to the state and the remittance response; a process in place at Partners. Partners has staff dedicated to the research, correction and resubmission of NCTracks denied encounters.
4.3 MCO has policies and procedures in place to reconcile and resubmit encounter data denied by DMA.	X					The PIHP has clear processes in place to address denied encounter submissions. A process based on the Adam Holtzman reports was put in place for staff to review and rebill denied encounters. Communications are established between multiple departments to address encounter denials based on provider taxonomy codes, enrollment changes, and unauthorized services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.4 The MCO has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to DMA	X					Communications are established between IT and Claims Departments to address NCTracks encounter denials. Partners developed approximately 250 reports to assist in enrollment, claims, and encounter data reconciliation. ***Recommendation: During the Onsite, Partners stated its denial rate may increase if it were to submit all the secondary ICD-10 diagnosis codes and any physical health related secondary diagnosis codes to NCTracks. CCME recommends that Partners discuss the denial criteria applied to secondary ICD-10 diagnosis codes by NCTracks with NC Medicaid.***

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					Policy and procedure *8.26U, Provider Credentialing*, policy and procedure *8.27, Selection and Retention of Network Providers*, and the *Credentialing Program Description* address the credentialing and recredentialing processes.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 Charter* and section XXI of the *Credentialing Program Description* provide details on the composition and responsibilities of the Credentialing Committee. The Credentialing Committee is composed of network providers representing various specialties, and Partners' employees. "The Committee has a quorum if greater than ½ of the filled positions of the voting membership are present. Although the Chair does not normally participate in the vote, in the event of a tie, the Chair casts the deciding vote."
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 were organized and contained appropriate information. The following issues were identified from the file review.
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements	X					One credentialing file did not include the Certificate of Insurance or attestation for Workers' Comp/Employers' Liability insurance. Another file did not contain a letter from the agency verifying that the provider is covered under the agency's insurance policies. ***Recommendation: Verify proof of all types of required insurance or the relevant waiver(s) (and a statement that the practitioner is covered under the agency insurance, if that is the case) is in all credentialing files. See DMA Contract Attachment B, section 7.7.***

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					No supervision contract was found in the file of providers with "Associate" licensure (such as LPC-A or LCSW-A) and the file of a provider who is a Licensed Psychological Associate (LPA). As was discussed during the Onsite visit, the NC Psychology Board has verified that, "even if the LPA is verified via the Board website, there is no guarantee that their supervision contract on file is current and up to date." Therefore, the PIHP must obtain the current supervision contract as part of the credentialing and recredentialing process. ***Recommendation: Contact licensure boards to determine how they are checking supervision contracts for practitioners with "associate" licensure and to confirm if a practitioner (with "associate" licensure) listed on the licensure board website is confirmation of a current supervision contract. Verify credentialing files include supervision contracts for practitioners for whom it is required (Licensed Psychological Associates and other practitioners with an "Associate" licensure designation, based on responses from licensure boards). See DMA Contract, Attachment O.***
3.1.3 Valid DEA certificate; and/or CDS certificate	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					
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					The *Credentialing Program Description* defines a "Complete Application" as "an application that includes a signed attestation and all required information and documentation in order for the credentialing verification to be completed." The *Credentialing Program Description* several times lists the requirement for an attestation that the application is complete and accurate. The submitted applications of practitioners joining agencies have attestations signed by agency personnel, rather than the application attestation signed by the actual applicant (the practitioner). Partners submitted a representative sample of the practitioner application attestations in response to CCME's *Onsite Request List*. ***Recommendation: Per the Credentialing Program Description, verify all credentialing files include attestations signed by the applicant (not the agency personnel).***

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);	X					No evidence of a query of the *State Exclusion List* was found in any submitted practitioner credentialing file, though the query evidence was submitted for agency files. Evidence was submitted in response to the *Onsite Request List*. A demonstration during the Onsite visit confirmed that the screen in the Cactus system is marked "met" for this query. A date is not displayed. Partners' staff conveyed a plan to go to a paper checklist for PSVs, and the date of the query will be recorded on the checklist. ***Recommendation: Verify credentialing files include documentation of the query of the State Exclusion List. See DMA Contract, Sections 1.14.4 and 7.6.4.***
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Ownership Disclosure is addressed.	X					The Ownership Disclosure information was not included in one of the initial credentialing files. ***Recommendation: Verify Ownership Disclosure information is in each credentialing file, including the files of licensed practitioners joining an agency. See DMA Contract, Attachment O.***
3.1.16 Criminal background Check	X					
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.	X					The review date on the *DHHS New Unlicensed Site Review Tool* completed for the initial credentialing file of one practitioner states, "06/14/18 via FaceTime." During the Onsite visit, Partners' staff confirmed the review was conducted via FaceTime and no Partners' staff member was present for a site review. Partners' staff also confirmed this process is not included in any policy or procedure, and has not been discussed with or approved by North Carolina Medicaid. ***Recommendation: Discuss with North Carolina Medicaid the practice of conducting a site visit via the FaceTime app, rather than Partners' staff conducting the site visit onsite. If approved by North Carolina Medicaid, retain documentation of the approval, and capture the practice in a Partners' policy and/or procedure.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.3 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 were organized and contained appropriate information. The following issues were identified in the file review.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					One recredentialing file did not contain the PSV of license. The PSV of the license in another recredentialing file was not dated. ***Recommendation: Verify PSV of required elements is completed, and that the PSVs display the date of the query.***
4.2.3 Valid DEA certificate; and/or CDS certificate	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					The *Credentialing Program Description* defines a "Complete Application as "an application that includes a signed attestation and all required information and documentation in order for the credentialing verification to be completed." The *Credentialing Program Description* lists the requirement for an attestation that the application is complete and accurate several times. The submitted applications of practitioners joining agencies had attestations signed by agency personnel rather than the application attestation signed by the actual applicant (the practitioner). Partners submitted a representative sample of the practitioner application attestations in response to CCME's *Onsite Request List*. Partners' staff confirmed they obtain attestations from applicants. ***Recommendation: Per the Credentialing Program Description, verify all recredentialing files include attestations signed by the applicant (not the agency personnel).***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					Some of the submitted NPDB query reports are illegible. Partners submitted a representative sample of the NPDB query reports in response to CCME's *Onsite Request List*. One copy was more legible; the other was still quite illegible, and Partners provided a hard copy during the Onsite visit. A demonstration during the Onsite visit confirmed the query is legible when displayed in the Cactus system. ***Recommendation: Verify PSV copies submitted for the EQR are legible and include the date of the query.***
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event;	X					No evidence of a query of the *State Exclusion List* was found in any submitted practitioner recredentialing file, though the query evidence was submitted for agency files. Partners submitted evidence in response to the CCME *Onsite Request List*. A demonstration during the Onsite visit confirmed that the screen in the Cactus system is marked "met" for this query. A date is not displayed. Partners' staff conveyed a plan to go to a paper checklist for PSVs, and the date of the query will be recorded on the checklist. ***Recommendation: Verify recredentialing files include documentation of the query of the State Exclusion List. See DMA Contract, Sections 1.14.4 and 7.6.4.***
4.2.9 Requery of the SAM.	X					Some of the submitted SAM query reports did not contain the date of the query. CCME requested and received a representative sample of the SAM queries that included the date of the PSV. A demonstration during the Onsite visit confirmed that the date of the query is displayed in the Cactus system. ***Recommendation: Verify PSV copies submitted for the EQR include the date of the query.***

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;	X					
4.2.11 Query of the Social Security Administration's Death Master File	X					
4.2.12 Query of the NPPES;	X					Some of the submitted NPPES query reports did not contain the date of the query. CCME requested a representative sample of the NPPES queries that included the date of the PSV. Partners submitted the query for the listed practitioners; however, no date existed on the query submitted for one of the two files. For the other file, Partners submitted screenshots from its licensed software, Cactus. The date of the PSV is clearly posted. A demonstration during the Onsite visit confirmed that the date of the query is displayed in the Cactus system. ***Recommendation: Verify PSV copies submitted for the EQR include the date of the query.***
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.2.14 Ownership Disclosure is addressed.	X					

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					Minutes from the Credentialing Committee meetings include references to provider performance issues and Quality of Care concerns.
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					
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					The *Credentialing Program Description* includes verification of accreditation as part of the process completed by the delegate for credentialing. Two of the initial organizational credentialing files and two of the recredentialing files required PSV of accreditation and all four files contained the PSV; however, the PSVs did not contain the date of the queries. ***Recommendation: Verify PSV of required elements is completed, and that the PSVs display the date of the query.***
II B. Adequacy of the Provider Network						
1. The PIHP maintains a network of providers that is sufficient to meet the health care needs of enrollees and is consistent with contract requirements.	X					Policy and procedure *8.22 U, Network Program Scope*, addresses network sufficiency.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 Enrollees have a Provider location within a 30 – mile distance of 30 minutes' drive time of their residence. Rural areas are 45 miles and 45 minutes. Longer distances as approved by DMA are allowed for facility based or specialty providers.	X					The *2017 Community Behavioral Health Provider and Service Gap Analysis* indicates choice and access standards were not met for Medicaid-funded Opioid Treatment and for Substance Abuse-Comprehensive Outpatient Treatment Program (SA-COT) services. Exception Requests were filed with NC Medicaid for both services. Partners has a workgroup to locate and recruit providers to address these needs. During the Onsite discussion, Partners' staff indicated the data collected for the 2018 gaps report demonstrates that the gap for Medicaid-funded Opioid Treatment was resolved, but the gap for SA-COT services continues. With the 2018 Gaps Analysis, Partners filed an Exception Request with NC Medicaid for SA-COT. The 30 miles/30 minutes and 45 miles/45 minutes standards are detailed on several pages of the *Provider Operations Manual* and in Partners' policy and procedure *8.00, Access and Availability Standards*.
1.2 Enrollees have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the enrollee may utilize an out-of-network specialist with no benefit penalty.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 The sufficiency of the provider network in meeting enrollee demand is formally assessed at least annually.	X					Partners conducts an annual *Gaps and Needs* analysis, as required by NC Medicaid.
1.4 Providers are available who can serve enrollees with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Partners gathers information regarding foreign languages spoken, diverse populations served, and clinical expertise and specialty areas on the *Credentialing Initiation Form*. Enhanced rates are provided when warranted, such as for providing outpatient services in an enrollee's home or for Mental Health/Substance Use Targeted Case Management.
1.5 The PIHP demonstrates significant efforts to increase the provider network when it is identified as not meeting enrollee demand.	X					
2. Provider Accessibility						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.1 The PIHP formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					The *Provider Operations Manual* informs providers of their responsibility to "provide services in accordance with access standards and appointment wait times as noted in the general conditions of the procurement contract". Policy and procedure *8.22 U, Network Program Scope*, states, "The Quality Improvement Committee (QIC) provides oversight of access and availability by reviewing various reports related to access and availability goals at least quarterly. Corrective action plan may be indicated when performance is continually outside the set performance standards."
II C. Provider Education						
1. The PIHP formulates and acts within policies and procedures related to initial education of providers.	X					Training and orientation of network providers is described in policy and procedure *8.13 U, Participating Provider Relations Program*. New providers receive the orientation packet link, which includes the telephone number and email address of their designated provider relations representative. The *Provider Orientation Toolkit* is a 4 page document with summary information and website links regarding AlphaMCS Provider Portal, Claims, Zixmail, Incidents, Housing, Grievances, Complaints or Concerns, and a variety of other topics.
2. Initial provider education includes:						Information regarding the following standards is included in the *Provider Operations Manual*, and/or on the Partners' website unless otherwise noted.
2.1 PIHP purpose and mission;	X					
2.2 Clinical Practice Standards;	X					The *Provider Operations Manual* references the Clinical Practice Guidelines and provides a link to the guidelines on the Partners' website. Both the *Provider Operations Manual* and the Clinical Practice Guidelines indicate providers are responsible for following the guidelines and adherence to the guidelines is monitored.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.3 Provider responsibilities;	X					Provider responsibilities are outlined throughout the *Provider Operations Manual*.
2.4 PIHP closed network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability.	X					
2.5 Access standards related to both appointments and wait times;	X					
2.6 Authorization, utilization review, and care management requirements;	X					
2.7 Care Coordination and discharge planning requirements;	X					
2.8 PIHP dispute resolution process;	X					
2.9 Complaint investigation and resolution procedures;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.10 Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements;	X					
2.11 Enrollee rights and responsibilities	X					
2.12 Provider program integrity requirements that include how to report suspected fraud, waste and abuse, training requirements as outlined in the False Claims Act, and other State and Federal requirements.	X					The *Provider Operations Manual* and the *Provider Orientation Toolkit* include how to report suspected fraud, waste, and abuse. The Program Integrity Department presented information about "Identifying Fraud and Abuse in Health Care" at the December 2017 Provider Forum. The webinar and slides are posted on the Partners' website.
3. The PIHP provides ongoing education to providers regarding changes and/or additions to its programs, practices, enrollee benefits, standards, policies and procedures.	X					The Partners' website offers extensive training information for providers, including a *Provider Knowledge Base* section and a *Training Academy* section. An "Upcoming Events" calendar is also posted on the website. Provider *Communication Bulletins* and *Provider Alerts* are posted on the website. Provider Forums are conducted quarterly. Videos and handouts from previous forums are posted on the website. *Provider Alerts* are sent via email to communicate time-sensitive information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II D. Clinical Practice Guidelines for Behavioral Health Management						
1. The PIHP develops clinical practice guidelines for behavioral health management of its enrollees that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Partners adopted Clinical Practice Guidelines from the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry. The adopted guidelines are approved by the Partners' Quality Improvement Committee (QIC) and its subcommittee, the Clinical Advisory Committee. Policy and procedure *13.09, Practice Guidelines*, details the process of researching, developing or adopting, and monitoring the guidelines.
2. The PIHP communicates the clinical practice guidelines for behavioral health management and the expectation that they will be followed for PIHP enrollees to providers.	X					The *Provider Operations Manual* informs providers about the Clinical Practice Guidelines and the expectation that care will be provided in accordance with the guidelines. Several locations in the manual include a link to the Clinical Practice Guidelines on the Partners' website. The manual also includes the Clinical Practice Guidelines, including the links posted on the Partners' website. The Clinical Practice Guidelines on the Partners' website and in the *Provider Operations Manual* have guidelines in sections, based on the population being treated (e.g., Adult Mental Health, Child Mental Health, Substance Use Disorders, etc.)
II E. Continuity of Care						
1. The PIHP monitors continuity and coordination of care between providers.	X					Coordination between providers is part of the required NC Provider Monitoring Process for PIHPs.
II F. Practitioner Medical Records						
1. The PIHP formulates policies and procedures outlining standards for acceptable documentation in the Enrollee medical records maintained by providers.	X					The *Provider Operations Manual* includes a "Medical Records Requirements" section that contains the requirements outlined in the *DMA Contract*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP monitors compliance with medical record documentation standards through formal periodic medical record audit and addresses any deficiencies with the providers.	X					Medical record documentation compliance is part of the routine monitoring process.
3. The PIHP has a process for handling abandoned records, as required by the contract.		X				During the Onsite visit Partners' staff communicated the required steps, but confirmed the "Abandoned Records" language found in *DMA Contract Attachment B*, section *8.2.1* is not in any Partners' policy or procedure. ***Corrective Action: Add to a policy or procedure the "Abandoned Records" steps identified in DMA Contract Attachment B, section 8.2.1.***

III. ENROLLEE SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III A. Enrollee Rights and Responsibilities						
1. The PIHP formulates policies outlining enrollee rights and procedures for informing enrollees of these rights.	X					Policy and procedure *7.01U, Consumer Rights and Responsibilities* outlines enrollee rights and responsibilities and the process for notifying enrollees of these rights.
2. Enrollee rights include, but are not limited to, the right:	X					Information regarding enrollee rights and the following standards is listed in policy and procedure *7.01U, Consumer Rights and Responsibilities*, the *Consumer/ Enrollee Handbook*, the *Provider Operations Manual*, and the Partners' website, unless otherwise noted.
2.1 To be treated with respect and due consideration of dignity and privacy;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;						
2.3 To participate in decisions regarding health care;						
2.4 To refuse treatment;						
2.5 To be free from any form of restraint of seclusion used as a means of coercion, discipline, convenience or retaliation;						
2.6 To request and receive a copy of his or her medical record, except as set forth in 45 C.F.R. §164.524 and in N.C.G.S. § 122C-53(d), and to request that the medical record be amended or corrected in accordance with 45 CFR Part 164.						
2.7 Of enrollees who live in Adult Care Homes to report any suspected violation of their enrollee rights, to the appropriate regulatory authority as outlined in NCGS§ 131-D21.						
III B. Enrollee PIHP Program Education						
1. Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid waiver managed care program which they are contractually entitled, including:		X				Within 14 days of the initial request for services, Partners provides new enrollees with a *Welcome Letter* and a copy of the *Notice of Privacy Practices*. The letter directs members to the PIHP website for information about eligible services, privacy, rights and responsibilities, committees enrollees can join, and other resources

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						like housing and employment. The letter includes the 24-hour Access to Care phone number and the TTY phone number. See individual sub-standards for recommendations and corrective actions.
1.1 A description of the benefits and services provided by the PIHP and of any limitations or exclusions applicable to covered services. These descriptions must have sufficient detail to ensure the Enrollees understand the benefits to which they are entitled and may include a web link to the PIHP Benefit Plan. This includes a descriptions of all Innovations Waiver services and supports;						
1.2 Benefits include access to a 2nd opinion from a qualified health care professional within the network, or arranges for the enrollees to obtain one outside the network, at no cost to the enrollee;						
1.3 Updates regarding program changes;						
1.4 A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;						
1.5 An explanation of the Enrollee's responsibilities and rights and protection;						
1.6 An explanation of the Enrollee's rights to select and change Network Providers						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.7 The restrictions, if any, on the enrollee's right to select and change Network Providers						
1.8 The procedure for selecting and changing Network Providers						
1.9 Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request);						The printed and online *Provider Directory* are missing the field for "provider accepting new patients." ***Corrective Action: Add the field for "provider accepting new patients" to the printed and online Provider Directory.***
1.10 The non-English languages, if any, spoken by each Network Provider;						The printed *Provider Directory* has a field for "Languages supported" which is unclear if this refers to interpreted language or languages spoken by the provider. The *Credentialing Initiation Form* has a question for "Languages other than English which you are able to communicate fluently." This is clear it is the provider's spoken language. ***Recommendation: Rename the field "Languages supported" in the printed Provider Directory to indicate if it is the provider spoken language or interpretation services available.***
1.11 The extent to which, and how, after-hours and emergency coverage are provided, including:						
1.11.1 What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services in accordance with 42 CFR§ 438.114 and EMTALA;						*Consumer/Enrollee Handbook* states, "Your behavioral health emergency care will include post-stabilization screenings and services to maintain the stabilized condition, or to improve or resolve your condition."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.11.2 The fact that prior authorization is not required for emergency services;						Emergency services are explained in the *Consumer/Enrollee Handbook* as they can "use any hospital or other setting for emergency care. You do not need permission before you choose."
1.11.3 The process and procedures for obtaining Emergency Services, the use of 911 telephone services or the equivalent;						
1.11.4 The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract;						There is no documentation in the enrollee written materials to explain locations of post stabilization services. ***Corrective Action: Add locations at which post stabilization services are furnished in the enrollee written materials.***
1.11.5 A statement that, subject to the provisions of the DMA this contract, the Enrollee has a right to use any hospital or other setting for Emergency care;						
1.12 The PIHP's policy on referrals for Specialty Care to include cost sharing, if any, and how to access Medicaid benefits that are not covered under this Contract;						
1.13 Any limitations that may apply to services obtained from Out-of Network Providers, including disclosures of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of Network Providers, and the procedures for						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
obtaining authorization for such services.						
1.14 How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost-sharing;						
1.15 Procedures for obtaining out-of-area or out-of-state coverage of or services, if special procedures exist;						
1.16 Information about medically necessary transportation services by the department of Social Services in each country;						
1.17 Identification and explanation of State laws and rules Policies regarding the treatment of minors;						
1.18 The enrollee's right to recommend changes in the PIHP's policies and procedures						
1.19 The procedure for recommending changes in the PHIP's policies and procedures;						
1.20 The Enrollee's right to formulate Advance Directives;						
1.21 The Enrollee's right to file a grievance concerning non-actions, and the Enrollee's right to file an appeal if PIHP takes an action against an Enrollee;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.22 The accommodations made for non-English speakers, as specified in 42 CFR §438.10(c)(5);						
1.23 Written information shall be made available in the non-English languages prevalent in the PIHP's services area.						Page 3 of the *Consumer/Enrollee Handbook* informs enrollees of translation services "available from the Call Center and your provider at no cost." This statement is also in Spanish in the *Consumer/Enrollee Handbook*.
1.24 The availability of oral interpretation service for non-English languages and how to access the service;						
1.25 The availability of interpretation of written information in prevalent languages and how to access those services						
1.26 Information on how to report fraud and abuse; and						Information is in the *Consumer/Enrollee Handbook* and the Partners' website.
1.27 Upon an Enrollee's request, the PIHP shall provide information on the structure and operation of the agency and any physician incentive plans.						
1.28 Information on grievance, appeal and fair hearing procedures and information specified in CFR §438.10 (g) and CFR §438.10 (f) (6).						
2. Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.	X					The annual mailing sent to enrollees includes this information.
3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in CFR 438.10 (f) (61) and 438.10 (g) at least 30 days	X					The *Consumer/Enrollee Handbook* states, "If a Medicaid service benefit is added or changed, you will be notified in writing thirty calendar days before the change happens."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
before calendar days before the intended effective date of the change; and (2) . termination of their provider within fifteen (15) calendar days after PIHP receives notice that DMA or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.						All terminated provider files met criteria for the review, and the process in place is being followed that allows enrollees to be notified promptly when their provider is terminated from the network.
4. Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation of prevalent non-English languages as required by the contract.	X					General enrollee written materials and large print materials are not prepared with a minimum size requirement per onsite interview. Font and size are not reference in a policy or procedure. ***Recommendation: Enrollee written materials must use a font size no smaller than 12 point, per 42 CFR § 438.10(d)(6)(ii), and large print is no smaller than 18 point, per 42 CFR § 438.10(d)(3). Include this reference in a marketing and communications policy and/or procedure for enrollee written materials and verify these are implemented.***
5. The PIHP maintains and informs Enrollees of how to access a toll-free vehicle for 24-hours Enrollee access to coverage information from the PIHP, including the availability of free oral translation services for all languages and care management services such as crisis interventions.	X					
III C. Behavioral Health and Chronic Disease Management Education						
1. The PIHP enables each enrollee to choose a Provider upon enrollment and provides assistance as needed.	X					The *Consumer/Enrollee Handbook* informs enrollees about the process for choosing a provider.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP informs enrollees about the behavioral health education services that are available to them and encourages them to utilize these benefits.	X					
3. The PIHP tracks the participation of enrollees in the behavioral health education services.	X					Policy and procedure *7.00, Consumer Enrollee Education*, notes, "Partners BHM shall keep attendance records at all Behavioral Health Education Activities." The Onsite interview visit confirmed that each department responsible for training keeps attendance records.
III D. Call Center						
1. The PIHP provides customer services that are responsible to the needs of the Enrollees and their families. Services include:	X					The triage process is outlined in policy and procedure *10.08U, Steps of the Triage Process*.
1.1 Respond appropriately to inquiries by enrollees and their family members (including those with limited English proficiency);	X					Page 3 of the *Consumer/Enrollee Handbook* states, "The Call Center has translation services available. The Call Center staff is able to help and get you connected to services even if you do not speak English. Translation services are available for any call and are available from the Call Center and your provider at no cost." Onsite discussions revealed Partners uses Fluent, a translation service. When a caller is non-English-speaking, the Partners' staff member connects the call with Fluent. The Partners' staff member stays on the call the entire time. Most non-English-speaking callers speak Spanish, with some Laotian and some Hmong.
1.2 Connect enrollees, family members and stakeholders to crisis services when clinically appropriate;	X					Policy and procedure *10.08U, Steps of the Triage Process*, states, "in the event that the triage determination is determined to be emergent or routine, the Access to Care Clinician, with the consumer on the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						line, actually schedules an appointment with the appropriate provider within the timeframe dictated by the triage determination." The *Consumer/Enrollee Handbook* provides detailed information about emergent and crisis situations
1.3 Provide information to enrollees and their family members on where and how to access behavioral health services;	X					*Consumer/Enrollee Handbook* provides clear information about access to services.
1.4 Train its staff to recognize third-party insurance issues, recipient appeals, and grievances and to route these issues to the appropriate individual;	X					Partners' *Access to Care Procedure Manual* includes information about insurance, appeals, and grievances and how to handle each.
1.5 Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;	X					Partners has a reciprocal contract with VayaHealth, another PIHP, for call overflow coverage. Call Center data is presented at the Partners' Quality Improvement Committee meetings. Partners meets or exceeds standards for speed of answer, call blockage, and call abandonment rates consistently.
1.6 Process referrals twenty-four (24) hours per day, seven (7) days per week; 365 days per year; and	X					
1.7 Process Call Center linkage and referral requests for services twenty-four (24) hours per day, seven (7) days per week, 365 days per year.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV A. The Quality Improvement (QI) Program						
1. The PIHP formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to enrollees.	X					
2. The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.			X			Partners' Provider Operations Manual and Quality Assurance/Quality Improvement Plan and Program Description explain several ways Clinical Practice Guidelines are monitored. During the Onsite discussion, staff could not describe or provide evidence of this monitoring. Monitoring provider compliance with Clinical Practice Guidelines is an EQR standard and was a best practice recommendation from last year's EQR. ***Corrective Action: Initiate a process to proactively and routinely monitor provider adherence to Clinical Practice Guidelines throughout the provider network. Offer technical assistance when needed.***
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					There is a policy and procedure for the detection of over and underutilization; services are monitored and analyzed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.	X					*The Quality Assurance / Quality Improvement Program Evaluation 2016-17* documents reflect no improvement is needed for enrollee satisfaction survey measures, although, there was no discussion documented in committee minutes that arrives at this decision. ***Recommendation: Create a process for committee discussion regarding lower scoring Enrollee survey measures for the purpose of identifying steps to improve these measures. Capture discussion and next steps within QIC minutes.***
5. The PIHP reports the results of the enrollee satisfaction survey to providers.	X					
6. The PIHP reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					
7. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, time frame for implementation and completion, and the person(s) responsible for the project(s).	X					
IV B. Quality Improvement Committee						
1. The PIHP has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					
2. The composition of the QI Committee reflects the membership required by the contract.	X					QIC is comprised of Partners' staff, CFAC members, and provider members. Attendance by CFAC and provider members is less than 50% during the last EQR. Partners improved attendance over the past year.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The QI Committee meets at regular intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					B and C Waiver measures included all necessary documentation and measures are reported according to specifications.
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					All PIPs are in the High Confidence range. For the complete validation results, see the attachments named *CCME EQR PIP Validation Worksheets*. The Performance Improvement Project Validation section of this Quality section also lists the specific errors by project and includes recommendations to correct the errors.
IV E. Provider Participation in Quality Improvement Activities						
1. The PIHP requires its providers to actively participate in QI activities.	X					Based on onsite interviews, providers involved in GQIC are actively participating in individual QI activities; although, Partners is not monitoring providers on individual QIPs. The *State Contract 18-19 Template* document on page 14, number 10, states, "Providers shall demonstrate a Continuous Quality Improvement (CQI) process by identifying a minimum of 3 improvement projects acted upon per

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						year. Projects and results will be reported to the LME-MCO in any quarter of completion." ***Recommendation: Implement and document a process that monitors the submission of provider QIPs to Partners.***
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Partners followed recommendations from the last EQR to separate results and analysis throughout the document. Analysis is completed to determine if further interventions are needed. There is a documented determination when additional data collection is needed, and if the item will be carried into the new program year.
2. The annual report of the QI program is submitted to the QI Committee and to the PIHP Board of Directors.	X					Partners' leadership presented the *2017-18 Quality Assurance/Quality Improvement Program Evaluation* to both the QIC and the Board of Directors.

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. The Utilization Management (UM) Program						
1. The PIHP formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 structure of the program;	X					Partners' Board of Directors provides overall governance and oversight to Partners, including the UM Program and its implementation. The Chief Medical Officer, Elizabeth Stanton, MD, provides oversight of medical decision making, clinical supervision, and oversight. The Chief Clinical Officer, Jane Harris, MSW, LCSW, directly supervises clinical operations.
1.2 lines of responsibility and accountability;	X					The *Utilization Management Plan* describes the UM Department's purpose, scope, structure, components, and staffing qualifications. The lines of responsibility and accountability are illustrated in the organizational chart.
1.3 guidelines / standards to be used in making utilization management decisions;	X					Policy and procedure *13.14, Utilization Management Criteria*, and the *UM Plan* define criteria used for medical necessity decision making.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Policy and procedure *13.15 Utilization Management Screening and Review* includes the time frame requirements for review of *SAR* and includes requirements for notification and the time timeframes for notifications.
1.5 consideration of new technology;	X					
1.6 the appeal process, including a mechanism for expedited appeal;	X					Policy and procedure *13.15 Utilization Management Screening and Review* includes the time frame requirements for review of SAR and requirements for expedited appeals.
1.7 the absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.8 mechanisms to detect underutilization and overutilization of services.	X					Policy and procedure *13.06 Detecting Overutilization and Under Utilization* is in place. The claims data is analyzed quarterly to examine trends and address possible case reviews. Underutilization is monitored by reviewing low service use compared to intensity/authorized levels.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Partners provided evidence during the Onsite review that the Chief Medical Officer is involved and has oversight in many aspects of the UM Programs.
3. The UM program design is reevaluated annually, including Provider input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The *UM Plan* is reviewed annually and was last reviewed on June 22, 2018. The process is managed by the Quality Management Department and completed annually.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Partners has a set of UM standards to determine medical necessity. These predetermined standards are available on the Partners' website for all providers.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Policy and procedure *13.15U UM Screening and Review* indicates that licensed medical providers and licensed clinical providers provide consultation.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Partners uses staff with expertise in MH/SU and I/DD for peer reviews and delegated peer reviewer.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Utilization management standards/criteria are consistently applied to all enrollees across all reviewers.	X					The IRR benchmark for UM Care Managers is 85%, yet the combined UM Department concordance rate for IRR is 98%. While this concordance rate demonstrates concordance across Care Managers, Partners is not maximizing the potential of the IRR process.
5. Emergency and post stabilization care are provided in a manner consistent with contract and federal regulations.	X					The *2017 EQR Report* recommendation included" Revise the *Provider Operation Manual* to include information on post-stabilization requirements and processes." Partners has included the post-stabilization information in *Provider Operations Manual* dated September 2018 on page 101 as recommended.
6. Utilization management standards/criteria are available for Providers.	X					
7. Utilization management decisions are made by appropriately trained reviewers	X					
8. Initial utilization decisions are made promptly after all necessary information is received	X					The file review indicated that the UM decisions are completed between 1- 11 days in all 25 files. In 9 files the approvals were completed within 2 days. None of the files were urgent requests and Notice letters were sent within the required timeframes.
9. Denials						
9.1 A responsible effort that is not burdensome on the enrollee or the provider is made to obtain all pertinent information prior to making the decisions to deny services	X					
9.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Dr. Elizabeth Stanton became the Chief Medical Officer (CMO) in September and assumed the role of the Chairperson on the Quality of Care Committee (QOC) as well as membership on other committees.
9.3 Denial decisions are promptly communicated to the provider and enrollee and include the basis for the	X					Denial decisions are completed within 13 days. Partners provided evidence of communication with providers. Licensed clinicians review the case and provide documentation to the psychiatrist. BHM or Prest is used to complete peer reviews for the MH/SU members. *Adverse*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
denials of service and the procedure for appeal						*Determination Letters* are sent in 3 days or less in 19 of the 25 files reviewed.
V C. Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					The *Mental Health /Substance Abuse Use Care Coordination Program Description* and the *Intellectual/ Developmental Disabilities Program Description* describe Partners' Care Coordination Program. Members are identified for Care Coordination through data monitoring, referrals and clinical alerts from other departments. Members with complex health needs and high-risk health conditions are identified in policies.
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					The Access to Care Department is responsible for providing 24/7/365 access to behavioral health services through screening, triage, and referral to appropriate resources based on the needs of the member.
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					The *MH/SU Care Coordination Program Description* and *the I/DD Program Description* provide an overview of the Care coordination process for staff to ensure that members receive care coordination services at the right time and with the right support. The care coordination policies include the time frame for completion of care coordination tasks, including development of Individual Service Plan (ISP) and monitoring of Person-Centered Plan and required assessment tools. Policies also include documentation time frames.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 Develop treatment plans for enrollees that meet all requirements;	X					Policy and procedure *9.06 I/DD, Care Coordination Monitoring of Plan Completion*, clarifies the process to ensure the requirements are met for I/DD members ISP. Policy and procedure *9.07 MH/SU Care Coordination*, clarifies the role of the MH/SU care coordinator in monitoring and ensuring that the Person-Centered Plan is complete and meets the requirements.
2.5 Quality monitoring and continuous quality improvement;	X					
2.6 Determine of which Behavioral Health Services are medically necessary;	X					Policy and procedure *9.06, MH/SU Care Coordination Admission Criteria*, provides specifics regarding the tools used and the procedure to support the clinical decisions and services for members. MH/SU Care Coordination staff participates in Child and Family team/treatment team meetings to ensure the *System of Care* principles are implemented, advocate for the member, and provide education and information on benefits, resources, and services.
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					Partners has Care Coordination staff located Onsite and in local hospitals. Care Coordinators are assigned to specified hospitals and coordinate discharge planning seamlessly with hospital care coordination staff.
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					Policy and procedure *9.01, Care Coordination Outreach and Follow-Up with High Risk Enrollees* provides the process and details of the care coordinators' role to ensure that follow-up activities are provided. Partners verifies the member completes the follow-up activity through care coordination monitoring activities.
2.10 Ensure privacy for each Enrollee is protected.	X					The *MH/SU Care Coordination Program Description* verifies that HIPPA/Confidentiality Training is provided for the Care Coordination Staff. CCME's Onsite interview confirmed that HIPPA training is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						provided to staff on the first day of employment as part of the onboarding/ training process.
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					The file review indicated that Care Coordination policies are followed.
V. D Transition to Community Living Initiative						
1. Transition to Community Living functions are performed by appropriately licensed, or certified, and trained staff.	X					Jeffery Sanders, LCSW, is the Transition to Community Living Initiative (TCLI) Program Manager. The program also has two supervisors and a Lead Transition Coordinator. Policy and procedure *9.08, Mental Health and Substance Use (MHSU) Care Coordination - Transition to Community Living and U.S. Department of Justice (TCL-DOJ) Initiative*, and the *TCLI How to Manual* provide the qualification requirements for each staff person in addition to their role and responsibilities in the TCLI Program.
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements includes all required elements.	X					Policy and procedure *9.08, Mental Health and Substance Use (MHSU) Care Coordination- Transition to Community Living (TCL) a DOJ Initiative*, provides an overview of TCLI requirements and the function of the TCLI Care Coordination guidelines and expectation. The *TCLI How to Manual* provides details and the role of each TCLI staff. The document also includes the *Transition to Community Living Checklist* with detailed information for completion.
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 Services, and Supported Employment services are included in the individual's transition, if applicable.	X					Assertive Community Treatment (ACT), Peer Support Services (PS), and Supportive Employment Services (SE) are offered to members when appropriate. During the Onsite interview, CCME and Partners discussed the loss of two SE providers due to not meeting fidelity, which resulted in a decrease of SE services provided during the year under review. Partners recruited additional providers who meet

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Supportive Employment Fidelity to increase the availability of this service to members over the next year.
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					Partners has a mechanism in place to provide one-time transitional support. The *TCLI Checklist* provides the steps for this process; however, the mechanism is not indicated or referenced in policy and procedure 9.08, *Mental Health and Substance Use (MHSU) Care Coordination- Transition to Community Living (TCL) a DOJ Initiative*. **Recommendations: Add into policy and procedure 9.08, Mental Health and Substance Use (MHSU) Care Coordination -Transition to Community Living and U.S. Department of Justice (TCL-DOJ) Initiative information about the availability of Transition Year Funds. In policy and procedure 9.08, either describe how to access these funds or reference an existing policy and procedure that has this detail.**
2.5 QOL Surveys are administered timely.	X					Policy and procedure *9.08, Mental Health and Substance Use (MHSU) Care Coordination- Transition to Community Living (TCL) a DOJ Initiative*, provides the time frames for the administration of the *Quality of Life (QOL) Surveys*. The *Transition to Community Living (TCLI) (Checklist*) identifies the time for completion of each QOL Survey. The review of the *TCLI Dashboard* indicated a significant improvement in QOL administration; the 2016-17 Summary is 48.9% completion and the 2017 -18 Summary is 87.7 % completion. During the Onsite interview, CCME noted that the completion of the QOL survey was returned to Partners' TCLI staff to monitor and complete resulting in an improved completion rate.
3. A diversion process is in place for individuals considering admissions into an Adult Care Home (ACH).	X					The *TCLI How To Manual* includes information about the diversion process and the *TCLI Checklist* includes the detailed steps of the diversion process.

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 DMA within the timeframes determined by DMA.	X					Partners regularly submits the required TCLI reporting data and provided the *DMA TCLI Database, Data Dashboard* as part of the desk review process.
5. The PIHP will develop a TCLI communication plan that includes materials and training about crisis hotline, services for enrollees with limited English proficiency and also to for external and internal stakeholders providing information on the TCL initiative, resources, and system navigation tools, etc.	X					During the Onsite visit, Partners' staff provided an overview of the *Transition to* the *Community initiative (TCLI) Communication Plan*. Mr. Sanders spoke about providing training for DHSR and DSS staff, hospital staff, and providers thought presentations at provider meetings. The methods of communication include presentations to various providers and information on the Partners' website, The *TCLI Communication Plan* was provided in an upload following the interview. Partners outlines the steps, communication process, presenters, and the completion date for each action item.
6. A review of files demonstrates the PIHP is following appropriate TCL policies, procedures and processes, as required by NC DMA, and developed by the PIHP.	X					*Quality of Life Surveys* were included in the files reviewed and when completed in the appropriate time frames. Several files contain documentation of "follow up" activities. Transition plans are present in all files; however, in 3 files the transition plan does not have the required signatures. ***Recommendation: Ensure transition plans contain the appropriate signatures.***

VI. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					The Grievance Program is overseen by the Legal Department. Andrew Walsh, JD, MBA is the Legal Officer. April Cash is the Grievance Coordinator. Policy and procedure *6.00U, Grievance Management Policy* is the overarching policy for grievance. Partners has a process for registering and responding to grievances.
1.1 Definition of a grievance and who may file a grievance;	X					Partners has one overarching grievance policy and procedure, 6.00U, *Grievance Management Policy*. Within the policy portion of this document, it is that grievances and complaints have similar procedures and, therefore, are "defined by Procedure, but substantially synonymous." Subsequently, the procedure portion of this document then uses these terms interchangeably. CCME recommends either the grievance and complaint processes are separated within the procedure or that these terms are represented as synonymous (i.e., "grievance/complaint"). This will prevent confusion of staff that may quickly reference the procedure portion of this document and not the policy portion. ***Recommendations: Either separate out, within the procedure portion of 6.00U, the procedures for "grievances" and "complaints" or consistently reference these terms as synonymous by using "grievance/complaint" throughout the policy and procedure.***
1.2 The procedure for filing and handling a grievance;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					Policy and procedure *6.00U, Grievance Management Policy* defines the standard and expedited timeframes consistent with the *DMA Contract*. On page four, item J, the policy and procedure explains the process followed if Partners or the consumer requests an extension. Item 2. b. states: "a written notice will be mailed to the consumer explaining the reason for the delay." The timeframe for sending this notification is missing. ***Recommendation: Include in policy and procedure 6.00U that, when Partners extends the grievance process, a notification of this extension is sent to the enrollee within 2 days, per 42 CFR § 438.402.***
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					
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.						
2. The PIHP applies the grievance policy and procedure as formulated.						The grievance files reflect that the grievance staff follow the set policy and procedures for handling grievances. The files are documented the grievances resolved within the established timeframes. Documentation of the Chief Medical Officer (CMO) involvement is maintained in the client contact logs. Documentation is maintained in the contact logs. CCME recommends defining a process that verifies this information is entered into the member's electronic medical record to detail the CMO's involvement.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.						Policy and procedure *6.00U, Grievance Management* indicates in the section *III. F. Tracking of Resolution*: "The Legal Department will track the timeliness of grievance resolution per department for the MCO, along with the number and outcome of grievance decisions that progress to higher levels of review." Patterns, trends and compliance data were reported in the *Quality Improvement, Quality of Care, Consumer and Family Advisory, and Human Rights* Committees.
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.						The Grievances are managed in accordance with the policies and procedures. • The Grievance files are well-organized • Information was well-documented • The *Notice letters* indicate the steps taken in the investigation The Grievance process was completed within 1-13 days, well within the 90-day timeframe.
VI. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to enrollee and/or provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					Policy and procedure *13.04U, Clinical Utilization Management Appeals* correctly defines an appeal as "a request of an 'adverse benefit determination or action.'" This same policy and procedure, under "Requesting an Appeal/Reconsideration" accurately states an appeal can be filed "by the consumer or the consumer's LRP" and "from the treating or ordering provider and/or facility rendering service (if acting on behalf of the consumer and with the consumer's written consent)."
1.2 The procedure for filing an appeal;		X				Policy and procedure *13.04U, Clinical Utilization Management Appeals* and the *Provider Operations Manual* do not clarify that Partners ensures that punitive action will not be taken against providers who file or assist with an appeal. See *DMA Contract Attachment M, H.8* and *42 CFR § 438.10(b)*. ***Corrective Action: Revise policy and procedure 13.04U to reflect Partners shall ensure that punitive action is not taken against a provider who requests or supports an enrollee's appeal.*** ***Recommendation: Clarify in the Provider Operations Manual Partners ensures punitive action is not taken against a provider who requests or supports an enrollee's appeal.*** *The Provider Operations Manual* and the *Consumer/Enrollee Handbook* do not provide clear information to potential appellants that any written request for appeal can initiate the appeal process. Page 109 of the *Provider Operations Manual* (states appellants, "must complete and return the Partners' Reconsideration Review Request". Similarly, page 18 of the *Consumer/Enrollee Handbook* references completion of "the form" and "the Reconsideration Review Request Form" as the only option for submitting a written appeal.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Add information into the Provider Operations Manual and Consumer/Enrollee Handbook that clarifies any version of a written request for appeal will initiate the appeal process and that the Partners' Request for Reconsideration Review Form is not required.
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				Revise policy and procedure 13.04, Clinical Utilization Management Appeals, to include the requirement that, when Partners extends the appeal resolution timeframe, reasonable efforts must be made by Partners to give the enrollee prompt oral notice of the delay and a written notice of the extension must be mailed to the appellant within two calendar days. Also include in this policy and procedure that the enrollee is notified of their right to file a grievance if they disagree with Partner's extension to the resolution timeframe. See DMA Contract Attachment M, G.6 and 42 CFR § 438.408(c)(2)(ii). ***Corrective Action: Revise policy and procedure 13.04, Clinical Utilization Management Appeals, to include the requirement***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						that, when Partners extends the appeal resolution timeframe, reasonable efforts must be made by Partners to give the enrollee prompt oral notice of the delay and a written notice of the extension must be mailed to the appellant within two calendar days. See DMA Contract Attachment M, G.6 and 42 CFR § 438.408 (c)(2)(ii).
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					Partners provided evidence that the Chief Medical Officer is very involved in the clinical aspects of appeals. The appeal staff is well-versed in the requirements of the appeals process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP applies the appeal policies and procedures as formulated.	X					One appeal file reviewed was identified as an invalid appeal request. Partners disclosed that, for a period of time and prior to January of 2018, appeal staff did not send invalid notifications to appellants when appropriate. While this process is not required by *DMA Contract*, it is also not described in Partners' policies and procedures. ***Recommendation: Clarify in policy and procedure 13.04, Clinical Utilization Management the steps for processing an invalid appeal, including acknowledging to the appellant the receipt of an invalid appeal.*** Partners does not consider the *Consumer Contact Log* to be a part of the appeal file, but many of the required appeal elements such as date and time of appeal receipt, oral notifications of expedited appeals, etc. are only found in these logs. ***Recommendation: Develop an appeal record monitoring process that ensures appeals are being processed within the DMA Contract requirements and that appeal records, including Consumer Contact Logs, are complete, consistent, and legible. Monitoring provides early detection of any steps taken by appeal staff outside what is required by Partners' policies and procedures.*** ***To demonstrate Partners is applying their policies and procedures as formulated, verify files submitted for any audit or review are complete, including all communications and notifications between Partners' staff and appellants.***
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Appeal data is reviewed and discussed in the UM Committee.

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					There is evidence within the files of appeals staff obtaining appropriate documentation to protect enrollee's confidentiality.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. Delegation						
1. The PIHP has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					
2. The PIHP conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the PIHP if the PIHP were directly performing the delegated functions.	X					The *Delegation Program Description* indicates Partners conducts an annual assessment that "includes a review of the Delegate's applicable written Policies and Procedures and other documents of activities related to delegated functions to confirm continued compliance with applicable URAC standards, and any applicable laws and regulations. If the Delegate is URAC accredited and maintains that accreditation the annual assessment is not required." In contrast, the *DMA Contract Attachment B*, section *11.1.2 d* states that subcontracts shall "provide that PIHP shall monitor the subcontractor's performance on an ongoing basis, at least annually, and subject it to formal review according to a periodic schedule consistent with industry standards." In contrast to the language in the *Delegation Program Description*, Partners submitted evidence of annual delegate monitoring.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Revise the Delegation Program Description to comply with DMA Contract Attachment B, section 11.1.2 language regarding monitoring "the subcontractor's performance on an ongoing basis, at least annually…"

VIII. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII A. General Requirements						
1. PIHP shall be familiar and comply with Section 1902(a)(68) of the Social Security Act, 42 C.F.R. Parts 438,455 and 1000 through 1008, as applicable, including proper payments to Providers and methods for detection of fraud and abuse.	X					This requirement is addressed in the *Regulatory Compliance Program Description/Plan* and the Program Integrity Provider Monitoring/Auditing Protocol.
2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents' and subcontractors,' compliance with the requirements of this Section 14.	X					This requirement is addressed in the *Regulatory Compliance Program Description/Plan.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					This requirement is addressed in the *Regulatory Compliance Program Description/Plan, Medicaid Agency Contract Template,* and *Agency Credentialing Application*.
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					This requirement is addressed in the process *Taking Complaint from Inception to Closure*, and in *WorkFlow-July 2017*.
VIII B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with 42 C.F.R. 438.608 that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the DMA Contract Administrator on an annual basis.	X					This requirement is addressed in the *Regulatory Compliance Program Description/Plan*. That the compliance plan is reviewed annually is addressed on page 6 of the *Regulatory Compliance Program Description/Plan*. Annual review dates are listed on page 1 of the same document. During the onsite interview, Partners explained that the last time the compliance plan was submitted to NC Medicaid was upon NC Medicaid's request. In general, the compliance plan is submitted once a year. After the compliance plan is reviewed and approved internally, it is typically submitted to NC Medicaid in several weeks. When the compliance plan is approved internally, it is made available to employees immediately via email notification and SharePoint.
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of 42 C.F.R. 438.608 and who retains authority to report directly to	X					This requirement is addressed in the *Regulatory Compliance Program Description/Plan* on pages 3–5. Partners submitted evidence of its monthly meetings with NC Medicaid.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under DMA Contract in accordance with 42 CFR 438.608(a)(1)(iv).						
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 DMA. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator.	X					This requirement is addressed in the *Regulatory Compliance Program Description/Plan*. The unit positions are described in the PI Org Chart, job descriptions for the various positions, and the *PI Employee List 2018* provides the names of job title holder in the unit.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. PIHP shall participate in quarterly Program Integrity meetings with DMA Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').	X					Partners submitted Program Integrity Committee meeting minutes as evidence of its quarterly program integrity meetings with NC Medicaid. During the onsite visit, Partners indicated that the PI director, Bill Owens, attends the quarterly meetings and keeps record of these meetings. The attendance sheets are kept by the entities running the meetings. Upon request, after the onsite review, Partners provided attendance sheets and minutes for the quarterly OCPI-MID and NC Medicaid meetings, providing evidence of participation in these meetings.
5. PIHP shall participate in monthly meetings with DMA Program Integrity, in the most productive setting, either telephonically or in person at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.	X					Partners submitted Program Integrity Committee meeting minutes as evidence of its monthly program integrity meetings with NC Medicaid.
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					Program Integrity Committee meeting minutes submitted by Partners evidence the attendance of appropriately qualified staff and productive discussion of issues.
7. PIHP shall also make Regulatory Compliance minutes and Program Integrity minutes, redacted as deemed appropriate by PIHP, available for review upon request by DMA.	X					The minutes submitted by Partners provide evidence of compliance with this requirement. During the onsite review, Partners explained that these minutes are submitted to NC Medicaid every month on an ongoing basis regardless of a request from NC Medicaid.
8. PIHP's written Compliance Plan shall, at a minimum include:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(66) of the Social Security Act;	X					This requirement is addressed on page 5 of the *Regulatory Compliance Program Description/Plan*. Partners submitted training materials for its employees, subcontractors, and providers and evidence of trainings within the review period.
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing and development of corrective action initiatives;	X					This requirement is addressed on pages 7-8 of the *Regulatory Compliance Program Description/Plan*.
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					This requirement is addressed on pages 9-10 of the *Regulatory Compliance Program Description/Plan*.
8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including DMA or MFCU/MID, and including promptly supplying all data and information requested for their respective investigations	X					This requirement is addressed on page 8 of the *Regulatory Compliance Program Description/Plan*.
9. In accordance with 42 CFR 436.606(a)(vii), PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under DMA Contract, prompt response to compliance issues as identified, investigation of potential compliance problems as identified	X					This requirement is addressed on pages 3 and 5-6 of the *Regulatory Compliance Program Description/Plan*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under DMA Contract; and making documentation of investigations and compliance available as requested by the State.						
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse.						
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse;	X					This requirement is addressed in the *Regulatory Compliance Program Description/Plan* on pages 7-8 and in the Program Integrity Provider Monitoring/Auditing Protocol.
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	X					Detailed workflow for taking a complaint from inception through closure is shown in v5_WorkFlow-July 2017. The Process Taking Complaint to Closure submitted by Partners also details the workflow, including the three types of review (desk, onsite, and referral to NC Medicaid).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						
10.3 In accordance with Attachment Y – Audits/Self-Audits/Investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an· overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					This requirement is addressed in the *Provider Overpayment Recovery Policy*. Partners provided the *TNOCompProcess Graham Chart* which shows the process from initiation through collection and the Tentative Notice of Overpayment (TNO) narrative, which details this process and meets this requirement. Partners also submitted monthly Attachment Y documents from July 2017 to June 2018, which evidence the implementation of this process.
10.4 Process for tracking overpayments and collections, and reporting on Attachment Y – Audits/Self-Audits/Investigations;	X					This requirement is addressed in *the Provider Overpayment Recovery Policy*. Partners provided the *TNOCompProcess Graham Chart* which shows the process from initiation through collection and the TNO narrative, which details this process and meets this requirement. Partners also submitted monthly Attachment Y documents from July 2017 to June 2018, which evidence the implementation of this process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.5 Process for handling self-audits and challenge audits;	X					This requirement is addressed in the Provider Self-Audit Protocol, Program Integrity Provider Monitoring/Auditing Protocol, and on pages 5–8 of the *Regulatory Compliance Program Description/Plan*. Partners also submitted a self-audit template designed as a tool for providers to use for self-audits. This template also provides a tool for designing a plan of correction based on self-audit findings.
10.6 Process for using data mining to determine leads;	X					This requirement is addressed in the *Program Integrity Department Data Mining Guidelines*.
10.7 Process for informing PIHP employees, subcontractors and providers regarding the False Claims Act;	X					The employee information requirement is addressed in the *Employee Training and Support Policy*. The subcontractors are informed in the contract between Partners and the subcontractor. Page 144 of the *Provider Operations Manual* cites *42 CFR § 455* under Reporting of Fraud, Waste and Abuse.
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					This requirement is addressed on pages 4, 5 and 9 of the *Regulatory Compliance Program Description/Plan*.
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains DMA-standardized elements or a DMA-approved template;	X					This requirement is addressed in the Program Integrity Provider Monitoring/Auditing Protocol. Partners uses an audit worksheet that contains NC Medicaid standardized elements to collect and verify information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						During the onsite visit, Partners explained that though there are ongoing considerations to send out electronic explanation of benefits (EOBs) every quarter, this is still based on mailing out paper EOBs. EOBs also go out from claims, and these are also paper based.
10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available database or other search mechanism.	X					This requirement is addressed in the *Provider Payback Interest and Penalties Policy*. The *Agency Credentialing Application* also includes questions regarding the prospective provider's outstanding overpayments, assessments, penalties, and fees. During the onsite review, Partners confirmed that there is a self-reporting aspect to obtaining financial information about providers during the credentialing application. Partners explained that the main route for obtaining such information is through the credentialing/recredentialing process. During the credentialing process, the Provider Network Department queries the PI Department about any potential outstanding payments or investigations for that particular provider. In addition, the Claims Department will receive information from the IRS if there is an IRS levy for the provider. Partners explained that this process requires close collaboration between the PI and Provider Network Departments, and for this reason, these departments meet once a week to discuss such issues.
11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.	X					This requirement is addressed in the *Provider Payback Interest and Penalties Policy*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to DMA within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					This requirement was not addressed in any policy or procedure submitted by Partners. During the onsite review, Partners confirmed that it does not have this requirement, including the timeliness elements, in any policy or procedure. However, Partners has the timeliness aspects of this requirement clearly stated in the *MCO/DMA Process Flow Chart (Work Flow 2017)*. This flow chart is not cited or attached to any policy or procedure and was not listed in the master list of policies and procedures. 15 of 15 files CCME reviewed documented the initiation of an investigation within 10 business days. Of these, 5 cases warranted a report to NC Medicaid; all 5 cases include a report to NC Medicaid within 5 business days of the final determination. Upon request and after the onsite review, Partners provided a *Program Integrity Quality Assurance Review Worksheet*, which includes the 2 timeliness aspects of this requirement and further evidences that Partners actively monitors the implementation of this requirement. ***Recommendation: Include the timeframe requirements for initiating a preliminary investigation in a policy and/or procedure, clearly stating the timeliness requirements. Partners can choose to cite the existing flow chart and worksheet and attach it to an existing policy or procedure, as these documents list the timeliness elements. Partners can also make the flow chart an official procedure document and list it in the master list of policies and procedures, or Partners can include the requirement explicitly in relevant policies and procedures.***
13. In each case where PIHP refers to DMA an allegation of fraud involving a Provider, PIHP shall provide DMA Program Integrity with the following						During the onsite review, Partners explained that in the last fiscal year, 4 cases were referred to DMA and none were accepted by DMA. Partners feels that these cases should have been accepted; however, in its communication with DMA Partners came to understand that the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
information on the DMA approved template:						cases were not at the top of the referrals to be taken further and due to stretched resources they were not accepted. Partners explained that the typical process for referral to DMA is: 1) conduct investigation, 2) write report, and 3) if fraud is detected, refer to DMA. However, if the case was originally referred from DMA to Partners (as the majority of the 15 files reviewed were), then the case is not referred back to DMA upon completion of investigation. If fraud is detected, Partners sends its findings, including any evidence, communications, TNOs, etc. in a report to DMA. Partners confirmed that none of the 17 files provided for file review were referred to DMA. Partners explained that if a file is indeed referred to DMA, then the *LME/MCO Suspected Provider Fraud and/or Abuse DMA Program* template is be used to meet this requirement. Partners explained that it developed this template in collaboration with MID to respond to this requirement. Partners acknowledged that though the template for referral meets requirement #13 and its subparts, Partners does not have a policy or procedure that addresses this requirement. In the following discussion, Partners suggested citing the template in their policies and procedures and adding it to relevant policies as an attachment, which will satisfy this requirement.
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					This requirement is not addressed in any of the policies or procedures submitted by Partners. The *LME/MCO Suspected Provider Fraud and/or Abuse DMA Program Integrity Referral* template submitted by Partners includes this requirement. File Review Results:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						15 of 15 files that were reviewed contained this requirement. ***Recommendation: Either include requirement #13 and its subparts in a policy and/or procedure or cite the LME/MCO Suspected Provider Fraud and/or Abuse DMA Program Integrity Referral template and attach it to relevant policies/procedures.***
13.2 Source/origin of complaint;	X					This requirement is not addressed in any of the policies or procedures submitted by Partners. The *LME/MCO Suspected Provider Fraud and/or Abuse DMA Program Integrity Referral* template submitted by Partners includes this requirement. File Review Results: 15 of 15 files reviewed contained this requirement. ***Recommendation: Either include requirement #13 and its subparts in a policy and/or procedure or cite the LME/MCO Suspected Provider Fraud and/or Abuse DMA Program Integrity Referral template and attach it to relevant policies/procedures.***
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					This requirement is not addressed in any of the policies or procedures submitted by Partners. The *LME/MCO Suspected Provider Fraud and/or Abuse DMA Program Integrity Referral* template submitted by Partners includes this requirement. File Review Results: 15 of 15 files reviewed contained this requirement. ***Recommendation: Either include requirement #13 and its subparts in a policy and/or procedure or cite the LME/MCO Suspected***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Provider Fraud and/or Abuse DMA Program Integrity Referral template and attach it to relevant policies/procedures.
13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations or policies violated; and dates of suspected intentional misconduct;	X					This requirement is not addressed in any of the policies or procedures submitted by Partners. The *LME/MCO Suspected Provider Fraud and/or Abuse DMA Program Integrity Referral* template submitted by Partners includes this requirement. File Review Results: 15 of 15 files reviewed contained this requirement. ***Recommendation: Either include requirement #13 and its subparts in a policy and/or procedure or cite the LME/MCO Suspected Provider Fraud and/or Abuse DMA Program Integrity Referral template and attach it to relevant policies/procedures.***
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					This requirement is not addressed in any of the policies or procedures submitted by Partners. The *LME/MCO Suspected Provider Fraud and/or Abuse DMA Program Integrity Referral* template submitted by Partners includes this requirement. File Review Results: This requirement is not applicable to 9 of the 15 files. The remaining 6 files contain this requirement. ***Recommendation: Either include requirement #13 and its subparts in a policy and/or procedure or cite the LME/MCO Suspected Provider Fraud and/or Abuse DMA Program Integrity Referral template and attach it to relevant policies/procedures.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.6 All communications between PIHP and the Provider concerning the conduct at issues, when available.	X					This requirement is not addressed in any of the policies or procedures submitted by Partners. The *LME/MCO Suspected Provider Fraud and/or Abuse DMA Program Integrity Referral* template submitted by Partners includes this requirement. File Review Results: This requirement is not applicable for 7 of the 15 files. The remaining 8 files contain this requirement. ***Recommendation: Either include requirement #13 and its subparts in a policy and/or procedure or cite the LME/MCO Suspected Provider Fraud and/or Abuse DMA Program Integrity Referral template and attach it to relevant policies/procedures.***
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					This requirement is not addressed in any of the policies or procedures submitted by Partners. The *LME/MCO Suspected Provider Fraud and/or Abuse DMA Program Integrity Referral* template submitted by Partners includes this requirement. File Review Results: 15 of 15 files reviewed contained this requirement. ***Recommendation: Either include requirement #13 and its subparts in a policy and/or procedure or cite the LME/MCO Suspected Provider Fraud and/or Abuse DMA Program Integrity Referral template and attach it to relevant policies/procedures.***
13.8 Sample/exposed dollar amount, when available.	X					This requirement is not addressed in any of the policies or procedures submitted by Partners.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The *LME/MCO Suspected Provider Fraud and/or Abuse DMA Program Integrity Referral* template submitted by Partners includes this requirement. File Review Results: This requirement is not applicable for 9 of the 15 files. The remaining 6 files contain this requirement. ***Recommendation: Either include requirement #13 and its subparts in a policy and/or procedure or cite the LME/MCO Suspected Provider Fraud and/or Abuse DMA Program Integrity Referral template and attach it to relevant policies/procedures.***
14. In each case where PIHP refers suspected Enrollee fraud to DMA, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:						Previously, Partners indicated that enrollee fraud reports are rare. Onsite, Partners indicated that there was one case of enrollee fraud (card sharing in an inpatient unit) last year. This case was referred to DMA. Partners explained that any efforts made to identify enrollee fraud are targets providers/prescribers via the clinical/pharmacy route. They use pharmacy data to identify potential fraud at the enrollee-level, but these efforts seem to still be directed at prescription patterns (provider end, not enrollee end). If patterns emerge about enrollee, these would be reported to PI for further investigation. During the onsite review, Partners acknowledged that it does not have a policy or procedure that addresses requirement #14 or its subparts. During the investigation of the single enrollee case last year, Partners developed a template for referral of such cases to DMA. Partners provided this template after the onsite visit as a part of reporting this case to DMA. This template meets this requirement and its subparts.
14.1 The Enrollee's name, birth date, and Medicaid number;	X					This requirement is not addressed in any of the policies or procedures submitted by Partners.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The *LME/MCO Suspected Enrollee Fraud and/or Abuse DMA Program Integrity Referral* template submitted after the onsite review includes this requirement. In the case this template was used, the Medicaid number of the enrollee is listed as unknown, but there is a field for this information in the template, as per requirement. File Review Results: No files within the sample of 15 involves a case of suspected enrollee fraud. ***Recommendation: Either include requirement #14 and its subparts in a policy and/or procedure or cite the LME/MCO Suspected Enrollee Fraud and/or Abuse DMA Program Integrity Referral template and attach it to relevant policies/procedures.***
14.2 The source of the allegation;	X					This requirement is not addressed in any of the policies or procedures submitted by Partners. The *LME/MCO Suspected Enrollee Fraud and/or Abuse DMA Program Integrity Referral* template submitted post-onsite by Partners includes this requirement. File Review Results: No file within the sample of 15 involves a case of suspected enrollee fraud. ***Recommendation: Either include requirement #14 and its subparts in a policy and/or procedure or cite the LME/MCO Suspected Enrollee Fraud and/or Abuse DMA Program Integrity Referral template and attach it to relevant policies/procedures.***
14.3 The nature of the allegation, including the timeframe of the allegation in question;	X					This requirement is not addressed in any of the policies or procedures submitted by Partners.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The *LME/MCO Suspected Enrollee Fraud and/or Abuse DMA Program Integrity Referral* template submitted post-onsite by Partners includes this requirement. File Review Results: No file within the sample of 15 involves a case of suspected enrollee fraud. ***Recommendation: Either include requirement #14 and its subparts in a policy and/or procedure or cite the LME/MCO Suspected Enrollee Fraud and/or Abuse DMA Program Integrity Referral template and attach it to relevant policies/procedures.***
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	X					This requirement is not addressed in any of the policies or procedures submitted by Partners. The *LME/MCO Suspected Enrollee Fraud and/or Abuse DMA Program Integrity Referral* template submitted after the onsite visit includes this requirement. The case that this template was submitted with does not have any communication, but the template has the required fields for this information. File Review Results: No file within the sample of 15 involves a case of suspected enrollee. ***Recommendation: Either include requirement #14 and its subparts in a policy and/or procedure or cite the LME/MCO Suspected Enrollee Fraud and/or Abuse DMA Program Integrity Referral template and attach it to relevant policies/procedures.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;	X					This requirement is not addressed in any of the policies or procedures submitted by Partners. The *LME/MCO Suspected Enrollee Fraud and/or Abuse DMA Program Integrity Referral* template submitted after the onsite visit includes this requirement. File Review Results: No file within the sample of 15 involves a case of suspected enrollee fraud. ***Recommendation: Either include requirement #14 and its subparts in a policy and/or procedure or cite the LME/MCO Suspected Enrollee Fraud and/or Abuse DMA Program Integrity Referral template and attach it to relevant policies/procedures.***
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and	X					This requirement is not addressed in any of the policies or procedures submitted by Partners. The *LME/MCO Suspected Enrollee Fraud and/or Abuse DMA Program Integrity Referral* template submitted after the onsite visit includes this requirement. File Review Results: No file within the sample of 15 involves a case of suspected enrollee fraud. ***Recommendation: Either include requirement #14 and its subparts in a policy and/or procedure or cite the LME/MCO Suspected Enrollee Fraud and/or Abuse DMA Program Integrity Referral template and attach it to relevant policies/procedures.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.7 The legal and administrative status of the case.	X					This requirement is not addressed in any of the policies or procedures submitted by Partners. The *LME/MCO Suspected Enrollee Fraud and/or Abuse DMA Program Integrity Referral* template submitted after the onsite visit includes this requirement. File Review Results: No file within the sample of 15 involves a case of suspected enrollee fraud. ***Recommendation: Either include requirement #14 and its subparts in a policy and/or procedure or cite the LME/MCO Suspected Enrollee Fraud and/or Abuse DMA Program Integrity Referral template and attach it to relevant policies/procedures.***
15. PIHP and DMA shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of State and Federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.	X					This requirement is addressed in the *Regulatory Compliance Program Description/Plan.*
16. PIHP shall use the DMA Fraud and Abuse Management System (FAMS) or a DMA approved alternative data mining technology solution to detect and prevent fraud, waste and abuse in managed care.	X					This requirement is addressed in the Process Taking Complaint from Inception to Closure document and the Program Integrity Department Data Mining Guidelines, and evidenced in the fraud tracking reports (Attachment Y) submitted by Partners.
17. If PIHP uses FAMS, PIHP shall work with the DMA designated Administrator to submit appropriate claims data to load into the DMA Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses	X					This requirement is not addressed in any policy or procedure submitted by Partners. During the onsite review, Partners confirmed that it does not have this requirement, including the timeliness elements, in any policy or procedure.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
FAMS, PIHP shall notify the DMA designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.						After the onsite review, Partners provided evidence of communication regarding removal of 2 FAMS users to DMA; however, it is not possible to determine if these requests were timely, as per this requirement (i.e., within 48 hours). One individual is listed as "on hold" in the PI Department in the organizational chart of 6/30/2018, and the request for FAMS user access removal is dated 8/24/2018. The other individual is listed under the QM Department in the same organizational chart, and the removal request from FAMS is dated 2/12/2018. The latter individual is listed in the FAMS user reports up until January 2018, and not listed in the user reports starting in February 2018, which aligns with the removal request of 2/12/2018. Partners actively monitors and reports its FAMS users and requests access removals from DMA. ***Recommendation: Include this requirement in a policy and procedure, clearly stating the timeliness requirements. Partners could consider including the date of change/termination of employment in the FAMS user removal request email to provide clear evidence that it is meeting the 48-hour requirement.***
18. PIHP shall submit to the DMA Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10^{th}) day of each month. Section 9.8 Fraud and Abuse Reports. In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to DMA Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall	X					This requirement is not addressed in any policy or procedure submitted by Partners. During the onsite visit, Partners confirmed that it does not have this requirement, including the timeliness elements, in any policy or procedure; however, Partners provided evidence that this requirement is being implemented: Partners submitted 8 monthly FAMS user reports for the period from July 2017 to June 2018 and 8 NCID holder reports from September 2017 to June 2018. Partners submitted a written explanation of missing reports: "We are missing the FAMS users reports for the months of October through December 2017 and January 2018. During the period October or November, we added one user, William Owens.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
be due by 11:59p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to DMA Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.						No other changes took place among PBHM's FAMS users until February when Craig Witkowski's access was removed. "We are missing NC TRACKS NCID user reports for the months of August 2017 and October through November 2017." During the onsite review, Partners explained that the individual handling these FAMS user reports is no longer employed by Partners, and though normally in such a case the reports would be found in the ex-employee's email account or files. In this case, Partners was unable to locate the missing FAMS user reports. After the onsite review, Partners provided email messages to DMA acknowledging that it submitted the FAMS user and NCID holder reports and DMA acknowledging these submissions. Partners then submitted 4 new FAMS user reports for October 2017 to January 2018, though these documents were submitted after the deadline. Partners also submitted Attachment Y reports for the review period evidencing monthly reporting of suspected and confirmed fraud and abuse cases by the 10th of the month. Upon request after the onsite visit, Partners also submitted Attachment Z reports for the review period evidencing monthly reporting of terminated providers or non-renewal of providers. These reports are timely, as per the requirement. ***Recommendation: Include this requirement in a policy and/or procedure, clearly stating the timeliness requirements.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
19. On a quarterly basis, DMA shall review a sample of cases where the PIHP's Special Investigation Unit has identified overpayments, investigated or audited a provider. The results of these reviews will be discussed during the PIHP monthly Program Integrity meetings to assure that DMA is providing consistent guidance on expectations with regard to referrals for potential cases of fraud. DMA shall also determine what additional technical assistance may be available to PIHP to support PIHP's efforts in making referrals.	X					This requirement is addressed with the monthly and quarterly meeting minutes submitted by Partners.
VIII C. Provider Payment Suspensions and Overpayments						
1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, DMA Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If DMA determines that a full investigation is warranted, DMA shall make a referral within five (5) business days of such determination to the MFCU/ MID and will suspend payments in accordance with 42 CFR § 455.23. At least monthly, DMA shall provide written notification to PIHP of the status of each such referral. If MFCU/ MID indicates that suspension will not impact their investigation, DMA may send a payment suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates that payment suspension will						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
impact the investigation, DMA shall temporarily withhold the suspension notice and notify PIHP. Suspension of payment actions under this Section 14.3 shall be temporary and shall not continue if either of the following occur: PIHP or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider; or Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.						
1.1 In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.	X					This requirement is not addressed in any policy or procedure submitted by Partners. During the onsite review, Partners confirmed that it does not have this requirement, including the timeliness elements, in any policy or procedure. After the onsite review, Partners provided evidence that none of the providers the DMA sent suspension notices for were in their network; therefore, none had any payments suspended. Partners submitted evidence of confirmation of this fact from the Finance Department, as well. ***Recommendation: Include this requirement in a policy and/or procedure, clearly stating the timeliness requirements.***
2. Upon receipt of a payment suspension notice from DMA Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of DMA Program Integrity's suspension and lasting until PIHP is notified by DMA Program Integrity in writing that the suspension has been lifted.	X					This requirement is not addressed in any policy or procedure submitted by Partners. During the onsite review, Partners confirmed that it does not have this requirement, or anything specific to payment suspensions, in any policy or procedure. After the onsite visit, Partners provided evidence that none of the providers the DMA sent suspension notices for were in their network; therefore, none had any payments suspended. Partners submitted

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						evidence of confirmation of this fact from the Finance Department, as well. ***Recommendation: Include this requirement in a policy and/or procedure, clearly stating the timeliness requirements (i.e., from effective date to receipt of written notification from DMA).***
3. PIHP shall provide to DMA all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					This requirement is addressed page 3 of the *Provider Overpayment Recovery Policy*.
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to DMA Program Integrity due to allegations of suspected fraud without prior written approval from DMA Program Integrity or the MFCU/MID.	X					This requirement is not addressed in any policy or procedure submitted by Partners. During the onsite visit, Partners confirmed that it does not have this requirement in any policy or procedure, though its practice is aligned with this requirement. After the onsite visit, Partners submitted evidence that for the 4 cases that had suspension notices from DMA, Partners took administrative action after receiving the notice, which provides evidence of implementing this requirement. ***Recommendation: Include this requirement in a policy and procedure.***
5. Notwithstanding the foregoing, nothing herein shall be construed as prohibiting PIHP from taking any action against a Network Provider in accordance with the terms and conditions of any written agreement with a Network Provider, including but not limited to prepayment review, identification and collection of overpayments, suspension of referrals, de-credentialing, contract nonrenewal, suspension or termination or other	X					This requirement is partially addressed in the *Provider Monitoring Policy*. That "such action shall not interfere with enrollee access to care" is not addressed in any policy or procedure." The *Consumer/Enrollee Handbook* encourages enrollees to report fraud, waste, and abuse; however, the handbook does not indicate that such an action does not interfere with enrollee's access to care. During the onsite visit, Partners explained that it has included information about protection of rights of people who report fraud, waste, and abuse (i.e., whistleblower rights and protection), but it

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
sanction, remedial or preventive efforts necessary to ensure continuous, quality care to Enrollees, regardless of any ongoing investigation being conducted by DMA, MFCU/MID or other oversight agency, to the extent that such action shall not interfere with Enrollee access to care or with any such ongoing investigation being conducted by DMA, MFCU/MID or other oversight agency.						does not have an explicit statement for enrollees about continuity of access to care. ***Recommendation: Include a statement that reporting fraud, waste and abuse does not affect or interfere with enrollee's access to care.***
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.	X					This requirement is addressed in the Provider *Overpayment Recovery Policy*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
7. Recovery Audit Contactors (RACs) for the Medicaid program may audit Providers in the PIHP Network and may work collaboratively with PIHP on identification of overpayments. DMA shall require RACs to give PIHP prior written notice of such audits and the results of any audits as permitted by law.						
8. The MFCU/MID reserves the right to prosecute or seek civil damages regardless of payments made by the Provider to PIHP. The Parties shall work collaboratively to develop a plan for the disbursement of the share of monies that are recovered and returned to the state by the MFCU/MID for fraudulent claims paid by PIHP. DMA will examine options to refund returned funds to PIHP and/or to appropriately account for these recoveries in the rate setting process.						

IX. FINANCIAL SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IX. Financial						
1. The PIHP has policies and systems in-place for submitting and reporting financial data.	X					Partners' policy and procedure review is conducted annually. All reports are submitted on time to NC Medicaid.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendations: Add the five-business day transfer requirement after capitation payment of risk reserve payment to policy and procedure 3.14, Management of Risk Reserve. ***Revise policy and procedure 4.11, Record Retention and Disposition to refer to the 10-year requirement of financial records required by DMA Contract, Section 8.3.2.***
2. The PIHP has and adheres to a cost allocation plan that meets the requirements of 42 CFR 433.34.	X					Partners recalculates its administrative cost allocation by spreadsheet on monthly, based on year-to-date service revenues. The indirect cost percentage does not vary greatly and is currently 86% Medicaid and 14% state/other.
3. PIHP maintains detailed records of the administrative costs and expenses incurred as required by the DMA contract. (DMA Contract, Section 8.3).	X					The administrative costs are captured by the general ledger in Great Plains and allocated to Medicaid via the monthly NC Medicaid report.
4. Maintains an accounting system in accordance with 42 CFR 433.32 (a).	X					Partners uses Great Plains, version 2012, for its accounting system, and AlphaMCS for claims processing.
5. The PIHP follows a record retention policy of retaining records for ten years.	X					Partners retains records for 10 years, with 2 fiscal years onsite, and 8 fiscal years offsite.
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution.	X					NC Capital Management Trust maintains the restricted risk reserve account, and it is federally-guaranteed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
7. The required minimum balance of the Risk Reserve Account meets the requirements of the DMA contract. (DMA Contract, Section 1.8 Restricted Risk Reserve Account)	X					The Finance Director and the Chief Financial Officer monitor the monthly contribution. They stated all deposits were made on time and that there were no unauthorized withdrawals.
8. All funds received by PIHP are accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as required by the DMA contract (DMA Contract, Section 1.9).	X					The segregation of *Title XIX* (Medicaid) funds is done by funding source. All reports and systems separately identify *Title XIX* funds, as well as the NC Medicaid reports separating Medicaid funds. There is a separate section within Great Plains accounting system for Medicaid revenue and expenses.
9. The Medical Loss Ratio (MLR) meets the requirements of 42 CFR 438.8 and the DMA contract (Amendment 2, Section 12.3 Item k).	X					The medical loss ratio is calculated monthly within the NC Medicaid report, and is published monthly on the dashboard which is presented to the Board of Directors. The year-to-date MLR percentage is 90.4%, exceeding the 85% requirement.

D. Attachment 5: Encounter Data Validation Report

Partners Behavioral Health

Encounter Data Validation Report

performed on behalf of

North Carolina Department of Health and Human Services, Division of Health Benefits

October 31, 2018

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 Partners Behavioral Health (Partners) to North Carolina Department of Health and Human Services, NC Medicaid (formerly DMA), 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. DHHS 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 utilize the encounter data as intended and provide proper oversight, NC Medicaid must be able to deem the data complete and accurate.

Overview

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

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

Review of Partners' ISCA response

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

NC Medicaid requires each PIHP to submit their encounter data for all paid claims on a weekly basis via 837 institutional and professional transactions. The companion guides follow the standard ASC X12 transaction set with a few modifications to some segments. For example, the MCO must submit their provider number and paid amount to NC Medicaid in the Contract Information CN104 and CN102 segment of Claim Information Loop 2300.

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

rendering provider accordingly, the appropriate Medicaid allowed amount is calculated for each encounter claim in order to shadow price what was paid by the MCO.

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

Looking at claims with dates of service in 2017, Partners submitted 1,347,304 unique encounters to the State. To date, less than 1% of all encounters submitted have not been corrected and accepted by NC Medicaid.

2017	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	65,365	64,951	56	358	1%
Professional	1,281,939	1,232,678	44,972	4,289	0%
Total	1,347,304	1,297,629	45,028	4,647	0%

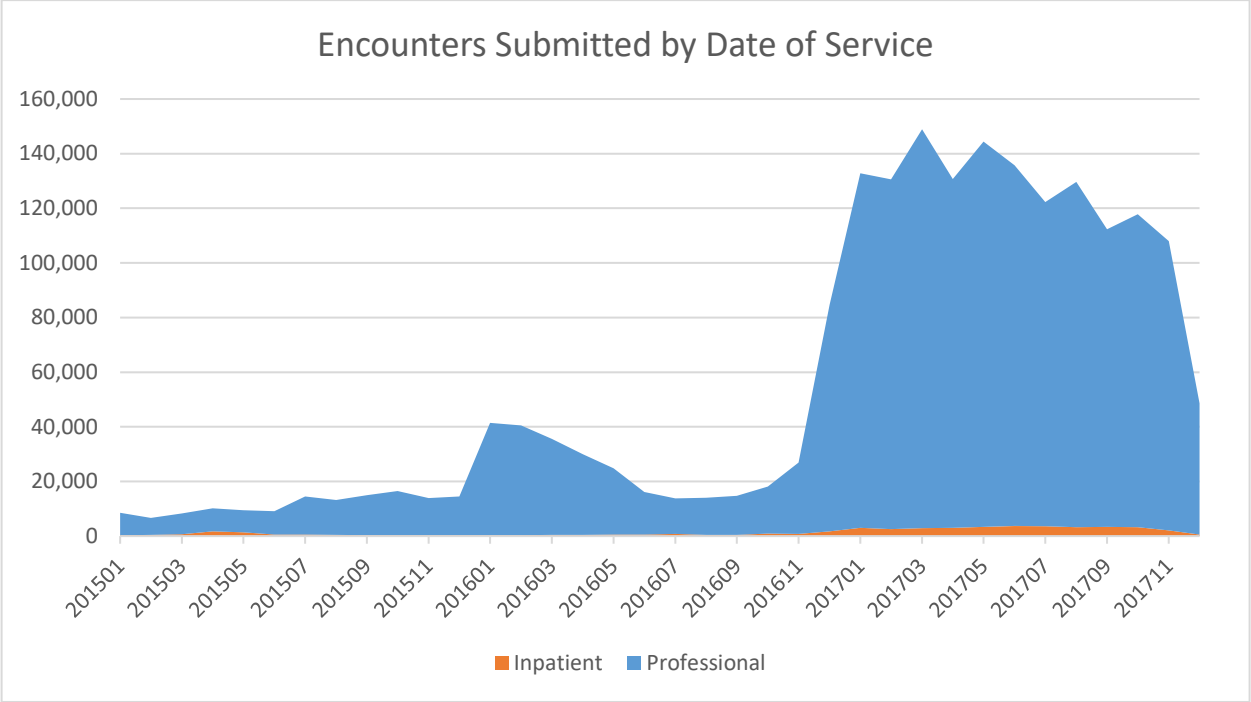
Compared to claims submitted in 2016, Partners has decreased the number of initial denials and total number of outstanding denials for claims submitted in 2017. According to Partners' response and review of NC Medicaid's acceptance report, 49% of all outstanding and ongoing denials are still related to invalid taxonomy codes for the billing and rendering Provider. Partners' strategy to continue to reduce, correct and resubmit encounter denials includes the following steps:

- Provider upload files (PUFs) to update essential provider taxonomy and address information
- Adding additional adjudication edits to AlphaMCS (i.e. all submitted diagnosis codes)
- Provider education guidelines
- Rebilling corrected encounter denials
- Submitting replacement claims upstream after voids are sent

As a result of their strategy, denied claims from 2016 that were reported in the EDV review last year has decreased from 3% (40,739 claims) to less than 1% (2,400 claims).

Analysis of Encounters

The analysis of encounter data evaluated whether Partners submitted complete, accurate, and valid data to NC Medicaid for all claims paid between January 1, 2017 through December 31, 2017. Partners pulled all claims adjudicated and submitted to NC Medicaid during 2017 and sent to HMS via SFTP. This included more than 3.6 million professional claims and just over 104,000 institutional claims. Data transmitted included voids and resubmissions for previously denied claims, so the numbers do not reconcile back to the metrics reported in the ISCA response.



In order to evaluate the data, HMS ingested the 837I and 837P data extracts, and loaded them to a consolidated database. After data onboarding was completed, HMS applied proprietary, internally designed data analysis logic within SAS to review each data element, focusing on the data elements defined as required. Our logic evaluates 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

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
		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-10-CM] lookup tables) for practitioner providers (not including transportation, lab, and other ancillary providers)

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

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

Encounter Accuracy and Completeness

The 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 pricing for the services paid by Partners.

Table: Evaluation of Key Fields

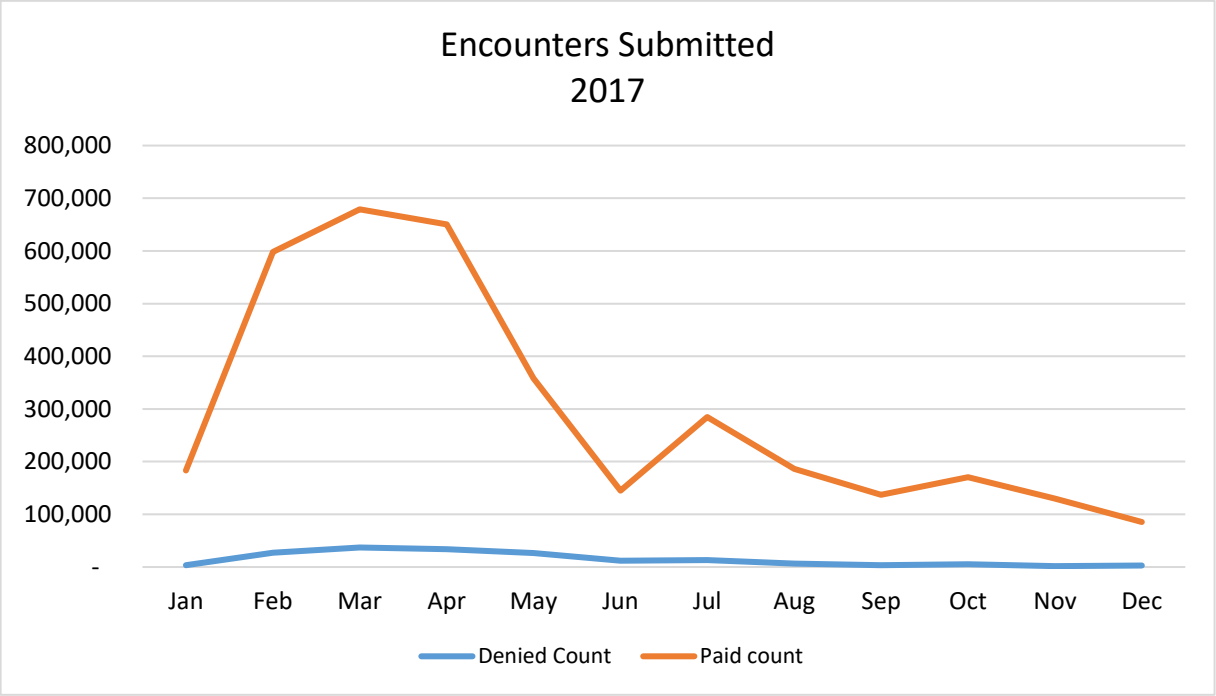
Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	3,773,978	100.000%	3,773,820	99.996%	3,773,820	100.00%	3,773,774	99.99%
Recipient Name	3,773,978	100.000%	3,773,978	100.000%	3,773,978	100.00%	3,773,978	100.00%
Recipient Date of Birth	3,773,978	100.000%	3,773,978	100.000%	3,773,978	100.00%	3,773,978	100.00%
MCO/PIHP ID	3,773,978	100.000%	3,773,978	100.000%	3,773,978	100.00%	3,773,978	100.00%
Provider ID	3,773,978	100.000%	3,773,978	100.000%	3,773,978	100.00%	3,773,978	100.00%
Attending/Renderring Provider ID	3,773,978	100.000%	3,773,978	100.000%	3,773,978	100.00%	3,773,978	100.00%
Provider Location	3,773,978	100.000%	3,773,978	100.000%	3,773,978	100.00%	3,773,978	100.00%
Place of Service	3,773,935	99.999%	3,773,935	99.999%	3,773,935	100.00%	3,773,935	100.00%
Specialty Code / Taxonomy - Billing	3,773,978	100.000%	3,773,978	100.000%	3,773,978	100.00%	3,773,978	100.00%
Specialty Code / Taxonomy - Rendering / Attending	3,773,978	100.000%	3,773,978	100.000%	3,773,978	100.00%	3,773,978	100.00%
Principal Diagnosis	3,773,974	100.000%	3,773,974	100.000%	3,773,974	100.00%	3,773,974	100.00%
Other Diagnosis	2,013,837	53.361%	2,013,837	53.361%	2,013,837	53.36%	2,013,837	53.36%
Dates of Service	3,720,231	98.576%	3,720,231	98.576%	3,720,231	98.58%	3,720,231	98.58%
Unit of Service (Quantity)	3,773,956	99.999%	3,773,956	99.999%	3,773,956	100.00%	3,767,447	99.83%
Procedure Code	3,712,352	98.367%	3,712,285	98.365%	3,711,834	98.35%	3,711,767	98.35%
Procedure Code Modifier	663,719	17.587%	663,719	17.587%	663,719	17.59%	663,719	17.59%
Patient Discharge Status Code Inpatient	104,349	100.000%	104,349	100.000%	104,349	100.00%	104,349	100.00%
Revenue Code	104,349	100.000%	104,349	100.000%	104,349	100.00%	104,349	100.00%

Overall, Partners has significantly improved the quality and accuracy of the encounter data submitted compared to last year's review of 2016 claims. Institutional claims contained complete and valid data in 16 of the 18 key fields (89%) with noted issues for Recipient Id and Dates of Service. The Recipient ID was not always populated with the appropriate values. The data present should be 10 bytes in length consisting of 9 numbers followed by an alpha character. In addition, over 53,000 claims were missing a date of service value which is required to adjudicate the claim.

Professional encounter claims submitted contained complete and accurate data in 14 of the 15 key professional fields (93%). Similar to institutional claims, the Recipient Id was not populated with valid values for a portion of the claims. The Recipient Id should be populated 100% of the time with the 10 digit alpha numeric Medicaid Id.

Encounter Acceptance Report

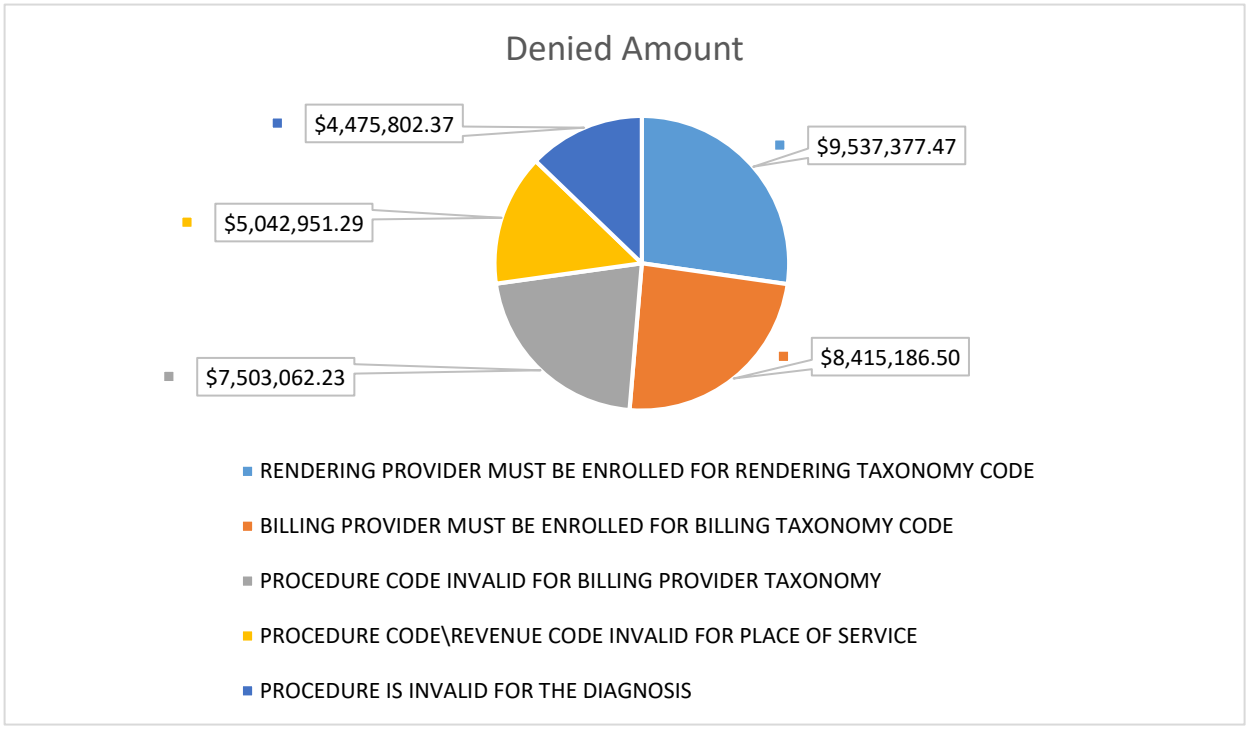
In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each LME/MCO. The report is tracked by check write which made it difficult to tie back to the ISCA response and submitted encounter files since only the Date of Service for each is available. During the 2017 weekly check write schedule, Partners submitted a total of 3,607,901encounters to NC Medicaid. On average, 5% of all encounters submitted were denied. Less than 1% of claims denied are still outstanding -- the rest have been reviewed, resubmitted, and accepted by NC Medicaid.

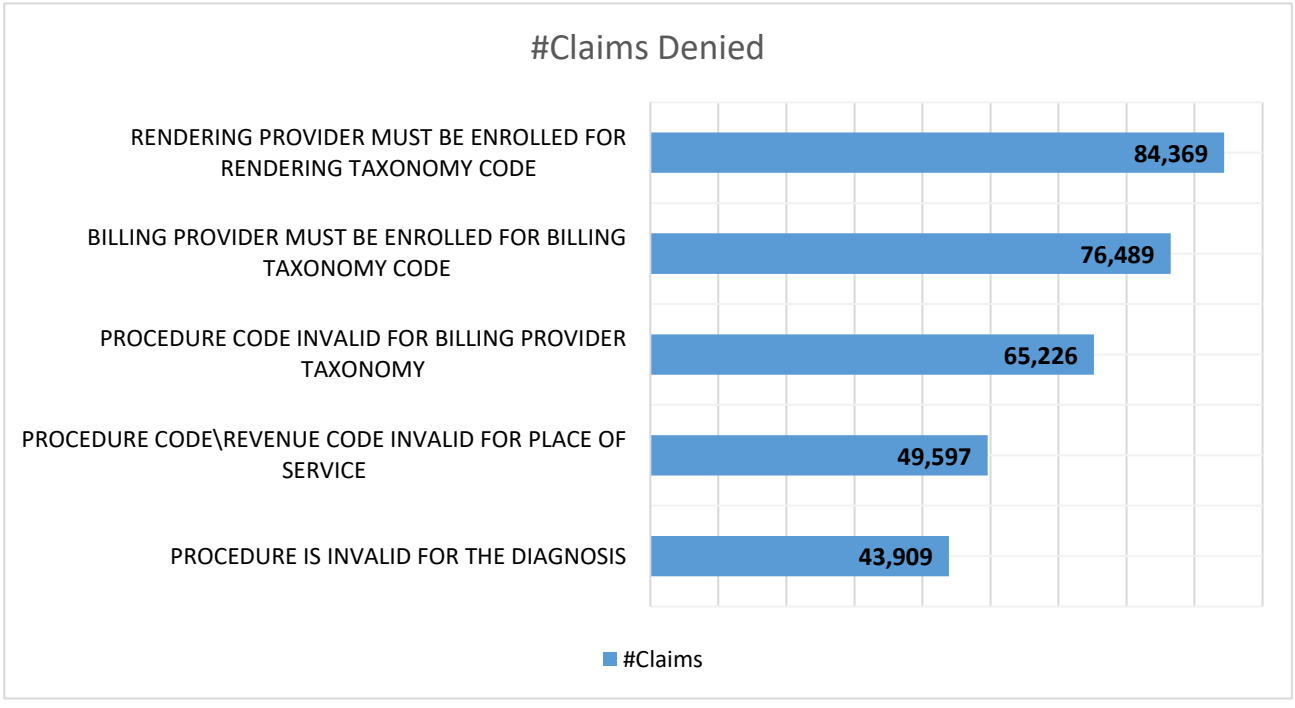


Evaluation of the top denials for Partners' encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis above. Encounters were denied primarily for:

- Rendering provider must be enrolled for rendering taxonomy code
- Billing provider must be enrolled for billing taxonomy code
- Procedure code invalid for billing provider taxonomy
- Procedure code \ revenue code invalid for place of service
- Procedure is invalid for the diagnosis

The charts below reflect the top 5 denials by paid amount and the number of claims impacted by each denial reason.





Results and Recommendations

Issue: Recipient Id

The Recipient Id was not consistently populated with valid data for professional or institutional claims. This information is key for passing the front end edits put in place by the State and to effectively price the claim. All Recipient Ids should be a ten byte, alpha numeric field. The value was always populated, however, not always with the correct length or expected format.

Resolution:

Partners should check their claims processing system and data warehouse to ensure the Recipient Id is being captured appropriately. Claims submitted through the portal or an 837 would be denied by Partners. Partners should double check their 837 encounter creation process and encounter data extract process to make sure data was not lost or manipulated during transformation.

Issue: Dates of Service

A valid date of service is required in order to properly adjudicate a claim. This issue only occurred in the institutional claims data provided.

Resolution:

Dates of service are a required field. Partners should be unable to pay institutional claims without this information. The MCO should check their claims processing system and data warehouse to ensure the field is required and being captured appropriately. If captured correctly, Partners should double check their 837 encounter creation process and encounter data extract process to make sure data was not lost during transformation.

Issue: Diagnosis Codes

Two items need to be addressed as it relates to diagnosis codes. The principal diagnosis was not populated for 100% of the claims. Typically, the claim would be denied by Partners when adjudicating claim, as well as denied by NC Medicaid when submitted as an encounter record. Also, there are never more than 2 diagnosis codes provided/submitted in the encounter data for professional or institutional claims.

Resolution:

The missing principal diagnosis code is not large enough to exceed the threshold outlined in the Data Quality Standards table above (>90%), however, Partners should review the data being captured and submitted to ensure that claims are never submitted without a principal diagnosis. The second part noted above will require action by Partners and NC Medicaid. NC Medicaid will need to work with the PIHPs and CSRA to determine what additional non-behavioral health diagnosis codes should be submitted and accepted when available. Currently, NCTracks will deny any encounter with a non behavioral health

diagnosis regardless of the position of the diagnosis code value (i.e. primary, secondary, tertiary, etc.). There are behavioral health services provided by the PIHPs that require medical services and medical diagnosis codes. Partners will need to work collaboratively with the state and AlphaMCS to ensure they can capture and report all diagnosis codes once NCTracks has been updated to accept.

Conclusion

Based on the analysis of Partners' encounter data, we have concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues were noted with both institutional and professional encounters. Based on Partners' ISCA response, overview of the AlphaMCS system, and limited number of data anomalies, HMS believes that the errors are associated with the creation of the 837 rather than the data received and maintained. Partners should take corrective action to resolve the issues identified with Recipient Id, Dates of Service, and diagnosis codes.

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 Partners. The goal is to ensure that Partners 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 DMA REQ FOR FIN REV	IGNORE
00334	ENCOUNTER TAXON M/I	PAY AND REPORT
00335	ENCOUNTER PROV NUM MISSING	DENY
00337	ENC PROC CODE NOT ON FILE	PAY AND REPORT
00339	PRCNG REC NOT FND FOR ENC CLM	PAY AND REPORT
00349	SERV DENIED FOR BEHAV HLTH LM	IGNORE
00353	NO FEE ON FILE	PAY AND REPORT
00355	MANUAL PRICING REQUIRED	PAY AND REPORT
00358	FACTOR CD IND PROC NON-CVRD	PAY AND REPORT
00359	PROV CHRGS ON PER DIEM	PAY AND REPORT
00361	NO CHARGES BILLED	DENY
00365	DRG - DIAG CANT BE PRIN DIAG	DENY
00366	DRG - DOES NOT MEET MCE CRIT.	PAY AND REPORT
00370	DRG - ILLOGICAL PRIN DIAG	PAY AND REPORT
00371	DRG - INVLD ICD-9-CM PRIN DIAG	DENY

00374	DRG PAY ON FIRST ACCOM LINE	DENY
00375	DRG CODE NOT ON PRICING FILE	PAY AND REPORT
00378	DRG RCC CODE NOT ON FILE DOS	PAY AND REPORT
00439	PROC\REV CD INVLD FOR AGE	IGNORE
00441	PROC INVLD FOR DIAG	IGNORE
00442	PROC INVLD FOR DIAG	IGNORE
00613	PRIM DIAG MISSING	DENY
00628	BILLING PROV ID REQUIRED	IGNORE
00686	ADJ/VOID REPLC TCN INVALID	DENY
00689	UNDEFINED CLAIM TYPE	IGNORE
00701	MISSING BILL PROV TAXON CODE	DENY
00800	PROC CODE/TAXON REQ PSYCH DX	PAY AND REPORT
00810	PRICING DTE INVALID	IGNORE
00811	PRICING CODE MOD REC M/I	IGNORE
00812	PRICING FACTOR CODE SEG M/I	IGNORE
00813	PRICING MOD PROC CODE DTE M/I	IGNORE
00814	SEC FACT CDE X & % SEG DTE M/I	IGNORE
00815	SEC FCT CDE Y PSTOP SEG DT M/I	IGNORE
01005	ANTHES PROC REQ ANTHES MODS	IGNORE
01060	ADMISSION HOUR INVALID	IGNORE
01061	ONLY ONE DOS PER CLAIM	IGNORE
01102	PRV TAXON CHCK - RAD PROF SRV	IGNORE
01200	INPAT CLM BILL ACCOM REV CDE	DENY
01201	MCE - ADMIT DTE = DISCH DTE	DENY
01202	M/I ADMIT AND DISCH HRS	DENY

01205	MCE: PAT STAT INVLD FOR TOB	DENY
01207	MCE - INVALID AGE	PAY AND REPORT
01208	MCE - INVALID SEX	PAY AND REPORT
01209	MCE - INVALID PATIENT STATUS	DENY
01705	PA REQD FOR CAPCH/DA/CO RECIP	PAY AND REPORT
01792	DME SUPPLIES INCLD IN PR DIEM	DENY
02101	INVALID MODIFIER COMB	IGNORE
02102	INVALID MODIFIERS	PAY AND REPORT
02104	TAXON NOT ALLOWED WITH MOD	PAY AND REPORT
02105	POST-OP DATES M/I WITH MOD 55	IGNORE
02106	LN W/ MOD 55 MST BE SAME DOS	IGNORE
02107	XOVER CLAIM FOR CAP PROVIDER	IGNORE
02111	MODIFIER CC INTERNAL USE ONLY	IGNORE
02143	CIRCUMCISION REQ MED RECS	IGNORE
03001	REV/HCPCS CD M/I COMBO	IGNORE
03010	M/I MOD FOR PROF XOVER	IGNORE
03012	HOME HLTH RECIP NOT ELG MCARE	IGNORE
03100	CARDIO CODE REQ LC LD LM RC RI	IGNORE
03101	MODIFIER Q7, Q8 OR Q9 REQ	IGNORE
03200	MCE - INVALID ICD-9 CM PROC	DENY
03201	MCE INVLD FOR SEX PRIN PROC	PAY AND REPORT
03224	MCE-PROC INCONSISTENT WITH LOS	PAY AND REPORT
03405	HIST CLM CANNOT BE ADJ/VOIDED	DENY
03406	HIST REC NOT FND FOR ADJ/VOID	DENY
03407	ADJ/VOID - PRV NOT ON HIST REC	DENY

04200	MCE - ADMITTING DIAG MISSING	DENY
04201	MCE - PRIN DIAG CODE MISSING	DENY
04202	MCE DIAG CD - ADMIT DIAG	DENY
04203	MCE DIAG CODE INVLD RECIP SEX	PAY AND REPORT
04206	MCE MANIFEST CODE AS PRIN DIAG	DENY
04207	MCE E-CODE AS PRIN DIAG	DENY
04208	MCE - UNACCEPTABLE PRIN DIAG	DENY
04209	MCE - PRIN DIAG REQ SEC DIAG	PAY AND REPORT
04210	MCE - DUPE OF PRIN DIAG	DENY
04506	PROC INVLD FOR DIAG	IGNORE
04507	PROC INVLD FOR DIAG	IGNORE
04508	PROC INVLD FOR DIAG	IGNORE
04509	PROC INVLD FOR DIAG	IGNORE
04510	PROC INVLD FOR DIAG	IGNORE
04511	PROC INVLD FOR DIAG	IGNORE
07001	TAXON FOR ATTND/REND PROV M/I	DENY
07011	INVLD BILLING PROV TAXON CODE	DENY
07012	INVLD REND PROV TAXONOMY CODE	DENY
07013	INVLD ATTEND PROV TAXON CODE	PAY AND REPORT
07100	ANESTH MUST BILL BY APPR PROV	IGNORE
07101	ASC MODIFIER REQUIREMENTS	IGNORE
13320	DUP-SAME PROV/AMT/DOS/PX	DENY
13420	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
13460	POSSIBLE DUP-SAME PROV/PX/DOS	PAY AND REPORT
13470	LESS SEV DUPLICATE OUTPATIENT	PAY AND REPORT

13480	POSSIBLE DUP SAME PROV/OVRLAP	PAY AND REPORT
13490	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13500	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13510	POSSIBLE DUP/SME PRV/OVRLP DOS	PAY AND REPORT
13580	DUPLICATE SAME PROV/AMT/DOS	PAY AND REPORT
13590	DUPLICATE-SAME PROV/AMT/DOS	PAY AND REPORT
25980	EXACT DUPE. SAME DOS/ADMT/NDC	PAY AND REPORT
34420	EXACT DUP SAME DOS/PX/MOD/AMT	PAY AND REPORT
34460	SEV DUP-SAME PX/PRV/IM/DOS/MOD	DENY
34490	DUP-PX/IM/DOS/MOD/$$/PRV/TCN	PAY AND REPORT
34550	SEV DUP-SAME PX/IM/MOD/DOS/TCN	PAY AND REPORT
39360	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
39380	EXACT/LESS SEVERE DUPLICATE	PAY AND REPORT
49450	PROCDURE CODE UNIT LIMIT	PAY AND REPORT
53800	Dupe service or procedure	PAY AND REPORT
53810	Dupe service or procedure	PAY AND REPORT
53820	Dupe service or procedure	PAY AND REPORT
53830	Dupe service or procedure	PAY AND REPORT
53840	Limit of one unit per day	PAY AND REPORT
53850	Limit of one unit per day	PAY AND REPORT
53860	Limit of one unit per month	PAY AND REPORT
53870	Limit of one unit per day	PAY AND REPORT
53880	Limit of 24 units per day	DENY
53890	Limit of 96 units per day	DENY
53900	Limit of 96 units per day	DENY