CCME

2020 External Quality Review

PARTNERS HEALTH MANAGEMENT

Submitted: July 6, 2021

Prepared on behalf of
North Carolina Medicaid

Table of Contents

EXECUTIVE SUMMARY

The *Balanced Budget Act of 1997* requires State Medicaid Agencies that contract with Prepaid Inpatient Health Plans (PIHPs) to evaluate their compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358 (42 CFR § 438.358)*. This review determines the level of performance demonstrated by Partners Health Management (Partners). This report contains a description of the process and the results of the 2020 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of North Carolina Medicaid (NC Medicaid).

Goals of the review are to:

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

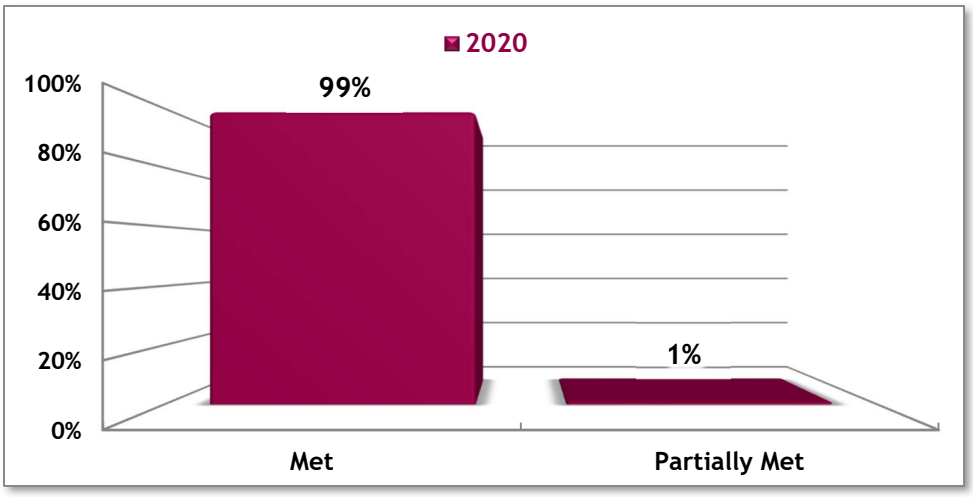
The process used for the EQR was based on the Centers for Medicare & Medicaid Services (CMS) protocols for EQR of Medicaid Managed Care Organizations (MCOs) and PIHPs. The review includes a Desk Review of documents, an Onsite visit, compliance review, validation of performance improvement projects (PIPs),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

Due to the COVID-19 pandemic, the 2020 EQR was delayed, and CCME implemented a focused review.

A. Overall Scoring

The 2020 Annual EQR reflects that Partners achieved a “Met” score for 99% of the standards reviewed. As Figure 1 indicates, 1% of the standards were scored as “Partially Met.” None of the standards were scored as “Not Met.”

Figure 1: Annual EQR Findings



B. Overall Findings

The following provides a global or high-level summary of the status of the Recommendations and Corrective Action items from the 2019 EQR and the findings of the 2020 EQR. Specific Recommendations and Corrective Actions are detailed in each section of this report.

Administration

In the 2019 EQR, Partners received two Corrective Actions related to the capture and submission of ICD-10 Procedure codes. Based on the findings in the 2020 EQR, Partners has addressed the two Corrective Actions and is now able to capture the ICD-10 Procedure codes on HIPAA files and the Provider Web Portal and also submit the ICD-10 Procedure codes on Institutional encounters to NCTracks.

Provider Services

In Partners' 2019 EQR, there were no items requiring Corrective Action and six Recommendations in the Credentialing/Recredentialing section of Provider Services. Partners addressed the six Recommendations. In the current EQR, Partners met 100% of the Credentialing/ Recredentialing standards, with no identified Weaknesses, Corrective Action items or Recommendations.

Quality Improvement

The Quality Improvement (QI) EQR included validation of Performance Measures (PMs) and Performance Improvement Projects (PIPs). In the 2019 EQR, all PIPs scored in the High Confidence range. For the PIPs reviewed, there were no Corrective Actions given, and four Recommendations were issued and implemented. There were no Recommendations given in the 2019 EQR for the PMs. The 2019 EQR validation scores for

(b) Waiver and (c) Waiver Performance Measures were Fully Compliant, with an average validation score of 100%.

For the 2020 EQR, the Performance Measure Query was accurate for (b) Waiver Measures, and all measures were validated at 100%, Fully Compliant, although the combined services rate of 7-day Follow-up After Hospitalization for Mental Illness declined from 50.1% to 40%, a decline of 10.1%. CCME recommended continuing current interventions for this PM, working to increase this rate. All (c) Waiver Performance Measures were above State benchmark rates and were validated at 100%. The five validated PIPs all scored in the High Confidence range, although four PIPs have Recommendations for improvement. In this 2020 EQR, 100% of the QI standards were met.

Utilization Management

For the 2019 EQR, Partners met 91% of Utilization Management (UM) standards. CCME issued three Corrective Actions and three Recommendations to Care Coordination and Transition to Community Living Initiative (TCLI). Partners addressed two Corrective Actions and three Recommendations. The remaining Corrective Action was partially implemented.

In this year's EQR, Partners met 92% of UM standards. CCME issued three Corrective Actions and one Recommendation. During the 2019 EQR, Partners addressed the process for transferring enrollees between Care Coordinators, region, and department but did not include a process for transferring enrollees to another PIHP. In the 2020 EQR, CCME issued a Recommendation that Partners update all relevant policies and procedures, program descriptions, and manuals to include the process for transferring an enrollee to a new PIHP.

The remaining three Corrective Actions target concerns within Mental Health/Substance Use (MH/SU), Intellectual/Developmental Disability (I/DD), and TCLI Care Coordination file review. In MH/SU and TCLI files, CCME noted significant inconsistencies in the discharge process and the transfer of enrollees to a new PIHP. Concerns in I/DD include a lack of completeness and quality of documentation by Care Coordinators regarding Home and Community Based Services and the required *State Monitoring Checklist*.

Revision: NC Medicaid reviewed the two Corrective Actions issued in the MH/SU and I/DD section and determined no Corrective Action is needed by Partners, as the finding does not relate to enrollee health and safety. The report now reflects these Corrective Actions are now best practice Recommendations. NC Medicaid did determine the TCLI Corrective Action should remain due to "the lack of continuity of care." This changed Partners' Utilization Management score from a 92% to a 96%.

Grievances and Appeals

In the 2019 EQR, Partners met 85% of the Grievance and Appeal standards. Three Corrective Actions and seven Recommendations were issued related to the Grievance and

Appeal policies and procedures, the *Provider Operations Manual*, the *Member Handbook*, and the Grievance and Appeal files reviewed.

In the 2020 EQR, Partners met all of the Grievance and Appeal standards. Two Recommendations were issued to improve upon the quality of the Grievance language within the Policy and Procedure 34U, Grievances and the *Provider Operations Manual*, as well as compliance issues noted within the Appeal files.

Program Integrity

In the 2019 EQR, eight Recommendations were issued to improve upon the language within Partners' Program Integrity (PI) policies and procedure to ensure compliance with Partners' NC Medicaid Contract, Section 14. No language was added to Partners' PI policies and procedures. However, Partners reported these Recommendations were added to Partners' Program Integrity Departmental Procedural Guidelines. Partners reports PI staff use this document "on a daily basis."

In the 2020 EQR, all PI standards were met. CCME issued one Recommendation to ensure staff complete and routinely update the Investigative Summary form to provide an overview of the investigation and its current status within the investigative process.

Encounter Data Validation

Based on the analysis of Partners' encounter data, it was concluded that the data submitted to NC Medicaid is complete and accurate as defined by CMS and NC Medicaid standards. The validation process found mostly minor issues with both institutional and professional encounters. Based on Partners' ISCA response, overview of the Alpha system, and limited number of data anomalies, it was noted that some of the errors are isolated cases that can be mitigated in the future by reviewing and modifying data validation rules, as necessary. Overall, Partners has shown continued improvements in the quality of encounter data, and this trend is consistent with the reduction in the rate of denials on first time encounter submissions. However, some of the errors noted are critical in nature. Therefore, Partners should review and take Corrective Action to resolve the issues identified.

For the next review period, it is recommended that the encounter data from NCTracks be reviewed to look at encounters that pass front end edits and are adjudicated to either a paid or denied status. It is difficult to reconcile the various tracking reports with the data submitted by the PIHP. Reviewing an extract from NCTracks would provide insight into how the State's Medicaid Management Information System (MMIS) is handling the encounter claims and could be reconciled back to reports requested from 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 Performance Measures, and validation of Performance Improvement Projects, as well as an optional activity in the area of Encounter Data Validation, conducted by CCME's subcontractor HMS. Additionally, as required by CCME's contract with NC Medicaid, an ISCA Audit and Medicaid Program Integrity (PI) review of the health plan was conducted by CCME's subcontractor IPRO.

On November 2, 2020, 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 to offer 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 on November 23, 2020 and reviewed by CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. The Desk Review included a review of Credentialing, Grievance, Program Integrity, Care Coordination, and Appeal files.

The second segment of the EQR is typically a two-day Onsite review conducted at the PIHP's offices. However, due to COVID-19, this Onsite was conducted through a teleconference platform on June 10, 2021. This Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's Onsite activities included:

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

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

FINDINGS

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

The review of Partners' system capabilities involves the use of the Information Systems Capabilities Assessment (ISCA) tool and review of supporting documentation, such as Partners' claim audit reports, enrollment workflows, and Information Technology staffing patterns. This system analysis is completed as specified in the CMS protocol. During the Onsite, staff presented a member and claims systems review. Responses on the ISCA tool and encounter denial reason codes were also discussed with Partners staff during the Onsite.

In the 2019 EQR ISCA Assessment, Partners received two Corrective Actions. These two Corrective Actions are related to Partners' ability to capture ICD-10 Procedure Codes and submit them on Institutional encounters to NCTracks. Partners, like many other PIHPs in North Carolina, uses the AlphaMCS transactional, a hosted system environment produced by WellSky, their vendor. The AlphaMCS system is used to process member enrollment, claims, submit encounters, and generate reports. WellSky modifies the user interface and conducts backend programming updates to the system.

The ISCA tool and supporting documentation for enrollment systems loading processes clearly define the process for enrollment data updates in the AlphaMCS enrollment system. During the ISCA Onsite, Partners provided a demonstration of the AlphaMCS enrollment system. The system maintains a member's enrollment history. The Global Eligibility File (GEF) file is imported daily into the AlphaMCS by WellSky. Partners stated that they also load the GEF files to a local SQL database that is used to compare the enrollment records with AlphaMCS and the enrollment records in their local SQL database always match the enrollment records in the AlphaMCS.

During the ISCA Onsite, Partners stated that there is a limit on the number of eligibility segments that can be present on the GEF file. One hundred eligibility records is the maximum number of eligibility segments that can be present on the GEF. As Partners has a large number of members with spenddown, they occasionally encounter members who have more than 100 eligibility segments. Partners identifies these members by running a claims report that identifies claims that were rejected due to enrollment issues. The

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

During the Onsite system demonstration, staff displayed the enrollment information that is captured and accessible within AlphaMCS. The AlphaMCS system is able to capture demographic data like race, ethnicity and language, and coordination of benefit (COB) information. Partners' enrollment counts for the past three years are presented in Table 1.

Table 1: Enrollment Counts

2017	2018	2019
156,533	149,774	156,412

Partners' claims and authorizations are processed in the AlphaMCS system. A review of Partners' processes for collecting, adjudicating, and reporting claims was conducted through a review of its ISCA response and supporting documentation. A demonstration of Partners' AlphaMCS claims processing system was performed during the Onsite and Institutional and Professional screens were reviewed. Partners receives claims from three methods, 837 electronic file, Provider Web Portal, and paper claims. During the Onsite, Partners stated that they receive claims from new and out-of-network providers on paper. Table 2 details the percentage of 2019 claims received via the three methods.

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

Source	HIPAA File	Paper	Provider Web Portal
Institutional	86.7%	0.1%	13.2%
Professional	83.5%	0.0%	16.5%

During the Onsite, Partners stated that, if a required field is missing from a claim, the provider portal will not allow the claim to be submitted to Partners. If the claim is being submitted via an electronic 837 file and one or more required fields are missing, the claim will be denied, and the provider will receive a response file advising the provider of the reason for denial. If the claim is submitted with fields missing, Partners claims processors do not change any information on the claims. Partners staff conduct random audits of all claims processed daily. During the Onsite, Partners noted that 100% of

Hospital claims, more than 3% of Professional claims, and 7% of COB claims are audited daily.

For Professional claims, Partners can receive and store up to 12 ICD-10 Diagnosis codes on both the Provider Web Portal and via HIPAA files. For Institutional claims, Partners can capture up to 29 ICD-10 Diagnosis codes if they are submitted on the claim via HIPAA files and up to 25 ICD-10 Diagnosis codes if they are submitted on the claim on the Provider Web Portal. Partners can capture ICD-10 Procedure codes and Diagnosis Related Groups (DRGs) on the Provider Web Portal and via HIPAA files.

Enrollment and claims history are maintained in the AlphaMCS and Partners' internal data warehouse. During the Onsite, Partners indicated that the internal data warehouse is backed up on a daily basis. Partners has a defined process in place for their encounter data submission for approved claims, with 837 files submitted to NC Medicaid and 999 and 835 response files received back from NC Medicaid through the NCTracks system. The 835 file from NCTracks and NC Medicaid Paid and Denied spreadsheets are used to review encounter denials. The extraction, submission, and reconciliation of encounter data are fully automated, but the correction of denials and resolution of the issues related to incorrect provider information or member eligibility information are conducted manually.

The breakdown of encounter data acceptance/denial rates by claim service detail counts was provided for encounters submitted in 2019. Table 3 provides a comparison of 2018 and 2019.

Table 3: Volume of 2018 and 2019 Submitted Encounter Data

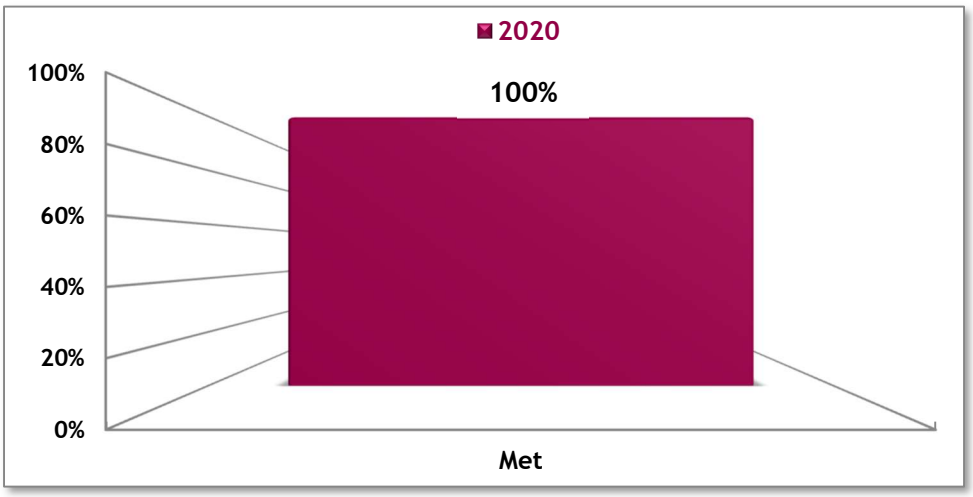
2019	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	81,722	190	227	82,139
Professional	1,356,233	8,040	84	1,364,357
2018	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	74,414	88	811	75,313
Professional	1,276,806	9,646	1,701	1,288,153

Partners has a 99.9% acceptance rate for both Professional and Institutional encounters with dates of service in 2019. Partners stated that the top denial reason for encounters submitted in 2019 was Provider Taxonomy mismatches. Partners submits an encounter

within an average of eight days from the time of adjudication to NCTracks. It takes Partners approximately 43 days to correct and resubmit a denied encounter to NCTracks. Partners uses the 835 response file to identify encounters that were denied. Partners' Claims Staff and an IT Business Analyst research, correct, and resubmit the denied encounters based on the denial code.

Partners advised that they are submitting all ICD-10 Diagnosis codes for Professional and Institutional encounters to NCTracks. Partners submits DRG and ICD-10 Procedure codes received from the provider on Institutional encounters to NCTracks. Figure 2 demonstrates that Partners met all of the Standards in the 2020 ISCA EQR.

Figure 2: ISCA Findings



Strengths

- Partners can capture up to 29 Diagnosis codes on Institutional claims on HIPAA files and 25 Diagnosis codes on the Provider Web Portal. Partners can capture up to 12 Diagnosis codes on Professional claims via HIPAA files and on the Provider Web Portal.
- Partners can capture the DRG and ICD-10 Procedure codes on Institutional claims on the Provider Web Portal and via HIPAA files.
- Partners can submit all ICD-10 Diagnosis codes submitted by the provider on the encounter data extracts to NCTracks.
- Partners can submit DRG and ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks.
- Partners' current NCTracks encounter data acceptance rate is 99.9% for the combined Professional and Institutional extracts.

B. Provider Services

The Provider Services EQR for Partners included Credentialing and Recredentialing as well as a discussion of provider education and network adequacy. CCME reviewed relevant policies and procedures, the *Credentialing Program Description Draft 10-15-20 (CPD)*, the *Credentialing Committee Charter (CCC)*, credentialing/recredentialing files, a sample of Credentialing Committee meeting minutes, and select items on Partners' website. Partners staff provided additional information during an Onsite interview.

In Partners' 2019 EQR of Credentialing/Recredentialing, there were no items requiring Corrective Action. There were six Recommendations in the Credentialing/Recredentialing section at the last EQR. Partners addressed all six Recommendations.

The *CPD*, the *CCC*, and several policies and procedures guide the credentialing and recredentialing processes. CCME's review of the credentialing and recredentialing files showed they were organized and contained appropriate information.

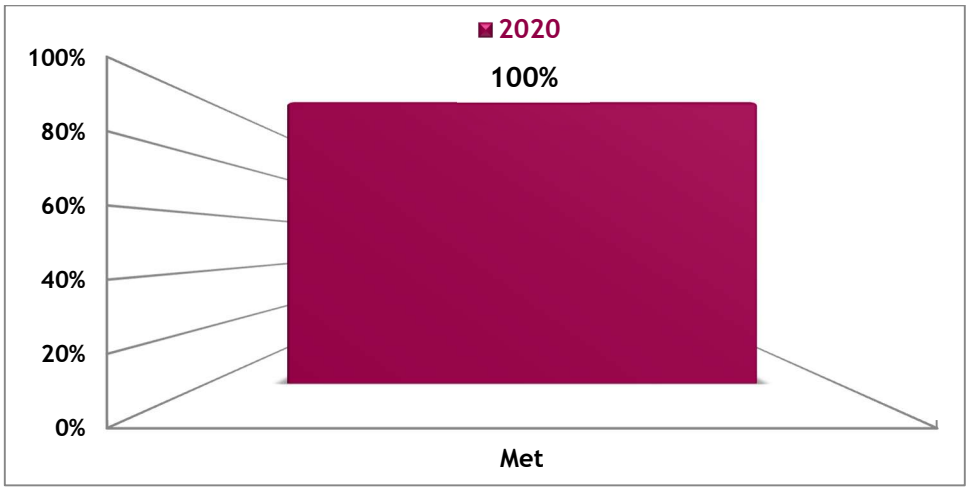
The Credentialing Committee includes Partners employees and network providers representing various specialties. Dr. Elizabeth Stanton, Chief Medical Officer (CMO) and a board-certified psychiatrist, or her designee, reviews and approves "unflagged" credentialing applications and chairs the Credentialing Committee. The *CPD* reports the Credentialing Committee meets at least quarterly and defines a quorum as "greater than half of the filled positions of the voting membership." The sample of Credentialing Committee meeting minutes reviewed for this EQR indicated a quorum was present.

Training and orientation of network providers is described in Policy and Procedure 8.13U, 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*, accessed via the Partners Provider Knowledge Base of the Partners website, is a five page document with summary information and website links that are helpful to new providers.

Under the COVID-19 flexibilities as outlined in *NC Medicaid Contract Amendment #9*, the annual *Network Adequacy and Accessibility Analysis* (Gaps Analysis) will be submitted "no later than ninety (90) calendar days after termination of the Amendment." At the last EQR, Partners identified a gap in Substance Abuse Comprehensive Outpatient Treatment Program (SA-COT) and filed an *Exception Request* with NC Medicaid. The *Exception Request* was approved through January 2020, and a NC Medicaid letter dated February 26, 2020 stated, "After review, it appears that Partners has taken the necessary actions to resolve the gap for SA." During the Onsite review for this EQR, Partners' staff reported their continued assessment revealed the SA-COT gap was eliminated but additional gaps for both State-funded and Medicaid-funded services were identified. Efforts to address the gaps are under way.

As Figure 3 indicates, 100% of the standards in the Provider Services review were scored as "Met".

Figure 3: Provider Services Findings



Strengths

- Partners has a Provider Help Desk with a dedicated toll-free number. Direct phone numbers and email addresses for various provider network personnel are listed on the Partners website.
- 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.
- In response to the COVID-19 pandemic, Partners took several steps to ensure member access to care, including providing cell phones to providers to distribute to members, and conducting provider information sessions to quickly disseminate information to providers.

C. Quality Improvement

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

In the 2019 EQR, all PIPs scored in the High Confidence range. There were no Corrective Actions, and CCME issued four Recommendations issued for the PIPs that were implemented and maintained. There were no Recommendations given in the 2019 EQR for the PMs. The 2019 EQR validation scores for (b) Waiver and (c) Waiver Performance Measures were fully compliant with an average validation score of 100%.

For the 2020 EQR, five PIPs were validated, and all PIPs scored in the High Confidence range. The 2020 EQR has no Corrective Action items, although four PIPs have Recommendations. The Performance Measure Query was accurate for (b) Waiver Measures, and all measures were validated at 100%, Fully Compliant, although the combined services rate of 7-day Follow-up After Hospitalization for Mental Illness declined from 50.1% to 40%, a decline of 10.1%. CCME recommended continuing current interventions for this PM, working to increase this rate. The (c) Waiver Measures exceeded State benchmarks and were validated at 100%, Fully Compliant.

Performance Measure Validation

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

Table 4: (b) Waiver Measures

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

Table 5: (c) Waiver Measures

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

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

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

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

(b) Waiver Measures Reported Results

These measure rates for FY2019-FY2020 as reported by Partners are included in the Tables below. The previous year's rate and the difference in the rates are displayed. When comparing the previous year to the current year's rates, there was substantial improvement in the 30-day Mental Health (MH) readmission rate, with a 12.9% decrease for Psychiatric Residential Treatment Facility (PRTF), from 24.7% in 2019 to 11.8% in

2020. The 7-day Follow-up After Hospitalization for MH PRTF improved from 22% in 2019 to 33.3% in 2020, an improvement of 11.3%. The Follow-up After Hospitalization for Substance Abuse (SA) for Detox and Facility Based Crisis (FBC) improved for 3-day by 28%. The 7-day rate improved 30%, and 30-day improved almost 34%. The combined services rate, however, declined for 7-day Follow-up After Hospitalization for Mental Illness from 50.1% to 40%, a decline of 10.1%. The current rate in comparison to last year's rate is presented in the Tables 6 through 15.

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

30-day Readmission Rates for Mental Health	2019	2020	Change
Inpatient (Community Hospital Only)	11.5%	12.4%	0.90%
Inpatient (State Hospital Only)	0.0%	0.0%	0.00%
Inpatient (Community and State Hospital Combined)	11.5%	12.7%	1.20%
Facility Based Crisis	8.8%	10.0%	1.20%
Psychiatric Residential Treatment Facility (PRTF)	24.7%	11.8%	-12.90%
Combined (includes cross-overs between services)	14.7%	14.6%	-0.10%

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

30-day Readmission Rates for Substance Abuse	2019	2020	Change
Inpatient (Community Hospital Only)	14.1%	19.5%	5.40%
Inpatient (State Hospital Only)	10.0%	2.6%	-7.40%
Inpatient (Community and State Hospital Combined)	14.6%	17.8%	3.20%
Detox/Facility Based Crisis	6.3%	6.1%	-0.20%
Combined (includes cross-overs between services)	13.9%	16.2%	2.30%

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

Follow-up after Hospitalization for Mental Illness	2019	2020	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	49.7%	38.5%	-11.20%
Percent Received Outpatient Visit Within 30 Days	63.4%	54.7%	-8.70%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	85.3%	92.6%	7.30%
Percent Received Outpatient Visit Within 30 Days	91.2%	96.3%	5.10%
PRTF			
Percent Received Outpatient Visit Within 7 Days	22%	33.3%	11.30%
Percent Received Outpatient Visit Within 30 Days	62.7%	62.5%	-0.20%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	50.1%	40.0%	-10.10%
Percent Received Outpatient Visit Within 30 Days	64.5%	56.1%	-8.40%

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

Follow-up after Hospitalization for Substance Abuse	2019	2020	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	**NA**
Percent Received Outpatient Visit Within 7 Days	19.7%	19.1%	-0.60%
Percent Received Outpatient Visit Within 30 Days	28.3%	28.9%	0.60%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	20.8%	49.1%	28.30%
Percent Received Outpatient Visit Within 7 Days	24.5%	54.7%	30.20%
Percent Received Outpatient Visit Within 30 Days	32.1%	66.0%	33.90%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	**NA**
Percent Received Outpatient Visit Within 7 Days	20.7%	26.7%	6.00%
Percent Received Outpatient Visit Within 30 Days	29.1%	36.8%	7.70%

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2019	2020	Change
Ages 13-17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	44.2%	51.3%	7.10%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	32.6%	36.0%	3.40%
Ages 18-20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	51.7%	45.3%	-6.40%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	33.5%	30.9%	-2.60%
Ages 21-34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	52.8%	54.8%	2.00%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	41.6%	42.9%	1.30%
Ages 35-64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	49.8%	50.3%	0.50%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	34.1%	35.8%	1.70%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	32.3%	28.6%	-3.70%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	16.9%	20.8%	3.90%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	50.1%	50.8%	0.70%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	36.0%	37.3%	1.30%

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

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		2019	2020	Change	2019	2020	Change
3–12	Male	0.2	0.3	0.1	45.2	33.9	-11.3
	Female	0.3	0.2	-0.1	20.7	14	-6.7
	Total	0.3	0.3	0	32.1	24.3	-7.8
13–17	Male	1.3	1.1	-0.2	43.6	38.5	-5.1
	Female	2.7	2	-0.7	21.3	21.3	0
	Total	2	1.6	-0.4	28.7	27.7	-1
18–20	Male	1.7	2	0.3	8.5	6.6	-1.9
	Female	1.9	1.8	-0.1	7.3	10.5	3.2
	Total	1.8	1.9	0.1	7.9	8.5	0.6
21–34	Male	4.5	4.6	0.1	8.2	7.2	-1
	Female	1.7	1.8	0.1	7.5	6.9	-0.6
	Total	2.4	2.4	0	7.9	7	-0.9
35–64	Male	3.8	3.7	-0.1	8.3	7.7	-0.6
	Female	2.5	2.7	0.2	8.1	8	-0.1
	Total	3	3.1	0.1	8.2	7.9	-0.3
65+	Male	0.7	0.8	0.1	14.5	10.6	-3.9
	Female	0.6	0.6	0	15.2	12	-3.2
	Total	0.6	0.6	0	15	11.5	-3.5
Unknown	Male	0	0	0	0	0	0
	Female	0	0	0	0	0	0
	Total	0	0	0	0	0	0
Total	**Male**	**1.5**	**1.5**	**0**	**16.7**	**13.9**	**-2.8**
	Female	**1.5**	**1.4**	**-0.1**	**12.2**	**11.1**	**-1.1**
	Total	**1.5**	**1.4**	**-0.1**	**14.2**	**12.3**	**-1.9**

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

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2019	2020	Change	2019	2020	Change	2019	2020	Change	2019	2020	Change
3-12	Male	15.19%	14.74%	-0.45%	0.09%	0.10%	0.01%	0.53%	0.53%	0.00%	15.12%	14.66%	-0.46%
	Female	11.60%	11.75%	0.15%	0.07%	0.04%	-0.03%	0.21%	0.18%	-0.03%	11.58%	11.70%	0.12%
	Total	13.43%	13.28%	-0.15%	0.08%	0.07%	-0.01%	0.37%	0.36%	-0.01%	13.39%	13.22%	-0.17%
13-17	Male	17.84%	16.79%	-1.05%	0.51%	0.47%	-0.04%	1.01%	0.81%	-0.20%	17.69%	16.61%	-1.08%
	Female	20.96%	20.73%	-0.23%	0.50%	0.42%	-0.08%	0.41%	0.32%	-0.09%	20.82%	20.68%	-0.14%
	Total	19.36%	18.72%	-0.64%	0.50%	0.45%	-0.05%	0.72%	0.57%	-0.15%	19.22%	18.60%	-0.62%
18-20	Male	10.51%	11.10%	0.59%	0.23%	0.19%	-0.04%	0.16%	0.14%	-0.02%	10.47%	11.08%	0.61%
	Female	13.88%	13.66%	-0.22%	0.11%	0.11%	0.00%	0.13%	0.05%	-0.08%	13.86%	13.64%	-0.22%
	Total	12.28%	12.44%	0.16%	0.17%	0.15%	-0.02%	0.15%	0.09%	-0.06%	12.25%	12.42%	0.17%
21-34	Male	26.79%	26.45%	-0.34%	0.43%	0.74%	0.31%	0.16%	0.15%	-0.01%	26.77%	26.45%	-0.32%
	Female	22.10%	20.63%	-1.47%	0.24%	0.20%	-0.04%	0.13%	0.14%	0.01%	22.08%	20.62%	-1.46%
	Total	23.19%	22.00%	-1.19%	0.29%	0.33%	0.04%	0.14%	0.14%	0.00%	23.17%	21.99%	-1.18%

2020 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		
		2019	2020	Change	2019	2020	Change	2019	2020	Change	2019	2020	Change
35-64	Male	24.75%	23.33%	-1.42%	0.46%	0.19%	-0.27%	0.14%	0.15%	0.01%	24.73%	23.32%	-1.41%
	Female	28.91%	28.17%	-0.74%	0.17%	0.21%	0.04%	0.20%	0.19%	-0.01%	28.91%	28.16%	-0.75%
	Total	27.33%	26.33%	-1.00%	0.28%	0.20%	-0.08%	0.18%	0.18%	0.00%	27.33%	26.32%	-1.01%
65+	Male	8.55%	8.13%	-0.42%	0.10%	0.02%	-0.08%	0.00%	0.00%	0.00%	8.53%	8.13%	-0.40%
	Female	8.65%	8.79%	0.14%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%	8.65%	8.79%	0.14%
	Total	8.62%	8.59%	-0.03%	0.03%	0.01%	-0.02%	0.01%	0.01%	0.00%	8.61%	8.59%	-0.02%
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	17.38%	16.75%	-0.63%	0.27%	0.23%	-0.04%	0.47%	0.43%	-0.04%	17.31%	16.68%	-0.63%
	Female	18.17%	17.84%	-0.33%	0.17%	0.16%	-0.01%	0.19%	0.17%	-0.02%	18.14%	17.81%	-0.33%
	Total	17.83%	17.37%	-0.46%	0.21%	0.19%	-0.02%	0.31%	0.28%	-0.03%	17.79%	17.33%	-0.46%

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

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2019	2020	Change	2019	2020	Change	2019	2020	Change	2019	2020	Change
3–12	Male	0.02%	0.04%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.04%	0.02%
	Female	0.01%	0.02%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.02%	0.01%
	Total	0.02%	0.03%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.03%	0.01%
13–17	Male	1.48%	1.12%	-0.36%	0.02%	0.05%	0.03%	0.22%	0.12%	-0.10%	1.38%	1.02%	-0.36%
	Female	1.05%	0.61%	-0.44%	0.03%	0.02%	-0.01%	0.09%	0.02%	-0.07%	1.00%	0.60%	-0.40%
	Total	1.27%	0.87%	-0.40%	0.03%	0.03%	0.00%	0.15%	0.07%	-0.08%	1.19%	0.82%	-0.37%
18–20	Male	2.26%	2.58%	0.32%	0.25%	0.19%	-0.06%	0.33%	0.23%	-0.10%	2.22%	2.53%	0.31%
	Female	2.14%	2.02%	-0.12%	0.19%	0.16%	-0.03%	0.28%	0.27%	-0.01%	2.08%	1.93%	-0.15%
	Total	2.20%	2.29%	0.09%	0.21%	0.18%	-0.03%	0.30%	0.25%	-0.05%	2.15%	2.21%	0.06%
21–34	Male	8.96%	9.04%	0.08%	0.85%	0.76%	-0.09%	0.96%	1.06%	0.10%	8.82%	8.74%	-0.08%
	Female	8.98%	8.05%	-0.93%	0.71%	0.60%	-0.11%	1.23%	1.13%	-0.10%	8.79%	7.82%	-0.97%
	Total	8.97%	8.28%	-0.69%	0.74%	0.64%	-0.10%	1.17%	1.11%	-0.06%	8.80%	8.04%	-0.76%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2019	2020	Change	2019	2020	Change	2019	2020	Change	2019	2020	Change
35–64	Male	8.40%	7.92%	-0.48%	0.91%	0.58%	-0.33%	0.74%	0.77%	0.03%	8.26%	7.72%	-0.54%
	Female	6.83%	7.21%	0.38%	0.47%	0.39%	-0.08%	0.78%	0.75%	-0.03%	6.68%	7.06%	0.38%
	Total	7.43%	7.48%	0.05%	0.63%	0.46%	-0.17%	0.77%	0.76%	-0.01%	7.28%	7.32%	0.04%
65+	Male	0.94%	1.16%	0.22%	0.05%	0.04%	-0.01%	0.00%	0.07%	0.07%	0.94%	1.11%	0.17%
	Female	0.27%	0.44%	0.17%	0.00%	0.02%	0.02%	0.00%	0.00%	0.00%	0.27%	0.44%	0.17%
	Total	0.47%	0.66%	0.19%	0.01%	0.03%	0.02%	0.00%	0.02%	0.02%	0.47%	0.64%	0.17%
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**	**2.60%**	**2.53%**	**-0.07%**	**0.24%**	**0.18%**	**-0.06%**	**0.26%**	**0.26%**	**0.00%**	**2.55%**	**2.45%**	**-0.10%**
	Female	**3.30%**	**3.18%**	**-0.12%**	**0.24%**	**0.20%**	**-0.04%**	**0.41%**	**0.37%**	**-0.04%**	**3.22%**	**3.10%**	**-0.12%**
	Total	**3.00%**	**2.90%**	**-0.10%**	**0.24%**	**0.19%**	**-0.05%**	**0.34%**	**0.32%**	**-0.02%**	**2.93%**	**2.82%**	**-0.11%**

Table 14: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2019	2020	Change	2019	2020	Change	2019	2020	Change	2019	2020	Change
	3-12			13-17			18-20			21-34		
Burke	0.02%	0.02%	0.00%	1.37%	0.93%	-0.44%	3.26%	2.21%	-1.05%	9.20%	7.94%	-1.26%
Catawba	0.01%	0.02%	0.01%	1.36%	0.71%	-0.65%	2.69%	2.23%	-0.46%	7.44%	6.35%	-1.09%
Cleveland	0.01%	0.03%	0.02%	0.83%	0.68%	-0.15%	1.67%	1.76%	0.09%	5.43%	6.02%	0.59%
Gaston	0.00%	0.01%	0.01%	1.62%	1.10%	-0.52%	2.10%	2.22%	0.12%	7.00%	6.47%	-0.53%
Iredell	0.01%	0.04%	0.03%	0.76%	0.68%	-0.08%	1.72%	2.08%	0.36%	5.53%	5.15%	-0.38%
Lincoln	0.00%	0.04%	0.04%	1.80%	1.32%	-0.48%	2.34%	2.90%	0.56%	9.08%	8.63%	-0.45%
Rutherford	0.00%	0.00%	0.00%	0.00%	0.34%	0.34%	0.00%	1.29%	1.29%	0.00%	5.62%	5.62%
Surry	0.02%	0.04%	0.02%	0.68%	0.53%	-0.15%	1.71%	1.89%	0.18%	6.50%	6.36%	-0.14%
Yadkin	0.08%	0.04%	-0.04%	0.81%	0.84%	0.03%	2.41%	1.96%	-0.45%	6.44%	6.54%	0.10%
	35-64			65+			Unknown			Total		
Burke	8.50%	7.76%	-0.74%	1.15%	0.96%	-0.19%	0.00%	0.00%	0.00%	3.59%	3.07%	-0.52%
Catawba	8.34%	7.78%	-0.56%	0.77%	0.73%	-0.04%	0.00%	0.00%	0.00%	3.03%	2.66%	-0.37%
Cleveland	5.92%	6.78%	0.86%	0.90%	1.02%	0.12%	0.00%	0.00%	0.00%	2.48%	2.73%	0.25%
Gaston	7.83%	8.59%	0.76%	0.85%	1.13%	0.28%	0.00%	0.00%	0.00%	3.08%	3.10%	0.02%
Iredell	6.70%	6.58%	-0.12%	0.27%	0.21%	-0.06%	0.00%	0.00%	0.00%	2.32%	2.26%	-0.06%
Lincoln	8.26%	7.81%	-0.45%	0.88%	0.52%	-0.36%	0.00%	0.00%	0.00%	3.55%	3.30%	-0.25%
Rutherford	0.00%	6.15%	6.15%	0.00%	0.69%	0.69%	0.00%	0.00%	0.00%	0.00%	2.43%	2.43%
Surry	5.04%	4.85%	-0.19%	0.17%	0.58%	0.41%	0.00%	0.00%	0.00%	2.16%	2.14%	-0.02%
Yadkin	6.29%	7.64%	1.35%	0.71%	0.88%	0.17%	0.00%	0.00%	0.00%	2.42%	2.64%	0.22%

Table 15: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2019	2020	Change	2019	2020	Change	2019	2020	Change	2019	2020	Change
	3-12			13-17			18-20			21-34		
Burke	11.63%	10.95%	-0.68%	15.83%	16.82%	0.99%	12.90%	10.14%	-2.76%	14.89%	13.95%	-0.94%
Catawba	9.99%	10.31%	0.32%	17.68%	17.71%	0.03%	10.89%	12.22%	1.33%	14.40%	12.59%	-1.81%
Cleveland	11.24%	10.92%	-0.32%	17.79%	16.69%	-1.10%	11.39%	10.25%	-1.14%	14.69%	15.64%	0.95%
Gaston	11.88%	11.05%	-0.83%	19.73%	19.57%	-0.16%	13.67%	13.31%	-0.36%	15.52%	14.99%	-0.53%
Iredell	9.03%	9.40%	0.37%	18.15%	18.06%	-0.09%	10.43%	10.49%	0.06%	12.13%	12.00%	-0.13%
Lincoln	12.50%	13.25%	0.75%	22.99%	22.41%	-0.58%	11.81%	12.71%	0.90%	15.29%	14.97%	-0.32%
Rutherford	0.00%	10.22%	10.22%	0.00%	16.56%	16.56%	0.00%	10.15%	10.15%	0.00%	15.07%	15.07%
Surry	8.93%	9.33%	0.40%	15.18%	14.37%	-0.81%	9.74%	9.30%	-0.44%	11.26%	12.07%	0.81%
Yadkin	10.32%	9.13%	-1.19%	16.71%	16.01%	-0.70%	9.46%	9.00%	-0.46%	10.67%	11.11%	0.44%
	35-64			65+			Unknown			Total		
Burke	23.73%	20.74%	-2.99%	11.75%	9.93%	-1.82%	0.00%	0.00%	0.00%	15.21%	14.05%	-1.16%
Catawba	22.71%	20.98%	-1.73%	11.14%	10.54%	-0.60%	0.00%	0.00%	0.00%	14.24%	13.89%	-0.35%
Cleveland	21.71%	21.46%	-0.25%	11.08%	11.11%	0.03%	0.00%	0.00%	0.00%	14.95%	14.72%	-0.23%
Gaston	25.88%	25.57%	-0.31%	10.42%	11.69%	1.27%	0.00%	0.00%	0.00%	16.37%	16.03%	-0.34%
Iredell	17.47%	17.14%	-0.33%	10.65%	9.87%	-0.78%	0.00%	0.00%	0.00%	12.64%	12.66%	0.02%
Lincoln	22.56%	22.42%	-0.14%	11.21%	12.79%	1.58%	0.00%	0.00%	0.00%	16.35%	16.68%	0.33%
Rutherford	0.00%	20.73%	20.73%	0.00%	10.39%	10.39%	0.00%	0.00%	0.00%	0.00%	14.23%	14.23%
Surry	14.55%	14.89%	0.34%	7.11%	9.60%	2.49%	0.00%	0.00%	0.00%	11.17%	11.62%	0.45%
Yadkin	16.27%	16.01%	-0.26%	6.50%	5.69%	-0.81%	0.00%	0.00%	0.00%	12.00%	11.36%	-0.64%

(b) Waiver Validation Results

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

Table 16: (b) Waiver Performance Measure Validation Scores

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

(c) Waiver Measures Reported Results

Five (c) Waiver Measures were chosen for validation. The rates reported by Partners and the State benchmarks are displayed in *Table 17: (c) Waiver Measures Reported Results 2019 - 2020*. Documentation on data sources, data validation, source code, and calculated rate for the five measures was provided. Additionally, all rates exceeded the State Performance Benchmarks.

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

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	Annually	1,186/1,186 = 100%	85%
Proportion of beneficiaries reporting they have a choice between providers.	Annually	394/394 = 100%	85%
Percentage of level 2 and 3 incidents reported within required timeframes.	Quarterly	31/36 = 86.11%	85%
Percentage of beneficiaries who received appropriate medication.	Quarterly	36/36 = 100%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.	Quarterly	11/11 = 100%	85%

(c) Waiver Validation

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

Table 18: C Waiver Performance Measures Validation Scores

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

Performance Improvement Project (PIP) Validation

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

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

PIP Validation Results

For the 2019 review, nine projects were submitted, and four were validated, including 7-day follow up for mental health treatment, 7-day follow up for SUD treatment, PCP referrals to behavioral health, and Reducing ED Utilization. The Onsite discussion focused on the impact of COVID-19 on the PIP activities as well as a recommendation from CCME to reduce the number of active PIPs to focus efforts on four or five topics instead of nine topics simultaneously.

For this year's 2020 EQR, there were nine PIPs submitted, all showing as active. The high number was surprising after last year's discussion of reducing the number of PIPs. Partners indicated that internal discussions had begun to pare down the number of PIPs, and some have recently closed. The four projects validated last year were validated again this year. There was an additional PIP validated, totaling five PIPs validated this year. The validated PIPs were: 7-day follow up for mental health treatment, 7-day follow up for SUD treatment, PCP referrals to behavioral health, Reducing ED Utilization, and TCLI-Member Housing Loss Reduction. The Onsite discussion noted some concerns with the results reported for the TCLI PIP. The PIP was resubmitted after the Onsite with updated report formatting and validated after the Onsite. Table 19, PIP Summary of Validation Scores, shows the current EQR score and the 2019 EQR scores.

Table 19: PIP Summary of Validation Scores

Project Type	Project	2019 Validation Score	2020 Validation Score
Clinical	Promoting Follow up Within 7 Days for Mental Health Treatment	84/85 = 99% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results
	Promoting Follow up Within 7 Days for SUD Treatment	84/85 = 99% High Confidence in Reported Results	74/79 = 94% High Confidence in Reported Results
	ED Utilization	84/85 = 99% High Confidence in Reported Results	68/74 = 92% High Confidence in Reported Results
Non Clinical	PCP Referrals to Behavioral Health	84/85 = 99% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
	TCLI Member Housing Loss Reduction	Not Validated	74/74 = 99% High Confidence in Reported Results

There are no Corrective Actions for the validated PIPS. For four of the five PIPs, there are Recommendations regarding the revision of interventions and initiation of additional interventions to improve rates, which showed a decline in the most recent remeasurement period. The project, section, reason, and Recommendations are displayed in Table 20 below.

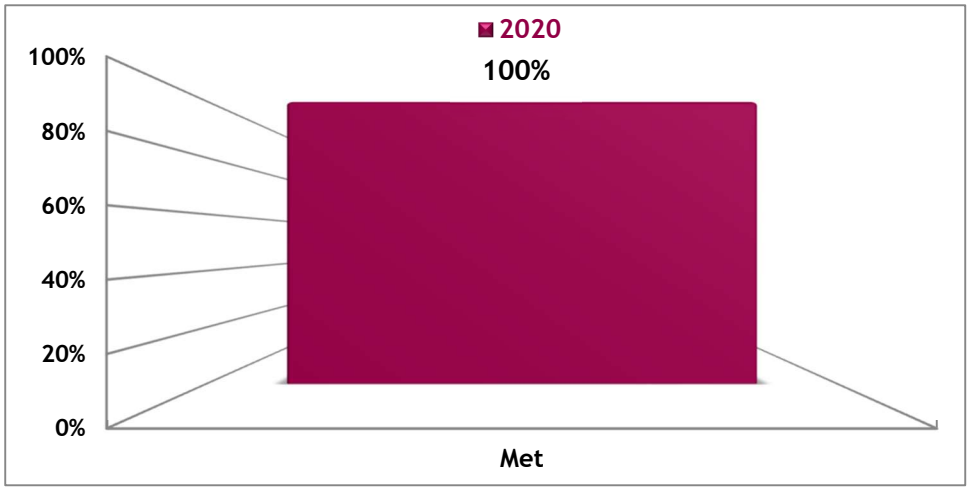
Table 20: Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Promoting follow up within 7 days for mental health treatment	Was there any documented, quantitative improvement in processes or outcomes of care?	There are four rates reported. The 7-day rates for Medicaid and non-Medicaid did not improve from Remeasurement 8 to Remeasurement 9. The 30-day rates improved from the Medicaid consumers from Remeasurement 2 to Remeasurement 3 but did not improve for the non-Medicaid consumers.	Continue to monitor interventions, especially given the new requirements for peer support to determine if rates begin to improve. Determine if the engagement specialist and provider communication are resulting in improvement. Continue working on contact information for consumers.
Promoting follow up within 7 days for SUD treatment	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	The indicator rates in the Findings/Results table do not match the graphical presentation of rates.	Update report so that results in Table and Graph are matched.
Reducing ED utilization of active members	Was there any documented, quantitative improvement in processes or outcomes of care?	The most recent rates increased from 56% to 62%.	Monitor interventions started in January 2020 including high touch care management, SDOH screening, crisis response training, and new member outreach to determine if rate starts to improve (decline) toward goal rate.
	Did the study use objective, clearly defined, measurable indicators?	The goal rate is listed as 29.5% in the graph and 26% on page 8. It is unclear which rate is the benchmark/target rate.	Include annotations on the report to allow the reader to know the benchmark/final target rate and the short-term goal rate.

TCLI Member Housing Loss Reduction	Was there any documented, quantitative improvement in processes or outcomes of care?	Rate declined and then remained at 0% for the latest two remeasurements.	The interventions are noted in the report and address barriers. Continue interventions to determine if the upcoming rates improve based on monthly visits, service provider discussions, and identification of lack of resources associated with evictions.

Details of the validation activities for the PMs and PIPs and specific outcomes related to each activity may be found in *Attachment 3, CCME EQR Validation Worksheets*. As demonstrated in Figure 4, Partners met all of the Quality Improvement standards in the 2020 EQR.

Figure 4: Quality Improvement Findings



Strengths

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

Weaknesses

- The (b) Waiver Performance Measure for the combined services rate of 7-day Follow-up After Hospitalization for Mental Illness declined from 50.1% to 40%, a decline of 10.1%.

- For the Promoting Follow up Within 7 Days for Mental Health Treatment PIP, rates have not consistently improved.
- For the Promoting Follow up Within 7 days for SUD Treatment PIP, the indicator rates in the Findings/Results table do not match the graphical presentation of rates.
- For the Reducing ED utilization of active members PIP, the most recent rates increased from 56% to 62%.
- For the Reducing ED Utilization of Active Members PIP, the goal rate is listed as 29.5% in the graph and 26% on page 8. It is unclear which rate is the benchmark/target rate.
- For the TCLI-Member Housing Loss Reduction PIP, the rate declined and then remained at 0% for the latest two remeasurements.

Recommendations

- Continue current interventions for the (b) Waiver Performance Measure for the combined services rate of 7-day Follow-up After Hospitalization for Mental Illness, working to increase this rate.
- For the Promoting Follow up Within 7 Days for Mental Health Treatment PIP, continue to monitor interventions, especially given the new requirements for peer support, to determine if rates begins to improve. Determine if the engagement specialist and provider communication are resulting in improvement. Continue working on contact information for consumers.
- For the Promoting Follow up Within 7 Days for SUD Treatment PIP, update the PIP report so that results in the table and graph are matched.
- For the Reducing ED Utilization of Active Members PIP, monitoring interventions started in January 2020, including high touch care management, SDOH screening, crisis response training, and new member outreach. Continue to monitor to determine if the rate starts to improve (decline) toward goal rate.
- For the Reducing ED Utilization of Active Members PIP, include annotations on the report to allow the reader to know the benchmark/final target rate and the short-term goal rate.
- For the TCLI-Member Housing Loss Reduction PIP, the interventions are noted in the report and address barriers. Continue interventions to determine if the upcoming rates improve based on monthly visits, service provider discussions, and identification of lack of resources associated with evictions.

D. Utilization Management

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

For the 2019 EQR, Partners met 91% of UM standards. CCME issued three Corrective Actions and three Recommendations to Care Coordination and TCLI. Two of the Corrective Action items were aimed at developing, documenting, and implementing a monitoring plan for MH/SU/I/DD/TCLI. These two Corrective Actions were implemented. The remaining Corrective Action and three Recommendations targeted updating policies and procedures. Partners fully implemented the three Recommendations.

The remaining Corrective Action was partially implemented. The Corrective Action required Partners to include a process for transferring enrollees between Care Coordinators, region, department, and to a new PIHP. Partners updated Policy and Procedure 9.05, MH/SU Care Management-Continuation Criteria/Discharge Criteria, the *MHSU Program Description*, and the *TCLI How-to Manual* but did not include the process for transferring enrollees to a new PIHP. In the 2020 EQR, as in the 2019 EQR, CCME recommends that Partners update Policy and Procedure 9.05, the *MHSU Program Description*, and the *TCLI How-to Manual* to include a process for transferring an enrollee to a new PIHP.

The 2020 EQR was the second year in a row in which the review of files for enrollees discharged from MH/SU Care Management and TCLI did not follow Partners' Policy and Procedure 9.05. Policy and Procedure 9.05 requires enrollees to be engaged in community services after Inpatient Care. Partners defines engagement as "1 timely follow-up appointment within 7 days of hospital discharge and 2 additional appointments within 30 days thereafter = total of minimum of 3 appointments in 5 weeks." The review found in one enrollee file that discharge from MH/SU Care Management occurred before meeting the engagement requirement. During the Onsite, Partners staff acknowledged that the enrollee did not meet discharge requirements due to readmission to an inpatient facility. CCME is issuing a Corrective Action for Partners to enhance its monitoring plan to include a comprehensive review of the files of enrollees scheduled for discharge. The process should ensure that progress notes and discharge summaries are clear and concise, include supervisor approval, and adhere to Policy and Procedure 9.05.

The review of TCLI files also found discrepancies in the discharge process. As noted, Partners does not have a process in place for transferring enrollees to a new PIHP. The review for this EQR found in one file that Partners discharged an enrollee from TCLI instead of transferring to the new PIHP. During the Onsite, Partners staff explained that

the enrollee wanted to be discharged from TCLI and did not want further assistance because services were already set up in the new catchment area. However, *The NC Transitions to Community Living Initiative (TCLI) In-Reach and Transition Manual* states, "a. For individuals who choose to move outside of their current home Medicaid County, the Transition Coordinator will coordinate efforts between the two DSS [Department of Social Services] agencies and the receiving LME/MCO (transfer of Medicaid and other support funding)." The file review showed the following:

- Partners did not contact the new PIHP to inform them of the relocation to a new catchment area.
- Partners did not contact the current DSS or the receiving DSS to coordinate the transfer of Medicaid and other support funding if needed.

Moreover, Partners did not contact the new service provider to ensure the continuation of service before discharge. CCME is issuing a Corrective Action for Partners to enhance the current monitoring plan to include a comprehensive review of the files of enrollees scheduled for discharge from TCLI or enrollees scheduled for transfer to another PIHP. The review process should ensure that the discharge and transfer process adheres to Partners' Policy and Procedure 9.05 and the *NC Transitions to Community Living Initiative (TCLI) In-Reach and Transition Manual*.

For the 2020 EQR, Partners showed significant improvement in the timeliness of progress notes and in the quality of Care Coordination and TCLI documentation. The review of I/DD files found that Partners utilized the required *State Monitoring Checklist* to evaluate Home and Community-Based Services (HCBS) quarterly for all qualifying services (day support, residential, supported employment) as identified in *NC Clinical Coverage Policy 8P* and *NCDHHS HCBS Final Rule Transition Plan*. However, the review found in two files of enrollees receiving residential supports and day supports that the required *State Monitoring Checklist* did not document all services. For enrollees who receive residential supports, PIHPs must complete the "Residential Only" section of the required *State Monitoring Checklist* when completing HCBS evaluations. The review found that only 50% of the required *State Monitoring Checklists* included the "Residential Only" review. CCME is requiring Partners to develop, document, and implement a process that routinely reviews the required *State Monitoring Checklist* for completeness and compliance with *NC Clinical Coverage Policy 8P* and *NCDHHS HCBS Final Rule Transition Plan*.

Revision: NC Medicaid reviewed the two Corrective Actions issued in the MH/SU and I/DD section and determined no Corrective Action is needed by Partners, as the finding does not relate to enrollee health and safety. The report now reflects these Corrective Actions are now best practice Recommendations. NC Medicaid did determine the TCLI Corrective Action should remain due to "the lack of continuity of care." This changed Partners' Utilization Management score from a 92% to a 96%.

Figure 5 shows 92% of the Utilization Management standards were scored as "Met" and 8% were scored as "Partially Met"

Figure 5: Utilization Management Comparative Findings

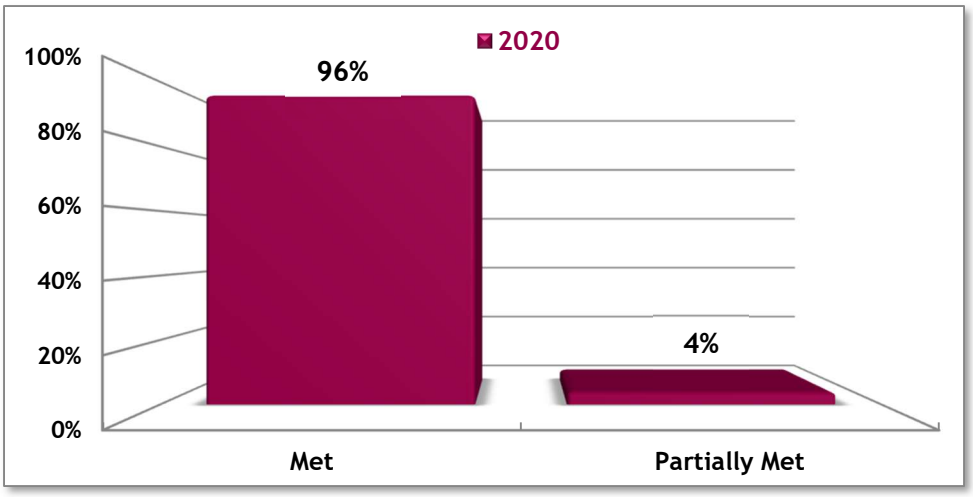


Table 21: Utilization Management

Section	Standard	2020 Review
Care Coordination	The PIHP applies the Care Coordination policies and procedures as formulated.	**Partially Met**
Transition to Community Living	A review of files demonstrates the PIHP is following appropriate TCL policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	**Partially Met**

Strengths

- During the Covid-19 Stay at Home Order, Partners' MH/SU department was able to meet the State requirement for timely follow-up by revising processes that require face-to-face visits and by participating in virtual huddles with hospital staff.
- TCLI has reduced the number of enrollees who lost housing by 50%.
- Partners has increased the number of enrollees engaged in (b)3 services by 5% as they await NC Innovations funding.

Weaknesses

- Partners partially implemented a 2019 Corrective Action to include a process for transferring enrollees to another PIHP.
- Partners does not have a process in place that reviews MH/SU Care Management documentation for enrollees scheduled for discharge.
- For I/DD enrollees receiving residential supports, 50% of the required *State Monitoring Checklist* did not include the "Residential Only" section.
- Partners' process for transferring TCLI enrollees to a new PIHP does not adhere to the *NC Transitions to Community Living Initiative (TCLI) In-Reach and Transition Manual*.

Corrective Action

- Enhance the current monitoring plan to include a comprehensive review of TCLI documentation for enrollees discharging from Partners to another PIHP. Ensure that the review process adheres to Partners' Policy and Procedure 9.05 and the *NC Transitions to Community Living Initiative (TCLI) In-Reach and Transition Manual*.

Recommendations

- Enhance the current monitoring plan to include a comprehensive review of Care Management documentation for enrollees scheduled for discharge or transfer to another PIHP as outlined in Partners Policy and Procedure 9.05.
- Develop, document, and implement a process that routinely reviews the required State Monitoring Checklist for completeness and compliance with NC Clinical Coverage Policy 8P and NCDHHS HCBS Final Rule Transition Plan.
- Update Policy and Procedure 9.05, the *MHSU Program Description*, and the *TCLI How-To Manual* to include the process for transferring enrollees to a new PIHP to ensure continuation of services and supports.

E. Grievances and Appeals

The Grievances and Appeals EQR for Partners included a Desk Review of policies and procedures, 10 Grievance and 17 Appeal files, the Grievances and Appeals Logs, the *Provider Operations Manual*, the *Member Handbook*, and information about Grievances and Appeals available on the Partners website. An Onsite discussion with Grievance and Appeal staff occurred to further clarify Partners' documentation and processes.

In the 2019 EQR, Partners met 85% of the Grievance and Appeal standards. Three Corrective Actions and seven Recommendations were issued related to the Grievance and Appeal policies and procedures, the *Provider Operations Manual*, the *Member Handbook*, and the Grievance and Appeal files reviewed. In the 2020 EQR, Partners met all of the Grievance and Appeal standards. Two Recommendations were issued to improve upon the quality of the Grievance language within the Grievance policy and procedure and the *Provider Operations Manual*, as well as compliance issues noted within the Appeal files.

Grievances

In the 2019 EQR, Partners was issued two Recommendations in the Grievance section. Both Recommendations were addressed by Partners. The first Recommendation was to add to Procedure 6.00U, Grievance Management, that, if the Grievance resolution time is extended by Partners, within two calendar days, a written notice of the extension would be issued to the grievant of the reason for the decision to extend the Grievance. The second Recommendation was to develop and document a monitoring process that reviews "high priority" Grievances. Partners developed a monitoring process for "high priority" cases that includes the use of a "High Priority Daily Grievance Tracking Log." During the 2020 EQR Onsite interview, Partners provided an overview of the process. The outcome of the monitoring process resulted in no "high priority" case identified since the start of the process, resulting in more accurate data reporting. The file review of Grievance files included the review of the priority level for each file, and all the files were noted to be "Routine".

In the 2020 review of Grievances, CCME issued one Recommendation. The Recommendation is related to the use of the term "Grievance/Complaint" and "Complaint/Grievance" in Procedure 6.00U, the *Member Handbook* and the *Provider Operations Manual*. CCME Recommends Partners select and define one term and consistently use it within all print material.

CCME selected 10 Grievance files to review from the Partners *Medicaid Grievance Log*. All files contained timely Acknowledgement and Resolution Letters. All Grievances were resolved within 30 days of the 90-day time frame allowed in Partners' policy and procedure. The Resolution Letters contained detailed steps Partners took to resolve each Grievance. The steps were supported within the Grievance file documentation. Two files, or 20% reviewed for this EQR, were from one residential placement, and the Grievances was related to member safety issues. During the Onsite interview, there was a discussion about monitoring providers who are identified during the Grievance process. Partners provided an overview of their monitoring process which includes Quality of Care Committee (QOC) review that involves Partners' Chief Medical Officer.

Grievances are tallied and analyzed for patterns, trends, and compliance. That data is reported in meetings of the Quality Improvement, Quality of Care, Consumer and Family

Advisory, and Human Rights committees. During the Onsite discussion, Partners noted that the number of Grievances received during the current EQR review period decreased from the last EQR. Grievance data was provided and reviewed, confirming a reduction in the number of Grievance Investigations over the timeframe under review.

Appeals

In the 2019 EQR, Partners was issued five Recommendations and three Corrective Actions, all of which were addressed, implemented, and maintained for this 2020 EQR. Policy and Procedure 13.04U, Clinical Utilization Management Appeals, is the primary procedure that governs Partners' Appeals process. In the 2019 EQR, this policy and procedure, the *Provider Operations Manual* and the *Member Handbook* were inconsistent when defining who can file an Appeal. The 2020 EQR confirmed all three documents now consistently and correctly define who can file an Appeal.

In the 2018 and 2019 EQRs, it was noted that Partners' *Provider Operations Manual* and *Member Handbook* incorrectly explained that, to initiate the Appeals process, enrollees must submit Partners' Request for Reconsideration form. CCME issued a Corrective Action in 2019 as this practice is more restrictive than the process defined in federal regulations and Partners' *NC Medicaid Contract*. Partners contested this finding in their 2019 Corrective Action response. The State upheld CCME's finding. In the 2020 EQR of these documents, there is now clear language in Partners' *Provider Operations Manual* and the *Member Handbook* that Partners' Request for Reconsideration form is not required to initiate an Appeal, and any written request may be submitted to initiate the Appeals process.

In the 2019 EQR, CCME recommended revision of Partners' Policy and Procedure 13.04U, Clinical Utilization Management Appeals, *Provider Operations Manual*, and *Member Handbook* to correctly state enrollees are notified of their right to file a Grievance when Partners denies their request to expedite an Appeal. In the 2020 EQR, it was noted the most current versions of Partners' *Provider Operations Manual* and *Member Handbook* now include this notification of the enrollee's right to file a Grievance.

In the 2019 EQR, CCME recommended revision of the Appeal policy and procedure to address missing language regarding the notifications Partners is required to issue when Partners extends the Appeal resolution timeframe. Partners addressed this Recommendation, and Policy and Procedure 13.04U is now compliant with *42 CFR § 438.408(c)(2)(ii)* and *NC Medicaid Contract, Attachment M, Section G.6*.

In the 2018 and 2019 EQRs, inconsistent practices by staff were noted in the files deemed invalid by Partners or withdrawn by the appellant. In this 2020 EQR, there was evidence that additional guidance was added to the Appeal policy and procedure regarding how to

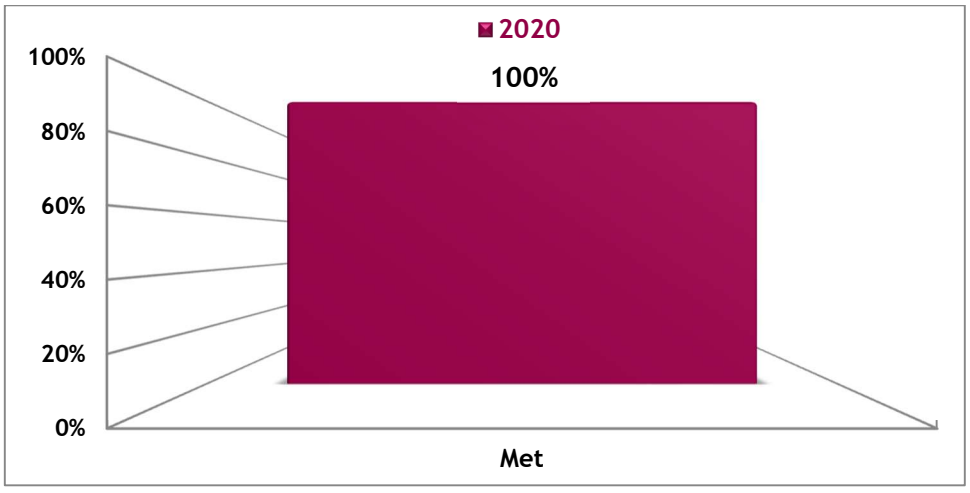
process invalid and withdrawn Appeals consistently and in compliance with *NC Medicaid Contract*, *Attachment M* and federal regulations.

In the 2019 EQR, compliance issues were noted in half of the Appeal files reviewed. Primary concerns were noted in those files that were submitted verbally, expedited, deemed invalid, and/or withdrawn. In 2019, CCME issued a Corrective Action for Partners to "develop and document an Appeal monitoring process that includes compliance monitoring of oral, invalid, expedited, and withdrawn Appeal files." This monitoring was to include monitoring of the Appeal Log, as several errors were also found within the Appeal Log reviewed in the 2019 EQR.

In the 2020 EQR, ten files were initially requested and reviewed. The initial file review showed compliance issues in half of the Appeal files reviewed. Additional files were requested to determine if Partners' Appeal monitoring process improved compliance in the processing of Appeals over time. The review of these additional files, which included withdrawn and expedited Appeals and Appeals submitted verbally, showed a significant increase in compliance. CCME recommends Partners continue to monitor Appeals to maintain this level of compliance. This monitoring should also include a focus on those Appeals that require intricate steps when processing, such as verbal, extended, expedited, and withdrawn Appeals, along with Appeals of Administratively Denied Service Authorizations.

Figure 6 shows Partners met 100% of the Grievance and Appeals standards.

Figure 6: Grievances and Appeals Findings



Strengths

- Partners implemented the two Recommendations issued in the 2019 EQR of Grievances.

- The Appeals monitoring process and Appeals Audit Form, implemented in November 2020, significantly improved compliance in the Appeal files reviewed.

Weaknesses

- Policy and Procedure 6.00U states that "Grievance" and "Complaint" are synonymous; however, these terms are used inconsistently throughout print documentation. "Grievance/Complaint" and "Complaint/Grievance," along with "Complaint and Grievance" are used interchangeably within Policy and Procedure 6.00U, the *Member Handbook*, and the *Provider Operations Manual*. Partners needs to select and define one term and consistently use it within Procedure 6.00U, Grievance Management, the *Member Handbook*, the *Provider Operations Manual*, and all print material.

- The EQR of Appeal files showed 30% of the files were out of compliance with requirements outlined in *NC Medicaid Contract, Attachment M* and federal regulations governing Medicaid Appeals.

Recommendation

- Within Policy and Procedure 6.00U, Grievance Management, the *Member Handbook* and the *Provider Operations Manual*, select and define one term for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination *42 C.F.R. 438.400(b).*" and consistently use it within Procedure 6.00U, Grievance Management, the *Member Handbook*, the *Provider Operations Manual*, and all print material.

- Continue Partners' Appeal monitoring process and focus on those Appeals that require intricate steps when processing, such as verbal, extended, expedited, and withdrawn Appeals, along with Appeals of Administratively Denied Service Authorizations.

F. Program Integrity

The Program Integrity (PI) EQR involved an assessment of Partners' compliance with federal and state regulations regarding PI functions. A Desk Review of Partners' documentation, including Partners' policies and procedures, training materials, Organizational Charts, job descriptions, committee meeting minutes and reports, Provider Agreements, enrollment application, PI workflows, *Provider Operations Manual*, conflict of interest forms, and Partners' Compliance Plan. Additionally, 15 PI files were selected for review from the period of October 1, 2019, through September 30, 2020. Onsite interviews were conducted to discuss the findings from the Desk Review and PI files.

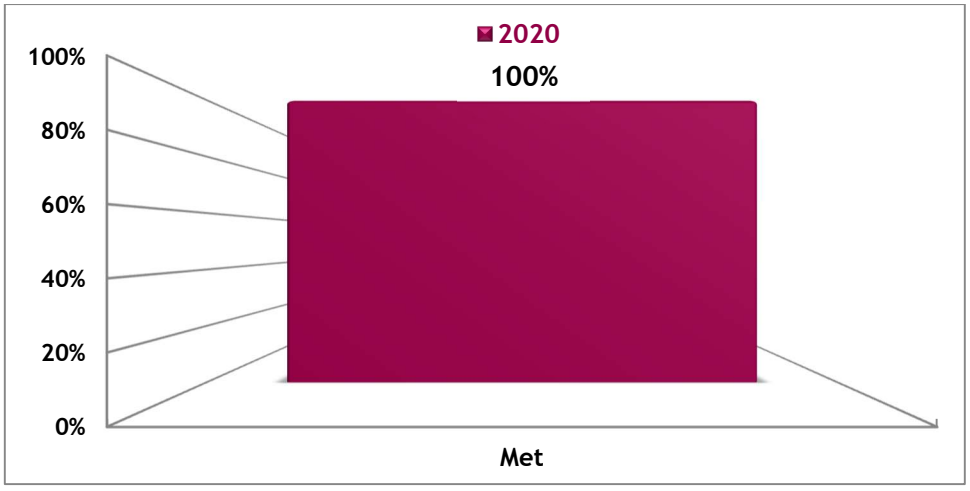
In the 2019 EQR, nine Recommendations were issued to improve upon the language within Partners' PI policies and procedures to ensure compliance with Partners' *NC Medicaid*

Contract, Section 14. No language was added to Partners' PI policies and procedures. However, Partners reported these Recommendations were added to their Program Integrity Departmental Procedural Guidelines. Partners reports PI staff use this document "on a daily basis."

For this 2020 EQR, CCME requested 15 PI files. There were no cases of enrollee fraud for review under this current review period. All 15 case files followed the federal and state regulations that are outlined in the *NC Medicaid Contract*. None of the files reviewed showed allegations of fraud were referred to NC Medicaid. However, during the Onsite, staff explained one allegation has since been substantiated by Partners and will soon be sent to NC Medicaid. Several of the PI files reviewed in this 2020 EQR showed the Investigative Summary form was not completed by all staff. CCME recommends Partners ensure staff complete and routinely update the Investigative Summary form to provide an overview of the investigation and its current status within the investigative process.

Figure 7 shows Partners met all of the PI standards in this 2020 EQR.

Figure 7: Program Integrity Findings



Strengths

- Partners reported increased effectiveness with interviewing and investigating providers through virtual conferences. Staff reported the number of provider disputes have decreased due to this increase in collaboration.
- Partners created a workplan document that includes goals and metrics for the PI department.

Weaknesses

- Several of the PI files reviewed in this 2020 EQR showed the Investigative Summary form was not completed by all staff.

Recommendations

- Ensure staff complete and routinely update the Investigative Summary form to provide an overview of the investigation and its current status within the investigative process.

G. 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 2019 through December 2019. All claims paid by Partners should be submitted and accepted as a valid encounter to NC Medicaid. 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: Other Diagnosis Codes

The Primary/Principal Diagnosis code was populated for 100% of the claims. However, less than 20% of all encounter records show at least one valid Other Diagnosis code. Given that Partners currently reports the maximum number of Diagnosis codes accepted by NCTracks, the low figure suggests that many providers may not be reporting the Other Diagnosis codes. Indeed, a closer examination reveals that some providers never report beyond the Primary/Principal Diagnosis code.

Recommendation:

Partners should continue to perform outreach to providers, with a particular focus on those who never submit the Other Diagnosis codes. This information is key for measuring member health, identifying areas of risk, and evaluating quality of care.

Issue: Procedure Codes

The Procedure code for institutional claims should be populated 99% of the time. For the current review period, we found that 77% of institutional claim line items contained a valid value in the Procedure code field. Our review excluded line-item charges where the Revenue code was sufficient for defining the service rendered.

Resolution:

Overall, there has been notable improvement in the quality of data, as Partners just missed meeting the Data Quality Standards threshold target for Procedure codes. Procedure codes were populated 98.76% of the time, and in each instance a valid value was present. However, when isolating for institutional claims, the percentage with a Procedure code dropped significantly to 77%.

Partners does a good job of denying outpatient institutional claims when certain Revenue codes are submitted without a Procedure code (e.g., Revenue code '0450'). A potential gap exists when the patient is first seen in an outpatient department, but is later admitted to an inpatient setting. In other cases, Partners indicated that they pay line items that are missing Procedure codes at the RCC rate. While this payment arrangement may be consistent with the way providers are contracted, this 2020 EQR recommends that Partners review requirements to ensure providers are submitting valid Procedure codes so that services that were rendered can be identified (e.g., submitting a valid Procedure code when billing Revenue code '0250,' which suggests a drug was administered but not the specific drug.)

Conclusion

Based on the analysis of Partners' encounter data, this review concluded that the data submitted to NC Medicaid is complete and accurate as defined by CMS and NC Medicaid standards. The validation process found mostly minor issues with both institutional and professional encounters. Based on Partners' ISCA response, overview of the Alpha system, and the limited number of data anomalies, HMS believes that some of the errors are isolated cases that can be mitigated in the future by reviewing and modifying data validation rules, as necessary. Overall, Partners has shown continued improvement in the quality of encounter data, and this is consistent with the reduction in the rate of denials on first time encounter submissions. However, some of the errors noted in this review are critical. Therefore, Partners should review and take Corrective Action to resolve the issues related to Procedure codes and Other 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 PIHP. Reviewing an extract from NCTracks would provide insight

into how the State's Medicaid Management Information System (MMIS) is handling the encounter claims and could be reconciled back to reports requested from Partners. The goal is to ensure that Partners is reporting all paid claims as encounters to NC Medicaid.

ATTACHMENTS

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

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

November 2, 2020

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

Dear Mr. Melton,

At the request of the North Carolina Medicaid (NC Medicaid) this letter serves as notification that the 2020 External Quality Review (EQR) of Partners Health 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 one-day, virtual Onsite that will address contractually required services.

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

The CMS EQR protocols can be found at:
https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

Due to COVID-19 and the issuance of the contractual flexibilities issued by the State outlined in Contract Amendment #9, the 2020 EQR will be a focused review. The focus of this review will be on the Corrective Actions from the previous EQR and Partners functions that impact enrollee health and safety. Similarly, for the 2020 EQR, the two day Onsite previously performed at PIHP offices will conducted during a one day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **June 10, 2021**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

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

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

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

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 5

Cc: Jackie Copeland, Partners Contract Manager
Monica Hamlin, NC Medicaid Contract Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager
Hope Newsome, NC Medicaid Quality Management Specialist

B. Attachment 2: Materials Requested for Onsite Review

PARTNERS

Focused External Quality Review 2020

MATERIALS REQUESTED FOR DESK REVIEW

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

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

10. By November 6, 2020, submit a copy of the complete Grievances log for the months of October 2019 through September 2020. Please indicate on the log: the nature of the Grievance, the date received, and the date of Grievance resolution.
11. Copies of all Appeal notification templates used for expedited, invalid, extended, and withdrawn Appeals.
12. For Appeals and Grievances, please submit a description of your monitoring process that reviews compliance of oral and written notifications, completeness of documentation within the Appeal and Grievance records, accuracy of Appeal and Grievance logs, etc. Provide details regarding frequency of monitoring and any benchmarks, performance metrics, and reporting of monitoring outcomes.
13. Please submit a summary of new provider orientation processes and include a list of materials and training provided to new providers.
14. For MH/SU, I/DD, and TCLI Care Coordination, please submit a description of your monitoring plan that reviews compliance of Care Coordinator documentation. Include in the description the elements reviewed (timeliness of progress notes, timeliness of Innovations monitoring, timeliness of Quality of Life surveys, review of quality, completeness of discharge notes, accuracy of documentation, etc.). Provide details regarding frequency of monitoring, and any benchmarks, performance metrics, and reporting of monitoring outcomes.
15. For Care Coordination enrollees files, please provide:
    a. three MH/SU Care Coordination enrollee files (two active since 2018 and one recently discharged)
    b. three I/DD Care Coordination enrollee files (two active since 2018 and one recently discharged)
    c. four TCLI Care Coordination enrollee files (one active since 2018, one who received In-Reach, one who transitioned to the community and one recently discharged).

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

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

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

Required information includes the following for each measure:

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

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

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

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

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

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

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

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

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

A. Insurance:

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

B. Other:

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

19. a. By November 6, 2020, submit a copy of the complete listing of Program Integrity case files active during October 2019 through September 2020. On this list, provide the following for each case file:
    i. Date case opened
    ii. Source of referral
    iii. Category of case (enrollee, provider, subcontractor)
    iv. Current status of the case (opened, closed)

    b. Program Integrity Plan and/or Compliance Plan.
    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.
    e. All 'Attachment Y' reports collected during the review period.
    f. All 'Attachment Z' reports collected during the review period.
    g. Provider Manual and Provider Application.
    h. Enrollee Handbook
    i. Subcontractor Agreement/Contract Template.
    j. Training and educational materials for the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
    k. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse.
    l. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors, and employees.

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

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

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

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

c. A copy of the IT Disaster Recovery Plan.

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

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

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

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

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

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

C. Attachment 3: EQR Validation Worksheets

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

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

- Performance Improvement Project Validation Worksheet
  - Promoting follow up within 7 days for mental health treatment
  - Promoting follow up within 7 days for SUD treatment
  - Reducing ED utilization of active members
  - PCP Referrals to Behavioral Health
  - TCLI Member Housing Loss Reduction

CCME EQR PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Readmission Rates for Substance Abuse**
Reporting Year:	**FY2020 (July 1, 2019-June 30, 2020)**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

UDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Follow-up After Hospitalization for Mental Illness**
Reporting Year:	**FY2020 (July 1, 2019-June 30, 2020)**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

UDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Follow-up After Hospitalization for Substance Abuse**
Reporting Year:	**FY2020 (July 1, 2019-June 30, 2020)**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**
Reporting Year:	**FY2020 (July 1, 2019-June 30, 2020)**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Mental Health Utilization- Inpatient Discharged and Average Length of Stay**
Reporting Year:	**FY2020 (July 1, 2019-June 30, 2020)**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Mental Health Utilization**
Reporting Year:	**FY2020 (July 1, 2019-June 30, 2020)**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Identification of Alcohol and Other Drug Services**
Reporting Year:	**FY2020 (July 1, 2019-June 30, 2020)**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Substance Abuse Penetration Rate**
Reporting Year:	**FY2020 (July 1, 2019-June 30, 2020)**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Mental Health Penetration Rate**
Reporting Year:	**FY2020 (July 1, 2019-June 30, 2020)**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.**
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA
SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Proportion of beneficiaries reporting they have a choice between providers.**
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Percentage of level 2 and 3 incidents reported within required timeframes.**
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Percentage of beneficiaries who received appropriate medication.**
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.**
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Partners**
Name of PIP:	**MH 7-DAY FOLLOW-UP**
Reporting Year:	**2020**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan?	**MET**	Data analysis plan is included in the report.
6.6 Were qualified staff and personnel used to collect the data?	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan?	**MET**	Rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	**MET**	The indicator rate is presented in table format with numerator, denominator, and rate.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?	**MET**	Analysis of data included rate evaluation by quarterly with interim monthly rates.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care?	**NOT MET**	There are four rates reported. The 7-day rates for Medicaid and non-Medicaid did not improve from Remeasurement 8 to Remeasurement 9. The 30-day rates improved from the Medicaid consumers from Remeasurement 2 to Remeasurement 3, but did not improve for the Non-Medicaid consumers. ***Recommendation: Continue to monitor interventions, especially given the new requirements for peer support to determine if rate begins to improve. Determine if engagement specialist and provider communication are resulting in improvement. Continue working on contact information for consumers.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)?	**NA**	Improvement only occurred for one indicator.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement?	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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

PIHP Name:	**Partners**
Name of PIP:	**7 DAY FOLLOW-UP SUD**
Reporting Year:	**2020**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**PARTIALLY MET**	The indicator rates in the Findings/Results table do not match the graphical presentation of rates. ***Recommendation: Update report so that results in Table and Graph are matched***
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by quarterly with interim monthly rates.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rates improved for Medicaid SUD 7-day and non-Medicaid SUD 7-day follow-up.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to the interventions of care coordination, provider data reporting, pairing providers, peer services, and consumer contact information updates
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**74**
Project Possible Score	**79**
Validation Findings	**94%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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

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

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	**NA**	Sampling was not used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**PARTIALLY MET**	The goal rate is listed as 29.5% in the graph and 26% on page 8. It is unclear which rate is the benchmark/target rate. ***Recommendation: Include annotations on the report to allow the reader to know the benchmark/final target rate and the short-term goal rate.***
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to processes of care and functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collection methods are documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are documented.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan?	**MET**	Data analysis plan is included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Rates are reported in table format.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation quarterly.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The most recent rates increased from 56% to 62%. ***Recommendation: Monitor interventions started in January 2020 including high touch care management, SDOH screening, crisis response training, and new member outreach to determine if rate starts to improve (decline) toward goal rate.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Rate did not improve.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**68**
Project Possible Score	**74**
Validation Findings	**94%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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

PIHP Name:	**Partners**
Name of PIP:	**PCP REFERRALS TO BH**
Reporting Year:	**2020**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	The indicator rate is presented in table format with numerator, denominator, and rate.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by quarterly with interim monthly rates.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate improved from 6% to 9% although it is still not at the goal rate of 15%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to the interventions of data capture, PCP education, and mailing.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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

PIHP Name:	**Partners**
Name of PIP:	**TCLI MEMBER HOUSING LOSS REDUCTION**
Reporting Year:	**2020/2021**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates and numbers are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	After the onsite, the PIP document was revised and uploaded for final validation. The results were presented clearly in Table format.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation monthly.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Rate declined and then remained at 0% for the latest two remeasurements. ***Recommendation: The interventions are noted in the report and address barriers. Continue interventions to determine if the upcoming rates improve based on monthly visits, service provider discussions, and identification of lack of resources associated with evictions.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement for the outcome rate.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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.*

D. Attachment 4: Tabular Spreadsheet

I. Information Systems Capabilities Assessment (ISCA)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I A. Management Information Systems						
1. Enrollment Systems						
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Partners has standard processes in place for enrollment data updates. WellSky uploads the daily and quarterly GEF files to the AlphaMCS enrollment system and the monthly 834 files. Partners also uploads the daily and quarterly GEF files to their internal data warehouse. Partners uses the monthly 820 capitation file in combination with the GEF and 834 files to reconcile current and retroactive PMPM payments and identify discrepancies between eligibility and payment processes. Demographic data is captured in the AlphaMCS system, and enrollee IDs are unique to members. Historical enrollment information is captured and maintained for all members.
1.2 The MCO is able to identify and review any errors identified during, or as a result, of the State enrollment file load process.	X					Partners compares the records loaded to the AlphaMCS with the records in their internal data warehouse. During the Onsite, Partners stated that they use reports to identify discrepancies between AlphaMCS and their internal data warehouse. Partners confirmed that they have not encountered any discrepancies in the comparison.
1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.	X					During the Onsite, Partners demonstrated the AlphaMCS enrollment screens and their capability to store the demographic information. All historical data for members is stored and merged under one unique Client ID.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Claims System						
2.1 The MCO processes provider claims in an accurate and timely fashion.	X					For 2019, 96.2% of the Institutional and 96.0% of Professional claims are auto-adjudicated. All Partners claims are processed through AlphaMCS' claims adjudication system. If a required field is missing from a claim, the provider portal will not allow the claim to be submitted to Partners. If the claim is being submitted electronically via an electronic 837 file and one or more required fields are missing, the claim will deny and provider will be notified of the denial through HIPAA 835 file, download reports and Remittance advice. Partners claims processors do not change any information on the claims.
2.2 The MCO has processes and procedures in place to monitor review and audit claims staff.	X					Partners conducts daily audits of claims processed. During the Onsite, Partners reported that 100% of Hospital claims, over 3% of Professional claims, and 7% of COB claims are audited on a daily 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					Partners indicated in their ISCA response that, for Institutional claims, 29 ICD-10 Diagnosis codes are captured on HIPAA files and 25 ICD-10 Diagnosis codes are captured on the Provider Web Portal. For Professional claims, 12 ICD-10 Diagnosis codes are captured on the HIPAA files and Provider Web Portal. ICD-10 Procedure codes and DRG codes received from the provider are captured.
2.4 The MCO's claim system screens store and track claim information and claim adjudication/payment information.	X					Onsite review of the claims system screens identified the capture of adjudication/payment information for the claims.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Reporting						
3.1 The MCO's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Partners captures all necessary data elements required for enrollment and claims reporting. ICD-10 Procedure and DRG codes are also captured when submitted on a claim by the provider.
3.2 The MCO has processes in place to back up the enrollment and claims data repositories.	X					Partners has processes in place that back up their internal data warehouse daily.
4. Encounter Data Submission						
4.1 The MCO has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	X					Partners' encounter data submission process allows all ICD-10 Diagnosis codes for Institutional and Professional encounters to be submitted to NCTracks. Partners' encounter data submission process allows for the DRG and ICD-10 Procedure codes received on an Institutional claim to be submitted to NCTracks.
4.2 The MCO has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					Partners uses the outgoing 837 encounter files, 835 encounter response file, and the NC Medicaid Paid/Denied spreadsheets to identify and reconcile encounter data denials.
4.3 MCO has policies and procedures in place to reconcile and resubmit encounter data denied by NC Medicaid.	X					Partners has several policies and procedures regarding denied encounter data reconciliation, and resubmission process. ISCA documentation shows workflows and procedures for encounter data submissions to NC Medicaid. Partners has an encounter data acceptance rate of 99.9%.
4.4 The MCO has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to NC Medicaid	X					Partners' Claims department staff and an IT Business analyst are responsible for working on the denied encounters. Partners' staff is well informed and is dedicated to improving encounter data submissions and reducing the number of denials.

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.
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* (*CCC)* and the *Credentialing Program Description* (*CPD)* provide details on the composition and responsibilities of the Credentialing Committee. The *CPD* states "...the Credentialing Committee is chaired by the CMO or designee." Dr. Stanton, Chief Medical Officer, chaired the meetings for which minutes were submitted for this EQR. Reviewed 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.
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Credentialing files reviewed for the EQR were organized and contained appropriate information.
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
3.1.3 Valid DEA certificate; and/or CDS certificate	X					
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					
3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.15 Ownership Disclosure is addressed.	X					
3.1.16 Criminal background Check	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files reviewed for the EQR were organized and contained appropriate information.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
4.2.3 Valid DEA certificate; and/or CDS certificate	X					
4.2.4 Board certification if claimed by the applicant;	X					
4.2.5 Malpractice claims since the previous credentialing event;	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					
4.2.14 Ownership Disclosure is addressed.	X					
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					The Credentialing Committee considers factors including "flags" as identified in the *Credentialing Program Description*, quality of care concerns, and information from Partners Program Integrity.
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					Policy and Procedure 8.21N, MCO-Issued Provider Sanctions, addresses sanctions issued "based on identified areas of risk and/or serious quality of care identified issues." Policy and Procedure 6.04, Quality of Care Concerns, "identifies potential concerns that might indicate a Quality of Care (QOC) Concern, the steps to resolution, and how Partners BHM reports and utilizes the information regarding QOCConcerns." (*sic)*
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					

III. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III. Quality Improvement						
III. A Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					All (c) Waiver Measures were above the State benchmark rates. The overall validation scores for all Performance Measures were in the Fully Compliant range, with an average validation score of 100% across the 10 (b) Waiver Measures and the five (c) Waiver Measures. The (b) Waiver Performance Measure for the combined services rate of 7-day Follow-up After Hospitalization for Mental Illness declined from 50.1% to 40%, a decline of 10.1%. ***Recommendation: Continue current interventions for the (b) Waiver Performance Measure for the combined services rate of 7-day Follow-up After Hospitalization for Mental Illness, working to increase this rate.***
III. B Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					Partners submitted nine projects for this 2020 EQR. These five were validated: • 7-day Follow Up for Mental Health Treatment • 7-day Follow Up for SUD Treatment • PCP Referrals to Behavioral Health • Reducing ED Utilization • TCLI- Member Housing Loss Reduction
2. The study design for QI projects meets the requirements of the CMS protocol	X					All five validated PIPs scored in the High Confidence range, although four PIPs had errors. See Recommendations below.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
"Validating Performance Improvement Projects".						For the Promoting Follow up Within 7 Days for Mental Health Treatment PIP, rates have not consistently improved. ***Recommendation: Continue to monitor interventions, especially given the new requirements for peer support, to determine if rates begins to improve. Determine if the engagement specialist and provider communication are resulting in improvement. Continue working on contact information for consumers.*** For the Promoting Follow up Within 7 days for SUD Treatment PIP, the indicator rates in the Findings/Results table do not match the graphical presentation of rates. ***Recommendation: Update the PIP report so that results in Table and Graph are matched.*** For the Reducing ED Utilization of Active Members PIP, the most recent rates increased from 56% to 62%. ***Recommendation: Monitoring interventions started in January 2020, including high touch care management, SDOH screening, crisis response training, and new member outreach. Continue to monitor to determine if the rate starts to improve (decline) toward goal rate.*** For the Reducing ED Utilization of Active Members PIP, the goal rate is listed as 29.5% in the graph and 26% on page 8. It is unclear which rate is the benchmark/target rate. ***Recommendation: Include annotations on the report to allow the reader to know the benchmark/final target rate and the short-term goal rate.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						For the TCLI-Member Housing Loss Reduction PIP, the rate declined and then remained at 0% for the latest two remeasurements. ***Recommendation: The interventions are noted in the report and address barriers. Continue interventions to determine if the upcoming rates improve based on monthly visits, service provider discussions, and identification of lack of resources associated with evictions.***

IV. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. A Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					
2. The case coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					
2.5 Quality monitoring and continuous quality improvement;	X					
2.6 Determination of which Behavioral Health Services are medically necessary;	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					During the 2019 EQR, CCME issued a Corrective Action to Partners to revise MH/SU Care Coordination policies and procedures to better define documentation requirements which included: • Timely submission of Care Coordination documentation. • The process of transferring enrollees between Care Coordinators, regions, departments, and to another PIHP. • Actions to be taken when an enrollee is difficult to locate. • The process for discharging an enrollee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Partners updated Policy and Procedure 9.05, the *MHSU Program Description*, and the *TCLI How-to Manual* but did not include the process for transferring enrollees to another PIHP. ***Recommendation: Update Policy and Procedure 9.05, the MHSU Program Description, and the TCLI How-to Manual to include the process for transferring enrollees to a new PIHP to ensure the continuation of services and support.*** During the 2019 EQR, CCME recommended that Partners update an I/DD policy and procedure to include the required steps and notification for when an enrollee is no longer engaged in Innovations services as outlined in *Clinical Coverage 8P, section L*. Partners implemented this Recommendation.
2.10 Ensure privacy for each Enrollee is protected.	X					
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					During the 2019 EQR, CCME issued a Recommendation for Partners to add details to Policy and Procedure 11.16, I/DD Care Manager Monitoring of Plan Implementation, regarding HCBS monitoring and the required *State Monitoring Checklist*. CCME also recommended that Partners update the *I/DD Care Management Program Description* to include day support and supported employment services as part of HCBS monitoring. Partners implemented the Recommendation. For this EQR, CCME identified discrepancies on the required *State Monitoring Checklist* for HCBS evaluation. CCME is requiring I/DD to increase monitoring of HCBS documentation through a Corrective Action detailed in Care Coordination Standard 3.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					The 2019 EQR file review of MH/SU Care Management found inconsistencies in staff documentation. There were patterns of blank notes, late progress notes, large gaps in notes (as much as six months), blank discharge notes, and abrupt endings in Care Coordination notes with no reference to discharging or transferring the enrollee from Care Coordination. Similar findings were identified in the review of I/DD Care Coordination files. Compliance issues identified within the I/DD files include gaps in notes (as much as five months), late progress notes, and delays in coordinating services when an enrollee transferred to another PIHP. Partners received a Corrective Action to develop, document, and implement a data-driven monitoring plan that routinely reviews I/DD and MH/SU documentation entered in TruCare. Partners implemented the Corrective Action. The review of I/DD and MH/SU files for this EQR found improvement in documentation standards and departmental processes. Partners utilized the required *State Monitoring Checklist* to quarterly evaluate HCBS, for all qualifying services (day support, residential, and supported employment) as identified in *NC Clinical Coverage Policy 8P* and *NCDHHS HCBS Final Rule Transition Plan*. However, in two files of enrollees receiving residential supports and day supports, 50% of the "Residential Only (below)" section of the *State Monitoring Checklist* was not completed. During the Onsite, Partners staff acknowledged that supervisors were not performing a thorough review of Care Coordination progress notes and documentation. Partners will need to implement strategies that will ensure the quality of completeness of Care Coordination documentation. ***Recommendation: Develop, document, and implement a process that routinely reviews the required State Monitoring Checklists for completeness and compliance with NC Clinical Coverage Policy 8P and NCDHHS HCBS Final Rule Transition Plan.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						For a second year, CCME identified issues with Partners' discharge process in MH/SU Care Management files. In one MH/SU file, CCME found that the number of engagements as defined in Policy and Procedure 9.05, was not met before discharge. Partners defines engagement as "1 timely follow up appointment within 7 days of hospital discharge and 2 additional appointments within 30 days thereafter = total of minimum of 3 appointments in 5 weeks." The enrollee was discharged from MH/SU Care Management before meeting the engagement requirement. ***Revision: NC Medicaid reviewed these two Corrective Actions and determined no action is needed by Partners as the finding does not relate to enrollee health and safety. The report now reflects these Corrective Actions are best practice Recommendations.*** ***Recommendation: Enhance the current monitoring plan to include a comprehensive review of Care Management documentation for enrollees scheduled for discharge or transfer to another PIHP as outlined in Partners Policy and Procedure 9.05.***
IV. B Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.1 Care Coordination activities occur, as required.	X					
2.2 Person Centered Plans are developed as required.	X					
2.3 Assertive Community Treatment, Peer Support, Supported Employment, Community Support Team, Psychosocial Rehabilitation, and other services as set forth in the DOJ Settlement are included in the individual's transition, if applicable.	X					
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					During the 2019 EQR, CCME issued a Recommendation to update Policy and Procedure 9.08, to describe how to access TYSR funds. Partners implemented this recommendation.
2.5 QOL Surveys are administered timely.	X					
3. Transition, diversion and discharge processes are in place for TCLI enrollees as outlined in the DOJ Settlement and *DHHS Contract*.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.	X					
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					
6. A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.		X				During the 2019 EQR review of TCLI files, CCME identified inconsistencies in staff documentation. For example, at least 75 progress notes were entered beyond the expected time frame of three days. One note was more than 300 days late. There was also a pattern of blank progress notes, blank discharge notes, large gaps in progress notes (nine months or more), and abrupt endings to TCLI Care Coordination interventions with no reference to discharge or transfers. Additionally, the file review found three Quality of Life (QOL) Surveys had not been completed, and at least four In-Reach Tools were either missing or incomplete. CCME issued a Corrective Action to Partners to develop, document, and implement a data-driven monitoring plan that routinely reviews TCLI documentation entered in TruCare. Partners implemented the Corrective Action. For this EQR, the review of TCLI files found improvement in progress notes and QOL surveys. However, for a second year, issues were identified in TCLI discharge and transfer of enrollees. In one TCLI

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						file, the review found that an enrollee who was actively engaged in services and relocating to a new PIHP catchment was discharged from TCLI. During the Onsite, Partners staff explained that no further action was taken because the enrollee expressed no longer wanting TCLI support and stated they had already set up services in the new catchment area. However, the *NC Transitions to Community Living Initiative (TCLI) In-Reach and Transition Manual* states, "a. For individuals who choose to move outside of their current home Medicaid County, the Transition Coordinator will coordinate efforts between the two DSS agencies and the receiving LME/MCO (transfer of Medicaid and other support funding)." According to the enrollee's progress notes, Partners • Did not contact the new PIHP to inform of the relocation to the new catchment area. • Did not contact the current DSS or the receiving DSS to coordinate the transfer of Medicaid and other support funding if needed. Furthermore, Partners did not contact the new service provider before discharge to ensure the continuation of service. *Revision: NC Medicaid did determine the TCLI Corrective Action should remain due to "the lack of continuity of care."* ***Corrective Action: Enhance the current monitoring plan to include a comprehensive review of files scheduled for discharge from TCLI and transfer to another PIHP. Ensure that the discharge and transfer process adhere to Partners Policy and Procedure 9.05 and the NC Transitions to Community Living Initiative (TCLI) In-Reach and Transition Manual.***

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					Policy and Procedure 6.00U, Grievance Management, is the primary policy and procedure describing Partners' process for resolving Grievances.
1.1 Definition of a Grievance and who may file a Grievance;	X					On page 1 of Policy and Procedure 6.00U, it is explained, "the expression(s) of dissatisfaction via a complaint or grievance (substantially synonymous as used in Procedure)". The review of the procedure reveals that Complaint/Grievances and Grievance/Complaint are used interchangeably. Within the procedure: • The term "Grievance/Complaint" is used 56 times. • The term "Complaint/Grievance" is used 16 times. • The term "Grievance" is used over 100 times. • The term "Complaint" is used over 15 times. The *Member Handbook* and the *Provider Operations Manual* also use inconsistent terms. For example, the *Provider Operations Manual* uses the term "complainant" to identify the person filing the Grievance. It was recommended in the 2018 EQR that Partners identify one term for the expression of a dissatisfaction and use it consistently. However, these public facing documents are still confusing. ***Recommendations: Within Policy and Procedure 6.00U, Grievance Management, the Member Handbook and the Provider Operations Manual select and define one term for "an expression of dissatisfaction about any matter other than an***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Adverse Benefit Determination", per 42 C.F.R. 438.400(b). Consistently use the chosen term within Procedure 6.00U, Grievance Management, the Member Handbook and the Provider Operations Manual and all print material.
1.2 The procedure for filing and handling a Grievance;	X					
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract;	X					In the 2019 EQR, a Recommendation was issued to include within the Grievance policy and procedure, "Partners will send written notice of the extension to the Grievance resolution timeframe to the grievant within two days." This Recommendation was implemented by Partners.
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 Grievance log for oral Grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Policy & Procedure 4.11, Record Retention and Disposition, details Partners' process and timeframe retention of Grievance files.
2. The PIHP applies the Grievance policy and procedure as formulated.	X					In the 2019 EQR, CCME issued a Recommendation to Partners to develop and document a monitoring process that reviews "High Priority" Grievances and whether staff identify these Grievances and take appropriate actions in compliance with Policy and Procedure 6.00U. Partners developed a monitoring process for "High" Priority cases and the use of the "High Priority Daily Grievance Tracking Log". During the Onsite interview, Partners staff provided an overview of the process. No "High" Priority cases were identified since the implementation of the monitoring process. The file review

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						of Grievance files included the review of the Priority level of each file. All files reviewed where identified as "Routine" Priority. This Recommendation was implemented by Partners. The file review included 10 Grievance files selected from Partners' Medicaid Grievance Log. All files contained timely Acknowledgement and Resolution letters and the Grievances were resolved within 30 days of the 90-day time frame per Partners' policy and procedure. Resolution Letters contained the detailed steps Partners took to resolve each Grievance. The steps were supported within the Grievance file documentation. Two, or 20%, of the files reviewed were from one residential placement, and the Grievances were related to member safety issues. During the Onsite interview, there was a discussion about monitoring providers who are identified during the Grievance process. Partners provided an overview of their monitoring process that includes the case being reviewed in the Quality of Care Committee (QOC) with involvement of the Chief Medical Officer (CMO) and a cross-departmental review process.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Grievances are tallied and analyzed for patterns, trends, and compliance. That data is reported in the Quality Improvement, Quality of Care, Consumer and Family Advisory, and Human Rights committees meetings. During the Onsite discussion, Partners noted that the number of Grievances received decreased from the last EQR year. Grievance data was provided and reviewed, confirming a decrease of Grievance Investigations over the timeframe under review.
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider Appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					Policy and Procedure 13.04U, Clinical Utilization Management Appeals, is the primary policy and procedure that governs Partners' Appeals process.
1.1 The definitions an Appeal and who may file an Appeal;	X					In the 2019 EQR, it was noted that Partners' Policy and Procedure 13.04U, Clinical Utilization Management Appeals, *Provider Operations Manual* and *Member Handbook* were inconsistent when defining who can file an Appeal. Partners revised all three of these documents. The most current version of Partners' *Provider Operations Manual* now has the correct explanation of who can file an Appeal.
1.2 The procedure for filing an Appeal;	X					In the 2018 and 2019 EQRs, it was noted Partners' *Provider Operations Manual* and *Member Handbook* incorrectly explain that, to initiate the Appeals process, enrollees must submit Partners' Request for Reconsideration form. CCME issued a Corrective Action in 2019, as this practice is more restrictive than the process defined in federal regulation and Partners' *NC Medicaid Contract*. Partners contested this finding in their 2019 Corrective Action response. The State upheld CCME's finding. In the 2020 EQR of these documents, there is now clear language in Partners' *Provider Operations Manual* and the *Member Handbook* that Partners' Request for Reconsideration form is not required to initiate an Appeal and any written request may be submitted to initiate the Appeals process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Review of any Appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited Appeal where the life or health of the enrollee would be jeopardized by delay;	X					In the 2019 EQR, CCME recommended that Partners' Policy and Procedure 13.04U, Clinical Utilization Management Appeals, the *Provider Operations Manual*, and the *Member Handbook* correctly state that, when Partners denies a request to expedite an Appeal, Partners gives notification of the member's right to file a Grievance. These documents currently state "the member's right to request reconsideration of the decision." This requirement is outlined in *42 CFR § 438.410(c)(2)* and *§ 438.408(l)(2)(ii)*. In the 2020 EQR, it was noted Partners revised all three documents to include this required notification to the enrollee.
1.5 Timeliness guidelines for resolution of the Appeal as specified in the contract;	X					In the 2019 EQR, CCME recommended revision of the Appeal policy and procedure to address missing language regarding the notifications Partners is required to issue when Partners extends the Appeal resolution timeframe. Partners addressed this Recommendation, and Policy and Procedure 13.04U is now compliant with *42 CFR § 438.408(c)(2)(ii)* and *NC Medicaid Contract, Attachment M, Section G.6.*
1.6 Written notice of the Appeal resolution as required by the contract;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.7 Other requirements as specified in the contract.	X					In the 2018 and 2019 EQRs, inconsistent practices by staff were noted in the files deemed invalid by Partners or withdrawn by the appellant. In this 2020 EQR, there was evidence that additional guidance was added to the Appeal policy and procedure regarding how to process invalid and withdrawn Appeals consistently and in compliance with *NC Medicaid Contract, Attachment M* and federal regulations.
2. The PIHP applies the Appeal policies and procedures as formulated.	X					In the 2018 and 2019 EQRs, CCME recommended that Partners "verify files requested for any audit or review are complete, including all communications and notifications between Partners' staff and appellants." These Recommendations were issued because Partners did not submit the Consumer Contact logs with the Appeal files requested. These logs are often the only documentation that capture steps that are required when staff are processing Appeals (e.g., oral notifications, outreach/assistance, phone calls from appellants, etc.) In the 2020 EQR, Partners submitted the Consumer Contact Logs for the files selected for review. In the 2019 EQR, compliance issues were noted in half of the Appeal files reviewed. Primary concerns were noted in those files that were submitted verbally, expedited, deemed invalid, and/or withdrawn. In 2019, CCME issued a Corrective Action for Partners to "develop and document an Appeal monitoring process that includes compliance monitoring of oral, invalid, expedited, and withdrawn Appeal files." This monitoring was to include monitoring of the Appeal Log, as several errors were also found within the Appeal Log reviewed in the 2019 EQR. In the 2020 EQR, ten files were initially requested and reviewed. The initial file review showed compliance issues in half of the Appeal files reviewed. Additional files were requested to determine if Partners' Appeal monitoring process improved compliance in the processing of Appeals over time. The review of these additional files, which included withdrawn and expedited Appeals and Appeals

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						submitted verbally, showed a significant increase in compliance. CCME recommends Partners continue to monitor Appeals to maintain this level of compliance. This monitoring should also include a focus on those Appeals that require intricate steps when processing, such as verbal, extended, expedited, and withdrawn Appeals, along with Appeals of Administratively Denied Service Authorizations. ***Recommendation: Continue Partners' Appeal monitoring process and focus on those Appeals that require intricate steps when processing, such as verbal, extended, expedited, and withdrawn Appeals, along with Appeals of Administratively Denied Service Authorizations.***
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					

VI. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI A. General Requirements						
1. PIHP shall be familiar and comply with *Section 1902 (a)(68)* of the *Social Security Act*, *42 CFR § 438.455* and *1000* through *1008*, as applicable, including proper payments to providers and methods for detection of fraud and abuse.	X					General requirements are 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* of the *NC Medicaid Contract*.	X					
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					Program Integrity requirements are addressed in the Sample Medicaid Agency Contract Template provided by Partners.
4. PIHP shall investigate all Grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					A description of Partners' Investigative process is found in the Regulatory Compliance Program Description/Plan on pages 7-8.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with *42 CFR 438.608* that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the NC Medicaid Contract Administrator on an annual basis.	X					
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of *42 CFR 438.608* and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the federal and State standards and requirements under NC Medicaid Contract in accordance with *42 CFR § 438.608(a)(1)(iv).*	X					The designation of Partners' compliance officer is addressed on pages 4-6 of the *Regulatory Compliance Program Description/Plan.*

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. PIHP shall send staff to participate in monthly meetings with NC Medicaid Program Integrity staff either telephonically or in person, at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.	X					
6. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information	X					
7. Within seven (7) business days of a request by the Division, PIHP shall also make portions of the PIHP's Regulatory Compliance and Program Integrity minutes relating to Program Integrity issues available for review, but the PIHP may, redact other portions of the minutes not relating to Regulatory Compliance or Program Integrity issues.	X					
8. PIHP's written Compliance Plan shall, at a minimum include:						
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False	X					A description of PI training process is addressed in Partners' Regulatory Compliance Program Description/Plan on page 5.

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9. In accordance with *42 CFR § 436.606(a)(vii),* PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under *NC Medicaid Contract*, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under *NC Medicaid Contract*; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month. PIHP shall be penalized One Hundred Dollars ($100) for each overpayment that is not specified in an Attachment Y Report within the applicable month. In addition, PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Partners' process for reporting overpayments is addressed in the Provider Overpayment Recovery policy and procedure.
10.4 Process for tracking overpayments and collections based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on Attachment Y – Audits/Self-Audits/investigations.	X					
10.5 Process for handling self-audits and challenge audits.	X					
10.6 Process for using data mining to determine leads.	X					Partners' process for data mining is outlined in the *Program Integrity Department Data Mining Guidelines*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.7 Process for informing PIHP employees, subcontractors, and providers regarding the *False Claims Act.*	X					
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					False claims and whistleblower protections are addressed within Partners' *Regulatory Compliance Program Description Plan.*
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid-standardized elements or a NC Medicaid-approved template;	X					
10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						
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					
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13. In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						All of the PI files reviewed in this 2020 EQR contained the information required to make referrals to NC Medicaid. Several of the PI files reviewed in this 2020 EQR showed the Investigative Summary form was not completed by all staff. CCME recommends Partners maximize the use of this form to provide a snapshot of the critical elements of each investigation, as well as updates on the status of each investigation. ***Recommendation: Ensure staff complete and routinely update the Investigative Summary form to provide an overview of the investigation and its current status within the investigative process.***
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					
13.2 Source/origin of complaint;	X					
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					
13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated; and dates of suspected intentional misconduct;	X					
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
alleged misconduct, whichever is greater;						
13.6 All communications between PIHP and the Provider concerning the conduct at issue, when available.	X					
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					
13.8 Total Sample Amount of Funds Investigated per Service Type	X					
14. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						No PI files showing potential enrollee fraud were provided for this 2020 EQR. Partners provided the *LME/MCO Suspected Enrollee Fraud and/or Abuse DHB Program Integrity Referral form*, which demonstrates Partners' ability to report an allegation in compliance with all NC Medicaid requirements.
14.1 The Enrollee's name, birth date, and Medicaid number;	X					
14.2 The source of the allegation;	X					
14.3 The nature of the allegation, including the timeframe of the allegation in question;	X					
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	X					

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					
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and	X					
14.7 The legal and administrative status of the case.	X					
14.8 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					
14.9 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					
14.10 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					
14.11 Information on Biller/Owner;	X					
14.12 Additional Provider Locations that are related to the allegations;	X					

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

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

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
continue if either of the following occur: PIHP or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider; or Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.						
1.1 In the circumstances described in *Section 14.3 (c)* above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.	X					
2. Upon receipt of a payment suspension notice from NC Medicaid Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of NC Medicaid Program Integrity's suspension and lasting until PIHP is notified by NC Medicaid Program Integrity in writing that the suspension has been lifted.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. PIHP shall provide to NC Medicaid all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					Support of NC Medicaid in defense of an investigation is addressed in the Provider Overpayment Recovery policy and procedure.
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid Program Integrity due to allegations of suspected fraud without prior written approval from NC Medicaid Program Integrity or the MFCU/MID. If PIHP takes administrative action, including issuing a Notice of Overpayment based on such fraud that precedes the submission date of a Division referral, the State will adjust the PIHP capitated payment in the amount of the original overpayment identified or One Thousand Dollars ($1,000) per case, whichever amount is greater.	X					

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

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

E. Attachment 5: Encounter Data Validation Report

Partners Health Management

Encounter Data Validation Report

performed on behalf of

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

June 23, 2021

Prepared By:

hms

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

Table of Contents

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Background

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

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

Overview

The scope of our review, guided by the CMS Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims and submitted to NC Medicaid by Partners for the period of January 2019 through December 2019. 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 its provider number and paid amount to NC Medicaid in the Contract Information CN104 and CN102 segment of Claim Information Loop 2300.

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

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

Looking at claims with dates of service in 2019, Partners submitted 1,446,496 unique encounters to the State. To date, 0.02% of all encounters submitted have not been corrected and accepted by NC Medicaid.

2019	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	82,139	81,722	190	227	0.28%
Professional	1,364,357	1,356,233	8,040	84	0.01%
Total	1,446,496	1,437,955	8,230	311	0.02%

During the past four review periods, Partners has made significant improvements to their encounter submission process, increasing their acceptance rate and quality of encounter data year over year. Those process improvements are best reflected in the reduction of initial denials from 79,566 in 2016 to 8,541 in 2019. The table below reflects the improvement in acceptance rate from 0.18% to 0.02%, well above NC Medicaid's expectations.

Year of Service	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
2016	1,424,700	1,345,134	77,162	2,404	0.17%
2017	1,347,304	1,297,629	45,028	4,647	0.34%
2018	1,363,466	1,351,220	9,734	2,512	0.18%
2019	1,446,496	1,437,955	8,230	311	0.02%

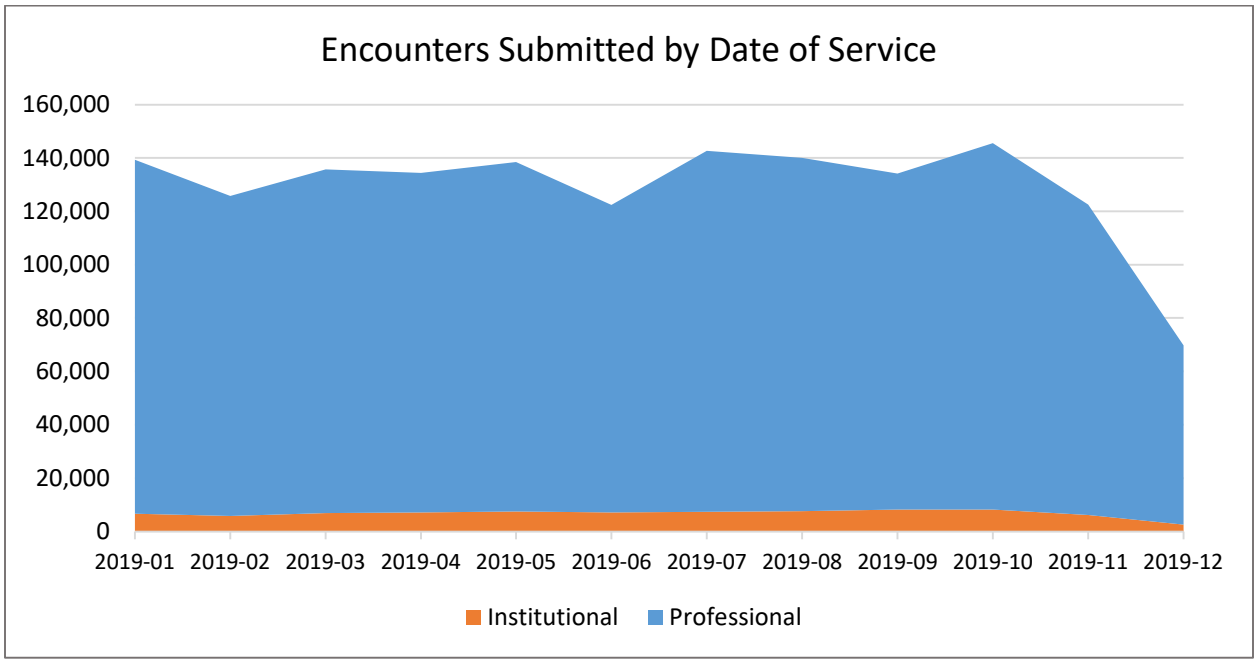
Compared to claims submitted in 2018 and prior years, Partners continued to decrease the total number of initial denials and outstanding denials each year. According to Partners' response and review of NC Medicaid's acceptance report, 24% of all outstanding and ongoing denials are still related to invalid Taxonomy codes for the billing and rendering Provider. Partners' strategy to continue to reduce, correct, and resubmit encounter denials includes the following steps:

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

As a result of this strategy, total initial denials in 2019 dropped to fewer than 10,000 of all encounter claims submitted, compared to nearly 80,000 in 2016.

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, 2019 through December 31, 2019. Partners pulled all claims adjudicated and submitted to NC Medicaid during 2019 and sent to HMS via SFTP. This included more than 1.5 million professional and just over 90,000 institutional claim line items. 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 following table depicts the specific data expectations and validity criteria applied.

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

Data Element	*Expectation*	*Validity Criteria*
Recipient ID	Should be valid ID as found in the State's eligibility file. Can use State's ID unless State also accepts Social Security Number.	100% valid
Recipient Name	Should be captured in such a way that makes separating pieces of name easy. Expect data to be present and of good quality	85% present. Lengths should vary, but there should be at least some last names of >8 digits and some first names of < 8 digits, validating that fields have not been truncated. Also, a high percentage of names should have at least a middle initial.
Recipient Date of Birth	Should not be missing and should be a valid date.	< 2% missing or invalid
MCO/PIHP ID	Critical Data Element	100% valid
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	95% valid
Attending Provider ID	Should be an enrolled provider listed in the provider enrollment file (will accept the MD license number if it is listed in the provider enrollment file).	> 85% match with provider file using either provider ID or MD license number
Provider Location	Minimal requirement is county code, but zip code is strongly advised.	> 95% with valid county code > 95% with valid zip code (if available)
Place of Service	Should be routinely coded, especially for physicians.	> 95% valid for physicians > 80% valid across all providers
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% nonmissing and valid on physician or other applicable provider type claims (e.g., other practitioners)
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid codes (using International Statistical

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

Data Element	*Expectation*	*Validity Criteria*
		Classifications of Diseases, Ninth Revision, Clinical Modification [ICD-10-CM] lookup tables) for practitioner providers (not including transportation, lab, and other ancillary providers)
Other Diagnosis	This is not expected to be coded on all claims even with applicable provider types, but should be coded with a fairly high frequency.	90% valid when present
Dates of Service	Dates should be evenly distributed across time.	If looking at a full year of data, 5%–7% of the records should be distributed across each month.
Unit of Service (Quantity)	The number should be routinely coded.	98% nonzero <70% should have one if Current Procedural Terminology (CPT) code is in 99200–99215 or 99241–99291 range.
Procedure Code	Critical Data Element	99% present (not zero, blank, or 8- or 9-filled). 100% should be valid, State-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.
Procedure Code Modifier	Important to separate out surgical procedures/ anesthesia/assistant surgeon, not applicable for all Procedure codes.	> 20% non-missing. Expect a variety of modifiers both numeric (CPT) and Alpha (Healthcare Common Procedure Coding System [HCPCS]).
Patient Discharge Status Code (Hospital)	Should be valid codes for inpatient claims, with the most common code being “Discharged to Home.” For outpatient claims, the code can be “not applicable.”	For inpatient claims, expect >90% “Discharged to Home.” Expect 1%–5% for all other values (except “not applicable” or “unknown”).
Revenue Code	If the facility uses a UB04 claim form, this should always be present	100% valid

Encounter Accuracy and Completeness

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

Table: Evaluation of Key Fields

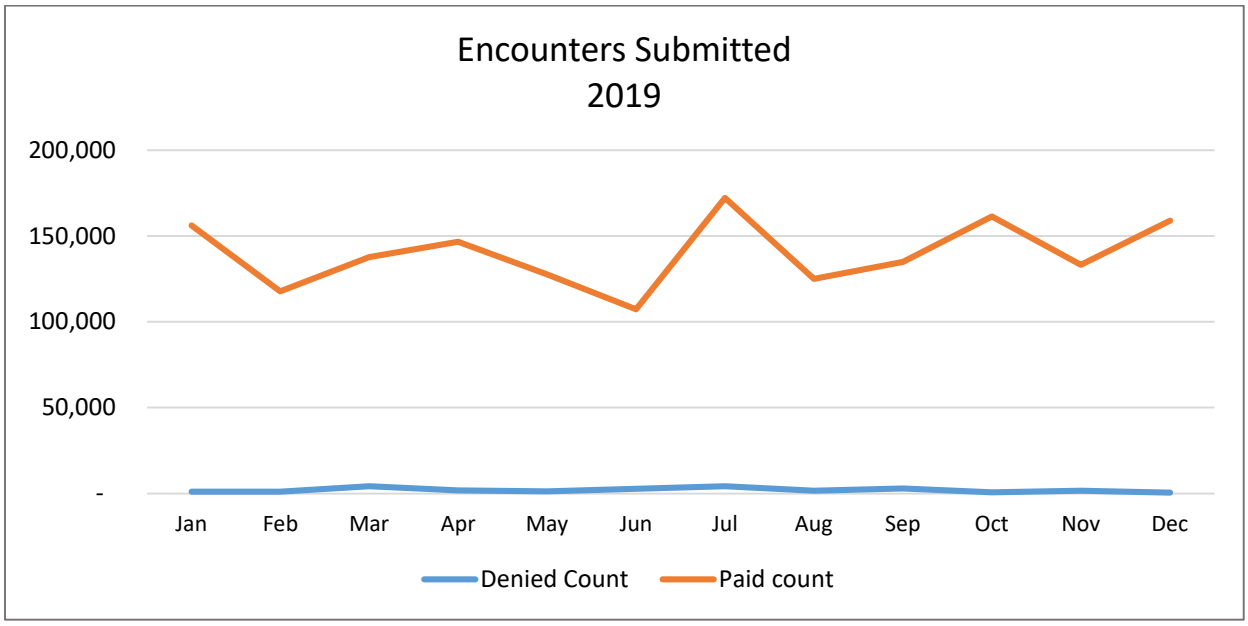
Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	1,678,248	100.00%	1,678,222	100.00%	1,678,222	100.00%	1,678,222	100.00%
Recipient Name	1,678,248	100.00%	1,678,248	100.00%	1,678,248	100.00%	1,678,248	100.00%
Recipient Date of Birth	1,678,248	100.00%	1,678,248	100.00%	1,678,248	100.00%	1,678,248	100.00%
MCO/PIHP ID	1,678,248	100.00%	1,678,248	100.00%	1,678,248	100.00%	1,678,248	100.00%
Provider ID	1,678,248	100.00%	1,678,231	100.00%	1,678,231	100.00%	1,678,231	100.00%
Attending/Rendering Provider ID	1,678,248	100.00%	1,678,248	100.00%	1,678,248	100.00%	1,678,248	100.00%
Provider Location	1,678,248	100.00%	1,678,248	100.00%	1,678,248	100.00%	1,678,248	100.00%
Place of Service	1,678,248	100.00%	1,678,248	100.00%	1,678,248	100.00%	1,678,248	100.00%
Specialty Code / Taxonomy - Billing	1,678,209	100.00%	1,678,209	100.00%	1,678,209	100.00%	1,678,209	100.00%
Specialty Code / Taxonomy - Rendering / Attending	1,678,178	100.00%	1,678,178	100.00%	1,678,178	100.00%	1,678,178	100.00%
Principal Diagnosis	1,678,248	100.00%	1,678,248	100.00%	1,678,248	100.00%	1,678,248	100.00%
Other Diagnosis	324,798	19.35%	324,798	19.35%	324,798	19.35%	324,798	19.35%
Dates of Service	1,678,248	100.00%	1,678,248	100.00%	1,678,248	100.00%	1,678,248	100.00%
Unit of Service (Quantity)	1,662,672	99.07%	1,678,248	100.00%	1,678,248	100.00%	1,678,248	100.00%
Procedure Code	1,657,516	98.76%	1,657,516	98.76%	1,657,516	98.76%	1,657,516	98.76%
Procedure Code Modifier	589,048	35.10%	589,048	35.10%	589,048	35.10%	589,048	35.10%
Patient Discharge Status Code Inpatient	90,091	100.00%	90,091	100.00%	90,091	100.00%	90,091	100.00%
Revenue Code	90,091	100.00%	90,090	100.00%	90,090	100.00%	90,090	100.00%

Overall, Partners has improved the quality and accuracy of the encounter data submitted compared to last year's review of 2018 claims. Institutional claims contained complete and valid data in 16 of the 18 key fields (94%) with noted issues for the Other Diagnosis and Procedure codes. The former was populated only 35% of the time, whereas the latter was missing on 23% of the line item charges where a Procedure code is needed to identify the service provided. Room & board type of charges were excluded when analyzing the Procedure codes.

Professional encounter claims submitted contained complete and accurate data in 15 of the 16 key professional fields (94%). The Other Diagnosis code was present on only 17% of all professional claims. Overall, Partners saw a significant reduction in the number of deficiencies compared to 2018, when five issues were noted – Billing Provider Id, Recipient Id, Billing Taxonomy, Rendering Taxonomy, and Procedure codes. In 2019, only the Other Diagnosis code fell below the expectations set by CMS and NC Medicaid. There were, however, a few minor issues found with Recipient Id, Billing and Rendering Taxonomy codes, and Units of Services. We will closely monitor these when reviewing next year's encounter data.

Encounter Acceptance Report

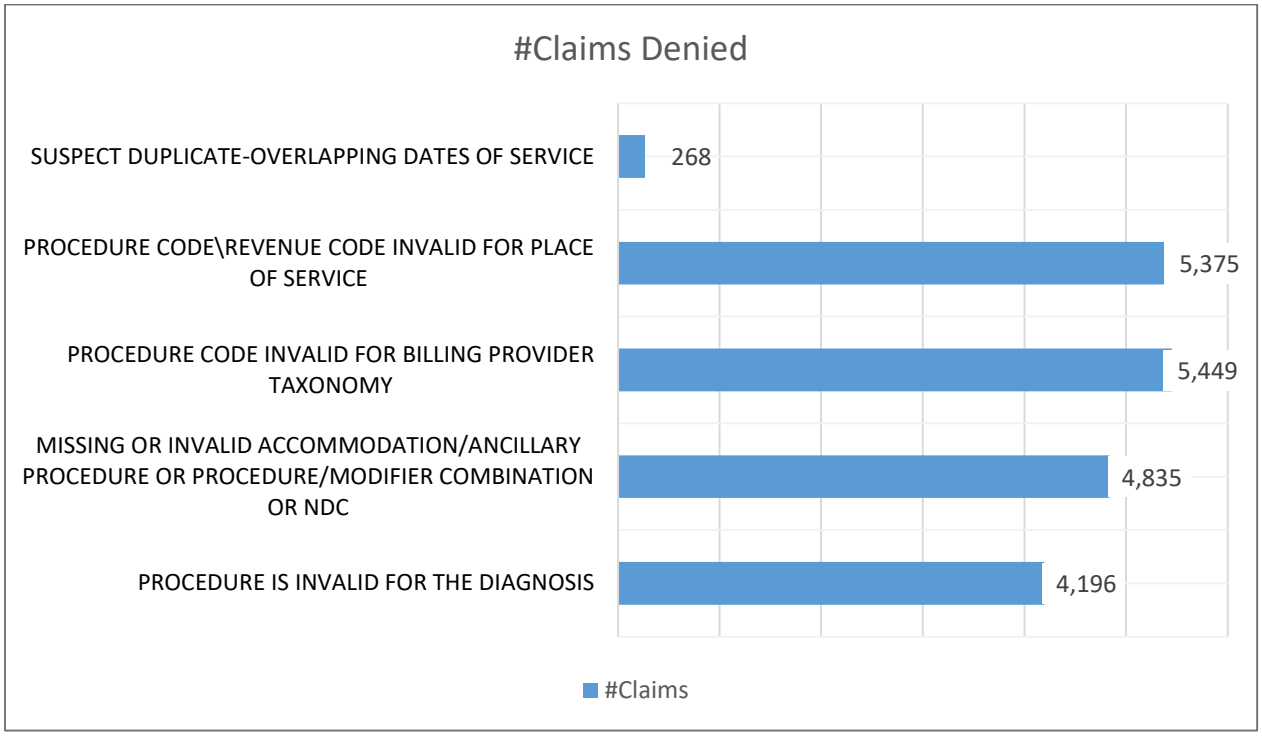
In addition to analyzing the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write which made it difficult to tie back to the ISCA response and submitted encounter files since only the Date of Service for each is available. During the 2019 weekly check write schedule, Partners submitted a total of 1,446,496 encounters to NC Medicaid. On average, 0.59% of all encounters submitted were initially denied. About 0.02% of denied claims are still outstanding -- the rest have been reviewed, resubmitted, and accepted by NC Medicaid.

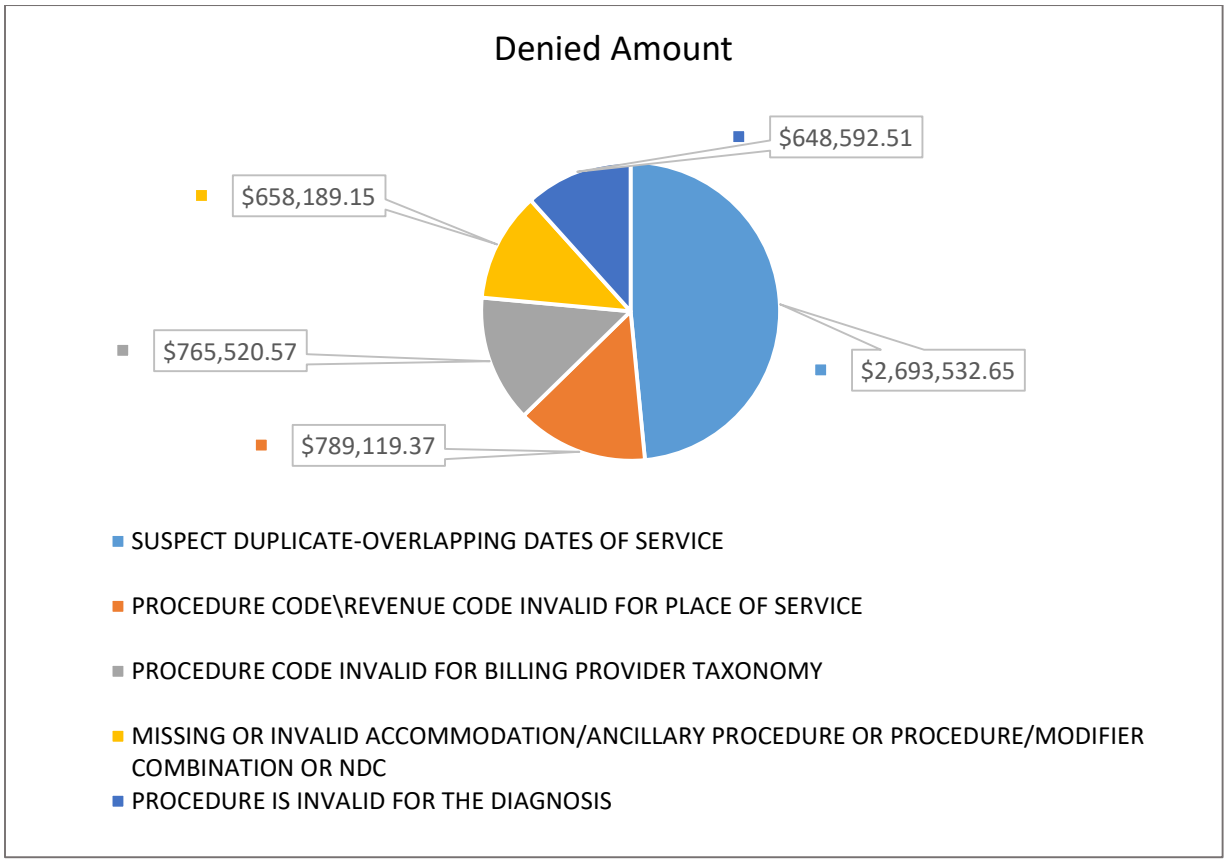


Evaluation of the top denials for Partners' encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis above. Encounters were denied primarily for:

- Suspect Duplicate-Overlapping Dates of Service
- Procedure code/Revenue code invalid for place of service
- Procedure code invalid for billing provider taxonomy
- Missing or invalid accommodation/ancillary procedure or procedure/modifier combination or NDC
- Procedure is invalid for the diagnosis

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





Results and Recommendations

Issue: Other Diagnosis Codes

The principal diagnosis was populated for 100% of the claims. However, less than 20% of all encounter records show at least one, valid Other Diagnosis code. Given that Partners currently reports the maximum number of Diagnosis codes accepted by NCTracks, the low figure suggests that many providers may not be reporting the Other Diagnosis codes. Indeed, a closer examination reveals that some providers never report beyond the Primary/Principal Diagnosis code.

Recommendation:

Partners should continue to perform outreach to providers, with a particular focus on those who never submit the Other Diagnosis codes. This information is key for measuring member health, identifying areas of risk, and evaluating quality of care.

Issue: Procedure Codes

The Procedure code for institutional claims should be populated 99% of the time. For the current review period, we found that 77% of institutional claim line items contained a valid value in the Procedure code field. Our excluded line item charges where the Revenue code is sufficient for defining the service that was rendered.

Resolution:

Overall, there has been a notable improvement in the quality of data as Partners just barely missed meeting the Data Quality Standards threshold target for Procedure codes. Procedure codes were populated 98.76% of the time and in each instance a valid value present. However, when isolating for institutional claims, the figure drops significantly to 77%.

Partners does a great job of denying outpatient institutional claims when certain Revenue codes are submitted without a Procedure code (e.g., Revenue code '0450') A potential gap exists when the patient is first seen in an outpatient department but is later admitted to an inpatient setting. In other cases, Partners indicated that they pay line items that are missing Procedure codes at the RCC rate. While this payment arrangement may be consistent with how providers are contracted, we urge Partners to review requirements to ensure providers are submitting a valid Procedure codes so that services that were rendered can be identified (e.g., submitting a valid Procedure code when billing Revenue code '0250', which suggests a drug was administered but not the specific drug.)

Conclusion

Based on the analysis of Partners' encounter data, it was concluded that the data submitted to NC Medicaid is complete and accurate as defined by CMS and NC Medicaid standards. The validation process found mostly minor issues 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 some of the errors are isolated cases that can be mitigated in the future by reviewing and modifying data validation rules, as necessary. Overall, Partners has shown continued improvement in the quality of encounter data, and this is consistent with the reductions seen in the rate of denials on first time encounter submissions. However, some of the errors noted in this analysis are critical in nature. Therefore, Partners should review and take Corrective Action to resolve the issues identified.

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