2021 External Quality Review

PARTNERS HEALTH MANAGEMENT

Submitted: April 14, 2022

Prepared on behalf of the
North Carolina Medicaid

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EXECUTIVE SUMMARY

The *Balanced Budget Act of 1997* requires State Medicaid Agencies that contract with Prepaid Inpatient Health Plans (PIHPs) to evaluate their compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358 (42 CFR § 438.358)*. This review determines the level of performance demonstrated by the Partners Health Management (Partners). This report contains a description of the process and the results of the 2021 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the North Carolina Medicaid (NC Medicaid).

Goals of the review are to:

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

The 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.

A. Overall Findings

Federal regulations require PIHPs to undergo a review to determine compliance with federal standards set forth in *42 CFR Part 438, Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. Specifically, the requirements related to:

- Coordination and Continuity of Care (*§ 438.208*)
- Coverage and Authorization of Services (*§ 438.210*)
- Provider Selection (*§ 438.214 and § 438.240*)
- Confidentiality (*§ 438.224*)
- Grievance and Appeal Systems (*§ 438, Subpart F*)
- Health Information Systems (*§ 438.242*)
- Quality Assessment and Performance Improvement Program (*§ 438.330)*

Due to the COVID-19 pandemic, CCME implemented a focused review, a decision based on the issuance by the State of the *COVID-19 flexibilities PIHP Contract Amendment #11.* This PIHP contract amendment stated PIHPs "shall be held harmless for any documentation or other PIHP errors identified through the EQR that are not directly related to member health and safety through the Term of the Amendment." The focused review included comprehensive evaluation of the PIHP's health systems capabilities and provider credentialing and recredentialing documentation and processes. The review includes validation of the PIHP's PIPs, PMs, and encounter data. Lastly, a thorough review of the PIHP's Utilization Management (UM), Grievances, and Appeals processes were conducted. What was not reviewed were the PIHP's network adequacy, availability of services, Subcontractual relationships, and Clinical Practice Guidelines (*42 CFR § 438.206, § 438.207, § 438.230, and § 438.236,* respectively*)*.

To access the health plan's compliance with federal regulations and contract, CCME's review was divided into six areas. The following is a high-level summary of the review results for those areas. Additional information regarding the reviews, including strengths, Weaknesses, and Recommendations, are in the narrative of this report.

B. Overall Recommendations

The following provides a global or high-level summary of the status of the Recommendations and Corrective Action items from the 2020 EQR and the findings of the 2021 EQR. Specific Recommendations and Corrective Actions are detailed in each section of this report.

Administration

42 CFR § 438.224 and 42 CFR § 438.242

In the 2020 EQR, Partners met 100% of the Administrative standards, which included the 2020 ISCA review. No Corrective Actions or Recommendations were issued. In the 2021 EQR, Partners again met 100% of the Administrative standards and again no Corrective Actions or Recommendations were issued. Partners has been able to maintain their encounter data acceptance rate of over 99.9% even though there was a 63.2% increase in claims submission due to realignment of Cabarrus, Union, Stanly, Forsyth, and Davie counties to Partners in 2021.

Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

In Partners' 2020 EQR of Credentialing/Recredentialing, there were no items requiring Corrective Action and one Recommendation. In the 2021 EQR, Partners met 100% of the Credentialing/Recredentialing standards. CCME issued a Recommendation to revise the *Credentialing Program Description* and any other documents that reference the Primary

Source Verifications conducted during the credentialing, recredentialing, or monthly monitoring processes to clearly include the *NC DHHS Excluded Provider List*. See *NC Medicaid Contract, Attachment B,* section *1.14.4.*

Quality Improvement

42 CFR § 438.330

In the 2020 EQR, Partners met 100% of the Quality standards and received four Recommendations related to four PIPs that were validated. One Recommendation was implemented and three were not applicable because the corresponding three PIPs were not submitted for the 2021 EQR.

For the 2021 EQR, Partners met all standards with no Corrective Actions. There are three Recommendations regarding the assessment of interventions and consideration for additional interventions to improve PIP rates, which were validated in the High Confidence range. Partners was Fully Compliant for (b) Waiver and (c) Waiver PMs, but one (b) Waiver PM showed a decline in rate compared to the previous measurement year. CCME issued a Recommendation for monitoring to determine if rates with substantial improvement or decline represent trends or anomalies in the PMs.

Utilization Management

42 CFR § 438.208

In the 2020 EQR, Partners initially met 92% of Utilization Management (UM) standards. CCME issued three Corrective Actions and one Recommendation related to the "Partially Met" Care Coordination and Transitions to Community Living (TCL) standards. However, NC Medicaid reviewed the two Corrective Actions issued to Care Coordination and determined no Corrective Action is needed by Partners, as the finding did not relate to enrollee health and safety. The one Corrective Action issued to TCL remained in place. This changed Partners' UM score from 92% to a 96%.

In the 2021 EQR, Partners met 100% of the UM standards. One Recommendation was issued in this year's EQR that related to the *Innovations Member and Family Handbook*. This handbook, which describes the Waiver Cost Limits and the exclusion listed in *NC Medicaid Joint Communications Bulletin #J362,* was developed and published by Partners in the past year. However, information in the handbook Appendices differ from handbook description regarding the Waiver Cost Limits. Additionally, it was found that all counties in Partners catchment area were not listed and did not include the recent addition of Cabarrus, Davie, Forsyth, Stanly, and Union counties.

Grievances and Appeals

42 CFR § 438, Subpart F, 42 CFR 483.430

In the 2020 EQR, Partners met 100% of the Grievance and Appeal standards and received no Corrective Actions and two Recommendations. There was evidence in the 2021 EQR that Partners implemented one of the Recommendations and partially implemented the other Recommendation.

In the 2021 EQR, Partners met 100% of the Grievance and Appeal standards again. The partially implemented Recommendation from the 2020 EQR was to select and define one term for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination" and for Partners to use that one term within Policy and Procedure 6.00U, Grievance Management, the *Member Handbook* and the *Provider Operations Manual*. In the past year, Partners revised the Grievance policy and procedure and *Provider Operations Manual*, which now consistently use the term "Grievance/Complaint." However, the *Member Handbook* continues to contain the terms "Grievance" and "Complaint" interchangeably and the term "Grievance/Complaint" is not used in the *Member Handbook*.

The 2021 Grievance EQR reviewed 10 files from Partners' Medicaid Grievance Log. All files contained timely Acknowledgement and Resolution letters, and the Grievances were resolved within the 90-day time frame required by 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.

The 2021 Appeal EQR reviewed 10 files selected from Partners Appeal Log, from which data were consistent with the data within the Appeal files. All required notifications were issued timely, including written and verbal notifications, and the Chief Medical Officer was consulted on Appeals involving concerns around enrollee health and safety. The 2021 Appeal file review was much improved over the 2020 file review in terms of compliance and the completeness and detail of staff documentation.

Program Integrity

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

In the 2020 EQR, Partners met 100% of the Program Integrity (PI) standards, and there were no Corrective Actions and one Recommendation issued. The 2020 Recommendation addressed the need for staff to ensure the PI case file summary forms were complete and current. There was evidence in the 2021 EQR that Partners implemented this Recommendation.

In the 2021 EQR, Partners again met 100% of the PI standards. No Corrective Actions or Recommendations were issued. In the past year, Partners has worked diligently to keep their PI caseload current to prevent a backlog of investigations. During the Onsite, Partners PI staff described several data-driven initiatives targeting potential fraud, waste, and abuse.

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.

Minor issues with both Institutional and Professional encounters were noted. 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 improvements 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 above are critical data elements as identified by CMS and NC Medicaid. Therefore, Partners should review and take Corrective Action to resolve the issues identified above.

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.

Corrective Actions and Recommendations from Previous EQR

In the 2020 EQR, Partners initially met 99% of the EQR standards. In its review, the State then determined that one of the two standards scored as “Partially Met” should be scored as “Met,” and the Corrective Actions associated with those standards changed to Recommendations. This decision by the State was based on Amendment #11 to the PIHPs’ contract amendment, which provided flexibilities during the COVID-19 pandemic and states, “PIHP shall be held harmless for any documentation or other PIHP errors identified through the EQR that are not directly related to member health and safety through the Term of the Amendment.” This change did not result in different score for the percent of standards met. The remaining standard still scored as “Partially Met” was in UM and the following is a high-level summary of those deficiencies:

- In the 2020 EQR, the TCL file review revealed an enrollee who was actively engaged in services and relocating to a new PIHP catchment was discharged from TCL. The file review showed minimal follow up by Partners to ensure the enrollees needs were met during that transition to a new PIHP. Additionally, the lack of follow up by TCL staff was out of compliance with the *NC Transitions to Community Living Initiative (TCLI) In-Reach and Transition Manual,* which requires multiple notifications from Partners to the new PIHP and the associated county's Department of Social Services. NC Medicaid agreed the file demonstrated a "lack of continuity of care."

- CCME issued a Corrective Action for Partners to enhance their current TCL documentation monitoring plan to include a comprehensive review of the files of enrollee's transferring PIHPs or discharging from Partners. This review should ensure procedural requirements outlined in the *NC Transitions to Community Living Initiative (TCLI) In-Reach and Transition Manual* occur.

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

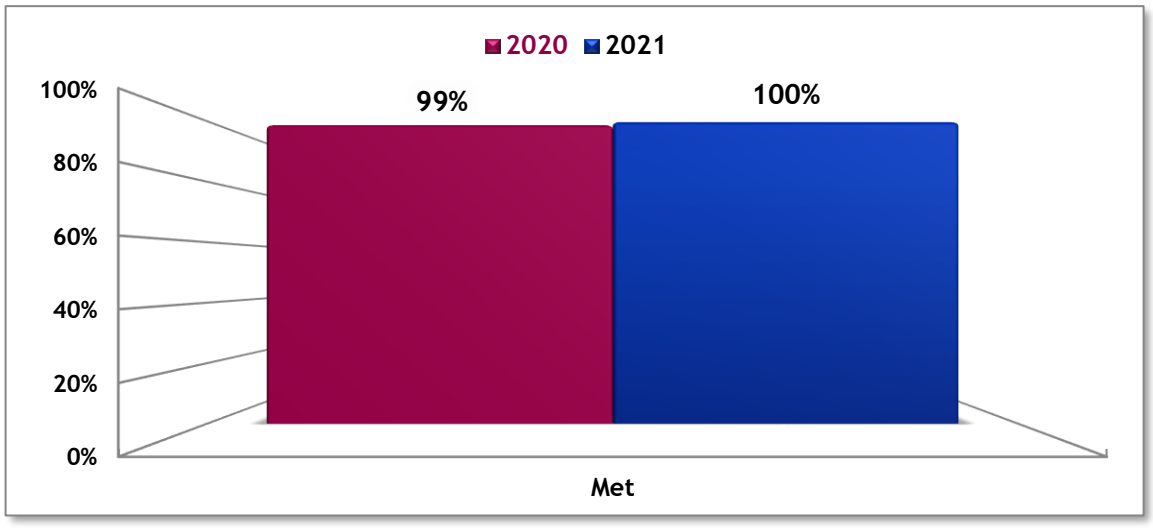
- In the 2021 EQR, the review of TCL files found that files scheduled for discharge followed Partners Policy and Procedure 9.05 and the *NC Transitions to Community Living Initiative (TCLI) In-Reach and Transition Manual*.

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

Conclusions

Overall, Partners has met the requirements set forth in their contract with NC Medicaid. The 2021 Annual EQR shows that Partners has achieved a "Met" score for 100% of the standards reviewed. As the following chart indicates, none of the standards were scored as "Partially Met" or "Not Met." *Figure 1, Annual EQR Comparative Results*, provides an overview of the scoring of the current annual review as compared to the 2020 review findings.

Figure 1: Annual EQR Comparative Results



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

Table 1: Partners' 2021 Overall Strengths, Weaknesses, and Recommendations

	Strengths	Weaknesses	Corrective Actions/ Recommendations
Quality	Partners can capture of up to 25 ICD-10 Diagnosis codes via the Provider web portal and up to 29 ICD-10 Diagnosis codes via the HIPAA files on Institutional claims. Partners can capture 12 ICD-10 Diagnosis codes on Professional claims via both the Provider web portal and HIPAA files.	In comparing the FY2020 to FY2021 rates for (b) Waiver Measures, Follow-up after Hospitalization for Substance Abuse showed substantial improvement in the Detox and Facility Based Crisis (FBC) for 3- and 7-day rates with a 17.6% improvement in the 3 day rate and a 12% improvement in the 7 day rate. For Initiation and Engagement of AODDT, the engagement rate for 18-20 year olds declined 10.5%.	***Recommendation: Continue to monitor (b) Waiver performance measure rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the performance measures.***

	Strengths	Weaknesses	Corrective Actions/ Recommendations
	Partners can submit up to 29 ICD-10 Diagnosis codes on Institutional encounters and up to 12 ICD-10 Diagnosis codes on Professional encounters to NCTracks.	Partners submitted five projects for this 2021 EQR: Opioid Engagement, Initial NC TOPPS Interviews, SUD Initiation and Engagement of Substance Use Members, TCL Housing Loss Reduction, and Registry of Unmet Needs. All five validated PIPs scored in the High Confidence range, although three PIPs had issues.	***Recommendations:*** ***• Initial NC TOPPS Interview: Determine if additional interventions are needed to improve interview rates, assess the impact of other interventions, and determine if continuation is beneficial to initial interview rates.*** ***• TCL Housing Loss Reduction: Continue evaluation of services provided and determine if additional services might be beneficial for I/DD members.*** ***• Registry of Unmet Needs - Percentage of I/DD members in services did not improve in the latest remeasurement. Continue evaluation of services provided and determine if additional services might be beneficial for I/DD members.***
	Partners is piloting KaiNexus, a continuous QI tool that automates some reporting with Performance Improvement Projects. It offers more extensive tools for Quality Improvement.		

	Strengths	Weaknesses	Corrective Actions/ Recommendations
	In the past year, Partners Grievance team has worked to improve the level of detail within the Grievance resolution letters. Staff reported this has decreased the number of 2nd level Grievances.		
	The 2021 Appeal file review was much improved over the 2020 file review. Partners attributes the improvement to the focused Appeals monitoring process and improved detailed documentation in the Appeal files.		
	Partners' Program Integrity Workplan outlines initiatives for the year and provides a blueprint for education, quality assurance activities, and data mining.		
	Partners has implemented a new metrics and reporting data warehouse to improve efforts to identify potential fraud, waste, and/or abuse.		

	Strengths	Weaknesses	Corrective Actions/ Recommendations
Timeliness	In the past year, Partners has worked diligently to keep their Program Integrity investigation caseload current.		
Access to Care		The *Credentialing Program Description* does not clearly state that the *NC DHHS Excluded Provider List* is queried during the credentialing or recredentialing process or as part of monthly monitoring.	***Recommendation: Revise the Credentialing Program Description and any other documents that reference the Primary Source Verifications conducted during the credentialing, recredentialing, or monthly monitoring processes to clearly include the NC DHHS Excluded Provider List. See NC Medicaid Contract, Attachment B, Section 1.14.4.***
		The review of the *Innovations Member and Family Handbook* found that: • Appendix A: Member Responsibility and Appendix H: The Acronym List and Glossary of Words & Terms to Know in this Appendix did not match the Waiver Cost Limits exemptions, as stated on page 22 and page 28 of the handbook. • Cabarrus, Davie, Forsyth, Stanly, and Union counties were not noted to be included in Partners' catchment area.	***Recommendations: Revise the Innovations Member and Family Handbook to provide consistent information regarding NC Innovations Waiver Cost Limits and exceptions. In the manual, include all of the counties within Partners' current catchment area.***

	Strengths	Weaknesses	Corrective Actions/ Recommendations
		In the past three EQRs, CCME issued a Recommendation for Partners to select one term for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination" and to use it consistently in Partners documentation. During the Onsite interview, Partners staff explained they have identified the term "Grievance/Complaint" and subsequently revised documentation. However, the *Member Handbook* continues to contain the terms "Grievance" and "Complaint" interchangeably and the term "Grievance/Complaint" is not used in the *Member Handbook*.	***Recommendations: Revise the Member Handbook to reflect one consistent term for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination."***

METHODOLOGY

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

On January 31, 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 PIHP to participate in a pre-Onsite conference call with CCME and NC Medicaid for purposes of offering Partners an opportunity to seek clarification on the review process and ask questions regarding any of the Desk Materials requested by CCME.

The review consisted of two segments. The first was a Desk Review of materials and documents received from Partners on February 21, 2022 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. Also included in the Desk Review was a review of Credentialing, Grievance, Utilization, Care Coordination, Program Integrity, 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 March 17, 2022 and 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 Partners' Information Technology (IT) staffing patterns. This system analysis is completed as specified in the Centers for Medicaid and Medicare Services (CMS) protocol. During the Onsite, staff presented a member and claims systems review. Questions regarding the ISCA tool were discussed with Partners staff.

In the 2020 EQR, Partners met 100% of the Administrative standards, which included the 2020 ISCA review. No Corrective Actions or Recommendations were issued. In the 2021 EQR, Partners again met 100% of the Administrative standards and again no Corrective Actions or Recommendation were issued.

In the 2021 EQR, the ISCA tool and supporting documentation submitted for this year's EQR outlined Partners' enrollment systems loading processes. This process is clearly defined for enrollment data updates in the AlphaMCS enrollment system. During the 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 downloaded and loaded into the AlphaMCS system by WellSky, which has alerts set up to notify Partners staff of errors that may occur during the GEF file upload process. Partners stated WellSky rarely encountered errors during the GEF file upload. Partners explained they receive a nightly backup of the AlphaMCS to restore to their internal Encounter Data Warehouse (EDW).

During the Onsite, Partners stated they manually update the eligibility data in the AlphaMCS system to inactivate the eligibility of a member when the GEF has incorrect information. Partners stores the Medicaid identification number (ID) received on the GEF. During the Onsite, Partners stated they rarely see members with multiple Medicaid IDs, but are able to research and merge the information into one Partners' unique member ID. The historical claims for the member are also merged into one Member ID. During the Onsite system demonstration, Partners' staff displayed the enrollment information is

viewable and captured within AlphaMCS. Partners' enrollment counts for the past three years is presented in Table 2.

Table 2: Enrollment Counts

2018	2019	2020
149,774	156,412	178,199

Partners' authorizations and claims 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 provided. A demonstration of Partners' Provider web claims entry portal and the AlphaMCS claims processing system was performed during the Onsite.

Partners receives claims from three methods, 837 electronic file, provider web portal and paper claims. During the Onsite, Partners stated they receive paper claims from new providers who have not been set up in AlphaMCS. Table 3 details the percentage of 2020 claims received via the three methods.

Table 3: Percent of claims with 2020 dates of service received via Electronic (HIPAA, Provider Web Portal) or Paper forms.

Source	HIPAA File	Paper	Provider Web Portal
Institutional	85.1%	0.1%	14.8%
Professional	86.9%	0.0%	13.1%

Partners adjudicates claims on a nightly basis. Approximately 95.1% of Professional claims and 95.5% of Institutional claims are auto-adjudicated. Partners can capture up to 25 ICD-10 Diagnosis codes via the provider web portal and up to 29 ICD-10 Diagnosis codes via the HIPAA files for Institutional claims. For Professional claims, the plan has the ability to receive and store up to 12 ICD-10 Diagnosis codes on both the provider web portal and via HIPAA files. Partners captures ICD-10 Procedure codes and Diagnosis Related Group (DRGs), if they are submitted on the claim. Partners confirmed they are able to capture and submit Telehealth modifier codes during the ongoing COVID-19 pandemic.

During the Onsite, Partners stated staff conduct random audits of 3% of Professional claims and approximately 10% of Institutional claims on a daily basis. Partners also conducts focused audits on Coordination of Benefits (COB) and claim overrides. Paper

claims are included in the daily random audit. Partners explained they conduct manual review of Emergency Department (ED) claims and claims in excess of $5,000. A pended claims report is generated daily for a claims processor to review and manually approve or deny claims. Partners also audits new hire claims examiners, and the tasks performed by them are monitored and audited by a claims supervisor. During the Onsite, Partners staff explained they backup their EDW on a nightly basis.

The breakdown of encounter data acceptance/denial rates by claim service detail counts was provided for encounters submitted in 2020. Table 4 provides a comparison of 2019 and 2020 encounter acceptance data.

Table 4: Volume of 2019 and 2020 Submitted Encounter Data

2020	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	78,871	208	139	79,218
Professional	1,300,619	3,920	91	1,304,630
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

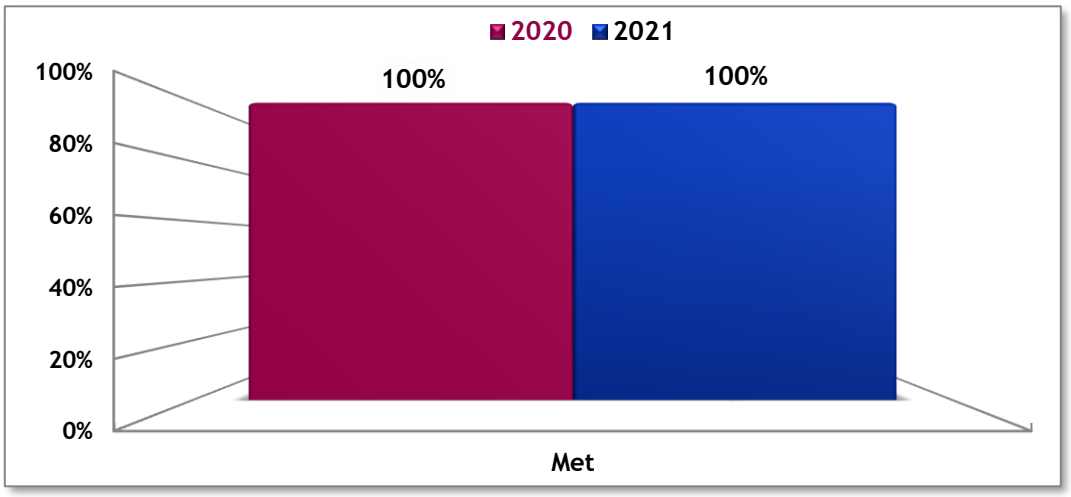
Partners has an 99.9% acceptance rate for both Professional and Institutional encounters with dates of service in 2020. During the Onsite, Partners clarified they encountered challenges due to the COVID-19 pandemic that included the addition of new codes, rate increases, and reprocessing of claims. Partners also stated, due to county realignment, they enrolled members who receive Medicaid or State-funded Services for intellectual or developmental disabilities, mental health or substance abuse disorders from Cabarrus, Union, Stanly, Forsyth, and Davie counties in 2021. Partners was able to maintain their very high encounter data acceptance rate even though there was a 63.2% increase in claim submissions due to the inclusion of the five counties. Partners provided the top two denial reasons for encounters submitted to NCTracks:

- Provider Taxonomy Assignments
- Possible duplicates

On average, Partners submits an encounter within nine days from the time of adjudication to NC Medicaid. It takes approximately 31 days to correct and resubmit an encounter to NC Medicaid. As stated in the ISCA, Partners has 367 Institutional and 884 Professional encounters that are still awaiting resubmission as of February 15, 2022. Partners exceeds the NC Medicaid standards for encounter submissions and has less than 0.1% denial rate of their encounter data submissions. Partners is submitting up to 29 ICD-10 Diagnosis codes for Institutional encounters and up to 12 ICD-10 Diagnosis codes for Professional encounters.

Figure 2 demonstrates Partners met all of the Standards in the 2020 and 2021 EQRs.

Figure 2: Administrative Findings



Strengths

- Partners can capture of up to 25 ICD-10 Diagnosis codes via the provider web portal and up to 29 ICD-10 Diagnosis codes via the HIPAA files on Institutional claims. Partners can capture 12 ICD-10 Diagnosis codes on Professional claims via both the Provider web portal and HIPAA files.

- Partners can submit up to 29 ICD-10 Diagnosis codes on Institutional encounters and up to 12 ICD-10 Diagnosis codes on Professional encounters to NCTracks.

- Partners has been able to maintain their encounter data acceptance rate of over 99.9% even though there was a 63.2% increase in claims submission due to realignment of five counties to Partners in 2021.

B. Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

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*, the *Credentialing Committee Charter,* credentialing/recredentialing files, a sample of Credentialing Committee meeting minutes, and select items on the Partners website. Partners staff provided additional information during an Onsite interview.

In the 2020 EQR, Partners met 100% of the Credentialing/Recredentialing standards, with no identified Weaknesses, Corrective Actions, or Recommendations. In the 2021 EQR, Partners met 100% of the Credentialing/Recredentialing standards and had one Recommendation.

The 2021 Recommendation addresses missing language regarding the *NC DHHS Excluded Provider List*. The *Credentialing Program Description* (*CPD*), the *Credentialing Committee Charter Revised 01/18/22* (*CCC*), Policy and Procedure 8.26U, Provider Credentialing, and Policy and Procedure 8.27, Selection and Retention of Network Providers address the credentialing and recredentialing processes.

The *CPD* does not clearly state that the *NC DHHS Excluded Provider List* is queried during the credentialing or recredentialing process or as part of monthly monitoring. However, the credentialing and recredentialing files submitted for this EQR included Primary Source Verification (PSV) of the *NC DHHS Excluded Provider List*. During the Onsite review, Partners staff confirmed they conduct the monthly query of the *NC DHHS Excluded Provider List* and provided evidence of the queries.

CCME's review of the credentialing and recredentialing files showed they were organized and contained appropriate information. Some items not included in the uploaded materials for Desk Review were provided upon CCME request.

The *CCC* and the *CPD* provide information about the Credentialing Committee, which is composed of Partners employees and "representatives from the Provider community." 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* states the Credentialing Committee "meets at least quarterly" and defines a quorum as "greater than half of the filled positions of the voting membership." The *CCC* indicates the committee meets monthly. During the Onsite, Partners staff verified the committee meets monthly. A quorum was present at the Credentialing Committee meetings for which minutes were submitted for this EQR.

Policy and Procedure 8.13U, Participating Provider Relations Program addresses the training and orientation of new providers, who receive a Welcome Packet, which includes

a Welcome Letter and a seven page *Orientation Toolkit*. The *Provider Orientation Toolkit* states, "the following provides links to forms, manuals and documents that will assist providers in becoming acquainted and conducting business with Partners."

Cabarrus, Union, and Stanly counties realigned from Cardinal Innovations to Partners effective September 1, 2021, and Forsyth and Davie counties realigned from Cardinal Innovations to Partners effective November 1, 2021. Partners provided information sessions, including sessions tailored to specific provider categories such as hospitals, Licensed Independent Practitioners, or for service lines such as Mental Health/Substance Use. Partners also created a "transition" webpage with information for providers and members. Partners subject matter experts attended monthly Open House sessions to help resolve issues and to provide technical assistance. Video recordings of the Member Events and of the Provider Events are posted on the Partners Community Realignment webpage.

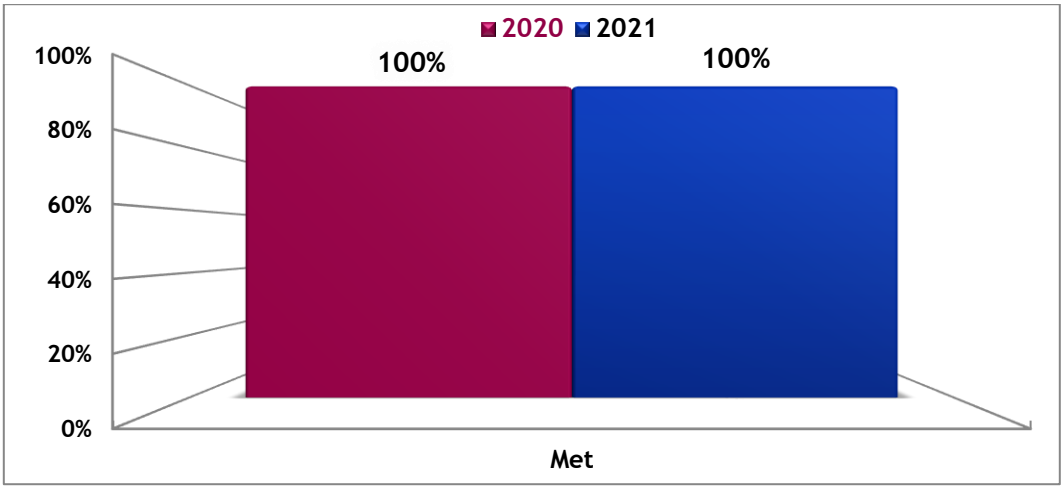
The COVID-19 flexibilities outlined in *NC Medicaid Contract Amendment #9* included a delay for the annual *Network Adequacy and Accessibility Analysis* (Gaps Analysis) report. NC DHHS notified PIHPs in January 2021 to submit the *SFY 2020 and 2021 Network Adequacy and Accessibility Analysis* by July 1, 2021, "although we will consult with the LME-MCOs if this date needs to be extended based on the evolving state of the COVID-19 pandemic. LME-MCOs are required to complete the 2020 analysis for Medicaid in its entirety."

At the last EQR, Partners' staff reported their continued assessment revealed the Substance Abuse Comprehensive Outpatient Treatment (SACOT) gap was eliminated but additional gaps for both State-funded and Medicaid-funded services were identified and "efforts to address the gaps are under way." Partners' *Network Adequacy and Accessibility Analysis 2020-2021* includes "a combination of data reflecting calendar years 2019 and 2020" and identifies gaps in access/choice for Medicaid-funded Partial Hospitalization (PH), Facility-Based Crisis-Child, Non-Hospital Detox, and Psychiatric Residential Treatment Facility (PRTF). The report attributes the gaps in PH, Non-Hospital Detox, and PRTF to "updated access and choice specifications in January 2020." Partners filed *Exception Requests* for these services.

During the Onsite interview, Partners staff reported progress on meeting the identified gaps, noting that the choice/access gaps for Facility-Based Crisis-Child and PRTF have been resolved. One additional provider is needed for Non-Hospital Detox. The gap had been met for Partial Hospital, but one provider "dropped" and has not yet been replaced, resulting in a gap again. It is of note that Partners reported the realignment of the five counties from Cardinal Innovations to Partners did not add any service gap.

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

Figure 3: Provider Services Comparative Findings



Strengths

- Partners held information sessions and other events for providers and for members in counties realigning from Cardinal Innovations and developed a transition webpage with information for those providers and members.
- 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.
- Credentialing and recredentialing files are well-organized and contain appropriate documentation.

Weaknesses

- The *Credentialing Program Description* does not clearly state that the *NC DHHS Excluded Provider List* is queried during the credentialing or recredentialing process or as part of monthly monitoring.

Recommendation

- Revise the *Credentialing Program Description* and any other documents that reference the Primary Source Verifications conducted during the credentialing, recredentialing, or monthly monitoring processes to clearly include the *NC DHHS Excluded Provider List*. See *NC Medicaid Contract, Attachment B, Section 1.14.4.*

C. Quality Improvement

42 CFR § 438.330

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

In the 2020 EQR, five PIPs were validated: 7 Day Follow-Up SUD, ED Utilization Reduction, MH 7-Day Follow Up, PCP Referrals to Behavioral Health, and TCL Housing Loss Reduction. All PIPs scored in the high confidence range and no Corrective Actions were issued. There were four Recommendations from the review. Table 5 displays the Project, Recommendations, and information about whether the Recommendation was implemented (if applicable). Of the four PIPs with a Recommendation in 2020, only one PIP was submitted for the 2021 EQR. The Recommendation was implemented for that PIP (TCL Housing Loss Reduction).

Table 5: 2020 PIP Recommendations

Project(s)	Recommendation	Recommendation Implemented in 2021 (Y/N/NA)
Promoting follow up within 7 days for mental health treatment- Clinical	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.	N/A
Promoting follow up within 7 days for SUD treatment- Clinical	Update report so that results in Table and Graph are matched.	N/A
Reducing ED utilization of active members-Clinical	Include annotations on the report to allow the reader to know the benchmark/final target rate and the short-term goal rate.	N/A
TCL Housing Loss Reduction- Non Clinical	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.	Y

N/A: PIP no longer active/not submitted for current review cycle

Performance Measure Validation

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

Table 6: (b) Waiver Measures

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

Table 7: (c) Waiver Measures

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

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

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

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

(b) Waiver Measures Reported Results

These measures' rates as reported by Partners for FY 2020 and FY 2021 are included in the table that follows. In comparing the FY2020 to FY2021 rates, Follow-up after Hospitalization for Substance Abuse showed substantial improvement in the Detox and Facility Based Crisis (FBC) for 3- and 7-day rates with a 17.6% improvement in the 3-day rate and a 12% improvement in the 7-day rate. For Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (AODDT), the engagement rate for 18-20 year olds declined 10.5%.

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

30-day Readmission Rates for Mental Health	FY 2020	FY 2021	Change
Inpatient (Community Hospital Only)	12.4%	10.9%	-1.50%
Inpatient (State Hospital Only)	0.0%	0.0%	0.00%
Inpatient (Community and State Hospital Combined)	12.7%	11.2%	-1.50%
Facility Based Crisis	10.0%	6.1%	-3.90%
Psychiatric Residential Treatment Facility (PRTF)	11.8%	9.5%	-2.30%
Combined (includes cross-overs between services)	14.6%	12.0%	-2.60%

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

30-day Readmission Rates for Substance Abuse	FY 2020	FY 2021	Change
Inpatient (Community Hospital Only)	19.5%	13.5%	-6.00%
Inpatient (State Hospital Only)	2.6%	4.3%	1.70%
Inpatient (Community and State Hospital Combined)	17.8%	14.1%	-3.70%
Detox/Facility Based Crisis	6.1%	6.8%	0.70%
Combined (includes cross-overs between services)	16.2%	14.0%	-2.20%

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

Follow-up after Hospitalization for Mental Illness	FY 2020	FY 2021	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	38.5%	42.2%	3.70%
Percent Received Outpatient Visit Within 30 Days	54.7%	57.8%	3.10%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	92.6%	92.6%	0.00%
Percent Received Outpatient Visit Within 30 Days	96.3%	96.3%	0.00%
PRTF			
Percent Received Outpatient Visit Within 7 Days	33.3%	38.3%	5.00%
Percent Received Outpatient Visit Within 30 Days	62.5%	66.0%	3.50%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	40.0%	42.8%	2.80%
Percent Received Outpatient Visit Within 30 Days	56.1%	58.6%	2.50%

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

Follow-up after Hospitalization for Substance Abuse	FY 2020	FY 2021	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	19.1%	19.8%	0.70%
Percent Received Outpatient Visit Within 30 Days	28.9%	32.2%	3.30%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	49.1%	66.7%	17.60%
Percent Received Outpatient Visit Within 7 Days	54.7%	66.7%	12.00%
Percent Received Outpatient Visit Within 30 Days	66.0%	68.8%	2.80%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	26.7%	28.6%	1.90%
Percent Received Outpatient Visit Within 30 Days	36.8%	39.1%	2.30%

*NR = Denominator is equal to zero.

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2020	FY 2021	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	51.3%	41.4%	-9.90%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	36.0%	26.5%	-9.50%
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	45.3%	38.7%	-6.60%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	30.9%	20.4%	**-10.50%**
Ages 21–34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	54.8%	53.2%	-1.60%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	42.9%	39.0%	-3.90%
Ages 35–64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	50.3%	45.9%	-4.40%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	35.8%	31.6%	-4.20%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	28.6%	30.9%	2.30%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	20.8%	13.6%	-7.20%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	50.8%	47.3%	-3.50%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	37.3%	32.7%	-4.60%

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

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3–12	Male	9.5	0.2	-0.1	33.9	28.8	-5.1
	Female	0.2	0.3	0.1	14.0	15.8	1.8
	Total	0.3	0.2	-0.1	24.3	21.2	-3.1
13–17	Male	1.1	1.0	-0.1	38.5	47.5	9.0
	Female	2.0	2.5	0.5	21.3	19.9	-1.4
	Total	1.6	1.8	0.2	27.7	28.1	0.4
18–20	Male	2.0	1.2	-0.8	6.6	7.5	0.9
	Female	1.8	1.6	-0.2	10.5	5.9	-4.6
	Total	1.9	1.4	-0.5	8.5	6.6	-1.9
21–34	Male	4.6	3.0	-1.6	7.2	8.1	0.9
	Female	1.8	1.5	-0.3	6.9	8.3	1.4
	Total	2.4	1.9	-0.5	7.0	8.3	1.3
35–64	Male	3.7	2.9	-0.8	7.7	8.5	0.8
	Female	2.7	2.1	-0.6	8.0	8.2	0.2
	Total	3.1	2.4	-0.7	7.9	8.3	0.4
65+	Male	0.8	0.4	-0.4	10.6	22.5	11.9
	Female	0.6	0.3	-0.3	12.0	14.2	2.2
	Total	0.6	0.3	-0.3	11.5	17.2	5.7
Unknown	Male	0.0	0.0	0.0	0.0	0.0	0.0
	Female	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0
Total	**Male**	**1.5**	**1.1**	**-0.4**	**13.9**	**16.6**	**2.7**
	Female	**1.4**	**1.3**	**-0.1**	**11.1**	**11.7**	**0.6**
	Total	**1.4**	**1.2**	**-0.2**	**12.3**	**13.6**	**1.3**

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

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3-12	Male	14.74%	11.90%	-2.84%	0.10%	0.06%	-0.04%	0.53%	0.37%	-0.16%	14.66%	11.79%	-2.87%
	Female	11.75%	10.32%	-1.43%	0.04%	0.03%	-0.01%	0.18%	0.10%	-0.08%	11.70%	10.29%	-1.41%
	Total	13.28%	11.13%	-2.15%	0.07%	0.05%	-0.02%	0.36%	0.24%	-0.12%	13.22%	11.06%	-2.16%
13-17	Male	16.79%	15.08%	-1.71%	0.47%	0.26%	-0.21%	0.81%	0.57%	-0.24%	16.61%	14.96%	-1.65%
	Female	20.73%	21.12%	0.39%	0.42%	0.37%	-0.05%	0.32%	0.33%	0.01%	20.68%	21.06%	0.38%
	Total	18.72%	18.05%	-0.67%	0.45%	0.32%	-0.13%	0.57%	0.45%	-0.12%	18.60%	17.96%	-0.64%
18-20	Male	11.10%	9.06%	-2.04%	0.19%	0.05%	-0.14%	0.14%	0.05%	-0.09%	11.08%	9.06%	-2.02%
	Female	13.66%	12.91%	-0.75%	0.11%	0.10%	-0.01%	0.05%	0.03%	-0.02%	13.64%	12.91%	-0.73%
	Total	12.44%	11.06%	-1.38%	0.15%	0.07%	-0.08%	0.09%	0.04%	-0.05%	12.42%	11.06%	-1.36%
21-34	Male	26.45%	20.41%	-6.04%	0.74%	0.22%	-0.52%	0.15%	0.12%	-0.03%	26.45%	20.39%	-6.06%
	Female	20.63%	16.94%	-3.69%	0.20%	0.14%	-0.06%	0.14%	0.10%	-0.04%	20.62%	16.94%	-3.68%
	Total	22.00%	17.74%	-4.26%	0.33%	0.16%	-0.17%	0.14%	0.11%	-0.03%	21.99%	17.73%	-4.26%

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Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
35-64	Male	23.33%	19.94%	-3.39%	0.19%	0.20%	0.01%	0.15%	0.11%	-0.04%	23.32%	19.94%	-3.38%
	Female	28.17%	23.69%	-4.48%	0.21%	0.17%	-0.04%	0.19%	0.13%	-0.06%	28.16%	23.68%	-4.48%
	Total	26.33%	22.29%	-4.04%	0.20%	0.18%	-0.02%	0.18%	0.12%	-0.06%	26.32%	22.29%	-4.03%
65+	Male	8.13%	7.70%	-0.43%	0.02%	0.00%	-0.02%	0.00%	0.02%	0.02%	8.13%	7.70%	-0.43%
	Female	8.79%	8.25%	-0.54%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%	8.79%	8.25%	-0.54%
	Total	8.59%	8.07%	-0.52%	0.01%	0.00%	-0.01%	0.01%	0.01%	0.00%	8.59%	8.07%	-0.52%
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**	**16.75%**	**14.06%**	**-2.69%**	**0.23%**	**0.13%**	**-0.10%**	**0.43%**	**0.29%**	**-0.14%**	**16.68%**	**13.99%**	**-2.69%**
	Female	**17.84%**	**15.94%**	**-1.90%**	**0.16%**	**0.13%**	**-0.03%**	**0.17%**	**0.12%**	**-0.05%**	**17.81%**	**15.92%**	**-1.89%**
	Total	**17.37%**	**15.14%**	**-2.23%**	**0.19%**	**0.13%**	**-0.06%**	**0.28%**	**0.20%**	**-0.08%**	**17.33%**	**15.10%**	**-2.23%**

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

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3–12	Male	0.04%	0.02%	-0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.04%	0.02%	-0.02%
	Female	0.02%	0.04%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.04%	0.02%
	Total	0.03%	0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%	0.03%	0.00%
13–17	Male	1.12%	0.89%	-0.23%	0.05%	0.00%	-0.05%	0.12%	0.12%	0.00%	1.02%	0.82%	-0.20%
	Female	0.61%	0.71%	0.10%	0.02%	0.01%	-0.01%	0.02%	0.02%	0.00%	0.60%	0.70%	0.10%
	Total	0.87%	0.80%	-0.07%	0.03%	0.01%	-0.02%	0.07%	0.07%	0.00%	0.82%	0.76%	-0.06%
18–20	Male	2.58%	1.85%	-0.73%	0.19%	0.11%	-0.08%	0.23%	0.09%	-0.14%	2.53%	1.83%	-0.70%
	Female	2.02%	1.71%	-0.31%	0.16%	0.14%	-0.02%	0.27%	0.14%	-0.13%	1.93%	1.70%	-0.23%
	Total	2.29%	1.78%	-0.51%	0.18%	0.12%	-0.06%	0.25%	0.12%	-0.13%	2.21%	1.76%	-0.45%
21–34	Male	9.04%	7.11%	-1.93%	0.76%	0.58%	-0.18%	1.06%	0.63%	-0.43%	8.74%	6.96%	-1.78%
	Female	8.05%	6.42%	-1.63%	0.60%	0.44%	-0.16%	1.13%	0.79%	-0.34%	7.82%	6.33%	-1.49%
	Total	8.28%	6.58%	-1.70%	0.64%	0.48%	-0.16%	1.11%	0.76%	-0.35%	8.04%	6.47%	-1.57%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
35–64	Male	7.92%	7.20%	-0.72%	0.58%	0.56%	-0.02%	0.77%	0.41%	-0.36%	7.72%	7.18%	-0.54%
	Female	7.21%	6.02%	-1.19%	0.39%	0.39%	0.00%	0.75%	0.52%	-0.23%	7.06%	5.90%	-1.16%
	Total	7.48%	6.46%	-1.02%	0.46%	0.46%	0.00%	0.76%	0.48%	-0.28%	7.32%	6.38%	-0.94%
65+	Male	1.16%	0.97%	-0.19%	0.04%	0.06%	0.02%	0.07%	0.06%	-0.01%	1.11%	0.93%	-0.18%
	Female	0.44%	0.25%	-0.19%	0.02%	0.01%	-0.01%	0.00%	0.02%	0.02%	0.44%	0.23%	-0.21%
	Total	0.66%	0.48%	-0.18%	0.03%	0.03%	0.00%	0.02%	0.03%	0.01%	0.64%	0.45%	-0.19%
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**	**2.53%**	**2.21%**	**-0.32%**	**0.18%**	**0.16%**	**-0.02%**	**0.26%**	**0.16%**	**-0.10%**	**2.45%**	**2.18%**	**-0.27%**
	Female	**3.18%**	**2.79%**	**-0.39%**	**0.20%**	**0.18%**	**-0.02%**	**0.37%**	**0.28%**	**-0.09%**	**3.10%**	**2.74%**	**-0.36%**
	Total	**2.90%**	**2.54%**	**-0.36%**	**0.19%**	**0.17%**	**-0.02%**	**0.32%**	**0.23%**	**-0.09%**	**2.82%**	**2.50**	**-0.32%**

Table 16: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	3-12			13-17			18-20			21-34		
Burke	0.02%	0.02%	0.00%	0.93%	1.05%	0.12%	2.21%	2.00%	-0.21%	7.94%	7.48%	-0.46%
Catawba	0.02%	0.01%	-0.01%	0.71%	1.10%	0.39%	2.23%	2.12%	-0.11%	6.35%	5.93%	-0.42%
Cleveland	0.03%	0.05%	0.02%	0.68%	0.68%	0.00%	1.76%	1.96%	0.20%	6.02%	6.39%	0.37%
Gaston	0.01%	0.04%	0.03%	1.10%	1.21%	0.11%	2.22%	1.90%	-0.32%	6.47%	6.02%	-0.45%
Iredell	0.04%	0.00%	-0.04%	0.68%	0.46%	-0.22%	2.08%	1.86%	-0.22%	5.15%	5.38%	0.23%
Lincoln	0.04%	0.04%	0.00%	1.32%	0.84%	-0.48%	2.90%	2.72%	-0.18%	8.63%	8.80%	0.17%
Rutherford	0.00%	0.04%	0.04%	0.34%	0.89%	0.55%	1.29%	2.97%	1.68%	5.62%	6.92%	1.30%
Surry	0.04%	0.00%	-0.04%	0.53%	0.38%	-0.15%	1.89%	1.45%	-0.44%	6.36%	6.61%	0.25%
Yadkin	0.04%	0.00%	-0.04%	0.84%	0.56%	-0.28%	1.96%	2.17%	0.21%	6.54%	7.47%	0.93%
	35-64			65+			Unknown			Total		
Burke	7.76%	7.63%	-0.13%	0.96%	0.81%	-0.15%	0.00%	0.00%	0.00%	3.07%	3.04%	-0.03%
Catawba	7.78%	7.42%	-0.36%	0.73%	0.88%	0.15%	0.00%	0.00%	0.00%	2.66%	2.64%	-0.02%
Cleveland	6.78%	7.40%	0.62%	1.02%	0.98%	-0.04%	0.00%	0.00%	0.00%	2.73%	2.92%	0.19%
Gaston	8.59%	8.08%	-0.51%	1.13%	0.80%	-0.33%	0.00%	0.00%	0.00%	3.10%	2.91%	-0.19%
Iredell	6.58%	6.07%	-0.51%	0.21%	0.48%	0.27%	0.00%	0.00%	0.00%	2.26%	2.19%	-0.07%
Lincoln	7.81%	8.77%	0.96%	0.52%	0.61%	0.09%	0.00%	0.00%	0.00%	3.30%	3.47%	0.17%
Rutherford	6.15%	6.10%	-0.05%	0.69%	0.75%	0.06%	0.00%	0.00%	0.00%	2.43%	2.82%	0.39%
Surry	4.85%	5.51%	0.66%	0.58%	0.47%	-0.11%	0.00%	0.00%	0.00%	2.14%	2.25%	0.11%
Yadkin	7.64%	6.97%	-0.67%	0.88%	0.60%	-0.28%	0.00%	0.00%	0.00%	2.64%	2.55%	-0.09%

Table 17: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	FY2020	FY2021	Change	FY2020	FY2021	Change	FY2020	FY2021	Change	FY2020	FY2021	Change
	3-12			13-17			18-20			21-34		
Burke	10.95%	8.84%	-2.11%	16.82%	15.99%	-0.83%	10.14%	9.99%	-0.15%	13.95%	12.56%	-1.39%
Catawba	10.31%	8.74%	-1.57%	17.71%	17.47%	-0.24%	12.22%	11.80%	-0.42%	12.59%	13.04%	0.45%
Cleveland	10.92%	9.83%	-1.09%	16.69%	17.66%	0.97%	10.25%	13.26%	3.01%	15.64%	16.27%	0.63%
Gaston	11.05%	9.46%	-1.59%	19.57%	19.06%	-0.51%	13.31%	13.39%	0.08%	14.99%	15.25%	0.26%
Iredell	9.40%	9.33%	-0.07%	18.06%	18.41%	0.35%	10.49%	13.43%	2.94%	12.00%	13.58%	1.58%
Lincoln	13.25%	11.70%	-1.55%	22.41%	22.14%	-0.27%	12.71%	15.07%	2.36%	14.97%	15.82%	0.85%
Rutherford	10.22%	9.38%	-0.84%	16.56%	17.43%	0.87%	10.15%	11.31%	1.16%	15.07%	16.91%	1.84%
Surry	9.33%	9.92%	0.59%	14.37%	16.72%	2.35%	9.30%	9.27%	-0.03%	12.07%	13.59%	1.52%
Yadkin	9.13%	10.11%	0.98%	16.01%	16.28%	0.27%	9.00%	14.31%	5.31%	11.11%	12.30%	1.19%
	35-64			65+			Unknown			Total		
Burke	20.74%	19.85%	-0.89%	9.93%	11.08%	1.15%	0.00%	0.00%	0.00%	14.05%	12.97%	-1.08%
Catawba	20.98%	19.68%	-1.30%	10.54%	10.57%	0.03%	0.00%	0.00%	0.00%	13.89%	13.10%	-0.79%
Cleveland	21.46%	22.07%	0.61%	11.11%	11.07%	-0.04%	0.00%	0.00%	0.00%	14.72%	14.93%	0.21%
Gaston	25.57%	23.80%	-1.77%	11.69%	11.57%	-0.12%	0.00%	0.00%	0.00%	16.03%	15.07%	-0.96%
Iredell	17.14%	16.37%	-0.77%	9.87%	8.37%	-1.50%	0.00%	0.00%	0.00%	12.66%	12.98%	0.32%
Lincoln	22.42%	22.15%	-0.27%	12.79%	12.74%	-0.05%	0.00%	0.00%	0.00%	16.68%	16.36%	-0.32%
Rutherford	20.73%	19.77%	-0.96%	10.39%	13.78%	3.39%	0.00%	0.00%	0.00%	14.23%	14.53%	0.30%
Surry	14.89%	16.12%	1.23%	9.60%	9.81%	0.21%	0.00%	0.00%	0.00%	11.62%	12.67%	1.05%
Yadkin	16.01%	16.33%	0.32%	5.69%	5.69%	0.00%	0.00%	0.00%	0.00%	11.36%	12.35%	0.99%

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

Table 18: (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 19: (c) Waiver Measures Reported Results 2020 - 2021*. Documentation on data sources, data validation, source code, and calculated rate for the five measures was provided. All measures were above the 85% State benchmark rate.

Table 19: (c) Waiver Measures Reported Results 2020-2021

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D10 CC	Annually	377/377 = 100%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D11	Annually	1080/1080 = 100%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	85/93 = 91.4%	85%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	91/91 = 97.9%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G9	Quarterly	93/93 = 100%	85%

** Latest reported rates are shown in Table from Excel file "Innovations Q4 Apr-Jun 2021"*

(c) Waiver Validation

All (c) Waiver Measures met the validation requirements and were Fully Compliant as shown in *Table 20, (c) Waiver Performance Measure Validation Scores*. The validation worksheets offer detailed information on validation and calculation steps for (c) Waiver Measures.

Table 20: C Waiver Performance Measures Validation Scores

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

Performance Improvement Project (PIP) Validation

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

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

PIP Validation Results

For the 2020 review, there were nine PIPs submitted and five validated. All PIPs scored in the High Confidence range. For the 2021 EQR, five PIPS were submitted and validated: Opioid Engagement, Initial NC TOPPS Interviews, SUD Initiate and Engagement, TCL Housing Loss Reduction, and Registry of Unmet Needs Engagement. The validation was conducted using *the CMS Protocol 1: Validating Performance Improvement Projects*. Only the TCL Housing Loss Reduction PIP from the current submission was also validated last year.

Table 21: PIP Summary of Validation Scores

Project Type	Project	2020 Validation Score	2021 Validation Score
Clinical	**Opioid Engagement**	Not Validated	79/79 = 100% High Confidence in Reported Results
	SUD Initiation and Engagement	Not Validated	79/79 = 100% High Confidence in Reported Results
	Registry of Unmet Needs Services	Not Validated	73/74 = 99% High Confidence in Reported Results
Non Clinical	**Initial NC TOPPS Interviews**	Not Validated	73/74 = 99% High Confidence in Reported Results
	TCL Housing Loss Reduction	73/74 = 99% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results

Table 22 displays the PIP project title and interventions reported by Partners for the current review year aimed at improving PIP outcomes.

Table 22: 2021 Review PIP Interventions

Project(s)	Interventions
Opioid Engagement	Transportation program, value-based contracting, provider training, member incentives, peer support services, office based Opioid Treatment centers, provider brainstorming meetings
SUD Initiation and Engagement	Value-based contracts, provider training, housing initiative, provider specific data-reporting, recovery support services.
Registry of Unmet Needs Services	Long term community supports, community living and supports, day supports, in-home skills building
Initial NC TOPPS Interviews	Provider scorecards, provider meetings, webinars, distribution list
TCL Housing Loss Reduction	Monthly visits, service provider discussions, lack of resource identification, communication, and outreach with members

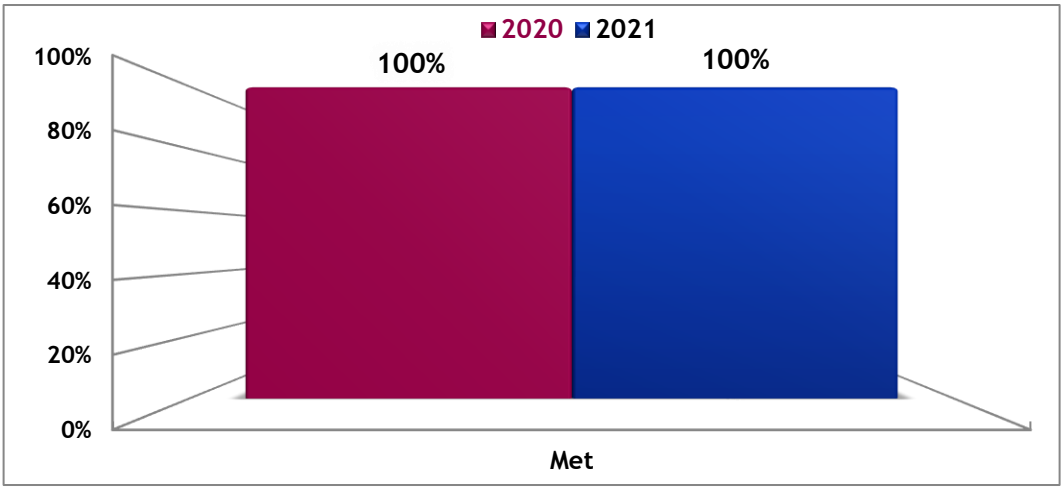
There are no Corrective Actions for the validated PIPS. For three of five PIPs, there are Recommendations for revising interventions to address outcomes that showed a decline in the most recent remeasurement period. The Project, Section, Reason, and Recommendations are displayed in Table 23 below.

Table 23: 2021 Performance Improvement Project Recommendations

Project	Section	Reason	Recommendations
Initial NC TOPPS Interview	Was there any documented, quantitative improvement in processes or outcomes of care?	The Medicaid rate declined from 50.7% in Aug 21 to 25% in Sept 21. The IPRS/State rate declined from 66.7% to 37.9% in Sept 21. The goal is 80%.	Determine if additional interventions are needed to improve interview rates; assess the impact of other interventions and determine if continuation is beneficial to initial interview rates.
TCL Housing Loss Reduction	Was there any documented, quantitative improvement in processes or outcomes of care?	The number who lost housing increased and the percentage rehoused declined.	Continue evaluation of services provided and determine if additional services might be beneficial for I/DD members
Registry of Unmet Needs	Was there any documented, quantitative improvement in processes or outcomes of care?	The percentage of I/DD members engaged in services declined in the most recent remeasurement from 46% to 43%. The goal is 55%.	Continue evaluation of services provided and determine if additional services might be beneficial for I/DD members.

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 the QI standards in the 2021 EQR.

Figure 4: Quality Improvement Comparative Findings



Strengths

- Partners has two staff who applied and were selected for the Disparities Leadership Program, a year-long executive education program that helps members develop strategies to eliminate ethnic and racial disparities. Partners is the only PIHP participating in this program.
- Partners is piloting KaiNexus, a continuous QI tool that automates some reporting with PIPs. It offers more extensive tools for QI.
- Partners is developing a Lean Six Sigma footprint in the organization and expanding that skill set in the organization.

Weaknesses

- The (b) Waiver measure validation noted substantial decline for Initiation and Engagement of AODDT, the engagement rate for 18-20 year olds declined 10.5%.
- TCL Housing Loss Reduction PIP rates declined, which does not indicate improvement.
- Engagement in services for I/DD members on the Registry of Unmet Needs did not improve in the latest remeasurement.
- Initial NC TOPPS Interview rates declined for Medicaid and IPRS/State rates.

Recommendations

- Continue to monitor (b) Waiver performance measure rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the performance measures.
- Initial NC TOPPS Interview: Determine if additional interventions are needed to improve interview rates, assess the impact of other interventions, and determine if continuation is beneficial to initial interview rates.
- TCL Housing Loss Reduction: Continue evaluation of services provided and determine if additional services might be beneficial for I/DD members.
- Registry of Unmet Needs: Percentage of I/DD members in services did not improve in the latest remeasurement. Continue evaluation of services provided and determine if additional services might be beneficial for I/DD members.

D. Utilization Management

42 CFR § 438.208

The EQR of Utilization Management (UM) included a review of the Care Coordination and Transition to Community Living (TCL) programs. CCME reviewed relevant policies and procedures, Partners' Organizational Chart, the *Member Handbook, the Innovations Member and Family Handbook,* and 11 files of enrollees participating in mental health/substance use (MH/SU), Intellectual/Developmental Disability (I/DD), and TCL Care Coordination.

In the 2020 EQR, Partners initially met 92% of UM standards. CCME issued three Corrective Actions and one Recommendation related to the "Partially Met" Care Coordination and TCL standards. However, NC Medicaid reviewed the two Corrective Actions issued to Care Coordination and determined no Corrective Action is needed by Partners, as the finding did not relate to enrollee health and safety. The one Corrective Action issued to TCL remained in place. This changed Partners' UM score from 92% to a 96%. The three Recommendations and one Corrective Action is outlined in Table 24.

Table 24: 2020 EQR Utilization Management Findings

2020 EQR Utilization Management findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Provide follow-up activities for Enrollees	***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.***	**Y**
2021 EQR Follow up: In the 2021 EQR, the review of Policy and Procedure 9.05, the *MHSU Program Description*, and the *TCLI How-to Manual* found that Partners addressed the Recommendation by adding the process for transferring enrollees to a new PIHP.		
The PIHP applies the Care Coordination policies and procedures as formulated.	***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.*** ***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.***	**Y**
2021 EQR Follow up: Partners updated the monitoring requirements to ensure a comprehensive review of Care Management documentation is conducted for enrollees discharging or transferring from TCL. Partners also revised their *Comprehensive Case Record Review Checklist* to ensure Care Coordination documentation is complete and compliant.		

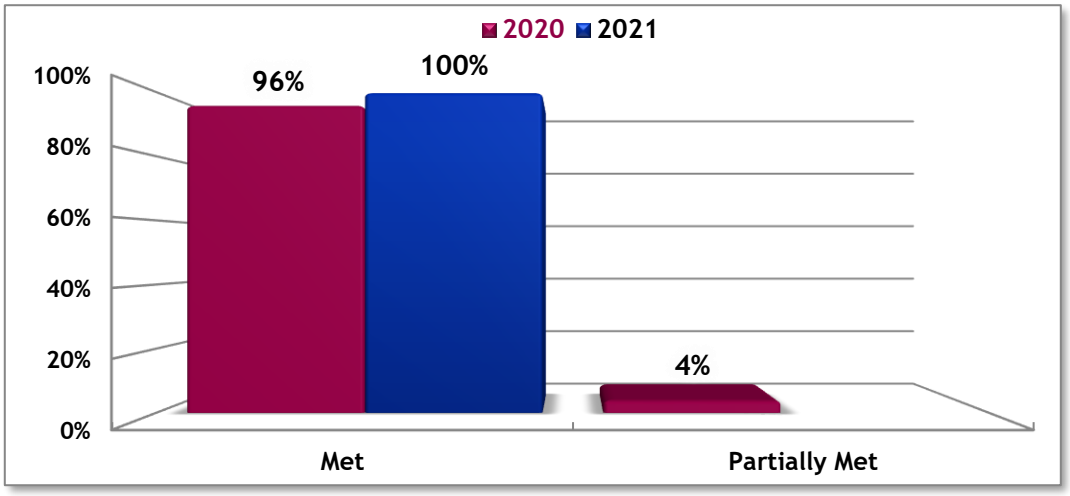
2020 EQR Utilization Management findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
A review of files demonstrates the PIHP is following appropriate TCL policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	***Corrective Action: Enhance the current monitoring plan to include a comprehensive review of files scheduled for discharge from TCL 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.***	**Y**
2021 EQR Follow up: In the 2021 EQR, the review of TCL files found that files scheduled for discharge followed Partners Policy and Procedure 9.05, and the *NC Transitions to Community Living Initiative (TCLI) In-Reach and Transition Manual*		

In the 2021 EQR, Partners met 100% of the UM standards. One Recommendation was issued in this year's EQR and relates to the *Innovations Member and Family Handbook*. This handbook was developed and published by Partners in the past year. The handbook describes the Waiver Cost Limits and the exclusion listed in *NC Medicaid Joint Communications Bulletin #J362*. However, information in the handbook Appendices differ from handbook description, regarding the Waiver Cost Limits. Additionally, it was also found that all counties in Partners catchment area were not listed. The handbook did not include the recent addition of Cabarrus, Davie, Forsyth, Stanly, and Union counties. CCME recommends that Partners review and revise the *Innovations Member and Family Handbook* to ensure that information is accurate and consistent and that it includes all counties within the Partners' catchment area.

The review of MH/SU, I/DD, and TCL files showed improvement in the quality, accuracy, and completeness of Care Coordination documentation when compared to the previous EQR. It was identified that Partners was compliant with the monitoring, engagement, and discharge requirements as outlined in Partners' policies and procedures and *NC Medicaid Contract*.

Figure 5 shows 100% of the UM standards were scored as "Met" and provides an overview of 2021 scores compared to the 2020 EQR UM score.

Figure 5: Utilization Management Comparative Findings



Strengths

- Partners showed significant improvement in the quality, accuracy, and completeness of Care Coordination and TCL documentation when compared to the file review from the previous EQR.

Weaknesses

- The *Innovations Member and Family Handbook* does not consistently include exemptions to NC Innovations Waiver Cost Limits, and it does not list all counties included in Partners catchment area.

Recommendations

- Revise the *Innovations Member and Family Handbook* to provide consistent information regarding NC Innovations Waiver Cost Limits and exceptions. Include in the manual all of the counties within Partners' current catchment area.

E. Grievances and Appeals

42 CFR § 438, Subpart F

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

In the 2020 EQR, Partners met 100% of the Grievance and Appeal standards and received no Corrective Actions and two Recommendations. Follow up to the 2020 EQR Grievance

and Appeal Recommendations is noted in Table 25 and detailed in the respective Grievance and Appeal sections.

In the 2021 EQR, Partners met 100% of the Grievance and Appeal standards again, resulting in no Corrective Actions and one Recommendation, which was a Recommendation from the 2020 EQR that was partially implemented by Partners. There is still a need for Partners to define one term for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination" and use it consistently in the *Member Handbook*.

Grievances

Table 25 outlines CCME's review of the Recommendation issued in the 2020 EQR that was not fully implemented by Partners.

Table 25: 2020 EQR Grievance Findings

2020 EQR Grievance Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Definition of a Grievance and who may file a Grievance	***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.***	**N**
***2021 EQR Follow Up*:** Partners updated the term Grievance/Complaint in the policy and procedure and in the *Provider Operations Manual*. The *Member Handbook* continues to contain the terms "Grievance" and "Complaint" separately throughout the handbook. There were no instances of using the term "Grievance/Complaint" in the *Member Handbook*.		

In the past three EQRs, CCME recommended Partners select one term for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination" and use it consistently in Partners' documentation. In the past year, Partners revised the Grievance policy and procedure and *Provider Operations Manual*, which now consistently use the term "Grievance/Complaint." However, the *Member Handbook* continues to contain the terms "Grievance" and "Complaint" interchangeably and the term "Grievance/Complaint" is not used in the *Member Handbook*. During the Onsite, CCME highlighted the consistent use of one term would reduce confusion, especially for those enrollees transferring from other PIHPs that may have used a different term. CCME continues to make this Recommendation in the 2021 EQR.

The 2021 EQR included review of 10 Grievance files from Partners' Medicaid Grievance Log. All files contained timely Acknowledgement and Resolution letters and the

Grievances were resolved within the 90-day time frame required by Partners' Grievance policy and procedure. Resolution Letters detailed steps staff took to resolve each Grievance, and the steps were supported within the Grievance file documentation reviewed. All notifications were sent within the required timeframes. The Chief Medical Officer (CMO) was consulted when applicable, per Partners' Grievance policy and procedure. During the Onsite, one Grievance file was reviewed with staff. This file showed the Grievance was resolved within 30 days but before Partners was able to connect by phone or email with the Grievant or the provider. The resolution notification explained, "Partners will continue to seek and accept information to resolve your Grievance fully." It was unclear why staff would not continue to attempt to reach the Grievant and provider given the 90 days allowed to resolve a Grievance. During the Onsite, staff explained the Consumer Rights Officer talked with the provider two days after the Grievance notification was mailed. That communication was not originally included in the Grievance file documentation, but Partners provided it during the Onsite. Partners' Policy and Procedure 6.00U, Grievance Management, states, "If further investigation or follow up is needed after the Grievance/Complaint is resolved, Member Engagement and/or Network Management assigns the issue(s) to the appropriate department(s) within the LME/MCO, with required timeframes as outlined in any assigned Plan of Correction (POC) found applicable." During the Onsite, staff also explained they attempt to resolve grievances within 30 days, when possible, to meet metrics specified by the State. CCME encouraged Partners to set resolution timeframes based on the best interest of the Grievant and to ensure Grievances are resolved thoroughly and in a timely manner.

Appeals

Table 26 outlines CCME's review of the Recommendation issued in the 2020 EQR and implementation by Partners.

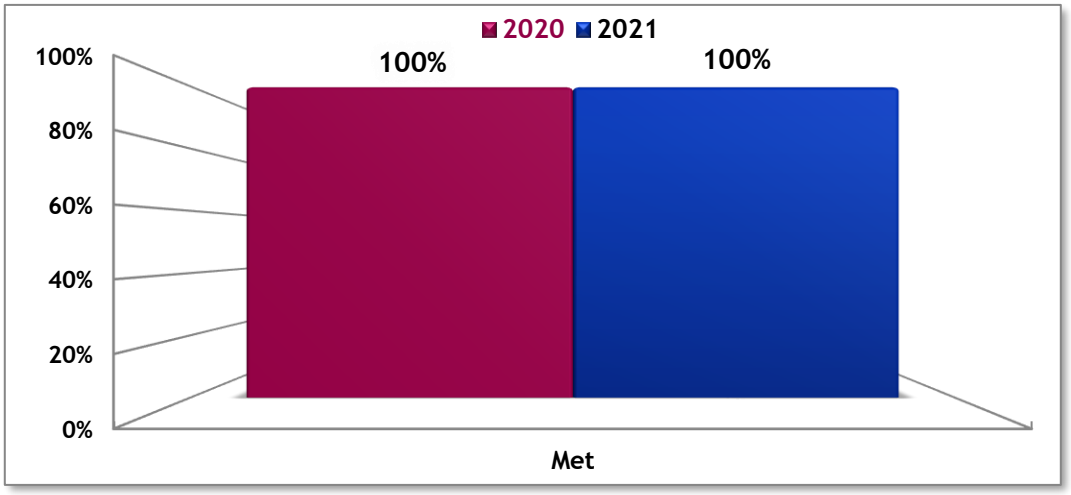
Table 26: 2020 EQR Appeals Findings

2020 EQR Appeals Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	***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.***	**Y**
2021 EQR Follow Up: In the Onsite interview, *Partners explained that they implemented a focused Appeals monitoring process after the 2020 EQR. Every Appeals Specialist is audited on one Appeal per month focusing on verbal, extended, expedited, withdrawn, or administratively denied Appeals.*		

The 2021 Appeal file review included various types of Appeals: three files where the Appeal resolution timeframe was extended by Partners, two files showing the Appellant withdrew their original Appeal, two Appeals where the request to expedite the Appeal was denied by Partners, one Appeal of an administratively-denied service request, and two standard Appeals. Review of the data within the Appeals Log showed data within the Log were consistent with the data within the Appeal files. All required notifications were issued timely, including written and verbal notifications. The CMO was consulted on Appeals involving concerns around enrollee health and safety. Although there were no Appeals where Partners agreed to expedite the Appeal, there was one Appeal that was appropriately prioritized by Partners and resolved quickly by the CMO based on new clinical information. In terms of compliance, the 2021 Appeal file review was much improved over the 2020 file review. This was highlighted by CCME during the Onsite discussion. Partners staff attributed the improvement to the focused Appeals monitoring process and increased detail by staff in their Appeal documentation.

As Figure 6 indicates, 100% of the standards in the Grievances and Appeals review were scored as "Met".

Figure 6: Grievances and Appeals Comparative Findings



Strengths

- In the past year, Partners Grievance team has worked to improve the level of detail within the Grievance resolution letters. Staff reported this has decreased the number of second level Grievances.

- The 2021 Appeal file review was much improved over the 2020 file review. Partners attributes the improvement to the focused Appeals monitoring process and improved detailed documentation in the Appeal files.

Weaknesses

- Partners' *Member Handbook* continues to use inconsistent terms for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination."

Recommendations

- Revise the *Member Handbook* to reflect one consistent term for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination."

F. Program Integrity

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

The 2021 Program Integrity EQR for Partners included a thorough Desk Review of Program Integrity (PI) policies and procedures, organizational charts, workflows, reports, training materials, committee minutes, and data mining documentation. As part of the Desk Review, sample of 15 PI case files were also reviewed. An Onsite discussion occurred with PI staff, including Partners' PI Director, PI Supervisor, Chief Compliance Officer, and Chief Counsel.

In the 2020 EQR, Partners met 100% of the PI standards, and there were no Corrective Actions and one Recommendation issued. Table 27 details the PI standard and related Recommendation, as well as the follow up in the 2021 EQR ensuring Partners addressed the 2020 EQR Recommendation. In the 2021 EQR, Partners met 100% of the PI standards again, and no Corrective Actions or Recommendations were issued.

Table 27: 2021 EQR Program Integrity Findings

2020 EQR Program Integrity findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
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	***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.***	**Y**
2021 EQR Follow up: Partners has a Report of Investigation (ROI) document for all cases referred to NC Medicaid Program Integrity, all remaining cases have Ethicspoint summaries.		

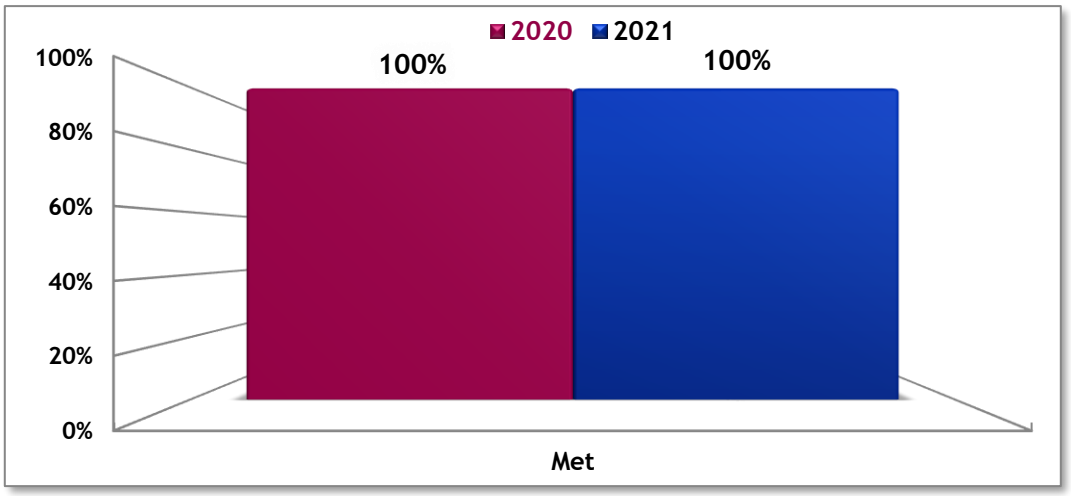
In the 2021 PI EQR Desk Review, it was noted Partners' R*egulatory Compliance Program Description* provides good detail regarding Partners' PI functions. The plan describes staffing and organizational structures, committee structures, investigative processes (detecting, investigating, and reporting), reporting requirements, processes around the use of FAMs, and training of PIHP staff, network providers, and Partners' Board of Directors. Partners' PI Workplan outlines initiatives for the year and provides a blueprint for education, quality assurance activities, and data mining.

Review of Partners PI documentation and discussion with staff during the Onsite revealed there has been no staff turnover within the PI Department. Partners also added a Registered Nurse to the PI team. Partners provided curriculum and training schedules for training of staff, providers, and the Board of Directors. Partners also provided a sample of education communications, such as provider bulletins. During the Onsite, Partners PI staff described several data-driven initiatives targeting potential fraud, waste, and abuse.

During the 2021 EQR PI file review, it was noted Partners has only one investigation case opened in 2020. Partners staff and NC Medicaid explained Partners worked diligently to eliminate the case backlog noted in previous EQRs. The EQR of PI files also evaluates the completeness of documentation and the timeliness of investigation initiation. All required elements were found within the sample of files reviewed and all investigations were initiated timely.

Figure 7 demonstrates Partners met 100% of the PI EQR standards in both the 2020 and 2021 EQRs.

Figure 7: Program Integrity Findings



Strengths

- In the past year, Partners has worked diligently to keep their PI investigation caseload current.
- Partners' PI Workplan outlines initiatives for the year and provides a blueprint for education, quality assurance activities, and data mining.
- Partners has implemented a new metrics and reporting data warehouse.

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 2020 through December 2020. 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 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 NC Tracks, the low figure suggests that many providers may not be reporting the Other Diagnosis codes. A closer examination reveals that some providers never report Other Diagnosis code. This issue is particularly acute for Professional encounters where only about 16% of all claims had at least one Other Diagnosis code.

Recommendation:

Partners should continue to perform an 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 all claims should be populated 99% of the time. For the current review period, only 76% of Institutional claim line items contained a valid value in the Procedure code field where one is needed to identify the service that was provided. The review 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 barely missed meeting the Data Quality Standards threshold target for Procedure codes. These codes were populated 98.36% of the time, and in each instance a valid value present. However, for Institutional claims, the figure drops significantly to 76%.

Partners effectively denies 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, Partners is urged to review requirements to ensure providers are submitting valid Procedure codes, so that services 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). In 2021, Partners implemented additional edits to deny claims that do not contain proper procedures where one is expected. Therefore, this issue is expected to be resolved for 2021 dates of service and beyond.

Conclusion

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

Minor issues with both Institutional and Professional encounters were found. Based on Partners' ISCA response, overview of the Alpha system, and limited number of data anomalies, it is believed 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 continue improvements 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 above are critical data elements as identified by CMS and NC Medicaid. Therefore, Partners should review and take Corrective Action to resolve the issues identified above.

For the next review period, it is recommended Partners review the encounter data from NCTracks to look at encounters that pass front end edits and are adjudicated to either a paid or denied status. It is difficult to reconcile the various tracking reports with the data

submitted by the PIHP. Reviewing an extract from NCTracks would provide insight into how the State's Medicaid Management Information System (MMIS) is handling the encounter claims and could be reconciled back to reports requested from 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: EQR Validation Worksheets
- Attachment 3: Tabular Spreadsheet
- Attachment 4: Encounter Data Validation Report

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

January 31, 2022

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 2021 External Quality Review (EQR) of 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 2021 EQR will be a focused review. The focus of this review will be on the PIHP's Corrective Actions from the previous EQR and PIHP functions that impact enrollee health and safety. Similarly, for the 2021 EQR, the two day Onsite previously performed at PIHP offices will conducted during a one day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **March 17, 2022**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

In preparation for the Desk Review, the items on the enclosed **Desk Materials List** are to be submitted electronically. **Please note that, to facilitate a timely review, there are three items on the Desk Materials List (items 9, 10, and 19.a) that should be submitted by no later than February 4, 2022,** and the remaining items are due by no later than **February 21, 2022**. 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 **February 21, 2022.**

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

https://eqro.thecarolinascenter.org

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 6

Cc: Jackie Copeland, Partners Waiver Contract Manager
Monica Hamlin, NC Medicaid Waiver Contract Manager
Deb Goda, NC Medicaid Associate Director, Behavioral Health and IDD
Hope Newsome, NC Medicaid Quality Specialist

Partners

Focused External Quality Review 2021

MATERIALS REQUESTED FOR DESK REVIEW

__Please note that the lists requested in items 9, 10, and 19.a must be uploaded by no later than February 4, 2022. The remainder of items must be uploaded by no later than February 21, 2022.__**

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 (January 2021 through December 2021). Include the date of approval of initial credentialing and the date of approval of recredentialing.

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

7. Minutes of committee meetings for the following committees:

   a) Credentialing (for the three most recent committee meetings)
   b) UM (for the three most recent committee meetings)
   c) Any clinical committee meeting minutes showing discussion of Clinical Practice Guidelines impacted by COVID-19.

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

9. **__**By February 4, 2022__**, a copy of the complete Appeal log for the months of January 2021 through December 2021. Please indicate on the log: the appeal type (standard, expedited, extended, withdrawn, or invalid), the service appealed, the date the appeal was received, and the date of appeal resolution notification.

10. **By February 4, 2022, a copy of the complete Grievances log for the months of January 2021 through December 2021. Please indicate on the log: the nature of the grievance, the date received, and the date of grievance resolution.

11. Copies of all appeal notification templates used for expedited, invalid, extended, and withdrawn appeals.

12. For appeals and grievances, please submit a description of your monitoring process that reviews compliance of oral and written notifications, completeness of documentation within the appeal and grievance records, accuracy of appeal and grievance logs, etc. Provide details regarding frequency of monitoring and any benchmarks, performance metrics, and reporting of monitoring outcomes.

13. Please submit a summary of new provider orientation processes and include a list of materials and training provided to new providers.

14. For MH/SU, I/DD, and TCLI Care Coordination, please submit a description of your monitoring plan that reviews compliance of Care Coordinator documentation. Include in the description the elements reviewed (timeliness of progress notes, timeliness of Innovations monitoring, timeliness of Quality of Life surveys, review of quality, completeness of discharge notes, accuracy of documentation, etc.). Provide details regarding frequency of monitoring, and any benchmarks, performance metrics, and reporting of monitoring outcomes.

15. For Care Coordination enrollees files, please provide:

    a. three MH/SU Care Coordination enrollee files (two active since 2019 and one recently discharged)

    b. three I/DD Care Coordination enrollee files (two active since 2019 and one recently discharged)

    c. four TCLI Care Coordination enrollee files (one active since 2019, one who received In-Reach, one who transitioned to the community and recently discharged).

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

16. Information regarding the following selected Performance Measures:

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

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

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

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

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

17. Documentation of all Performance Improvement Projects (PIPs) completed or planned in the last year, and any interim information available for those projects currently in progress. This documentation should include information from the project that

explains and documents all aspects of the project cycle (i.e., research question (s), analytic plans, reasons for choosing the topic including how the topic impacts the Medicaid population overall, measurement definitions, qualifications of personnel collecting/abstracting the data, barriers to improvement and interventions planned or implemented to address each barrier, calculated result, results, etc.)

18. Provide copies of the following files:

a. Credentialing files for the four most recently credentialed practitioners (as listed below)

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

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

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

i. Insurance:

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

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

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

iii. Ownership disclosure information/form.

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

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

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

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

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

ii. Insurance:

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

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

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

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

v. Ownership disclosure information/form.

NOTE: Appeals, Grievances, and Program Integrity files will be selected from the logs submitted on February 4, 2022. A request will then be sent to the plan to send electronic copies of the files to CCME. The entire file will be needed.

19. Provide the following for Program Integrity:

a. ****File Review: By February 4, 2022**, Please produce a listing of all active files during the review period (January 2021 through December 2021). The list should include the following information:

i. Date case opened

ii. Source of referral

iii. Category of case (enrollee, provider, subcontractor)

iv. Current status of the case (opened, closed)

b. Program Integrity Plan and/or Compliance Plan.

c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.

d. Workflow of process of taking complaint from inception through closure.

e. All 'Attachment Y' reports collected during the review period.

f. All 'Attachment Z' reports collected during the review period.

g. Provider Manual and Provider Application.

h. Enrollee Handbook.
i. Subcontractor Agreement/Contract Template.
j. Training and educational materials for the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
k. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse.
l. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors, and employees.
m. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other State or Federal agency.
n. Code of Ethics and Business Conduct.
o. Internal and/or external monitoring and auditing materials.
p. Materials pertaining to how the PIHP captures and tracks complaints.
q. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
    i. NC Medicaid approved reporting templates.
r. Sample Data Mining Reports.
s. NC Medicaid Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
t. Monthly reports of NCID holders/FAMS-users in PIHP.
u. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
v. Corrective action plans including any relevant follow-up documentation.
w. Policies/Procedures for:
    i. Program Integrity
    ii. HIPAA and Compliance
    iii. Internal and external monitoring and auditing
    iv. Annual ownership and financial disclosures
    v. Investigative Process
    vi. Detecting and preventing fraud
    vii. Employee Training
    viii. Collecting overpayments
    ix. Corrective Actions
    x. Reporting Requirements
    xi. Credentialing and Recredentialing Policies
    xii. Disciplinary Guidelines

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

    a. A completed ISCA.

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

Section	Question Number	Attachment
Enrollment Systems	1b	Enrollment system loading process
Enrollment Systems	1f	Enrollment loading error process reports
Enrollment Systems	1g	Enrollment loading completeness reports
Enrollment Systems	2c	Enrollment reporting system load process
Enrollment Systems	2e	Enrollment reporting system completeness reports
Claims Systems	2	Claim process flowchart
Claims Systems	2p	Claim exception report.
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, 2020 – December 31, 2020. Follow the format used to submit encounter data to NC Medicaid (i.e., 837I and 837P). If you archive your outbound files to NC Medicaid, you can forward those to HMS for the specified time period. In

addition, please convert each 837I and 837P to a pipe delimited text file or excel sheet using an EDI translator. If your EDI translator does not support this functionality, please reach out immediately to HMS.

b. Provide a report of all paid claims by service type from January 1, 2020 – December 31, 2020. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

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

B. Attachment 2: EQR Validation Worksheets

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

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

- Performance Improvement Project Validation Worksheet
  - Opioid Engagement
  - SUD Initiation and Engagement
  - Registry of Unmet Needs Services
  - Initial NC TOPPS Interviews
  - TCL Housing Loss Reduction

CCME Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Readmission Rates for Mental Health**
Reporting Year:	**FY2021**
Review Performed:	**2022**

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 specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Readmission Rates for Substance Abuse**
Reporting Year:	**FY2021**
Review Performed:	**2022**

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 specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Follow-up After Hospitalization for Mental Illness**
Reporting Year:	**FY2021**
Review Performed:	**2020**

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 specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Follow-up After Hospitalization for Substance Abuse**
Reporting Year:	**FY2021**
Review Performed:	**2020**

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 specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**
Reporting Year:	**FY2021**
Review Performed:	**2020**

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 specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Mental Health Utilization- Inpatient Discharges and Average Length of Stay**
Reporting Year:	**FY2021**
Review Performed:	**2020**

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 specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Mental Health Utilization**
Reporting Year:	**FY2021**
Review Performed:	**2020**

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 specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Identification of Alcohol and Other Drug Services**
Reporting Year:	**FY2021**
Review Performed:	**2020**

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 specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Substance Abuse Penetration Rate**
Reporting Year:	**FY2021**
Review Performed:	**2020**

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 specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Mental Health Penetration Rate**
Reporting Year:	**FY2021**
Review Performed:	**2020**

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 specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure 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:	**2021**
Review Performed:	**2022**

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 specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid Waiver measures template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Proportion of beneficiaries reporting they have a choice between providers**
Reporting Year:	**2021**
Review Performed:	**2022**

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 specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid Waiver measures template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Percentage of level 2 and 3 incidents reported within required timeframes**
Reporting Year:	**2021**
Review Performed:	**2022**

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 specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid Waiver measures template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Percentage of beneficiaries who received appropriate medication**
Reporting Year:	**2021**
Review Performed:	**2022**

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 specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid Waiver measures template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure 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:	**2021**
Review Performed:	**2022**

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 specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid Waiver measures template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Improvement Project Validation Worksheet

PIHP Name:	**Partners**
Name of PIP:	**OPIOID ENGAGEMENT**
Reporting Year:	2021
Review Performed:	2022

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**	Topic was chosen based on increasing rate of opioid overdose deaths.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**Met**	Statement of goal was appropriate and adequate.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	PIP addresses key aspects of behavioral health services.
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 is inclusive of relevant populations.
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 not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Indicators are clearly 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 measure changes in processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data type is clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Data sources are reported.
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 collection methods allow for systematic pull of data.

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**	Instruments provide consistent methods to collect data.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis cycle is reported.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel for the project are reported.
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**	Data analysis was conducted per data analysis plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are reported clearly using the indicator value and a comparison goal value.
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 remeasurements are reported for the indicators.
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 the findings and trends in results is provided.
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**	Barriers and interventions to address those barriers are reported in the interventions table.
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**	Medicaid rate improved from 66% to 82.6% with a goal of 62%. Non Medicaid Rate improved from 63% to 74% with a goal of 57.8%. Both rates improved and are above the goal rates.
9.2 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement appears to be related to interventions that have been implemented.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not required as sampling was not utilized
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to determine

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 Performance Improvement Project Validation Worksheet

PIHP Name:	**Partners**
Name of PIP:	**SUD INITIATION AND ENGAGEMENT**
Reporting Year:	2021
Review Performed:	2022

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**	Topic was chosen based on under target rates for SUD members.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**Met**	Statement of goal was appropriate and adequate.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	PIP addresses key aspects of behavioral health services.
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 is inclusive of relevant populations.
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 not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Indicator is clearly defined from 2 visits after initial SU service.
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 measure changes in processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data type is clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Data sources are reported.
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 collection methods allow for systematic pull of data.

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**	Instruments provide consistent methods to collect data.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis cycle is reported.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel for the project are reported.
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**	Data analysis was conducted per data analysis plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are reported clearly using the indicator value and a comparison goal value.
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 remeasurements are reported for the indicators.
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 the findings and trends in results is provided.
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**	Barriers and interventions to address those barriers are reported in the interventions table.
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**	The rate improved from 30.2% to 42.5%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement appears to be related to interventions that have been implemented.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not required as sampling was not utilized
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to determine

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 Performance Improvement Project Validation Worksheet

PIHP Name:	**Partners**
Name of PIP:	**REGISTRY OF UNMET NEEDS**
Reporting Year:	2021
Review Performed:	2022

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**	Topic was chosen based lack of I/DD members in appropriate services.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**Met**	Statement of goal was appropriate and adequate.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	PIP addresses key aspects of behavioral health services.
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 is inclusive of relevant populations.
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 not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Indicators are clearly defined as I/DD member utilization of services.
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 measure changes in processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data type is clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Data sources are reported.
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 collection methods allow for systematic pull of data.

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**	Instruments provide consistent methods to collect data.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis cycle is reported.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel for the project are reported.
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**	Data analysis was conducted per data analysis plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are reported clearly using the indicator value and a comparison goal value.
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 remeasurements are reported for the indicators.
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 the findings and trends in results is provided.
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**	Barriers and interventions to address those barriers are reported in the interventions table.
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 percentage declined from 46% to 43% at the latest remeasurement. The goal is 55%. ***Recommendation: Continue evaluation of services provided and determine if additional services might be beneficial for I/DD members.***
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 to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not required as sampling was not utilized
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to determine

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	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 Performance Improvement Project Validation Worksheet

PIHP Name:	**Partners**
Name of PIP:	**INITIAL NC TOPPS INTERVIEW**
Reporting Year:	2021
Review Performed:	2022

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**	Topic was chosen based lack of initial interviews completed in a timely manner.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**Met**	Statement of goal was appropriate and adequate.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	PIP addresses key aspects of behavioral health services.
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 is inclusive of relevant populations.
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 not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Indicators are clearly defined as initial interview completed for Medicaid and IPRS/State population.
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 measure changes in processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data type is clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Data sources are reported.
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 collection methods allow for systematic pull of data.

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**	Instruments provide consistent methods to collect data.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis cycle is reported.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel for the project are reported.
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**	Data analysis was conducted per data analysis plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are reported clearly using the indicator value and a comparison goal value.
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 remeasurements are reported for the indicators.
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 the findings and trends in results is provided.
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**	Barriers and interventions to address those barriers are reported in the interventions table.
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 percentage declined from 50% to 25% for Medicaid and 67% to 38% for IPRS/State. The goal is 80%. ***Recommendations: Determine if additional interventions are needed to improve interview rates; assess the impact of other interventions and determine if continuation is beneficial to initial interview rates.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not required as sampling was not utilized
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to determine

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	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 Performance Improvement Project Validation Worksheet

PIHP Name:	**Partners**
Name of PIP:	**TCL PIP HOUSING LOSS REDUCTION**
Reporting Year:	2021
Review Performed:	2022

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**	Topic was chosen based on high housing loss and low re-housing rates.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**Met**	Statement of goal was appropriate and adequate.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	PIP addresses key aspects of behavioral health services.
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 is inclusive of relevant populations.
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 not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Indicators are clearly defined as number who lost housing and % of members rehoused.
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 measure changes in processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data type is clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Data sources are reported.
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 collection methods allow for systematic pull of data.

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**	Instruments provide consistent methods to collect data.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis cycle is reported.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel for the project are reported.
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**	Data analysis was conducted per data analysis plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are reported clearly using the indicator value and a comparison goal value.
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 remeasurements are reported for the indicators.
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 the findings and trends in results is provided.
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**	Barriers and interventions to address those barriers are reported in the interventions table.
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 number who lost housing increased in the most recent remeasurement. The % rehoused reduced from 25% to 11%. ***Recommendation: Continue evaluation of services provided and determine if additional services might be beneficial for I/DD members.***
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 to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not required as sampling was not utilized
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to determine

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	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.*

C. Attachment 3: Tabular Spreadsheet

I. A. 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 downloads and loads the daily GEF files to the AlphaMCS enrollment system. Partners uses the monthly 820 capitation file in combination with the GEF and 834 files to reconcile current and retroactive payments. Demographic data is captured in the AlphaMCS system and patients IDs are unique to members. Historical enrollment information is captured and maintained for all members.
1.2 The PIHP is able to identify and review any errors identified during, or as a result, of the State enrollment file load process.	X					During the Onsite, Partners stated WellSky is able to capture the GEF records that are unable to be loaded to AlphaMCS and notify Partners. Partners stated WellSky rarely encountered issues during the upload of GEF files to AlphaMCS.
1.3 The PIHP'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 member ID.
2. Claims System						
2.1 The PIHP processes provider claims in an accurate and timely fashion.	X					The majority of claims received are electronic on a HIPAA file or through the provider web portal. Very few claims from new providers who have not gained access to the AlphaMCS are received via paper claims (approximately less than 0.1%). For claims received in 2020, 95.5% of Institutional and 95.1% of Professional claims were auto-adjudicated on a nightly basis.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Partners pends claims with amounts greater than $5,000 and ED claims for manual review. A pended claims report is generated daily for a claims processor to review and manually approve or deny the claims. Claims requiring medical review are determined by length of stay in the ED or if the claim has questionable services outside of the behavioral health scope of work. The claims requiring medical review are reviewed at the level of Medical Director for approval or denial.
2.2 The PIHP has processes and procedures in place to monitor review and audit claims staff.	X					Partners audits a random sample of 3% of Professional claims and 10% of Institutional claims processed on a daily basis. Partners also conducts focused audits on COB and Claim Overrides. Paper claims are included in the daily random audit. ED claims and claims in excess of $5,000 are pended for manual review. Partners also audits new hire claims examiners and the tasks performed by them are monitored and audited by a claims supervisor.
2.3 The PIHP has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	X					During the Onsite, Partners demonstrated the AlphaMCS claims system and capabilities to receive and store all ICD-10 Diagnosis codes. Partners indicated ICD-10 Procedure codes, Revenue codes and Diagnosis Related Group (DRG) codes are captured in the AlphaMCS system electronically and via the provider web portal. Up to 25 ICD-10 Diagnosis codes are captured via the web portal and up to 29 ICD-10 Diagnosis codes are captured via HIPAA files for Institutional claims. For Professional encounters, up to 12 ICD-10 Diagnosis codes are captured via the web portal and HIPAA files.
2.4 The PIHP's claim system screens store and track claim information and claim adjudication/payment information.	X					During the Onsite, Partners demonstrated their provider web portal, claim system screens, and claim adjudication/payment information. Partners demonstrated their claim systems ability to capture all the ICD-10 Diagnosis codes, DRGs, Revenue codes, CPT/HCPCS, ICD-10 Procedure codes and adjudication information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Reporting						
3.1 The PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					During the Onsite, Partners stated they receive a nightly backup of the AlphaMCS is restored to their EDW. Partners captures all required ICD-10 Diagnosis codes and is capable of capturing additional procedures, DRGs, and Revenue codes are submitted on the claims. Partners stores the DRG and ICD-10 Procedure codes for reporting.
3.2 The PIHP has processes in place to back up the enrollment and claims data repositories.	X					During the Onsite, Partners stated they have processes in place to back up their EDW on a daily basis. A business continuity plan was provided along with the ISCA tool.
4. Encounter Data Submission						
4.1 The PIHP has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	X					Partners can submit up to 29 ICD-10 Diagnosis codes on Institutional encounters and up to 12 ICD-10 Diagnosis codes on Professional encounters to NCTracks.
4.2 The PIHP has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					During the Onsite, Partners stated they review an internally generated Encounter Claims Reconcile Report to ensure all outgoing claims on an 837 encounter file are received on the incoming 835 file. Partners uses the 835 encounter response file to identify and reconcile the returned 835 information with the claims paid to providers in the AlphaMCS system. The DMA Paid/Denied spreadsheets along with the outgoing 837 encounter files and incoming 835 response files are used to investigate discrepancies, correct issues, and submit missing or corrected encounters.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.3 PIHP has policies and procedures in place to reconcile and resubmit encounter data denied by NC Medicaid.	X					Partners loads the incoming 835 file into a SQL database to identify denied encounters by denied reason, taxonomy, and member. Partners uses this data to research the claim and identify the necessary correction. If additional information is needed, then Partners uses the DMA Paid and Denied spreadsheets. Partners creates a Manual Rebill file with claims for which a solution has been found and is submitted into the AlphaMCS system to go through the resubmission process. Partners has an encounter acceptance rate of approximately 99.9%. Partners has been able to maintain the very high encounter acceptance rate that was observed in last year's EQR review as well. During the Onsite, Partners stated they encountered challenges due to the COVID-19 pandemic that included the addition of new codes, rate increases, and reprocessing of claims. Partners also stated, due to county realignment, they enrolled members who receive Medicaid or State-funded Services for intellectual or developmental disabilities, mental health or substance abuse disorders from Cabarrus, Union, Stanly, Forsyth, and Davie counties in 2021. Partners was able to maintain their very high encounter data acceptance rate even though they had a 63.2% increase in claim submissions was due to the inclusion of five counties.
4.4 The PIHP 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 encounter claims research, correction, and resubmission process. Partners' staff was able to speak to encounter data submissions and reconciliation process.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II A. Credentialing and Recredentialing						
1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					The *Credentialing Program Description* (*CPD*) and several policies and procedures address the credentialing and recredentialing processes. The *CPD* defines "flagged" ("unclean") and "unflagged" ("clean") applications. The *CPD* does not clearly state that the *NC DHHS Excluded Provider List* is queried during the credentialing or recredentialing process or as part of monthly monitoring. However, the credentialing files included Primary Source Verification (PSV) of the *NC DHHS Excluded Provider List*. During the Onsite review, Partners staff confirmed they also conduct the monthly query of the *NC DHHS Excluded Provider List* and provided evidence of the queries. ***Recommendation: Revise the CPD and any other documents that reference the PSVs conducted during the credentialing, recredentialing, or monthly monitoring processes to clearly include the NC DHHS Excluded Provider List. See NC Medicaid Contract, Attachment B, Section 1.14.4.***
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)* summarizes the committee purpose, responsibilities, committee meeting logistics, and composition of the committee membership. The *Credentialing Program Description* (*CPD)* states, "The Credentialing Committee is responsible for making independent decisions about applications for credentialing, recredentialing and sanctions as set forth in Section XXI of the Credentialing Program Description." Dr. Stanton, Chief Medical Officer (CMO), chairs the Credentialing Committee, which the *CPD* describes as "a peer review body composed of a cross-functional team of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						representatives internal and external to the organization that represent the range of practitioners that participate in the network." For the 2021 EQR, CCME reviewed the minutes of three Credentialing Committee meetings. The meeting minutes include the lists of "clean" or "unflagged" applications approved by the CMO. Meeting Agenda packets include detailed information for "flagged" applications, and meeting minutes reflect committee discussion of, and decisions regarding, these applications.
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Credentialing files reviewed for the EQR were organized and contained appropriate information.
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
3.1.3 Valid DEA certificate; and/or CDS certificate	X					
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	X					
3.1.14 Names of hospitals at which the physician has admitting privileges if any	X					
3.1.15 Ownership Disclosure is addressed.	X					
3.1.16 Criminal background Check	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files reviewed for the EQR were organized and contained appropriate information.
4.1 Recredentialing every three years;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					The agency recredentialing file submitted for the 2021 EQR did not include a Certificate of Insurance (COI) or other verification for professional liability and general liability coverage. Partners submitted the COI in response to CCME's request on the *Missing Desk Materials List*.
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
4.2.3 Valid DEA certificate; and/or CDS certificate	X					
4.2.4 Board certification if claimed by the applicant;	X					
4.2.5 Malpractice claims since the previous credentialing event;	X					
4.2.6 Practitioner attestation statement;	X					
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					The agency recredentialing file submitted for the 2021 EQR did not include Primary Source Verification (PSV) of the *NC State Excluded Provider* list. The document labeled as the *NC State Excluded Provider* list was a screenshot of the NC DHHS Excluded Providers webpage, rather than a screenshot of the actual excluded provider list. Partners submitted the PSV of the *NC State Excluded Provider List* in response to CCME's request on the *Missing Desk Materials List*.
4.2.9 Requery of the SAM.	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (OIG LEIE);	X					
4.2.11 Requery of the Social Security Administration's Death Master File	X					
4.2.12 Requery of the NPPES;	X					
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					The physician recredentialing file submitted for this EQR did not include information regarding hospital admitting privileges. Partners submitted the documentation in response to CCME's request on the *Missing Desk Materials List*.
4.2.14 Ownership Disclosure is addressed.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					The *CPD* states, "Credentialing Committee review also includes review of provider performance data, including but not limited to findings of quality management/quality improvement activities, utilization management activities, and member/provider complaints/grievances." During Onsite discussion, Partners staff described the process for obtaining this information. The reviewed Credentialing Committee meeting minutes/Agenda Packets reflect the committee's consideration of these kinds of "flags"/issues/ concerns.
5. The PIHP formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the PIHP for serious quality of care or service issues.	X					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 reports and utilizes the information regarding QOC Concerns."
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 (PMs) were in the Fully Compliant range, with an average validation score of 100% across the 10 (b) Waiver Measures and the five (c) Waiver Measures. In comparing the FY2020 to FY2021 rates for (b) Waiver Measures, Follow-up after Hospitalization for Substance Abuse showed substantial improvement in the Detox and Facility Based Crisis (FBC) for 3- and 7-day rates with a 17.6% improvement in the 3 day rate and a 12% improvement in the 7 day rate. For Initiation and Engagement of AODDT, the engagement rate for 18-20 year olds declined 10.5%. ***Recommendation: Continue to monitor (b) Waiver performance measure rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the PMs.***
III. B Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					Partners submitted five projects for this 2021 EQR: Opioid Engagement, Initial NC TOPPS Interviews, SUD Initiation and Engagement of Substance Use Members, TCL Housing Loss Reduction, and Registry of Unmet Needs.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					All five validated PIPs scored in the High Confidence range, although three PIPs had issues. See Recommendations below. ***Recommendations:*** • ***Initial NC TOPPS Interview: Determine if additional interventions are needed to improve interview rates, assess the impact of other interventions, and determine if continuation is beneficial to initial interview rates.*** • ***TCL Housing Loss Reduction: Continue evaluation of services provided and determine if additional services might be beneficial for I/DD members.*** • ***Registry of Unmet Needs: Percentage of I/DD members in services did not improve in the latest remeasurement. Continue evaluation of services provided and determine if additional services might be beneficial for I/DD members.***

IV. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. A Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					
2. The case coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					
2.5 Quality monitoring and continuous quality improvement;	X					In the 2021 EQR, it was noted that Partners has implemented a quality monitoring and review process of I/DD Care Coordination documentation to include the use of the *Comprehensive Case Record Review Checklist*. Partners also has Policy and Procedure 9.15 and the *MHSU/TCLI Documentation and Monitoring Plan* that include the revised quality monitoring and review process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Since the previous EQR, Partners has also developed and published the *Innovations Member and Family Handbook*. The review of the *Innovations Member and Family Handbook* found that: • *Appendix A: Member Responsibility and Appendix H*: The Acronym List and Glossary of Words & Terms to Know in this Appendix did not match the Waiver Cost Limits exemptions, as stated on page 22 and page 28 of the handbook. • Cabarrus, Davie, Forsyth, Stanly, and Union counties were not noted to be included in Partners' catchment area. CCME recommends that Partners revise the *Innovations Member and Family Handbook* to ensure information is consistent throughout the manual and appendices. The handbook should also be revised to include the recent addition of Cabarrus, Davie, Forsyth, Stanly, and Union counties to Partners' catchment area. ***Recommendations: Revise the Innovations Member and Family Handbook to provide consistent information regarding NC Innovations Waiver Cost Limits and exceptions. Include in the manual all of the counties within Partners' current catchment area.***
2.6 Determination of which Behavioral Health Services are medically necessary;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					In the 2020 EQR, it was noted for a second year Partners did not have a documented process for transferring MHSU/TCL enrollees to a new PIHP. CCME recommended Partners 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. Review of these documents in the 2021 EQR showed Partners revised Policy and Procedure 9.05, the *MHSU Program Description*, and the *TCLI How-to Manual* to include a process.
2.10 Ensure privacy for each Enrollee is protected.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					In the 2020 EQR, two of the files selected by Partners for the EQR were for enrollees receiving Residential Support and Day Support services. The *State Monitoring Checklist for Home and Community Based Services (HCBS)* was not complete in one of the files. Additionally, for a second year, CCME identified compliance issues in MH/SU Care Management files of enrollees discharging from Care Coordination. In the EQR, CCME issued two Recommendations to address these findings. The first Recommendation was for I/DD to 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*. The second Recommendation, issued to MH/SU, was to enhance the current monitoring plan to include a comprehensive review of Care Management documentation for enrollees discharging from Care Coordination or transferring to another PIHP. In the 2021 EQR, the review of Care Coordination files for the 2021 EQR showed compliance with Partners policies and procedures and with the requirements outlined in Partners' *NC Medicaid Contract*. The file review showed the State Monitoring Checklists were complete and accurate and staff efforts to engage and ensure continuity of care for enrollees transferring or discharging from Care Coordination was much improved.

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					
2.5 QOL Surveys are administered timely.	X					The 2021 file review of TCL found that all QOL Surveys were complete and submitted within the required intervals.
3. Transition, diversion and discharge processes are in place for TCLI members as outlined in the DOJ Settlement and *DHHS Contract*.	X					
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI, 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 TCL policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	X					In the 2020 EQR, the review of TCL files found improvement in progress notes and QOL surveys. However, for a second year, issues were identified in TCL discharge and transfer of enrollees. In one of the TCLI files reviewed in the 2020 EQR, the file showed an enrollee who was actively engaged in services and relocating to a new PIHP catchment. This enrollee was discharged from TCL. The discharge/transfer process did not comply with the *NC Transitions to Community Living Initiative (TCLI) In-Reach and Transition Manual*. CCME issued a Corrective Action in the 2020 EQR to "Enhance the current monitoring plan to include a comprehensive review of files scheduled for discharge from TCL and transfer to another PIHP." and to "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.*" The review of TCL files for the 2021 EQR showed staff ensured the enrollees' discharging or transferring from TCL received adequate support. Documented steps taken by staff during the transfer or transition of enrollees followed the requirements outlined in Partners' procedures and the *NC Transitions to Community Living Initiative (TCLI) In-Reach and Transition Manual*.

V. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee Grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy and Procedure 6.00U, Grievance Management, is the primary policy and procedure describing Partners' processes for resolving Grievances.
1.1 Definition of a Grievance and who may file a Grievance;	X					In the past three EQRs, CCME issued a Recommendation for Partners to select one term for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination" and to use it consistently in Partners documentation. During the Onsite interview, Partners staff explained they have identified the term "Grievance/Complaint" and subsequently revised documentation. However, the *Member Handbook* continues to contain the terms "Grievance" and "Complaint" interchangeably and the term "Grievance/Complaint" is not used in the *Member Handbook*. CCME highlighted during the Onsite, the consistent use of one term would reduce confusion, especially for those enrollees transferring from other PIHPs that may have used a different term. ***Recommendations: Revise the Member Handbook to reflect one consistent term for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination".***
1.2 The procedure for filing and handling a Grievance;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract;	X					
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 and Procedure 4.11, Record Retention and Disposition, details Partners' process and required timeframe for retention of Grievance files.
2. The PIHP applies the grievance policy and procedure as formulated.						The 2021 EQR included review of 10 Grievance files from Partners' Medicaid Grievance Log. All files contained timely Acknowledgement and Resolution letters and the Grievances were resolved within the 90-day time frame required by Partners' Grievance policy and procedure. Resolution Letters detailed steps staff took to resolve each Grievance. The steps were supported within the Grievance file documentation reviewed. All notifications were sent within the required timeframes. The Chief Medical Officer (CMO) was consulted when applicable, per Partners' Grievance policy and procedure.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						During the Onsite, one Grievance file was reviewed with staff, which showed the Grievance was resolved within 30 days but before Partners was able to connect by phone or email with the Grievant or the provider. The resolution notification explained, "Partners will continue to seek and accept information to resolve your Grievance fully." It was unclear why staff would not continue to attempt to reach the Grievant and provider given the 90 days allowed to resolve a Grievance. During the Onsite, staff explained the Consumer Rights Officer talked with the provider two days after the Grievance notification was mailed. That communication was not originally included in the Grievance file documentation, but Partners provided it during the Onsite. Partners' Policy and Procedure 6.00U, Grievance Management, states, "If further investigation or follow up is needed after the Grievance/Complaint is resolved, Member Engagement and/or Network Management assigns the issue(s) to the appropriate department(s) within the LME/MCO, with required timeframes as outlined in any assigned Plan of Correction (POC) found applicable." During the Onsite, staff also explained they attempt to resolve grievances within 30 days, when possible, to meet metrics specified by the State. CCME encouraged Partners to set resolution timeframes based on the best interest of the Grievant and to ensure Grievances are resolved thoroughly as well as timely.
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. Grievance data is reported in the Quality Improvement, Quality of Care, Consumer and Family Advisory, and Client Rights committees meetings.
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider Appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					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					
1.2 The procedure for filing an Appeal;	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.5 Timeliness guidelines for resolution of the Appeal as specified in the contract;	X					
1.6 Written notice of the Appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The PIHP applies the Appeal policies and procedures as formulated.						The 2021 Appeal file review included various types of Appeals: three files where the Appeal resolution timeframe was extended by Partners, two files showing the Appellant withdrew their original Appeal, two Appeals where the request to expedite the Appeal was denied by Partners, one Appeal of an administratively denied service request, and two standard Appeals. Review of the data within the Appeals Log showed data within the Log were consistent with the data within the Appeal files. All required notifications were issued timely, including written and verbal notifications. The CMO was consulted on Appeals involving concerns around enrollee health and safety. Although there were no Appeals where Partners agreed to expedite the Appeal, there was one Appeal that was appropriately prioritized by Partners and resolved quickly by the CMO based on new clinical information. The 2021 Appeal file review was much improved over the 2020 file review in terms of compliance and the completeness and detail of staff documentation. Partners staff attributed the improvement to the focused Appeals monitoring process and increased detail by staff in their Appeal documentation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					In the 2020 EQR, CCME issued a Recommendation for Partners to continue the Appeal monitoring process and focus on those Appeals that require more complex steps when processing. These complex Appeals are appeals submitted verbally, appeals where the Appeal resolution timeframe was extended by Partners, extended, and expedited Appeals, withdrawn Appeals and Appeals of Administratively Denied Service Authorizations. In the 2021 EQR Partners explained that they implemented a focused Appeals monitoring process after the 2020 EQR. This audit focuses on complex Appeals.
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					In addition to Partners' *Regulatory Compliance Program Description/Plan*, Partners provided a PI Workplan that outlines initiatives for the year and provides a blueprint for education, quality assurance activities, and data mining.
2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents', and subcontractors,' compliance with the requirements of this *Section 14* of the *NC Medicaid Contract*.	X					
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					The requirement to investigate all internal and external incidents of fraud is found in the *Regulatory Compliance Program Description/Plan*.

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					Partners' R*egulatory Compliance Program Description* provides good detail regarding Partners' PI functions. The plan describes staffing and organizational structures, committee structures, investigative processes (detecting, investigating, and reporting), reporting requirements, processes around the use of FAMs, and training of PIHP staff, network providers, and Partners' Board of Directors.
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 a compliance officer is addressed in 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					Partners Organizational Chart showed no staff turnover in the PI Department in the past year. Partners has also added a Registered Nurse to the staff to contribute to compliance efforts for Standard and Tailored plan providers.
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:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in *Section 1902 (a)(66)* of the *Social Security Act;*	X					In addition to the training requirements outlined in Partners' *Regulatory Compliance Program Description/Plan,* Partners provided a log of webinars, publications, and other trainings delivered to internal and external stakeholders.
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*	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
Contract Section 13.2-Monetary Penalties.						
9. In accordance with *42 CFR § 438.608 (a)(vii),* PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under *NC Medicaid Contract*, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under *NC Medicaid Contract*; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month. PIHP shall be penalized One Hundred Dollars ($100) for each overpayment that is not specified in an Attachment Y Report within the applicable month. In addition, PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse.	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	X					Partners provided the Compliance Workflow that showed no changes to this workflow since finalizing the document in 2017.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
permitted to retain some or all of the recoveries of overpayments. This provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.						
10.3 In accordance with Attachment Y - Audits/Self-Audits/investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					
10.4 Process for tracking overpayments and collections based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on Attachment Y – Audits/Self-Audits/investigations.	X					
10.5 Process for handling self-audits and challenge audits.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.6 Process for using data mining to determine leads.	X					
10.7 Process for informing PIHP employees, subcontractors, and providers regarding the *False Claims Act.*	X					
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					Partners' *Regulatory Compliance Program Description/Plan* details the False claims and whistleblower protections.
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					Partners' use of Explanation of Benefits (EOBs) to verify services is described in the *Program Integrity Provider Monitoring/Auditing Protocol* and the audit worksheet provided for the Desk Review.
10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments,	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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:						In the 2020 EQR, it was recommended that Partners maximize the use of the Investigative Summary within each PI file by ensuring this form is complete and kept current by staff. In the 2021 EQR, there was evidence in the PI files reviewed that Partners implemented this 2020 Recommendation. In the 2021 EQR, the PI files reviewed showed investigation documentation was complete and current. Additionally, all investigations were initiated timely.
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					
13.2 Source/origin of complaint;	X					
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					
13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated; and dates of suspected intentional misconduct;	X					
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.6 All communications between PIHP and the Provider concerning the conduct at 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:						There were no cases of enrollee fraud investigated by Partners for the period in the review. Information regarding enrollee fraud processes are addressed in the *Partners Knowledge Base*.
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					
14.13 Legal and Administrative Status of Case.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Evidence of FAMS use and data mining efforts was demonstrated through the Data Mining Guidelines.
17. If PIHP uses FAMS, PIHP shall work with the NC Medicaid designated Administrator to submit appropriate claims data to load into the NC Medicaid Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	X					
18. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current	X					

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

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Chapter 6 of Partners' *Program Integrity Department Procedural Guidelines* describes the process for establishing and lifting payments suspensions that were requested by NC Medicaid.
2. Upon receipt of a payment suspension notice from NC Medicaid Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of NC Medicaid Program Integrity's suspension and lasting until PIHP is notified by NC Medicaid Program Integrity in writing that the suspension has been lifted.	X					
3. PIHP shall provide to NC Medicaid all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid Program Integrity due to allegations of suspected fraud without prior written approval from NC Medicaid Program Integrity or the MFCU/MID. If PIHP takes administrative action, including issuing a Notice of Overpayment based on such fraud that precedes the submission date of a Division referral, the State will adjust the PIHP capitated payment in the amount of the original overpayment identified or One Thousand Dollars ($1,000) per case, whichever amount is greater.	X					

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					Partners' Policy and Procedure, Provider Overpayment Recovery, addresses the process for collection of overpayments.

D. Attachment 4: Encounter Data Validation Report

Partners Health Management

Encounter Data Validation Report

performed on behalf of

North Carolina Medicaid

March 30, 2022

Prepared By:

hms

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

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Background

Health Management Systems (HMS) has completed a review of the encounter data submitted by Partners Health Management (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."

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 the 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 2020 through December 2020. All claims paid by Partners should be submitted and accepted as a valid encounter to NC Medicaid. The 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 PIHP must submit their provider number and paid amount to NC Medicaid in the Contract Information CN104 and CN102 segment of Claim Information Loop 2300.

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

The PIHP is required to resubmit encounters for claims that may be rejected due to compliance errors or NC Medicaid edits marked as "DENY" in Appendix 1.
Looking at claims with dates of service in 2020, Partners submitted 1,383,848 unique encounters to the State. To date, 0.02% of all encounters submitted have not been corrected and accepted by NC Medicaid.

2020	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	79,218	78,871	208	139	0.18%
Professional	1,304,630	1,300,619	3,920	91	0.01%
Total	1,383,848	1,379,490	4,128	230	0.02%

Over the years, Partners has improved 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 79,162 in 2016 to 4,128 in 2020. The table below shows the latest overall acceptance rate of 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%
2020	1,383,848	1,379,490	4,128	230	0.02%

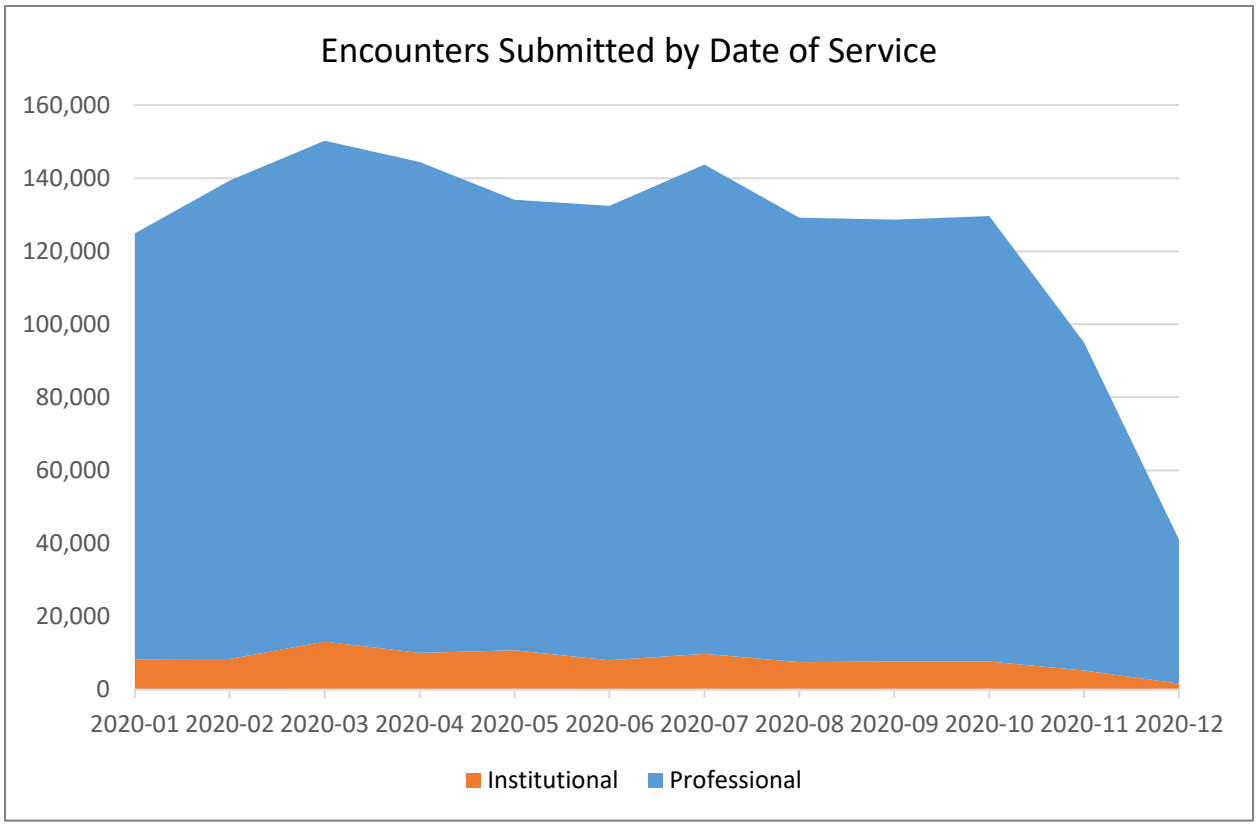
Compared to claims submitted in prior years, Partners continued to decrease the total number of initial denials and outstanding denials each year. According to Partners' response and review of NC Medicaid 's acceptance report, most of the outstanding and ongoing denials are related to suspected duplicates related to a timing issue in submitting adjusted encounters before the prior encounter records have been voided in NCTracks. 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 in Provider upload files (PUFs) to update essential provider taxonomy and address information
- Adding additional adjudication edits to AlphaMCS (i.e., all submitted Diagnosis codes) Provider education guidelines
- Rebilling corrected encounter denials
- Submitting replacement claims upstream after voids are sent

As a result of their strategy, total initial denials in 2020 dropped to less than 5,000 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, 2020 through December 31, 2020. Partners pulled all claims adjudicated and submitted to NC Medicaid during 2020 and sent to HMS via CCME Portal. This included slightly under 1.5 million Professional and over 100,000 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.



To evaluate the data, HMS ingested the 837I and 837P data extracts and loaded them to a consolidated database. After the PIHP uploaded their data, HMS applied proprietary, internally designed data analysis logic within SAS to review each data element, focusing on the data elements defined as required.

The logic evaluates the presence of data in each field within a record as well as whether the value for the field is within accepted standards. Results of these checks were compared with general expectations for each data field and to the CMS standards adopted for encounter data. The table below depicts the specific data expectations and validity criteria applied.

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

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

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

Data Element	*Expectation*	*Validity Criteria*
		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 the data populated was valid. Although the complete data set was analyzed and all data values validated, the fields below are key to properly pricing for the services paid by Partners.

Table: Evaluation of Key Fields

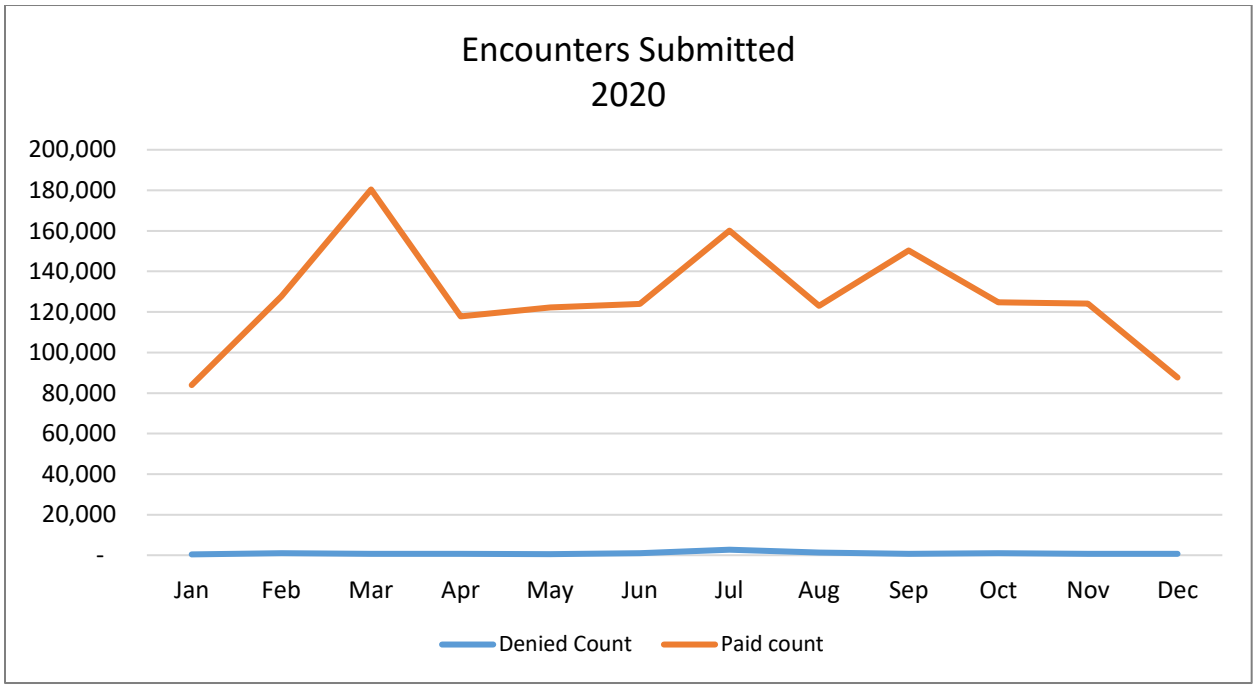
Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	1,579,427	100.00%	1,579,396	100.00%	1,579,396	100.00%	1,579,396	100.00%
Recipient Name	1,579,427	100.00%	1,579,427	100.00%	1,579,427	100.00%	1,579,427	100.00%
Recipient Date of Birth	1,579,427	100.00%	1,579,427	100.00%	1,579,427	100.00%	1,579,427	100.00%
PIHP ID	1,579,427	100.00%	1,579,427	100.00%	1,579,427	100.00%	1,579,427	100.00%
Provider ID	1,579,427	100.00%	1,579,423	100.00%	1,579,423	100.00%	1,579,423	100.00%
Attending/Rendering Provider ID	1,579,427	100.00%	1,579,422	100.00%	1,579,422	100.00%	1,579,422	100.00%
Provider Location	1,579,427	100.00%	1,579,427	100.00%	1,579,427	100.00%	1,579,427	100.00%
Place of Service	1,579,427	100.00%	1,579,427	100.00%	1,579,427	100.00%	1,579,427	100.00%
Specialty Code / Taxonomy - Billing	1,579,427	100.00%	1,579,413	100.00%	1,579,413	100.00%	1,579,413	100.00%
Specialty Code / Taxonomy - Rendering / Attending	1,579,427	100.00%	1,579,419	100.00%	1,579,419	100.00%	1,579,419	100.00%
Principal Diagnosis	1,579,427	100.00%	1,579,427	100.00%	1,579,427	100.00%	1,579,427	100.00%
Other Diagnosis	309,656	19.61%	309,656	19.61%	309,656	19.61%	309,656	19.61%
Dates of Service	1,579,427	100.00%	1,579,427	100.00%	1,579,427	100.00%	1,579,427	100.00%
Unit of Service (Quantity)	1,579,427	100.00%	1,559,054	98.71%	1,559,054	98.71%	1,559,054	98.71%
Procedure Code	1,553,555	98.36%	1,553,555	98.36%	1,553,555	98.36%	1,553,555	98.36%
Procedure Code Modifier	766,247	48.51%	766,247	48.51%	766,247	48.51%	766,247	48.51%
Patient Discharge Status Code Inpatient	108,029	100.00%	107,219	99.25%	107,219	99.25%	107,219	99.25%
Revenue Code	108,029	100.00%	108,028	100.00%	108,028	100.00%	108,028	100.00%

Overall, Partners has improved the quality and accuracy of the encounter data submitted compared to last year's review of 2019 claims. Institutional claims contained complete and valid data in 17 of the 18 key fields (94%) with the only issue noted in the Procedure codes. Around 24% of the Institutional claim line items were missing a Procedure code where one is needed to identify the service provided. Room & board type of charges were excluded when analyzing the Procedure codes. In the current review period, minor issues with Units of Service and Patient Status codes were noted. These data elements should be closely monitored when reviewing next year's encounter data.

Professional encounter claims submitted contained complete and accurate data in 15 of the 16 key Professional fields (94%). The Other Diagnosis code was present in only 16% of all Professional claims. Overall, Partners saw a significant reduction in the number of deficiencies compared to 2018, when five (5) issues were noted – Billing Provider Id, Recipient Id, Billing Taxonomy, Rendering Taxonomy, and Procedure codes.

Encounter Acceptance Report

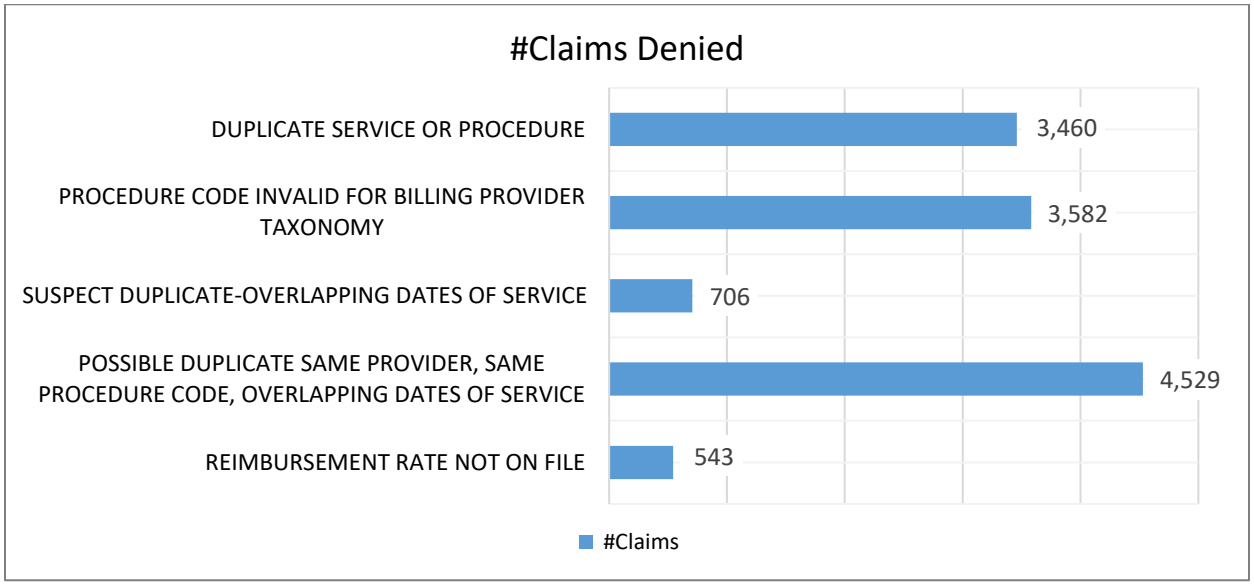
In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by Check Write which made it difficult to tie back to the ISCA response and submitted encounter files since only the Date of Service for each is available. During the 2020 weekly Check Write schedule, Partners submitted a total of 1,383,848 encounters to NC Medicaid. On average, 0.31% of all encounters submitted were initially denied. About 0.02% of denied claims are still outstanding, and the rest have been reviewed, resubmitted, and accepted by NC Medicaid.



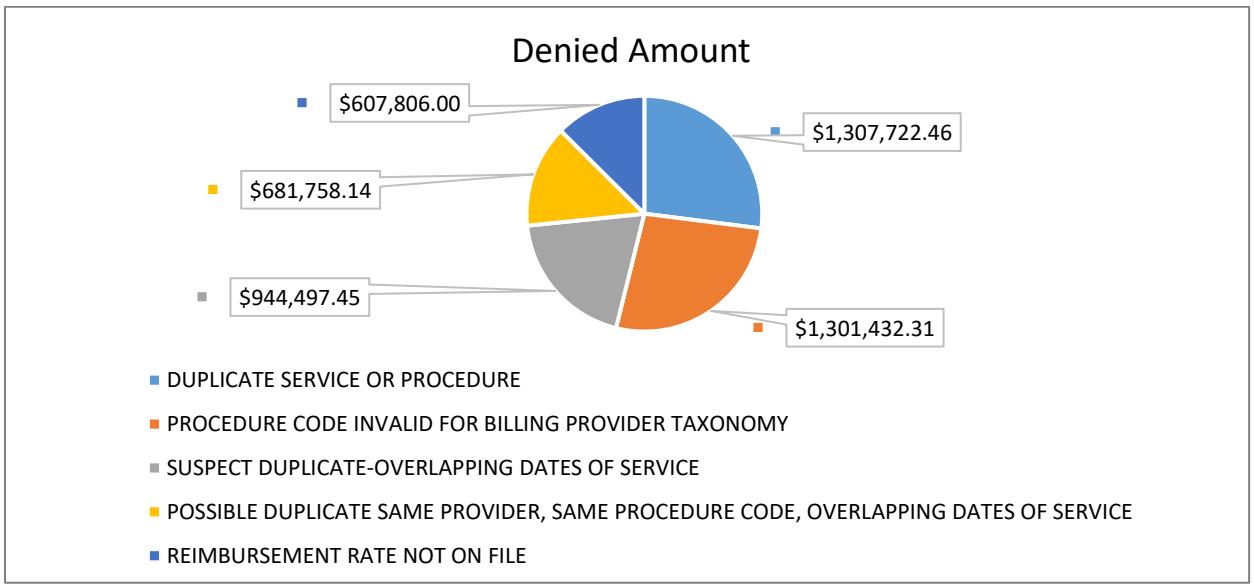
Evaluation of the top denials for Partners encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis above. Encounters were denied primarily for:

- Duplicate service or procedure
- Procedure code invalid for billing provider taxonomy
- Suspect duplicate-overlapping dates of service
- Possible duplicate same provider, same procedure, overlapping dates of service
- Reimbursement rate not on file

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



The pie chart below reflects the top five denials by claim dollar amount.



Results and Recommendations

Issue: Other Diagnosis Codes

The 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 NC Tracks, the low figure suggests that many providers may not be reporting the Other Diagnosis codes. A closer examination reveals that some providers never report the Other Diagnosis code. This issue is particularly acute for Professional encounters where only about 16% of all claims had at least one Other Diagnosis code.

Recommendation:

Partners should continue to perform an 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 all claims should be populated 99% of the time. For the current review period, only 76% of Institutional claim line items contained a valid value in the Procedure code field where one is needed to identify the service that was provided. The review 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 barely missed meeting the Data Quality Standards threshold target for Procedure codes. Procedure codes were populated 98.36% of the time, and in each instance, a valid value present. However, for Institutional claims, the figure drops significantly to 76%.

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, Partners should 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). Partners implemented additional edits in 2021 to deny claims that do not contain proper procedures where one is expected. Therefore, this issue is expected to be resolved for 2021 dates of service and beyond.

Conclusion

Based on the analysis of Partners' encounter data, it has been concluded that the data submitted to NC Medicaid is complete and accurate as defined by CMS and NC Medicaid standards.

Minor issues were noted with both Institutional and Professional encounters. Based on Partners' ISCA response, overview of the Alpha system, and limited number of data anomalies, HMS believes that 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 continue improvements 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 above are critical data elements as identified by CMS and NC Medicaid. Therefore, Partners should review and take Corrective Action to resolve the issues identified above.

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