CCME

2019 External Quality Review

PARTNERS HEALTH MANAGEMENT

Submitted: August 28, 2020

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

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EXECUTIVE SUMMARY

The *Balanced Budget Act of 1997* requires State Medicaid agencies that contract with Prepaid Inpatient Health Plans (PIHPs) to evaluate their compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFRs) 438.358 (42 CFR § 438.358)*. This review determines the performance level of the Partners Health Management (Partners). This report contains a description of the process and the results of Partners' 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:

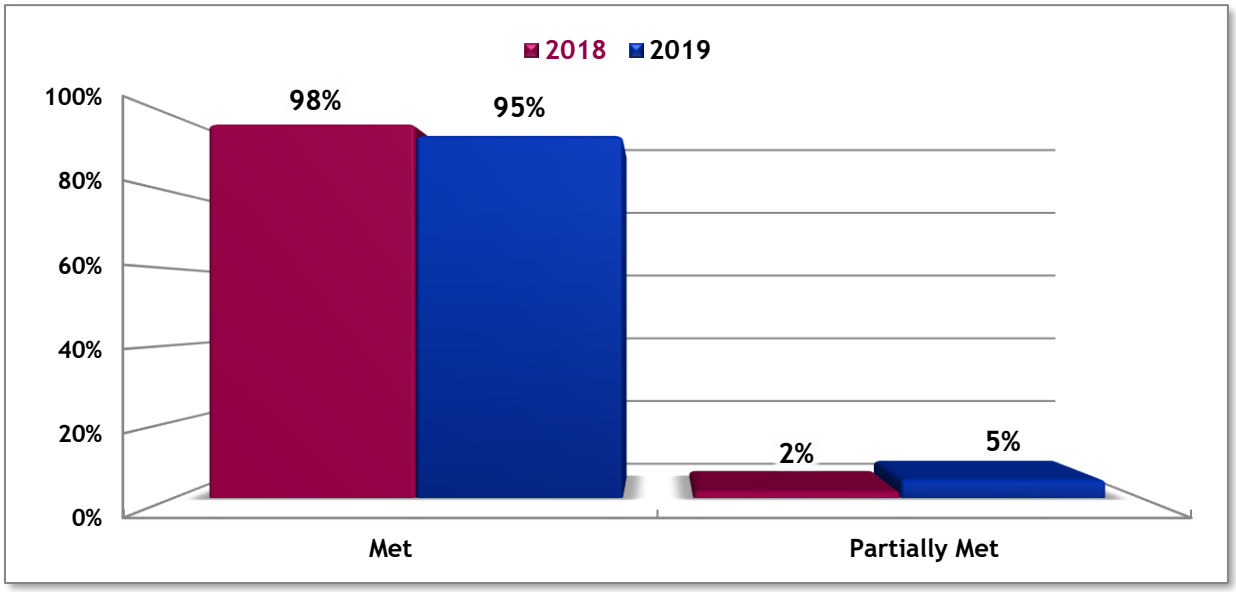
- Determine if Partners complies with service delivery as mandated by their *NC Medicaid Contract*
- Provide feedback for potential areas of further improvement
- Verify the delivery and determine the quality of contracted health care services

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

A. Overall Findings

The 2019 Annual EQR reflects that Partners met 95% of the standards reviewed. As Figure 1 indicates, 5% of the standards were scored as "Partially Met". Less than 1% of the standards were scored as "Not Met" and are not represented in Figure 1. Figure 1 provides a comparison of Partners' 2018 review results to their 2019 results.

Figure 1: Annual EQR Review Results



B. Overall Recommendations

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

Administration

Partners met 90% of the Administration standards in this year's EQR. One Recommendation addresses missing and incorrect information in the policy and procedure governing Partners' management, tracking, and annual review of their policies and procedures. A second Recommendation addresses missing information from the Organizational Chart pertaining to the clinical oversight provided by the Associate Medical Director.

Two Corrective Actions were issued in the ISCA standards to ensure Partners is able to capture and submit all available International Classification of Diseases 10th Revision Procedure Coding System (ICD-10 Procedure Codes). Partners does not capture the ICD-10 Procedure Codes submitted electronically or through the provider web portal. Partners does not submit ICD-10 Procedure Codes on the Institutional encounter data extracts to NCTracks.

Provider Services

The Provider Services EQR is comprised of Credentialing and Recredentialing, and Provider Services, which includes Network Adequacy, Provider Accessibility, Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, and

Practitioner Medical Records. At the last EQR, one item in the Credentialing/Recredentialing section of Provider Services required Corrective Action. Partners addressed the Corrective Action item. There were two Recommendations in the Credentialing/Recredentialing section at the last EQR. Partners addressed most of the identified issues in that section. Partners partially addressed the other Recommendation, and the NC Medicaid Contract no longer includes that item.

At the previous EQR, there were no Corrective Action items or Recommendations in the Provider Education, Adequacy of the Provider Network, Clinical Practice Guidelines for Behavioral Health Management, or Continuity of Care sections. In the Practitioner Medical Record area at the last EQR, there were no Recommendations and one Corrective Action. Partners addressed the Corrective Action item.

Partners met 100% of the Provider Services standards in the current EQR. There are six Recommendations in the Credentialing/Recredentialing areas, with two of the Recommendations occurring in both the Credentialing and the Recredentialing areas. There is one Recommendation in the Provider Education area.

Enrollee Services

The Enrollee Services EQR focuses on member rights and responsibilities, member program education, behavioral health and chronic disease management education, and the Call Center. In this year's EQR, Partners met 100% of the Enrollee standards.

In the previous EQR, there were two Corrective Actions, both were corrected and maintained for this review. There were also two Recommendations in the previous EQR. One was implemented, and the other is yet to be implemented.

In this year's EQR, there are no Corrective Actions and three Recommendations. These Recommendations aimed to improve language and readability within materials for enrollees.

Quality Improvement

The Quality Improvement (QI) section covers the QI Program, QI Committees, provider participation in QI, the QI Annual Evaluation, performance measures, and Performance Improvement Projects (PIPs).

In the previous EQR, there was one Corrective Action and four Recommendations. The Corrective Action was partially addressed. Two Recommendations were implemented, and two recommendations were not fully implemented.

In this year's EQR, there are two Corrective Actions and one Recommendation. The first Corrective Action focuses on the monitoring provider compliance to Clinical Practices Guidelines. While Partners reports they have a current process for monitoring, no monitoring

occurred during the period of review nor any previous EQR review periods. Partners provided a Corrective Action response in the previous EQR that was accepted based on its commitment to complete provider monitoring by March 2019.

Similarly, the second Corrective Action focused on Partners' lack of response to enrollee satisfaction surveys. Partners has not implemented any interventions to improve lower scoring satisfaction survey areas in the year in review nor any previous EQR review periods despite multiple commitments to do so.

Utilization Management

In this year's EQR, Partners met 89% of Utilization Management (UM) standards. CCME has issued five Corrective Actions and six Recommendations across the service authorization request process in Utilization Management and Care Coordination functions.

Two Corrective Actions and four Recommendations are regarding needed enhancements to program descriptions, policies, and procedures. Within the UM documentation, signatures, and credentials for UM Reviewers and Peer Reviewers were missing in the Service Authorization Request (SAR) files. The Recommendation encourages collaboration between Intellectual/Developmental Disability (I/DD) Care Coordinators, network providers and UM Reviewers to ensure that information supporting the SARs meet all documentation requirements and reflects the enrollee's current care needs.

The remaining three Corrective Actions and two Recommendations target concerns within the UM, Mental Health/Substance Use (MH/SU), I/DD, and Transition to Community Living Initiative (TCLI) Care Coordination files reviewed. In the MH/SU, I/DD and TCLI Care Coordination files, CCME noted significant inconsistencies in the follow-up activities, completeness, and quality of documentation by Care Coordinators across all three departments.

Grievances and Appeals

Partners met 85% of the grievance and appeal standards in this year's EQR. The grievance review resulted in two Recommendations. The first Recommendation aims to improve procedural language around grievance resolution timeframes extended by Partners. The second Recommendation was based on the review of the grievance files, the majority of which were indicated as "high priority" grievances. Review of the files and feedback from staff during the Onsite indicate there may be a disconnect between the processes staff follow when identifying and resolving "high priority" grievances and the grievance policy and procedure. CCME recommends Partners closely monitor "high priority" grievances to ensure staff comply with the expectations outlined in Policy and Procedure 6.00U, Grievance Management Policy.

In this year's EQR of appeals, three Corrective Actions and five Recommendations were issued. These primarily targeted missing or incorrect information in Partners' appeal policy and procedure, *Provider Operations Manual* and *Member Handbook*. Review of the sample of appeal files submitted by Partners showed a lack of compliance by staff when processing oral, expedited, invalid, and withdrawn appeals. These errors impacted almost half of the files reviewed. A Corrective Action was issued to ensure Partners closely monitors their appeals files for compliance to Partners' appeals policy and procedure, *NC Medicaid Contract*, and federal regulations governing appeals.

Delegation

Partners currently has two delegated entities, with fully executed Delegation Agreements and Business Associates Agreements with both delegates. A Delegation Agreement with Prest & Associates ended on October 31, 2019, and a Delegation Agreement with Vaya Health ended on June 30, 2019. Partners conducted annual monitoring for all delegates.

At the last EQR, there were no Corrective Action items and one Recommendation, which Partners partially addressed. During the current EQR, there are no Delegation items that require corrective action. CCME recommends that Partners include in the annual assessments the timeframe covered by the assessment, the date the assessment is completed, and the date it is signed by the Partners staff member. Partners added *NC Medicaid Contract* language regarding annual assessments as per the Recommendation at the last EQR. However, Partners maintained language indicating an annual assessment is not required if the delegate is accredited. This is in conflict with the requirements of *NC Medicaid Contract Attachment B, section 11.1,* and CCME issued a Recommendation to correct this language. Additionally, Partners should submit the annual assessments with other Desk Materials, as requested in the *External Quality Review Materials Requested for Desk Review*.

Program Integrity

In this year's EQR, Partners met 100% of the Program Integrity (PI) standards. Nine Recommendations were issued to address contractual language missing from Partners' policies and procedures. These same Recommendations were issued in the previous year's EQR and were not addressed by Partners. CCME again recommends Partners' Program Integrity policies and procedures reflect their contractual requirements. This will ensure consistent information and compliance by Partners.

A sample of 15 PI files for the period of March 1, 2019 through February 29, 2020 were selected from a universe of files and submitted by Partners. These PI files were reviewed and found to be compliant with *NC Medicaid Contract* requirements. There were no cases of suspected enrollee fraud during the review period.

Financial Services

Partners met 100% of the Financial Services standards in this year's EQR. There were two Recommendations from 2018's EQR, and both had been implemented. Three Recommendations were issued this year for Financial Services. Two Recommendations were issued to address missing information in the policy concerning Partners' NC Medicaid report due date and target percentage for Medical Loss Ratio. A third Recommendation was issued to address formalizing Partners' Cost Allocation Plan with percentage estimate rather than simply explaining methodology.

Encounter Data Validation

Based on the analysis of Partners' encounter data, we have concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues were noted with both Institutional and Professional encounters. Based on Partners' ISCA response, overview of the Alpha system, and limited number of data anomalies, HMS believes that 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 in nature. Therefore, Partners should review and take corrective action to resolve the issues identified above.

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

METHODOLOGY

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

Partners' 2019 EQR was initially scheduled for May 2020. However, due to COVID-19, the EQR was postponed to July 2020. The Onsite occurred via a secure virtual meeting platform.

On April 20, 2020, CCME sent notification to Partners that the annual EQR was being initiated (see *Attachment 1*). This notification included:

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

Further, an invitation was extended to the health plan to participate in a pre-Onsite conference call with CCME and NC Medicaid 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 April 27, 2020 and reviewed in the offices of CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, Quality Improvement (QI) and Medical Management Programs. Also included in the Desk Review was a review of credentialing, grievance, utilization, care coordination, case management, and appeal files.

The second segment was a two-day Onsite review conducted on July 29 and July 30, 2020. Due to COVID-19, Partners' Onsite review was conducted virtually. CCME's Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's Onsite activities included:

- Entrance and Exit Conferences
- Interviews with Partners' administration and staff

All interested parties were invited to the Entrance and Exit Conferences.

FINDINGS

The findings of the EQR are summarized in the following pages of this report and are based on the regulations set forth in *42 CFR § 438.358* and the *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. Administration

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

Policies & Procedures

For the EQR of policies and procedures, Partners submitted 201 Policies and Procedures, 11 program descriptions/plans, 13 standalone policies, and a Master Tracking List. When compared to the program descriptions/plans, review of the Master Tracking List submitted showed some disconnect in tracking program descriptions/plans. Eleven program descriptions/plans were submitted with the policies and procedures, but the Master Tracking List shows 12 program descriptions/plans, and, in a separate folder, Partners uploaded a total of 16 program descriptions/plans.

Policy and Procedure 1.09U indicates, "Each procedure and program description/plan is reviewed initially and then at least annually by the Department Director/Designee." However, at least one of Partners' program descriptions/plan (Partners' Disaster Plan) has not been reviewed in two years. Staff also explained during the Onsite that some program descriptions/plans follow a different process for annual review than is outlined in Policy and Procedure 1.09U.

Policy and Procedure 1.09U, Policy, Procedure, Plan and Program Description Compliance Policy, describes the process for the creation, annual review, revision, and maintenance of Partners' policies, procedures, and program descriptions/plans. The procedure indicates that Master Tracking Lists include comprehensive information such as the "document title, category, and reference number, Department responsible, original approval date, and all subsequent review/approval dates." However, the Master Lists submitted for this EQR contain only the title, number, and category of each policy and procedure and do not include the subsequent review/approval dates. Staff explained the history of policy and procedure revision is now tracked separately from the Master Lists.

It was also noted that Policy and Procedure 1.09U requires the chronology of policy and procedure revisions to be captured in the footer of each policy and procedure. This process was abandoned by Partners' in 2018. During the Onsite, staff confirmed an internal drive maintains a list of policy and procedure revision dates and all previous versions of policies and procedures.

Organizational Staffing/ Management

Dr. Stanton serves as Partners' Chief Medical Officer (CMO) and Dr. Edwards joined Partners' medical staff as the Associate Medical Director (AMD) in June 2019. Both physicians have identical job descriptions. It was recommended in the past EQR that departmental oversight by the CMO is reflected on the Organizational Chart. This Recommendation was implemented, but the current Organizational Chart does not reflect the departmental involvement or oversight by Dr. Edwards. During the Onsite, staff could describe Dr. Edwards' functions at Partners, however, there is no documentation to show which departments or functions he supports.

Confidentiality

Partners' policies and procedures address confidentiality practices and requirement and including, but not limited to:

- Accounting of Disclosure of Confidential Information
- Assurance of Confidentiality
- HIPAA Breach Notification
- HIPAA Security Incident Response and Reporting
- Legal Proceedings Involving Confidential Member Information
- Maintenance of Confidentiality with Shredding Vendors
- Member Privacy Rights
- Member Request for Amendment of Health Information
- Member Records management
- Member Request to Access Protected Health Information
- Minimum Necessary
- Release of Information with Member Consent
- Release of Information without Member Consent
- Security and Accessibility of Member Information
- Verbal Consent

During the Onsite, staff explained confidentiality training of new staff occurs in the first two days of the new staff's employment and prior to exposure to Protected Health Information.

Procedure 2.15U, Employee Training and Support, further indicates that Partners provides "initial orientation and training for all employees before assuming assigned roles and responsibilities" and that this initial orientation includes training on confidentiality and other regulatory compliance topics.

Information Systems Capabilities Assessment

A review was conducted of Partners' information system capabilities utilizing the Information Systems Capabilities Assessment (ISCA), as specified in the CMS protocol.

Upon receipt of the completed ISCA tool and supporting documentation from Partners, IPRO reviewed the responses and followed up on areas requiring clarification via interviews. Additionally, staff presented a member and claims systems review upon request on a teleconference on July 30, 2020. Due to COVID-19, a teleconference platform was used for the ISCA review. Partners' employees were prepared to speak on existing processes and reports during the ISCA review. Questions regarding the ISCA tool and follow-up on last year's findings were discussed with the health plan. The teleconference format of the ISCA review did not impact the review and the PIHP was able to provide a demonstration of the enrollment and claims screens without any issues.

Like many other PIHPs in North Carolina, Partners uses the AlphaMCS transactional, a hosted system environment produced by WellSky (formerly known as Mediware). The AlphaMCS system is used to process member enrollment, claims, submit encounters, and generate reports. WellSky modifies the user interface and conducts backend programming updates to the system.

Partners has experienced a small decrease in enrollment over the past two years. The year-end enrollment from 2016 to 2018 is shown in Table 1.

Table 1: Enrollment Counts

2016	2017	2018
158,238	156,533	149,774

The ISCA tool and supporting documentation clearly define the process for enrollment data updates in the AlphaMCS enrollment system. During the ISCA teleconference review, Partners provided a demonstration of the AlphaMCS enrollment system, which maintains a member's enrollment history. The Global Eligibility File (GEF) file is imported daily into the AlphaMCS with the files received the previous day. The quarterly GEF file is imported quarterly upon receipt. The daily and quarterly eligibility files are compared to existing eligibility in the

AlphaMCS. The member enrollment records are processed and checked against the existing data in the database. Existing data in the eligibility database is updated and new records are added to the database.

During the teleconference, Partners stated that the GEF files are loaded into a local data warehouse that is used for reporting. Partners produces reports that compare total record counts in each database in the data warehouse that is used to research discrepancies. The data in the warehouse is also compared with the AlphaMCS system to ensure that there are no discrepancies between the AlphaMCS and Partners' data warehouse. Partners stated that they rarely encounter any errors while processing the GEF files.

Partners internally assigns a Unique Client identification (ID) number to all members. Partners identifies enrollees by the Medicaid ID number that is received on the GEF and the Unique Client ID. If the enrollee is assigned a new Medicaid ID, then Partners' system is able to track the prior Medicaid ID and link the historical enrollment records to the new Medicaid ID as the member will have the same Unique Client ID. The Unique Client ID may change if there is merging of duplicate records. If a member is assigned to more than one Unique Client ID then only one Unique Client ID is retained and the other IDs are inactivated after historical information is moved to the retained Unique Client ID. Partners has the capability to track historical claim and encounter data for an enrollee.

During the Onsite teleconference, Partners indicated that they rarely see members with multiple IDs but are able to research and merge the information into one member ID. The historical claims for the member are also merged into one member ID.

Partners' providers have the capability to confirm a member's eligibility in the AlphaMCS Provider Portal.

Partners advised that the enrollment start date of a member will always be the first day of the respective month. Members with spend-down amounts associated with their eligibility may be enrolled on the day of the month they qualify for Medicaid. There are no other situations in which the member would not be enrolled on the first day of a respective month. Typically, Partners disenrolls members on the last day of the respective month and also on their date of death.

Member deaths are captured through the GEF file, and Partners also uses the monthly 820 file to confirm and identify member's date of death.

On a monthly basis, Partners uses the 820 Capitation file along with the GEF and the monthly 834 files to reconcile current and retroactive per member per month (PMPM) payments and to identify discrepancies between the eligibility and payment processes. Partners also compares the current and historical eligibility data with the 820 file to identify discrepancies and adjust, as necessary.

During the teleconference, staff displayed the enrollment information that is viewable and captured within AlphaMCS, which is able to capture demographic data like race, ethnicity, and language.

Partners' authorizations and claims are processed in the AlphaMCS system. The ISCA tool and supporting documentation for claims processes for receiving, adjudicating, and auditing claims are clearly defined. A demonstration of the AlphaMCS claims processing system was performed during the teleconference review. Partners also provided an overview of the processes for receiving, adjudicating, and auditing claims.

Partners receives claims from three methods, 837 electronic file, Provider Web Portal, and paper claims. During the teleconference, Partners stated that they accept claims on paper from new providers. If existing providers continuously submit paper claims, then Partners does not accept the paper claims and advises the providers to submit claims electronically or through Partners' Provider Web Portal. The below table details the percentage of 2018 claims received via the three methods.

Table 2: Percent of claims with 2018 dates of service that were received via Electronic (HIPAA, Provider Web Portal) or Paper forms.

Source	HIPAA File	Paper	Provider Web Portal
Institutional	76.6%	0.3%	23.1%
Professional	64.7%	0%	35.3%

During the teleconference, Partners indicated that if a required field is missing from a claim, its provider portal will not allow the claim to be submitted to Partners. The fields are validated prior to submitting the claim for processing. If the claim is being submitted electronically via an electronic 837 file and one or more required fields are missing, then the provider would receive a 999 file advising them of the claim failure. If the claim is submitted and a field such as provider National Provider Identifier (NPI) is missing or invalid, then the claim will be processed and denied. Partners stated that they rarely see claims denied due to incorrect provider NPI. Partners' claims processors do not change any information on the claims. Claims processors may reprocess claims but do not update any data on the claims.

Partners adjudicates claims on a nightly basis. Approximately 99.3% of Professional claims and 95.6% of Institutional claims are auto-adjudicated. Approximately 100% of all claims are processed and complete within three months of the close of the reporting period.

Partners conducts audits of claims processed on a daily, weekly, monthly, and quarterly basis. Partners staff conduct random audits of approximately 3% of all claims processed on a daily

basis. Paper claims are also included in the random sample of 3%. Approximately 7% of Co-ordination of Benefit (COB) claims are randomly selected for audit that compares the COB with the Explanation of Benefits (EOB) received from the providers. All claims that are higher than $5,000 are audited on a daily basis. Partners also uses an Override report that is generated on a daily basis to verify who is overriding a claim.

For Institutional claims, Partners captures up to 25 International Statistical Classification of Diseases and Related Health Problems (ICD-10) diagnosis codes on the Provider Web Portal and up to 29 ICD-10 diagnosis codes for Institutional claims on the HIPAA 837I file. For Professional claims, the PIHP has the ability to receive and store up to 12 ICD-10 diagnosis codes on both the Provider Web Portal and HIPAA 837P file. Partners captures Diagnosis Related Group (DRG) codes that are submitted on a claim through the HIPAA 837I file and Provider Web Portal. Partners does not capture ICD-10 procedure codes on a claim through the HIPAA 837I file or Provider Web Portal.

As discussed during the teleconference, Partners has the capability to capture and submit Healthcare Common Procedure Coding System (HCPCS) codes along with required revenue codes for specific claims regarding lab, drug, or radiology services.

Partners pends claims that have a billed amount higher than $5,000, including Emergency Department (ED) claims and professional claims. The pended claims are manually reviewed by the Quality Review Analyst for accuracy prior to approval or denial. Claims that require medical review, based on length of stay in ED, or claims that have questionable services are pended and sent to Partners' CMO for approval or denial. Claims pended for medical review are completed within seven days.

During the teleconference, Partners stated that they have worked with NC Medicaid and updated their processes to capture and submit Telehealth modifier codes during COVID-19. Partners worked with their providers to update and resubmit claim to include the Telehealth modifier codes.

Partners uses the AlphaMCS' On-line Transactional Processing (OLTP) database and Structured Query Language (SQL) Server Reporting Services to generate Performance Measure reports. Partners also uses the Physical Health (PH) claims data provided by NC Medicaid for performance measures that require PH claims data. Partners uses Microsoft SQL programming language to extract data and create reports. SQL Server Integration Services and SQL Analysis Server are used for Business Intelligence dashboards and Key Performance Indicator reporting.

Partners conducts several levels of verification and testing on the performance measure reports. Component level review and testing of programs are conducted to ensure that the codes sets, and populations included by the performance measure programs meet the specifications. Detailed records are output at multiple key points in the program for verification against datasets and records generated. Partners also compares the eligible

members, counts of claims, and counts of discharges against known operational level data. All calculations are verified and compared against specifications during testing. The testing results are documented and reviewed by a cross departmental team to ensure validation of all testing levels. Partners has three SQL programmers who create, validate, and test performance measure programs. Partners noted the claims data in the AlphaMCS database is backed up on a daily and weekly basis.

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

Partners has a defined process in place for their encounter data submission with 837 files submitted to NC Medicaid and 835 files received back from NC Medicaid through the NCTracks system. Partners has the ability to track claims from the adjudication process to their encounter submissions status. The 835 file from NCTracks is used to review denials. The extraction and submission of encounter data are fully automated. The reconciliation of encounter data is performed manually, while resubmission of encounters is automated.

For the dates of service in 2018 and a 2017 year comparison, a breakdown of encounter data acceptance/denial rates are listed in Table 3.

Table 3: Volume of Submitted Encounter Data with dates of service in 2017 and 2018

2018	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	74,414	88	811	75,313
Professional	1,276,806	9,646	1,701	1,288,153
2017	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	65,020	56	354	65,430
Professional	1,249,496	54,466	690	1,304,652

For dates of service in 2018, Partners has approximately 99% acceptance rate for both Professional and Institutional encounters. The encounter data acceptance rate is consistent with last year's audit findings with the acceptance rate of approximately between 98%-100%. During the teleconference, Partners noted their encounter data acceptance rate for 2019 also was approximately 99%. Partners exceeds the NC Medicaid standards for encounter data

submission. Partners indicated that the three top denial reason codes were duplicate claims, Billing Provider Taxonomy, and Rendering Provider Taxonomy, respectively.

On average, Partners submits an encounter within nine days from the time of adjudication to NCTracks. It takes approximately 54 days to correct and resubmit an encounter to NCTracks. Partners uses a report that was developed in-house based on the 835 response file to identify denied encounters and the reason for denial. Partners also uses the NC Medicaid Adam Holtzman's paid and denied report for additional information on the denied encounters.

During the teleconference, Partners explained the number of ICD-10 diagnosis codes submitted on Institutional and Professional encounters to NC Medicaid. Partners has updated their system in December 2018 to submit up to 29 ICD-10 diagnosis codes for Institutional and up to 12 ICD-10 diagnosis codes for Professional encounters. Partners has addressed the corrective action from the previous EQR review to submit all secondary diagnosis codes on Institutional and Professional encounters to NCTracks.

Partners submits the DRG codes submitted by the provider on a claim to NCTracks. However, Partners does not submit ICD-10 procedure codes to NCTracks.

During the teleconference, Partners stated that they can submit lab, drug, or radiologic services that have revenue codes along with the HCPCS procedure code on the encounter data extracts.

Partners met 90% of the Administrative standards in this year's EQR. Figure 2 provides a comparison to the previous year's Administrative score.

Figure 2: Administration Comparative Findings

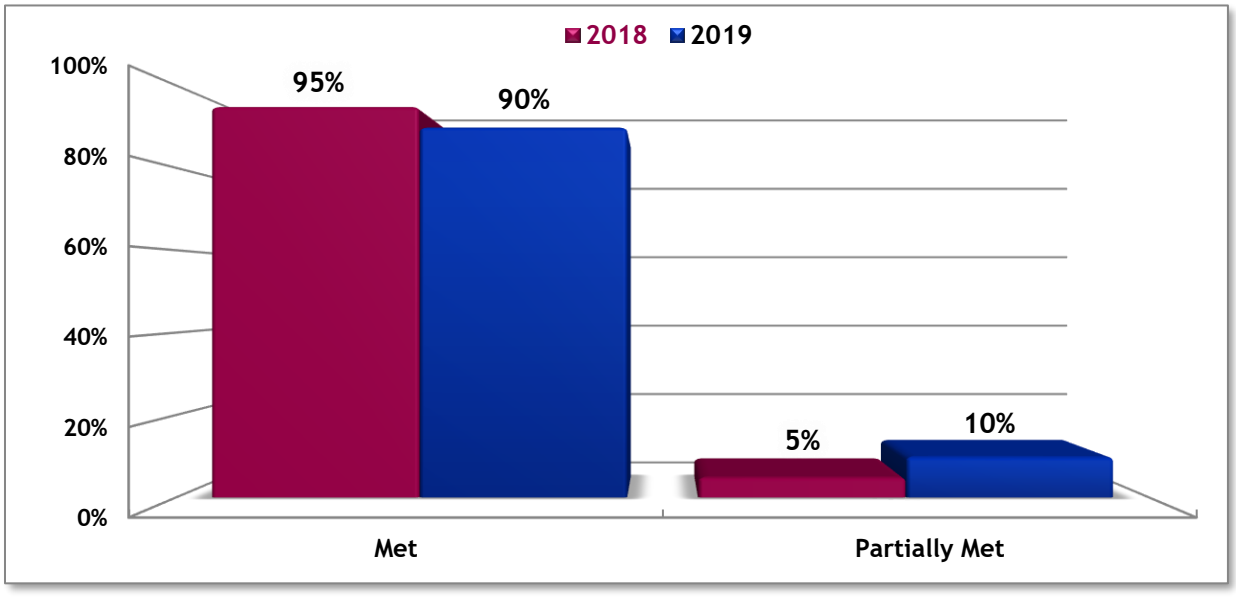


Table 4: Administration

Section	Standard	2019 Review
Management Information Systems	The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 diagnosis codes received on an 837 Institutional and 837 Professional file capabilities of receiving and storing ICD-10 procedure codes on an 837 Institutional file.	Partially Met
	The MCO has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data.	Partially Met

Strengths

- Partners auto-adjudicates claims; 95.6% of Institutional claims and 99.3% of Professional claims.
- Partners' current NCTracks encounter data acceptance rate is approximately 99%.
- As of December 2018, Partners can submit of up to 29 diagnosis codes on Institutional claims and 12 diagnosis codes on Professional claims.

Weaknesses

- Partners' Policy and Procedure 1.09U does not reflect Partners' current process for tracking, managing, and annually reviewing policies, procedures, and program descriptions/plans.
- Partners' Organizational Chart does not reflect the departmental involvement or oversight by the AMD Dr. Edwards.
- Partners does not have the ability to capture all available ICD-10 procedure codes on the Institutional claims through their Provider Web Portal and 837I HIPAA files.
- Partners does not have the ability to submit ICD-10 procedure codes on encounters to NCTracks.

Corrective Action

- Update Partners' Provider Web Portal and AlphaMCS system to capture all available ICD-10 procedure codes on the Institutional claims.

- Update Partners' encounter data submission process to submit all available ICD-10 procedure codes on the 831I encounter files to NCTracks.

Recommendations

- Revise Policy and Procedure 1.09U to accurately reflect Partners' current process for tracking revisions of all policies and procedures. In this revision, include an accurate description of the process Partners follows to annually review all program descriptions/plans.

- Revise the Organizational Chart to include the AMD in the departments he supports.

B. Provider Services

The Provider Services External Quality Review (EQR) is comprised of Credentialing and Recredentialing, Network Adequacy, Provider Accessibility, Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, and Practitioner Medical Records. CCME reviewed relevant policies and procedures, the *Credentialing Program Description*, the *Credentialing Committee Charter*, credentialing/recredentialing files, provider training and educational materials (including the *Provider Orientation Toolkit*, and the electronic Provider Knowledge Base and Partners' Training Academy sections on the Partners' website), the *Provider Operations Manual (Effective November 27, 2019)*, Credentialing Committee meeting minutes and documents, provider network information, Clinical Practice Guidelines, the *2019 Community Mental Health, Substance Use and Developmental Disabilities Services Network Adequacy and Accessibility Analysis* (Gaps Analysis), the *Partners' Member Handbook*, and the Partners' website. Partners' staff provided additional information during the Onsite interview.

In Partners' 2018 EQR, one item in the Credentialing/Recredentialing section of Provider Services required Corrective Action. Partners addressed the Corrective Action item. There were two Recommendations in the Credentialing/Recredentialing section at the previous EQR.

The first Recommendation was "Verify credentialing and recredentialing files contain all required information and Primary Source Verifications." This one overarching Recommendation was to address issues such as missing Primary Source Verification (PSV) documentation that occurred in one or two of the credentialing/recredentialing files. Partners addressed the specific items listed in the previous EQR, though the file review in the current EQR resulted in additional Recommendations.

The second Recommendation in the Credentialing/Recredentialing section of Provider Services at the previous EQR was related to Partners completing site reviews via the FaceTime app, rather than in person. This practice was not captured in any policy or procedure and had not been discussed with or approved by NC Medicaid. This Recommendation was addressed, as Partners added the language to the Policy 8.08 and

contacted NC Medicaid regarding this practice. There was no final resolution to this issue, but the NC Medicaid Contract no longer requires site assessments before enrollment.

At the previous EQR, there were no Corrective Action items or Recommendations in the Provider Education, Adequacy of the Provider Network, Clinical Practice Guidelines for Behavioral Health Management, or Continuity of Care sections. In the Practitioner Medical Record area at the previous EQR, there were no Recommendations and one Corrective Action, which Partners addressed.

The Credentialing Committee includes Partners' employees and network providers representing various specialties. Dr. Elizabeth Stanton, Chief Medical Officer (CMO) and a board-certified psychiatrist, reviews and approves "clean" credentialing applications and chairs the Credentialing Committee. The *Credentialing Program Description* states "...the CMO chairs the credentialing committee, reviews and approves Providers' credentialing files that meet criteria for participation as delegated by the CR Committee." No alternate Credentialing Committee Chair is listed, though Dr. C. Stephen Edwards, the Associate Medical Director (AMD) and a board-certified psychiatrist, chaired the December 2019 meeting.

The *Credentialing Program Description* states, "The function of signing-off on each complete credentials review sheet may be delegated to the Assistant CMO and/or Clinical Director, if needed." Onsite discussion confirmed there is no "Assistant CMO", and the designation should be "Associate Medical Director". Some of the reviewed files were signed/approved by Dr. Edwards, AMD.

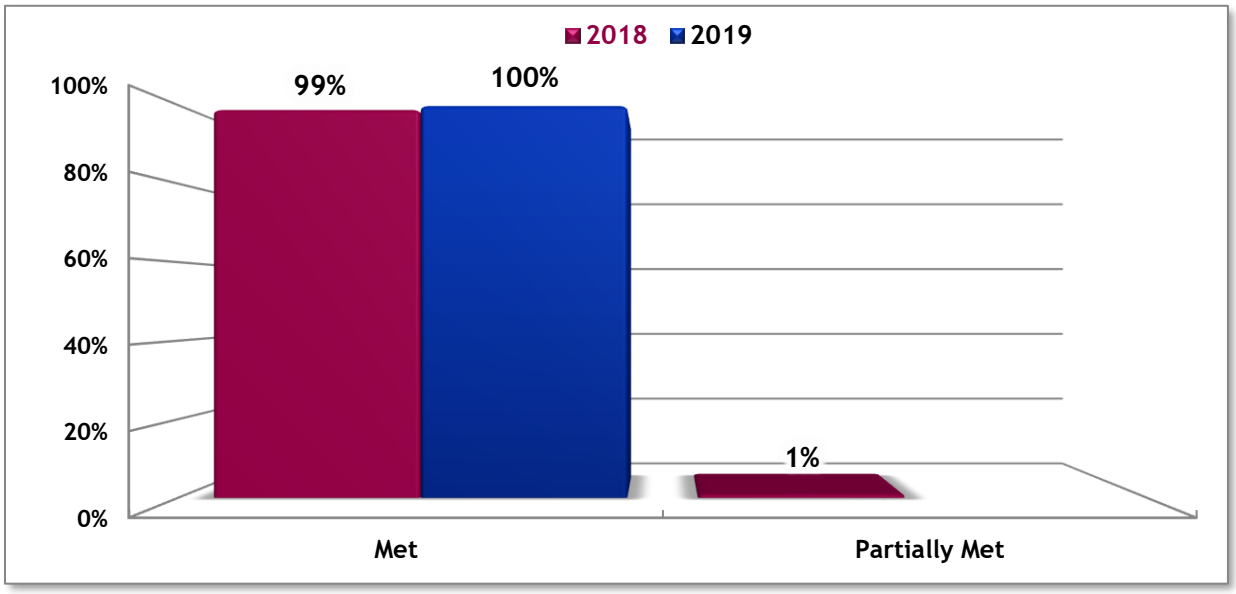
During most of the review period for this EQR, the Credentialing Committee had 10 voting members, three of whom are Partners' employees. The *Credentialing Committee Charter* defines quorum as "greater than half of the filled positions of the voting membership." The Credentialing Committee meets at least quarterly, with meeting minutes showing monthly committee meetings with a quorum present at all meetings from March 2019 through February 2020. Attendance of voting members ranged from one member who attended 75% of the meetings at which they were a member, to four members (or alternates or designees) who attended 100% of the meetings at which they were a member. Reviewed committee meeting minutes include lists of credentialing and recredentialing applications that were "Approved by Medical Director." Credentialing Committee meeting minutes reflect discussion and votes on the credentialing and recredentialing applications "flagged" for committee review.

Credentialing/recredentialing files were well organized and contained appropriate documentation, though Partners did not submit some items until CCME requested them. Several issues at the current EQR resulted in Recommendations. Details regarding these items are contained in the Tabular Spreadsheet (see *Attachment 4*).

The *2019 Community Mental Health, Substance Use and Developmental Disabilities Services Network Adequacy and Accessibility Analysis* identified choice and access gaps for Substance Abuse Comprehensive Outpatient Treatment Programs (SA-COTs). Partners filed an *Exception Request* with NC Medicaid for this service. The *Exception Request* was approved through the end of January 2020. A letter dated February 26, 2020 from NC Medicaid states, "After review, it appears that Partners has taken the necessary actions to resolve the gap for SA Comprehensive Outpatient Treatment Program and no longer requires an exception request." During Onsite discussion, Partners' staff reported continued efforts to address SA-COT, including the addition of two program locations currently awaiting licensure from the State, which was delayed due to COVID-19. When in-network providers are not available to provide medically necessary services, Partners uses Out of Network Consumer Specific Agreements (CSAs) to obtain the services. Partners' Care Coordination and Access to Care staff members can submit an internal form to identify specific service needs, including the location of the enrollee needing services.

Figure 3 shows 100% of the standards in the Provider Services section were scored as "Met" and provides an overview of 2019 scores compared to 2018 scores.

Figure 3: Provider Services Comparative Findings



Strengths

- Partners has a Provider Help Desk with a dedicated toll-free number. Direct phone numbers and email addresses for various provider network personnel are listed on the Partners' website.
- Every provider has an assigned Provider Account Specialist.

- The Partners website has numerous resources for providers, including the Provider Knowledge Base and Partners' Training Academy.
- Credentialing and recredentialing files are well-organized and contain appropriate documentation.
- The *2019 Network Adequacy and Accessibility Analysis* reports "Partners was able to close gaps in the provider network for Opioid Treatment services during the last fiscal year."
- A February 26, 2020 letter from North Carolina Department of Health and Human Services (NC DHHS) states "Partners has taken the necessary actions to resolve the gap for SA Comprehensive Outpatient Treatment Program and no longer requires an exception request."
- Provider Forums are offered quarterly via webinar to minimize loss of billable time for providers, and due to COVID-19.
- The Provider Network Department has two trainers assigned to the department. Due to COVID-19, training sessions are offered virtually.
- Communication Bulletins and Provider Alerts communicate important information to providers.

Weaknesses

- The Credentialing Program Description references the "Assistant CMO", a position which does not exist. Onsite discussion confirmed this should be the Associate Medical Director.
- The Credentialing Program Description states "...the CMO chairs the credentialing committee, reviews and approves Providers' credentialing files that meet criteria for participation as delegated by the CR Committee." There is no alternate Chair listed. The AMD chaired the December 2019 Credentialing Committee meeting and approved some of the credentialing/recredentialing files submitted for the EQR. Onsite discussion confirmed the AMD would chair the Credentialing Committee meeting any time the CMO is absent/unable to chair.
- The Credentialing Committee Charter lists "membership position description" and "member Name". The Credentialing Committee Charter submitted for the EQR was revised May 15, 2019, but it includes some individuals who are no longer on the committee.
- The Credentialing Program Description and Partners' credentialing and recredentialing processes do not include collecting Supervisory Agreement documentation for Physician Assistant (PA) applicants, and Partners did not collect supervision agreements for Licensed

Psychological Associates (LPA) applicants or applicants with "associate" licensure until March 2020, despite this being a Recommendation at the previous EQR.

- Partners does not verify education for physicians licensed prior to August 1, 2010, as they assume the North Carolina Medical Board (NCMB) conducted the primary source verification (PSV); however, Partners was unable to provide confirmation of this from the NCMB.
- Partners does not ask Licensed Independent Practitioner (LIP) applicants for information about persons with an "ownership or control interest in the provider" or about agents or managing employees. Therefore, it does not conduct required exclusion and criminal background checks for any of these individuals.
- Partners' Policy and Procedure 8.00, Access and Availability Standards, section II.A. states "Emergency Services: Providers must provide face-to-face emergency care within no more than two hours and fifteen minutes after the request for emergency care is received by provider staff from the LME/MCO or directly from the consumer", rather than within two hours as required by NC Medicaid Contract, Attachment S.

Recommendations

- Revise the Credentialing Program Description and any other documents that reference the "Assistant CMO" to reflect the correct title ("Associate Medical Director").
- To reflect the coverage plan if the CMO is absent, revise the Credentialing Program Description and any other documents that reference the Chair of the Credentialing Committee, to indicate the committee meetings are chaired by the CMO or designee.
- Update the Credentialing Committee Charter to include and maintain current membership.
- Revise the Credentialing Program Description and the credentialing/recredentialing processes to include the requirement to collect documentation of the supervision agreement for practitioners with "associate" licensure and for LPAs, and to collect the Supervisory Arrangement documentation for PAs. See NC Medicaid Contract Attachment O.
- Contact the NCMB to confirm that the NCMB conducted PSV of education for all physicians licensed prior to August 1, 2010. If confirmation is received, maintain the documentation. Otherwise, Partners remains responsible for conducting PSV of education for physicians who are not board certified or do not have the Educational Commission for Foreign Medical Graduates (ECFMG) certification.
- Revise the Credentialing Program Description and the credentialing/recredentialing processes for LIPs to include the requirement to collect the identifying information and conduct the required exclusion and criminal background checks for persons with an

ownership or control interest in the provider, and agents and managing employees of the provider, as outlined in the NC Medicaid Contract and the CFRs.

- Correct Partners' Policy and Procedure 8.00, Access, and Availability Standards to reflect the NC Medicaid Contract Attachment S requirement that providers "must provide face-to-face emergency services within two hours" (not within two hours and fifteen minutes).

C. Enrollee Services

The Enrollee Services EQR focuses on member rights and responsibilities, member program education, behavioral health and chronic disease management education, and the Call Center.

In the previous EQR, there were two Corrective Actions, which were both corrected and maintained for this review. There were also two Recommendations in the previous EQR. One was implemented, and the other still needs to be implemented. For the current EQR, there are no Corrective Actions and three Recommendations.

Policy 7.05, Member Notifications, explains that "within 14 days after a member schedules an appointment for services, Front Desk staff will use the New Member report generated in the AlphaMCS to mail a Welcome Letter which contains written information on Partners, Medicaid managed care and state funded services access, and how to view the *Member Handbook*, Rights and Responsibilities, and the Notice of Privacy Practices." Partners has all the *NC Medicaid Contract* required items in the written materials produced for enrollees. CCME has one Recommendation within the *Member Handbook* to add a definition and explanation of out-of-state services and the procedure for obtaining that service, if needed.

The annual mailing is available in English and Spanish. It is mailed to all current members each year, usually in October, and explains how to access online and request printed copies of any materials. When a provider is terminating from the network, Partners' process is to notify enrollees within 15 days. The EQR included a review of files with voluntary provider termination, with termination for cause and termination due to the provider's death. All terminated provider files met review criteria.

In the previous EQR, there was a Recommendation, "Enrollee written materials must use a font size no smaller than 12 point", per *42 CFR § 438.10(d)(6)(ii)*, and large print is no smaller than 18 point, per *42 CFR § 438.10(d)(3)*. Include this reference in a marketing and communications policy and/or procedure for enrollee written materials and verify these are implemented." For the current review, Partners confirmed this reference is not in any policy or procedure, but all enrollee written materials are no smaller than 12 point font, and all large print materials are no smaller than 18 point font. The same Recommendation was made again this year.

Page 28 of the *Member Handbook* includes a section with links to various member resources. The Members section of the Partners' website has a Resources section with three main categories: Print Materials, Housing & Transport, and Resources. Partners' Training Academy posts upcoming events online. The Training Academy is not explained in the *Member Handbook* and would be a great reference to members. CCME Recommends that Partners explain the Partners' Training Academy and post a link to the Training Academy in the *Member Handbook*.

Partners has several policies and procedures addressing customer service needs of their enrollees. The main policies and procedures reviewed include, 10.00U Access to Care Timeliness Standards, 10.01U Clinical Decision Support Tools, 10.02U Access to Community Crisis Services, 10.04U Access to Care Documentation of the Triage Process, 10.09 Access to Care Inter-Rater Reliability, 10.03U Access to Care Member Health and Safety, and 10.08U Steps of the Triage Process.

Policy and Procedure 10.08U, Steps of the Triage Process guides Access to Care staff to respond appropriately to members. Members with limited English are offered interpretation services from Pacific Solutions, Fluent Interpreting, or on the phone with Partners' staff.

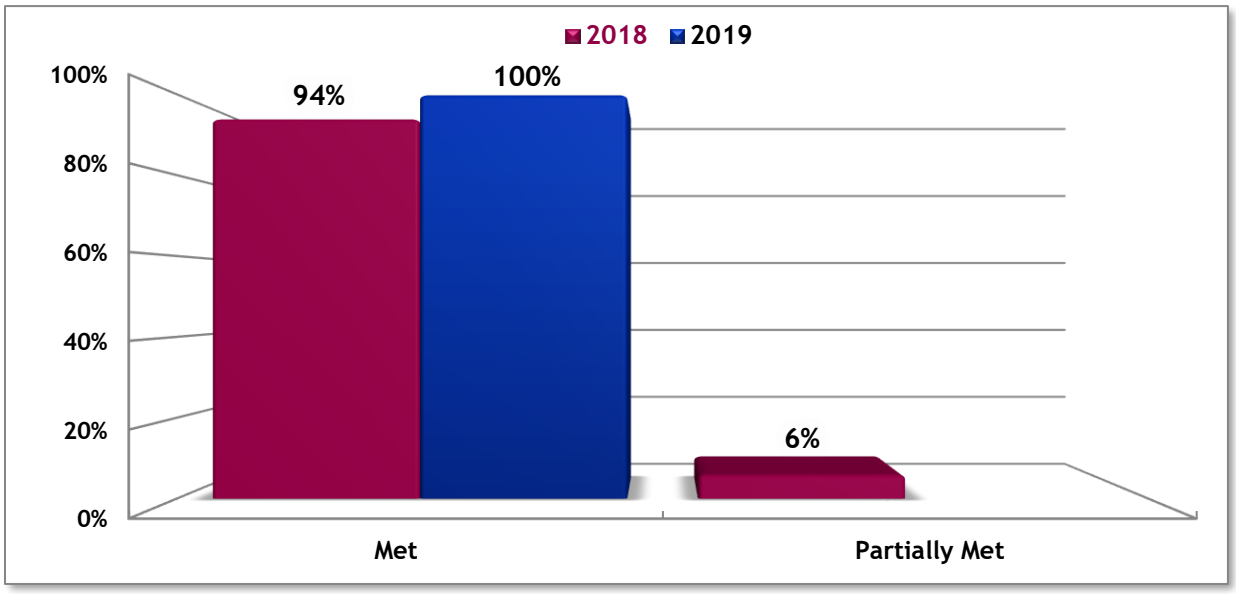
The Access to Care triage process and Policy and Procedure 10.02U, Access to Care Community Crisis Services guides staff to connect callers to crisis services when needed.

The *Member Handbook* provides clear information about access to services, and the Access to Care team refers callers to specific areas of this handbook when appropriate.

Partners meets or exceeds standards for speed of answer, call blockage, and call abandonment rates consistently. Partners explained at the Onsite that the most challenging metric is answering the calls in less than 30 seconds, although they consistently meet this metric. With Access to Care staff working from home during the pandemic, each call connection takes longer than answering from the call center.

Partners met 100% of the Enrollee Services EQR standards. Figure 4 shows a comparison of the percentage scores for 2018 and 2019.

Figure 4: Enrollee Services Comparative Findings



Strengths

- All Partners' staff members have access to software named "Aunt Bertha", a community resource search engine used to assist members and track referrals for food, housing, care needs, legal needs, and more.
- Partners worked with the provider network on a cell phone project. Providers sent a list of members who needed phones, and Partners rapidly distributed 500 cell phones through the providers to those members with the agreement that they would upload the Pyx Health app, crisis, and provider numbers, etc. This gave Partners the opportunity to have current numbers and email addresses for members to survey them and provided members with access to additional support, including telehealth, during the pandemic.
- Partners is launching a community newsletter geared toward members by the end of this calendar year.

Weaknesses

- Out-of-area and out-of-network are explained in the *Member Handbook* on page 22. How to attain out-of-state services is not specifically explained. Reference*: NC Medicaid Contract 6.9.1 (n).*
- There is no indication in a policy and procedure that enrollee-written materials must use a font size no smaller than 12 point, per *42 CFR § 438.10(d)(6)(ii)*, and large print is no smaller than 18 point, per *42 CFR § 438.10(d)(3*).

- Partners' Training Academy is not explained in the *Member Handbook* and would be a great reference to members. Reference: *NC Medicaid Contract Section 6.12*.

Recommendations

- Within the *Member Handbook*, add a definition and explanation of out-of-state services and the procedure for obtaining that service, if needed.
- Include reference in a marketing and communications policy and/or procedure for enrollee written materials to be produced in a font no smaller than 12 point font, and large print no smaller than 18 point font.
- Explain the Partners' Training Academy and post a link to the Training Academy in the *Member Handbook*.

D. Quality Improvement

The Quality Improvement (QI) section covers the QI Program, QI Committees, QI work plan, provider participation in QI, the QI Annual Evaluation, performance measures, and Performance Improvement Projects (PIPs).

Partners' *Quality Management Plan & Program Description* outlines the QI program used including goals, structure, scope, and methodology directed at improving enrollee health care quality.

In the previous EQR, there was one Corrective Action and four Recommendations. The Corrective Action was partially addressed. Two Recommendations were implemented, and two Recommendations were not fully implemented.

Again, this EQR, the standard for "The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines" scores less than a Met, scoring "Not Met." While Partners reports they have a current process for monitoring, no monitoring occurred during the review period. Partners provided a Corrective Action response in the previous EQR that was accepted based on its commitment to complete provider monitoring by March 2019. Corrective Action includes:

- Update Policy 13.09, Practice Guidelines to reflect the current process for monitoring provider practice guidelines using the Relias reports explained during the Onsite and in the May 2020 QIC minutes.
- Continue with monitoring using the Relias reports. Submit the next Relias monitoring report data that follows the baseline report, showing discussion in CAC and QIC for that quarterly standing agenda item.

- Include the monitoring results in the next Quality Management Program Annual Evaluation.

The following standard had a Recommendation in the previous EQR and has a Corrective Action this EQR: "The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey." For the current review, Partners has elected to focus on one area in each population (adult and child) of the ECHO Survey. The *Organizational Quality Activities Plan "OQOP" SFY: 2019-2020* has a Survey Activity table for four surveys completed during the year, including the ECHO Survey. All surveys are missing tasks for implementing interventions related to the recommendations and reporting back to QIC on updates from the implemented interventions. There is no evidence showing discussion of implementing interventions for the two chosen lower scoring ECHO Survey items. CCME issues a Corrective Action that includes:

- Implement interventions for lower scoring enrollee survey items related to QIC recommendations from the survey results. Show this on a Plan/Do/Study/Act (PDSA) or formal tracking project process.

- If improvement is addressed through Partners' Access to Care and MH/SU Care Coordination Departments, bring updates back to QIC for discussion and recommendations for changes needed to the interventions and document on the PDSA or formal tracking project.

The QIC is charged with oversight of the QI program at Partners. QIC is comprised of Partners' staff, Consumer Family Advisory Committee (CFAC) members, Global Continuous Quality Improvement (GCQI) Committee members, and provider members. Reported information flows from CFAC and GCQI meetings to QIC. A quorum was present at every meeting. Several QIC members, including one CFAC member and three Partners' staff members, had poor attendance. CCME recommends adjusting QIC membership when members cannot attend the majority of the meetings.

GCQI Committee was comprised of a fluctuating count of between 14 and 21 voting members from March 2019 through June 2020. There were seven quarterly meetings held during this time frame. All voting members listed on each meeting minutes were present at that meeting, resulting in a quorum for each meeting. Recommendations from the previous EQR were implemented for the PIPs that were validated.

The 2018 EQR had a Recommendation to "Implement and document a process that monitors the submission of provider QIPs to Partners." This Recommendation was followed. Partners' IT created a Share File for providers to submit QIPs, which are then discussed in GCQI Committee.

The *Quality Management (QM) Program Annual Evaluation* covers the period of July 2018 through June 2019. This document gives an overview and analysis of the QM program, the

QIPs, informal quality projects, access and availability standards, satisfaction evaluations, and other initiatives. Areas within each item addressed are goal, status/evaluation, issue/barriers, interventions, and goal to continue or not continue for the next fiscal year. The *Quality Management Program Annual Evaluation* is reviewed by the QM Director, Chief Medical Officer (CMO), QIC, and Board of Directors.

Performance Measure Validation

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

Table 5: (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 6: (c) Waiver Measures

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

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

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

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

(b) Waiver Measures Results

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

The (b) Waiver measure percentages in Tables 7 through 16 are for FY 2017 and 2019. FY 2018 was not validated due to the timing of the review. Follow-up after hospitalization for mental illness 7-day and 30-day for facility-based crisis and combined services 7-day and 30-day follow-up improved more than 10%. PRTF 7-day follow up for MH declined by almost 11%. Average Mental Health Length of Stay (LOS) decreased by over 10 days for the population 65+ males and for total population. Average Mental Health LOS increased more than 10 days for males aged 3-12 years. There was an increase in 30-day readmissions for inpatient members for State hospital. Follow-up for Substance Use (SU) inpatient hospital 30-days had a 12% decline.

Table 7: A.1. Readmission Rates for Mental Health

30-day Readmission Rates for Mental Health	2017	2019	Change
Inpatient (Community Hospital Only)	6.7%	11.5%	4.80%
Inpatient (State Hospital Only)	0.0%	0.0%	0.00%
Inpatient (Community and State Hospital Combined)	6.7%	11.5%	4.80%
Facility Based Crisis	11.8%	8.8%	-3.00%
Psychiatric Residential Treatment Facility (PRTF)	16.1%	24.7%	8.60%
Combined (includes cross-overs between services)	9.5%	14.7%	5.20%

Table 8: A.2. Readmission Rate for Substance Abuse

30-day Readmission Rates for Substance Abuse	2017	2019	Change
Inpatient (Community Hospital Only)	7.8%	14.1%	6.30%
Inpatient (State Hospital Only)	0.0%	10.0%	10.00%
Inpatient (Community and State Hospital Combined)	7.7%	14.6%	6.90%
Detox/Facility Based Crisis	6.9%	6.3%	-0.60%
Combined (includes cross-overs between services)	8.5%	13.9%	5.40%

Table 9: A.3. Follow-Up after Hospitalization for Mental Illness

Follow-up after Hospitalization for Mental Illness	2017	2019	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	46.5%	49.7%	3.20%
Percent Received Outpatient Visit Within 30 Days	64.2%	63.4%	-0.80%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	26.1%	85.3%	59.20%
Percent Received Outpatient Visit Within 30 Days	34.8%	91.2%	56.40%
PRTF			
Percent Received Outpatient Visit Within 7 Days	32.9%	22%	-10.90%
Percent Received Outpatient Visit Within 30 Days	62.0%	62.7%	0.70%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	23.9%	50.1%	26.20%
Percent Received Outpatient Visit Within 30 Days	45.5%	64.5%	19.00%

Table 10: A.4. Follow-Up After Hospitalization for Substance Abuse

Follow-up after Hospitalization for Substance Abuse	2017	2019	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NR
Percent Received Outpatient Visit Within 7 Days	26.6%	19.7%	-6.90%
Percent Received Outpatient Visit Within 30 Days	40.3%	28.3%	-12.00%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	11.5%	20.8%	9.30%
Percent Received Outpatient Visit Within 7 Days	16.4%	24.5%	8.10%
Percent Received Outpatient Visit Within 30 Days	37.7%	32.1%	-5.60%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NR
Percent Received Outpatient Visit Within 7 Days	14.6%	20.7%	6.10%
Percent Received Outpatient Visit Within 30 Days	29.9%	29.1%	-0.80%

Table 11: B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2017	2019	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	51.9%	44.2%	-7.70%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	33.2%	32.6%	-0.60%
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	50.5%	51.7%	1.20%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	26.9%	33.5%	6.60%
Ages 21–34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	57.5%	52.8%	-4.70%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	43.4%	41.6%	-1.80%
Ages 35–64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	50.0%	49.8%	-0.20%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	31.1%	34.1%	3.00%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	34.9%	32.3%	-2.60%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	12.7%	16.9%	4.20%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	52.6%	50.1%	-2.50%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	35.2%	36.0%	0.80%

Table 12: D.1. Mental Health Utilization-Inpatient Discharges and Average Length of Stay

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		2017	2019	Change	2017	2019	Change
3–12	Male	0.3	0.2	-0.10	34.1	45.2	11.10
	Female	0.2	0.3	0.10	14.7	20.7	6.00
	Total	0.2	0.3	0.10	27.1	32.1	5.00
13–17	Male	1.5	1.3	-0.20	44.3	43.6	-0.70
	Female	2.6	2.7	0.10	21.2	21.3	0.10
	Total	2.0	2.0	0.00	29.7	28.7	-1.00
18–20	Male	1.5	1.7	0.20	7.3	8.5	1.20
	Female	1.5	1.9	0.40	7.1	7.3	0.20
	Total	1.5	1.8	0.30	7.2	7.9	0.70
21–34	Male	4.5	4.5	0.00	7.6	8.2	0.60
	Female	1.7	1.7	0.00	6.5	7.5	1.00
	Total	2.3	2.4	0.10	7.0	7.9	0.90
35–64	Male	3.8	3.8	0.00	9.1	8.3	-0.80
	Female	2.7	2.5	-0.20	7.8	8.1	0.30
	Total	3.1	3.0	-0.10	8.4	8.2	-0.20
65+	Male	0.6	0.7	0.10	63.5	14.5	-49.00
	Female	0.3	0.6	0.30	15.9	15.2	-0.70
	Total	0.4	0.6	0.20	35.4	15.0	-20.40
Unknown	Male	0.0	0.0	0.00	0.0	0.0	0.00
	Female	0.0	0.0	0.00	0.0	0.0	0.00
	Total	0.0	0.0	0.00	0.0	0.0	0.00
Total	**Male**	**1.5**	**1.5**	**0.00**	**18.0**	**16.7**	**-1.30**
	Female	**1.4**	**1.5**	**0.10**	**11.2**	**12.2**	**1.00**
	Total	**1.5**	**1.5**	**0.00**	**14.3**	**14.2**	**-0.10**

Table 13: 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		
		2017	2019	Change	2017	2019	Change	2017	2019	Change	2017	2019	Change
3-12	Male	12.84%	15.19%	2.35%	0.19%	0.09%	-0.1%	0.54%	0.53%	0.54%	12.80%	15.12%	2.32%
	Female	9.37%	11.60%	2.23%	0.13%	0.07%	-0.1%	0.14%	0.21%	0.14%	9.34%	11.58%	2.24%
	Total	11.14%	13.43%	2.29%	0.16%	0.08%	-0.1%	0.34%	0.37%	0.34%	11.10%	13.39%	2.29%
13-17	Male	15.24%	17.84%	2.60%	1.25%	0.51%	-0.7%	0.96%	1.01%	0.96%	15.06%	17.69%	2.63%
	Female	18.18%	20.96%	2.78%	1.84%	0.50%	-1.3%	0.53%	0.41%	0.53%	18.00%	20.82%	2.82%
	Total	16.68%	19.36%	2.68%	1.54%	0.50%	-1.0%	0.75%	0.72%	0.75%	16.50%	19.22%	2.72%
18-20	Male	8.61%	10.51%	1.90%	0.96%	0.23%	-0.7%	0.12%	0.16%	0.12%	8.47%	10.47%	2.00%
	Female	11.60%	13.88%	2.28%	0.98%	0.11%	-0.9%	0.15%	0.13%	0.15%	11.42%	13.86%	2.44%
	Total	10.19%	12.28%	2.09%	0.97%	0.17%	-0.8%	0.14%	0.15%	0.14%	10.03%	12.25%	2.22%
21-34	Male	24.67%	26.79%	2.12%	3.11%	0.43%	-2.7%	0.09%	0.16%	0.09%	24.44%	26.77%	2.33%
	Female	21.24%	22.10%	0.86%	1.23%	0.24%	-1.0%	0.07%	0.13%	0.07%	21.16%	22.08%	0.92%
	Total	22.03%	23.19%	1.16%	1.66%	0.29%	-1.4%	0.07%	0.14%	0.07%	21.91%	23.17%	1.26%
35-64	Male	23.69%	24.75%	1.06%	2.42%	0.46%	-2.0%	0.15%	0.14%	0.15%	23.44%	24.73%	1.29%
	Female	26.99%	28.91%	1.92%	1.88%	0.17%	-1.7%	0.17%	0.20%	0.17%	26.86%	28.91%	2.05%
	Total	25.75%	27.33%	1.58%	2.08%	0.28%	-1.8%	0.16%	0.18%	0.16%	25.57%	27.33%	1.76%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2017	2019	Change	2017	2019	Change	2017	2019	Change	2017	2019	Change
65+	Male	9.08%	8.55%	-0.53%	0.49%	0.10%	-0.4%	0.00%	0.00%	0.00%	8.99%	8.53%	-0.46%
	Female	7.73%	8.65%	0.92%	0.31%	0.00%	-0.3%	0.02%	0.01%	0.02%	7.67%	8.65%	0.98%
	Total	8.12%	8.62%	0.50%	0.36%	0.03%	-0.3%	0.01%	0.01%	0.01%	8.05%	8.61%	0.56%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**Male**	15.56%	17.38%	1.82%	1.08%	0.27%	-0.8%	0.45%	0.47%	0.45%	15.43%	17.31%	1.88%
	Female	16.46%	18.17%	1.71%	1.01%	0.17%	-0.8%	0.17%	0.19%	0.17%	16.37%	18.14%	1.77%
	Total	16.08%	17.83%	1.75%	1.04%	0.21%	-0.8%	0.29%	0.31%	0.29%	15.97%	17.79%	1.82%

Table 14: D.3. Identification of Alcohol and Other Drug Services

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2017	2019	Change	2017	2019	Change	2017	2019	Change	2017	2019	Change
3–12	Male	0.03%	0.02%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%	0.02%	-0.01%
	Female	0.00%	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%
	Total	0.02%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.02%	0.00%
13–17	Male	1.64%	1.48%	-0.16%	0.08%	0.02%	-0.06%	0.41%	0.22%	-0.19%	1.44%	1.38%	-0.06%
	Female	0.81%	1.05%	0.24%	0.12%	0.03%	-0.09%	0.12%	0.09%	-0.03%	0.70%	1.00%	0.30%
	Total	1.24%	1.27%	0.03%	0.10%	0.03%	-0.07%	0.27%	0.15%	-0.12%	1.08%	1.19%	0.11%
18–20	Male	2.32%	2.26%	-0.06%	0.31%	0.25%	-0.06%	0.36%	0.33%	-0.03%	2.20%	2.22%	0.02%
	Female	1.85%	2.14%	0.29%	0.23%	0.19%	-0.04%	0.21%	0.28%	0.07%	1.79%	2.08%	0.29%
	Total	2.08%	2.20%	0.12%	0.27%	0.21%	-0.06%	0.28%	0.30%	0.02%	1.99%	2.15%	0.16%
21–34	Male	9.98%	8.96%	-1.02%	1.28%	0.85%	-0.43%	0.99%	0.96%	-0.03%	9.78%	8.82%	-0.96%
	Female	9.07%	8.98%	-0.09%	1.01%	0.71%	-0.30%	1.18%	1.23%	0.05%	8.94%	8.79%	-0.15%
	Total	9.28%	8.97%	-0.31%	1.07%	0.74%	-0.33%	1.13%	1.17%	0.04%	9.14%	8.80%	-0.34%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2017	2019	Change	2017	2019	Change	2017	2019	Change	2017	2019	Change
35–64	Male	8.04%	8.40%	0.36%	1.54%	0.91%	-0.63%	0.57%	0.74%	0.17%	7.69%	8.26%	0.57%
	Female	5.82%	6.83%	1.01%	0.69%	0.47%	-0.22%	0.43%	0.78%	0.35%	5.63%	6.68%	1.05%
	Total	6.66%	7.43%	0.77%	1.01%	0.63%	-0.38%	0.48%	0.77%	0.29%	6.41%	7.28%	0.87%
65+	Male	1.12%	0.94%	-0.18%	0.36%	0.05%	-0.31%	0.04%	0.00%	-0.04%	0.92%	0.94%	0.02%
	Female	0.30%	0.27%	-0.03%	0.04%	0.00%	-0.04%	0.00%	0.00%	0.00%	0.28%	0.27%	-0.01%
	Total	0.53%	0.47%	-0.06%	0.13%	0.01%	-0.12%	0.01%	0.00%	-0.01%	0.46%	0.47%	0.01%
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**	2.74%	2.60%	-0.14%	0.43%	0.24%	-0.19%	0.28%	0.26%	-0.02%	2.60%	2.55%	-0.05%
	Female	3.16%	3.30%	0.14%	0.37%	0.24%	-0.13%	0.34%	0.41%	0.07%	3.08%	3.22%	0.14%
	Total	2.98%	3.00%	0.02%	0.39%	0.24%	-0.15%	0.31%	0.34%	0.03%	2.88%	2.93%	0.05%

Table 15: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2017	2019	Change	2017	2019	Change	2017	2019	Change	2017	2019	Change
	3-12			13-17			18-20			21-34		
Burke	0.03%	0.02%	-0.01%	1.47%	1.37%	-0.10%	1.84%	3.26%	1.42%	10.64%	9.20%	-1.44%
Catawba	0.00%	0.01%	0.01%	1.25%	1.36%	0.11%	1.95%	2.69%	0.74%	7.83%	7.44%	-0.39%
Cleveland	0.00%	0.01%	0.01%	1.03%	0.83%	-0.20%	1.73%	1.67%	-0.06%	6.27%	5.43%	-0.84%
Gaston	0.01%	0.00%	-0.01%	1.30%	1.62%	0.32%	2.32%	2.10%	-0.22%	7.20%	7.00%	-0.20%
Iredell	0.00%	0.01%	0.01%	1.00%	0.76%	-0.24%	1.90%	1.72%	-0.18%	6.57%	5.53%	-1.04%
Lincoln	0.04%	0.00%	-0.04%	1.68%	1.80%	0.12%	2.55%	2.34%	-0.21%	9.40%	9.08%	-0.32%
Rutherford	--	0.00%	--		0.00%	--		0.00%	--		0.00%	--
Surry	0.00%	0.02%	0.02%	0.78%	0.68%	-0.10%	2.40%	1.71%	-0.69%	7.46%	6.50%	-0.96%
Yadkin	0.00%	0.08%	0.08%	0.77%	0.81%	0.04%	2.01%	2.41%	0.40%	7.08%	6.44%	-0.64%
	35-64			65+			Unknown			Total		
Burke	8.95%	8.50%	-0.45%	0.59%	1.15%	0.56%	0.00%	0.00%	0.00%	3.88%	3.59%	-0.29%
Catawba	8.59%	8.34%	-0.25%	1.03%	0.77%	-0.26%	0.00%	0.00%	0.00%	3.10%	3.03%	-0.07%
Cleveland	5.81%	5.92%	0.11%	1.03%	0.90%	-0.13%	0.00%	0.00%	0.00%	2.63%	2.48%	-0.15%
Gaston	7.04%	7.83%	0.79%	0.72%	0.85%	0.13%	0.00%	0.00%	0.00%	3.01%	3.08%	0.07%

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2017	2019	Change	2017	2019	Change	2017	2019	Change	2017	2019	Change
Iredell	6.06%	6.70%	0.64%	0.44%	0.27%	-0.17%	0.00%	0.00%	0.00%	2.46%	2.32%	-0.14%
Lincoln	7.12%	8.26%	1.14%	0.63%	0.88%	0.25%	0.00%	0.00%	0.00%	3.42%	3.55%	0.13%
Rutherford	--	0.00%	--	--	0.00%	--	--	0.00%	--	--	0.00%	--
Surry	5.96%	5.04%	-0.92%	0.34%	0.17%	-0.17%	0.00%	0.00%	0.00%	2.55%	2.16%	-0.39%
Yadkin	7.15%	6.29%	-0.86%	0.14%	0.71%	0.57%	0.00%	0.00%	0.00%	2.47%	2.42%	-0.05%

Table 16: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2017	2019	Change	2017	2019	Change	2017	2019	Change	2017	2019	Change
	3-12			13-17			18-20			21-34		
Burke	9.85%	11.63%	1.78%	15.05%	15.83%	0.78%	9.15%	12.90%	3.75%	14.17%	14.89%	0.72%
Catawba	8.83%	9.99%	1.16%	16.22%	17.68%	1.46%	10.29%	10.89%	0.60%	13.65%	14.40%	0.75%
Cleveland	9.61%	11.24%	1.63%	16.99%	17.79%	0.80%	10.13%	11.39%	1.26%	13.41%	14.69%	1.28%
Gaston	11.74%	11.88%	0.14%	20.25%	19.73%	-0.52%	12.53%	13.67%	1.14%	15.75%	15.52%	-0.23%
Iredell	8.73%	9.03%	0.30%	16.37%	18.15%	1.78%	8.90%	10.43%	1.53%	11.54%	12.13%	0.59%
Lincoln	10.15%	12.50%	2.35%	19.02%	22.99%	3.97%	11.16%	11.81%	0.65%	16.01%	15.29%	-0.72%

2019 External Quality Review

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2017	2019	Change	2017	2019	Change	2017	2019	Change	2017	2019	Change
	3-12			13-17			18-20			21-34		
Rutherford	--	0.00%	--	--	0.00%	--	--	0.00%	--	--	0.00%	--
Surry	8.84%	8.93%	0.09%	13.32%	15.18%	1.86%	9.41%	9.74%	0.33%	13.19%	11.26%	-1.93%
Yadkin	7.06%	10.32%	3.26%	14.04%	16.71%	2.67%	7.50%	9.46%	1.96%	10.04%	10.67%	0.63%
	35-64			65+			Unknown			Total		
Burke	24.73%	23.73%	-1.00%	9.56%	11.75%	2.19%	0.00%	0.00%	0.00%	14.16%	15.21%	1.05%
Catawba	23.81%	22.71%	-1.10%	12.73%	11.14%	-1.59%	0.00%	0.00%	0.00%	13.72%	14.24%	0.52%
Cleveland	23.04%	21.71%	-1.33%	13.73%	11.08%	-2.65%	0.00%	0.00%	0.00%	14.49%	14.95%	0.46%
Gaston	27.44%	25.88%	-1.56%	12.82%	10.42%	-2.40%	0.00%	0.00%	0.00%	16.97%	16.37%	-0.60%
Iredell	16.83%	17.47%	0.64%	10.41%	10.65%	0.24%	0.00%	0.00%	0.00%	11.92%	12.64%	0.72%
Lincoln	24.57%	22.56%	-2.01%	16.11%	11.21%	-4.90%	0.00%	0.00%	0.00%	15.84%	16.35%	0.51%
Rutherford	--	0.00%	--	--	0.00%	--	--	0.00%	--	--	0.00%	--
Surry	18.66%	14.55%	-4.11%	8.68%	7.11%	-1.57%	0.00%	0.00%	0.00%	12.14%	11.17%	-0.97%
Yadkin	16.50%	16.27%	-0.23%	5.40%	6.50%	1.10%	0.00%	0.00%	0.00%	10.11%	12.00%	1.89%

(b) Waiver Validation Results

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

Table 17 contains validation scores for each of the 10 (b) Waiver Performance Measures.

Table 17: (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

For reviews of 2018-2019 (c) Waiver measures, there were changes made to the measures that were validated. Eight new measures were chosen, and two previously validated measures were retained. Documentation was included for all 10 (c) Waiver measures. The rates reported by Partners are displayed in Table 18.

Table 18: (c) Waiver Measures Reported Results 2018-2019

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals. IW D1 ISP	Annual	1001/1001 = 100%	85%
Proportion of Individual Support Plans that address identified health and safety risk factors. IW D2 ISP	Semi Annually	690/690 = 100%	85%
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need. IW D3 ISP	Annually	1001/1001 = 100%	85%
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	1001/1001 = 100%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	1001/1001 = 100%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	51/56 = 91.07%	85%
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required. IW G3	Quarterly	4/4 = 100%	85%
Percentage of medication errors resulting in medical treatment. IW G4	Quarterly	0/0 = N/A	15%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	1177/1177 = 100%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	18/18 = 100%	85%

(c) Waiver Validation

Validation scores are fully compliant with an average validation score of 100% across the 10 measures. The validation scores are shown in *Table 19, (c) Waiver Performance Measure Validation Scores*. Documentation on data sources, data validation, source code, and calculated rate for the 10 (c) Waiver measures was provided. The validation worksheets offer detailed information on point deduction when validating each (c) Waiver measure.

Table 19: (c) Waiver Performance Measures Validation Scores

Performance Measure	Validation Score
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals. IW D1 ISP	100%
Proportion of Individual Support Plans that address identified health and safety risk factors. IW D2 ISP	100%
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need. IW D3 ISP	100%
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	100%
Proportion of beneficiaries reporting they have a choice between providers IW D10	100%
Percentage of level 2 and 3 incidents reported within required timeframes IW G2	100%
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required. IW G3	100%
Percentage of medication errors resulting in medical treatment. IW G4	100%
Percentage of beneficiaries who received appropriate medication. IW G5	100%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	100%
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 3: Validating Performance Improvement Projects Version 2.0, September 2012. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

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

PIP Validation Results

For the 2018 review four projects were validated: TCLI Transitioned in 90 days, promoting follow-up within 7 days for mental health treatment, Promoting follow up within 7 days for SUD treatment, PCP referrals to Behavioral Health. The PCP referrals to behavioral health methodology had changed and a new baseline for this new methodology has been established. The primary issues with the PIP documentation were the baseline goal and benchmark rates and presentation of the results. Recommendations were made to revise the definition of indicators and results presentation. The reports for the current EQR contain appropriate indicator definition and results presentation.

For the current EQR, four projects were validated, including 7 day follow-up for mental health treatment, 7 day follow-up for SUD treatment, and PCP referrals to behavioral health, and a new PIP titled “Reducing ED Utilization.” For the 7 day MH follow up, there were two new measures added regarding 30 day follow-up rates. It appears that the rates were improving for Medicaid and non-Medicaid enrollees, and then decreased for the most recent two remeasurements which was the last two quarters of 2019. For the 7-day SUD follow-up, there was a similar trend where improvement occurred, and then the most recent two reported rates were declines from the upward trend. For PCP referrals, the goal rate is 15%, and it is active through June 2020. The rate improved for the few several remeasurements, and then declined again for the last two quarters of 2019. There was documentation of an issue with being able to accurately collect data with the current methodology and specification and that a workgroup would potentially form. At the time of the Onsite discussion, the workgroup had met three times and the reconciliation of data had occurred.

For ED utilization, the rate initially increased and then decreased, but is still above the baseline rate of 55%. The project was approved in February 2020 and will continue as an active PIP to reduce ED utilization. The Onsite discussion focused on the impact of COVID-19 on the PIP activities as well as a recommendation from CCME to reduce the number of active PIPs to focus efforts on four or five topics instead of nine topics simultaneously. Partners indicated that internal discussions began decrease the number of PIPs. Validation scores for the previous review year and current review year are shown in Table 20.

Table 20: PIP Summary of Validation Scores

Project Type	Project	2018 Validation Score	2019 Validation Score
Clinical	Promoting follow up within 7 days for mental health treatment	86/91 = 95% High Confidence in Reported Results	84/85 = 99% High Confidence in Reported Results
	Promoting follow up within 7 days for SUD treatment	91/91 = 100% High Confidence in Reported Results	84/85 = 99% High Confidence in Reported Results
Non-Clinical	TCLI Transitioned in 90 days	86/91 = 95% High Confidence in Reported Results	Not Validated
	PCP referrals to Behavioral Health	84/84 = 100% High Confidence in Reported Results	84/85 = 99% High Confidence in Reported Results
	ED Utilization	Not Validated	84/85 = 99% High Confidence in Reported Results

There were no specific errors for projects that require Corrective Action.

Table 21 lists the specific errors for projects that have Recommendations.

Table 21: Performance Improvement Project Errors and Recommendations

Project	Section	Reason	Recommendation
Promoting follow up within 7 days for mental health treatment- Clinical	Was there any documented, quantitative improvement in processes or outcomes of care?	Rate was improving and then decreased for the two most recent remeasurements.	Continue peer support and provider engagement interventions to determine if they are impacting follow up.
Promoting follow up within 7 days for SUD treatment- Clinical	Was there any documented, quantitative improvement in processes or outcomes of care?	Rate was improving and then decreased for the two most recent remeasurements.	Continue interventions focused on low provider engagement to determine the impact on SUD follow-up rates.
Reducing ED utilization of active members- Clinical	Was there any documented, quantitative improvement in processes or outcomes of care?	Initial increase (non-improvement) occurred, and then the rate decreased but it still above baseline.	Continue to explore new interventions that will help high ED utilizing members to seek appropriate services.
Physical health/primary care physician referrals to behavioral health- Nonclinical	Was there any documented, quantitative improvement in processes or outcomes of care?	There was a new baseline in 2018 and the rate was around 14% and then dropped to 8.2% in the most recent remeasurement	Conduct analysis to determine if unknown barriers exist for referrals; determine if initiatives for referrals are appropriate; gather information from PCPs on reasons for lack of referrals.

Figure 5 provides a comparison of the 2018 scores versus the 2019 scores. The 2019 review shows 89% of the standards were scored as "Met" and 11% of the standards were scored "Not Met."

Figure 5: Quality Improvement Comparative Findings

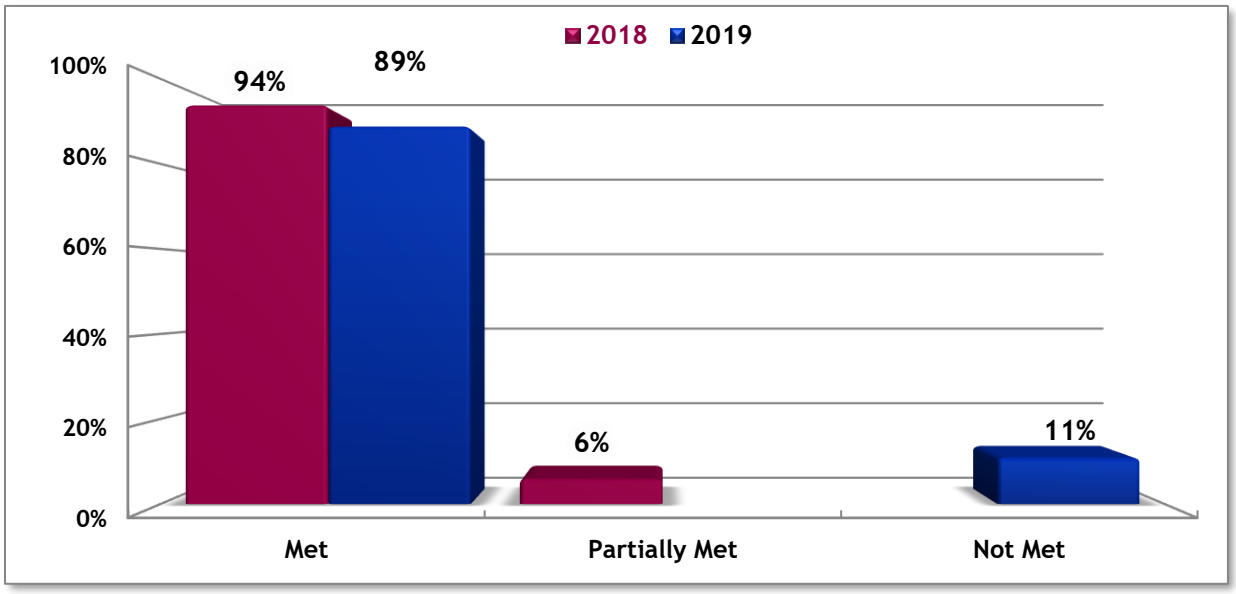


Table 22: Quality Improvement

Section	Standard	2019 Review
The Quality Improvement (QI) Program	The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.	Not Met
	The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.	Not Met

Strengths

- (b) and (c) waiver measures included all necessary documentation, and measures were reported according to specifications.
- There is a policy for the detection of over and underutilization. Services are being monitored and analyzed.
- All PIPs were scored in the High Confidence range.

- Partners has actively participated in the National Quality Forum initiatives for the past three years. This year, at an upcoming session, Partners will speak on behavioral health integration.
- Partners is currently working on five SAMHSA grants and has published a paper with the work they have done with Relias on high levels of morphine equivalence and the reduction that is noticed.

Weaknesses

- The monitoring process for provider clinical practice guidelines is in place now, but baseline data started after the current EQR review period. Planning was underway during the review period.
- There is no evidence showing discussion of implementing interventions for the two chosen lower scoring ECHO Survey items from the May 2019 QIC Meeting Packet on page 62.
- Several QIC members, including one CFAC member and three Partners' staff members, had poor meeting attendance.

Corrective Action

- Update Policy 13.09, Practice Guidelines to reflect the current process for monitoring provider practice guidelines using the Relias reports explained during the Onsite and in the May 2020 QIC minutes. Continue with monitoring using the Relias reports. Submit the next Relias provider clinical guideline monitoring report data that follows the baseline report, showing discussion in CAC and QIC for that quarterly standing agenda item. Include the monitoring results in the Quality Management Program Annual Evaluation.
- Implement interventions for lower scoring enrollee survey items related to QIC recommendations from the survey results. Show this on a PDSA or formal tracking project process. If improvement is addressed through Partners' Access to Care and MH/SU Care Coordination Departments, bring updates back to QIC for discussion and recommendations for changes needed to the interventions, and document on the PDSA or formal tracking project to implement.

Recommendations

- Consider adjusting QIC membership when members cannot attend the majority of the meetings.

E. Utilization Management

The EQR of Utilization Management (UM) includes a review of the *Utilization Management Plan* (*UM Plan*), Partners' *Organizational Chart*, UM policies and procedures, and 50 Service Authorization Request (SAR) files. Also included in the EQR of PIHP UM functions is the review of the Care Coordination and Transition to Community Living (TCLI) programs. CCME reviewed

relevant policies, procedures, staffing patterns, job descriptions, and 35 files of enrollees participating in Mental Health/Substance Use (MH/SU), Intellectual/Developmental Disability (I/DD), and TCLI Care Coordination. Onsite discussion with staff provided additional information. In this year's EQR, Partners met 89% of UM standards. CCME has issued five Corrective Actions and six Recommendations to address the issues noted in the UM EQR.

Partners' *UM Plan* reflects the most up-to-date information related to program functioning and organizational changes. The review of the *UM Plan* found several grammatical and spelling errors. Partners also did not update the *UM Plan* to reflect the addition of Rutherford County to its catchment area, increasing the counties they support from eight to nine.

The process for rendering SAR decisions is outlined in Policy and Procedure 13.15U, Utilization Management Screening and Review. The procedure includes an initial clinical review of the necessary documentation to support service requests. During the Onsite discussion, Partners staff described an "Administrative Approval" process where in which providers submit a request for service authorization as a part of the initial "pass-through" period for some services. This "Administrative Approval" process for pass-through SARs is not outlined in any policy and procedure and was observed in the SAR approval files reviewed. Further, Policy and Procedure 13.15U, Utilization Management Screening and Review requires that "initial clinical review is conducted by UM Reviewers who hold an active, unrestricted license in the State of North Carolina." However, Partners uses non-clinical, unlicensed staff to render "Administrative Approvals" of pass-through services. Corrective Action is needed to capture the "Administrative Approval" process in a policy or procedure and does not contradict Partners' current UM policies and procedures.

Partners uses a *Service Review Criteria Checklist* to determine if a SAR is unable to be processed or is an invalid request due to a lack of supportive documentation. The checklist ensures that a complete and current treatment plan (e.g., signatures and service orders) and Comprehensive Clinical Assessment (e.g., signature and recommendation) are submitted. Two SAR files that were approved contained Comprehensive Clinical Assessments (CCA) that were over four years old. The CCAs did not capture relevant changes in the enrollees' current living and/or health status. *NC Records and Retention Manual APSM 45-2, Chapter 3-2,* states, "a CCA is required before service delivery except when there is a current CCA on file, and there has not been a substantive change in the person's condition since the last CCA." Partners needs to continue to collaborate with providers, as well as I/DD, MH/SU and TCLI Care Coordinators to ensure the documentation accompanying service authorization requests reflects the enrollee's current treatment needs.

The SAR file review also found that 16% of the approved MH/SU SARs did not contain the credentials of the UM Reviewer that rendered the decision. *NC Medicaid Contract 8.2.2.1.e* requires, "The name and credentials of the individual conducting the review." The review of denied MH/SU SARs found 16% without the UM Reviewer credentials. Similarly, the review of

I/DD denial SARs found 80% of files peer-reviewed by a medical professional did not include the full signature and credentials of the reviewer who rendered the decision to deny services. *NC Medicaid Contract 8.2.2.1.f,* requires "The name, signature, and credentials of the individual who made the decision to deny, reduce, or terminate authorization for the requested service." In order to comply with contractual requirements, Partners must ensure complete names and credentials of staff rendering service authorization decisions are available in the files, prior to issuing a decision.

Partners has several policies and procedures and program descriptions that govern Care Coordination. However, little guidance is provided in MH/SU policies and procedures to ensure consistent follow-up by Care Managers. For example, there is no time frame regarding the documentation expectations for follow up activities. Also, MH/SU policies and procedures do not outline a process for attempting to contact enrollees who are difficult to engage in services (number of attempts, types of attempts, when to discharge, etc.). As a result, inconsistent practices by Care Coordinators were evident in the MH/SU Care Coordination file review.

I/DD Care Coordination has Policy and Procedure 11.25, Caseload Management details the movement of an enrollee between Care Coordinators. The review of Desk Materials found several examples of enrollees moving from I/DD to MH/SU as part of the Complex Case Management Program. However, the policies and procedures do not outline the expectations of Care Coordinators when initiating, transferring, or discharging enrollees from Care Coordination. As a result, there was no punctuation of interventions within the files and the care provided appeared chaotic. reviewed process of transferring enrollees to or from another department as well as to or from another PIHP. Partners will need to review MH/SU policies and procedures and update, where appropriate, the expectations of timeliness of progress note, types of follow up, transfer and discharge activities, and how discharges should be documented. Ideally, I/DD Care Coordination Policy and Procedure 11.25, Caseload Management should include the steps taken by staff when an enrollee is transferred from I/DD to MH/SU and to another PIHP. Partners should also develop, document, and implement a data-driven monitoring process to improve the quality and completeness of I/DD, MH/SU, and TCLI Care Coordination documentation. The monitoring plan should identify the frequency of monitoring, departmental benchmarks for compliance, and how and when outcomes of monitoring are captured, reviewed, and reported. This is especially important as Partners has recently started using a new Care Management platform called TruCare.

I/DD Innovations requires PIHPs to monitor service utilization to ensure enrollees are receiving the amount of services identified in the Individual Support Plan. When no services are accessed by an enrollee, *NC Clinical Coverage Policy 8P, L.* requires that PIHPs follow specific steps and notifications to intervene to prevent the loss of an enrollee's Innovations slot. The *I/DD Desk Reference* guidance to Care Coordinators aligns with *NC Clinical Coverage 8P. T*he requirements noted in the Desk Reference are not in any policy or procedure or

the *I/DD Program Description*. CCME recommends that Partners update the appropriate policy and procedure to include the steps and notifications or reference the Desk Reference in a procedure.

Partners' Policy and Procedure 11.16, I/DD Care Manager Monitoring of Plan Implementation is in place to ensure that the monitoring of Innovations enrollee services occurs per *Clinical Coverage Policy 8P* guidance. This policy does not include the monitoring standards for Home Community Based Services (HCBS), as required by *Clinical Coverage Policy 8P*, nor does it reference the state required Monitoring Checklist. Also, the *I/DD Care Management Program Description* does not reference Day Supports and Supported Employment as a part of HCBS.

The EQR revealed several inconsistencies between the documentation and information in the Partners' policies and procedures or program descriptions. The review of Desk Materials found at least 10% of MH/SU progress notes were entered beyond the required three day time frame reported by staff during the Onsite. There was also a pattern of blank progress notes, blank discharge notes, significant gaps in progress notes (6 months or more), and abrupt endings to Care Coordination interventions with no reference to discharge or transfer. Similarly, inconsistencies were found in I/DD Care Coordination documentation. While improvements in I/DD documentation over time were evident, the I/DD files also had gaps in notes (up to five months), late progress notes, and delays in coordinating services when an enrollee transferred to another PIHP.

During the previous EQR, CCME recommended that Policy and Procedure 9.08, Mental Health and Substance Use (MHSU) Care Coordination Transition to Community Living and US Department of Justice (TCL-DOJ) Initiative, describe how to access the one-time transitional support funds (TYSR). Partners updated the policy and procedure to include more information about these funds. However, there is still a lack of detail about the procedure for accessing TYSR funds. CCME recommends again that Partners revise the policy and procedure to better detail for staff what steps and notifications are required to access these funds for the enrollee.

The review of Desk Material of TCLI files found similar inconsistencies in staff documentation as in Care Coordination. For example, the expectation to submit progress notes was reported to be within three calendar days from the date of the intervention. However, at least 75 of the progress notes were entered beyond that time frame. One progress note was more than 300 days late. Also noted were patterns of blank progress notes, blank discharge notes, large gaps in progress notes (nine months or more), and abrupt endings to TCLI Care Coordination interventions with no reference to discharge or transfer.

A review of the TCLI progress notes also showed inconsistent follow-up activities between different TCLI staff. For example, one enrollee was referred to TCLI, but the enrollee's legal representative declined services in June 2017. In-Reach activities continued as scheduled for

two years, despite the legal representative continuously declining TCLI services. Efforts to remove the enrollee from the TCLI database did not occur until February of 2019. In another TCLI file, an enrollee was referred to TCLI in October of 2018. No In-Reach activities occurred for eight months. By the time In-Reach activities resumed in June 2019, the enrollee had been deceased since the time of TCLI referral. Partners should also develop, document, and implement a data-driven monitoring process that reviews TCLI documentation. The monitoring plan should include a routine review of timeliness of activities (e.g., documentation of completed activities, follow up activities, In-Reach and Quality of Life survey activities, etc.), as well as the quality and completeness of Care Coordinator documentation around transferring and discharging enrollees from TCLI Care Coordination.

The 2019 Annual EQR reflects that Partners achieved a "Met" score of 89% of the standards reviewed. As Figure 6 indicates, 11% of the standards were scored as "Partially Met". Figure 1 also provides a comparison of Partners' 2018 review results to 2019 results.

Figure 6: Utilization Management Comparative Findings

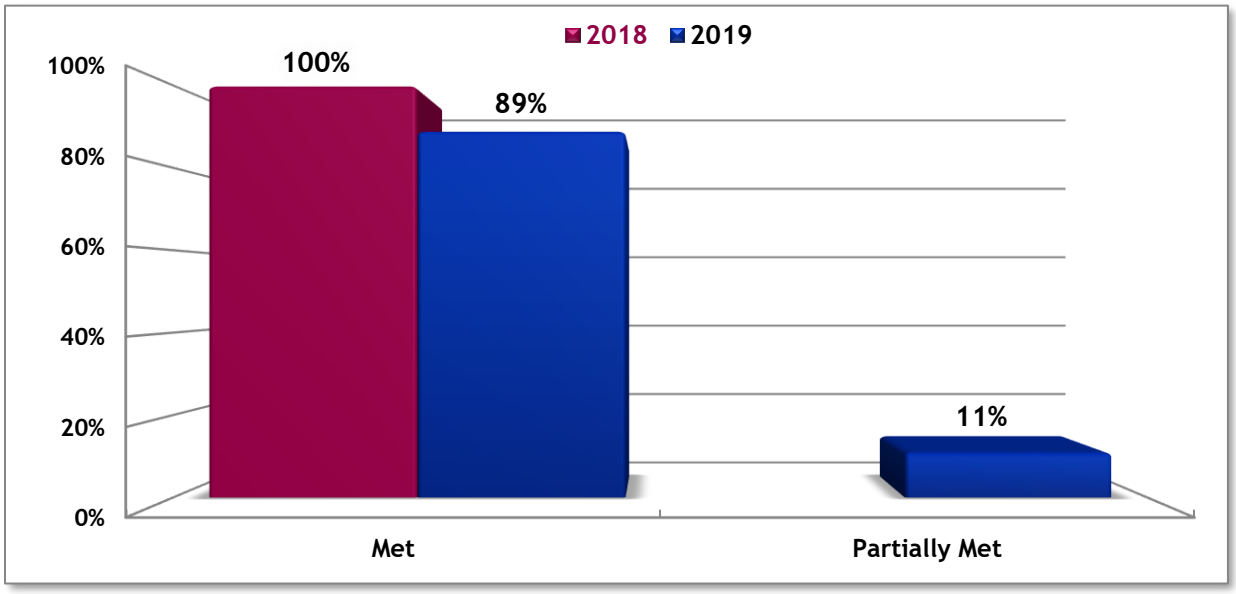


Table 23: Utilization Management

Section	Standard	2019 Review
The Utilization Management (UM) Program	Guidelines / standards to be used in making utilization management decisions:	Partially Met
Medical Necessity Determinations	All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	Partially Met

Section	Standard	2019 Review
Care Coordination	Provide follow-up activities for enrollees;	Partially Met
	The PIHP applies the Care Coordination policies and procedures as formulated.	Partially Met
Transition to Community Living	A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	Partially Met

Strengths

- Partners expanded its Medical Department to include an Associate Medical Director to provide oversight and support to the UM Department and Care Coordination.
- Partners launched a new Care Management platform, TruCare.
- Partners has a detailed quality monitoring plan in place for I/DD Care Coordination. The plan includes core performance standards, performance measurements, and a comprehensive improvement plan.
- Partners has a Complex Case Management Program in place that provides support to individuals with dual diagnoses whose needs may not be met through traditional services.

Weaknesses

- There are several areas within the *UM Plan* that need updating.
- Policies and procedures do address the "Administrative Approval" process that Partners is implementing for pass-through services.
- The review of approved SARs showed providers submitted out of date documentation to support their service request.
- Within the service authorization files reviewed, there was no evidence of the UM Reviewer's credentials in 16% (4) approved files and 16% (4) denied files.
- The review of I/DD denial SARs found 80% (9) files that did not include the full signature and credentials used to render the decision to deny services.
- Little guidance is provided in MH/SU policies and procedures to ensure consistent follow up and follow up documentation by Care Coordinators.
- There is no description of the steps and notifications required by *Clinical Coverage Policy 8P, L. Failure to Use Services* in any I/DD policy or procedure.

- Policy and Procedure 11.16, I/DD Care Manager Monitoring of Plan Implementation, and the *IDD Care Management Program Description* are missing details regarding the monitoring of Home and Community Based services.
- The EQR of MH/SU and I/DD Care Coordination documentation showed inconsistencies and errors in staff documentation.
- The process for accessing TYSR funds is not described in Policy and Procedure 9.08, Mental Health and Substance Use (MHSU) Care Coordination -Transition to Community Living and U.S. Department of Justice (TCL-DOJ) Initiative.
- The EQR of TCLI files found inconsistencies and errors in staff documentation.

Corrective Action

- Detail the "Administrative Approval" process in policies and procedures. Update Policy and Procedure 13.15U, to reflect the use of non-clinical, unlicensed staff in the "Administrative Approval" process.
- Develop, document, and implement a monitoring process that ensures the credentials of clinicians rendering service authorization denials are consistently documented in all SARs, as required by NC Medicaid Contract, Section 8.2.2.1.
- Revise MH/SU Care Coordination policies and procedures to better define documentation requirements to include:
  - Timely submission of documentation into the TruCare platform
  - Transfer of enrollees from a Care Coordinator to another Care Coordinator, region, department, or PIHP and the content expectations of the transfer documentation
  - The expected steps Care Coordinators follow when they are having difficulty locating and engaging enrollees in Care Coordination
  - Discharging enrollees and the content expectations for those discharge notes
- Develop, document, and implement a data-driven monitoring plan that routinely reviews I/DD and MH/SU documentation entered into TruCare. The monitoring plan should identify:
  - the frequency of monitoring
  - departmental benchmarks for compliance
  - how and when outcomes of monitoring are captured, reviewed, and reported

The monitoring plan should include:

  - routine review of timeliness of activities (e.g., documentation of completed activities, follow up activities, HCBS monitoring, etc.)

  - quality and completeness of Care Coordinator documentation
  - quality and completeness of Care Coordination documentation around transferring and discharging enrollees from Care Coordination

- Develop, document, and implement a data-driven monitoring plan that routinely reviews I/DD and MH/SU documentation entered into TruCare. The monitoring plan should identify:
  - the frequency of monitoring
  - departmental benchmarks for compliance
  - how and when outcomes of monitoring are captured, reviewed, and reported.

The monitoring plan should include:

  - routine review of timeliness of activities (e.g., documentation of completed activities, In Reach activities, etc.)
  - quality and completeness of Care Coordinator documentation (e.g., Quality of Life surveys),
  - quality and completeness of Care Coordination documentation around transferring and discharging enrollees from Care Coordination.

Recommendations

- Revise the *Utilization Management Plan* to update Partners' catchment area. Include more detail describing the process Partners follows for identifying and intervening with over and underutilized services.
- Continue to collaborate with Provider Network, I/DD, MH/SU and TCLI Departments to ensure documentation submitted with SARs adequately reflects the enrollee's current clinical needs.
- Develop, document, and implement a monitoring process that ensures the credentials of clinicians rendering service authorization approvals are consistently documented in the service authorization request files.
- Add details to Policy and Procedure 11.16 regarding HCBS monitoring to include the use of the required State Monitoring Checklist. Moreover, ensure that the I/DD Care Management Program Description is updated to include Day Support and Supported Employment as a part of HCBS.
- Include the required steps and notification outlined in *Clinical Coverage 8P, L. Failure to Use Services* in an I/DD policy and procedure.
- Add to Policy and Procedure 9.08, detail describing the process staff follow to access TYSR funds for TCLI enrollees.

F. Grievances and Appeals

The Grievances and Appeals review for Partners included a Desk Review of policies and procedures, 20 grievance files, 25 appeal files, the Grievances and Appeals Logs, the *Provider Operations Manual*, the *Member Handbook*, and information about grievances and appeals available on Partners' website. An Onsite discussion with Grievance and Appeal staff occurred to further clarify Partners' documentation and processes.

Grievances

Policy and Procedure 6.00U, Grievance Management Policy is the primary policy and procedure describing Partners' process for receiving, tracking, responding, and resolving grievances. In the previous EQR, CCME provided two Recommendations aimed at improving language within this policy. Both Recommendations were addressed by Partners.

Partners provided 20 grievance files selected by CCME from their Medicaid grievance log. Two of the files submitted were indicated to be grievances related to State-funded services and not Medicaid. Therefore, these two files were not reviewed.

In the review of the remaining 18 grievance files provided by Partners, all grievances were acknowledged and resolved within the required timeframes. Resolution notices contained detailed steps Partners took to resolve each grievance.

Fifteen of the 18 files, or 83%, were indicated to be "high priority". Partners' grievance policy identifies an accelerated process for resolving grievances that are "high priority". These are typically grievances that are escalated due to immediate threats of harm, clients' rights issues, or serious quality of care issues. Policy and Procedure 6.00U requires staff to take immediate action (within 72 hours) to address the concerns.

During the Onsite, staff were surprised that such a large portion of the grievance file sample was marked "high priority". They indicated only a small portion of grievances are escalated to "high priority" status. Further, review of files showed no actions were documented by staff within 72 hours in the majority of the "high priority" files.

Given these findings are not congruent with Partners' grievance policy and procedure, CCME recommends Partners closely monitors the "high priority" grievance process. Monitoring should look at how and when grievances are identified as "high priority" and whether staff are clearly documenting in the grievance file the immediate actions taken to address concerns. This monitoring can also provide valuable grievance data to support the effectiveness of the "high priority" grievance process.

Appeals

In the previous EQR, Partners was issued two corrective actions and five Recommendations. One of the Corrective Actions was implemented, one corrective action was partially implemented and none of the Recommendations were addressed.

Policy and Procedure 13.04U, Clinical Utilization Management Appeals is the primary procedure that governs Partners' appeals process. This policy and procedure, *Provider Operations Manual* and *Member Handbook* are inconsistent when defining who can file an appeal. Per *NC Medicaid Contract, Attachment M, G.1* and the *42 CFR § 438.402(c)1(ii),* "with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee." Policy and Procedure 13.04U correctly states, "Partners BHM allows an authorized representative to act on behalf of the member or provides help to any member (or member's LRP) who requests assistance in filing an appeal." However, this information is contradicted in other places within the procedure. For example, the first section of the procedure, I. Timeframe, describes the timeframe for processing an appeal begins "when Partners receives the appeals "from the member/LRP (or the provider acting upon the member's behalf and with the 's/LRP's member's written consent to do so." There is no reference to other stakeholders serving as representatives during the appeal process.

It was recommended in the previous EQR that Partners clarify in the *Provider Operations Manual* and *Member Handbook* that any written request for an appeal can initiate the appeal process and Partners' Request for Reconsideration Review Form is not required. This Recommendation was not addressed. The *Provider Operations Manual* and *Member Handbook* still state Partners' form is required. For example, the Provider Operations Manual states that to request an appeal, the appellant "must complete and return the Partners' Reconsideration Review Request." This practice was also found within the appeal file review. This requirement by Partners in their *Provider Operations Manual* and *Member Handbook* is more restrictive than the *NC Medicaid Contract* and Partners' appeal policy.

Policy and Procedure 13.04U, Clinical Utilization Management Appeals, the *Provider Operations Manual*, and *Member Handbook* incorrectly state that, when Partners denies a request to expedite an appeal, Partners gives notification of the "the member's right to request reconsideration of the decision." The requirement, per *42 CFR § 438.410(c)(2)* and *42 CFR § 438.408(c)(2)ii*, is when Partners denies a request to expedite an appeal, the enrollee must be notified of their right to file a grievance. It was also evident in the review of expedited appeal files, appellants were not notified of their right to file a grievance.

There is also an error in Policy and Procedure 13.04U regarding the timeframe for providing written notification of an expedited appeal resolution to the enrollee. The correct timeframe is outlined in Section V.B of the policy and procedure. However, under Section VI.A, the policy and procedure states, "For expedited appeal request, written notification to the

member of the decision occurs within 3 calendar days of the receipt of the appeal request." *The NC Medicaid Contract*, *Attachment M* and *42 CFR § 438.408(b)(3)* require notification within 72 hours.

In the previous EQR, a Corrective Action was issued addressing missing language in Policy and Procedure 13.04U, Clinical Utilization Management Appeals regarding the requirements around extending the appeal resolution timeframe. Partners addressed this Corrective Action and added language to their policy and procedure but missed the requirement to notify of the enrollee of their right to file a grievance. *42 CFR § 438.408(c)(2)(ii)* requires that when Partners extends the timeframe for resolving an appeal, the enrollee is notified of their right to file a grievance against Partners.

In the previous EQR, CCME recommended that Partners include in Policy and Procedure 13.04U, the steps staff should follow when processing appeals that are invalid or withdrawn. This Recommendation was not addressed. Policy and Procedure 13.04U, requires that "Partners acknowledges receipt of the appeal in writing via a letter to the appellant dated the next working day" and "for all appeals, regardless of the final decision, Partners BHM sends written notification to the aforementioned parties". However, review of the appeal files showed staff did not consistently provide written notifications to appellants when processing invalid or withdrawn appeals. This provides further evidence that staff need procedural guidance to ensure a consistent and fair process is followed.

In the previous EQR, CCME recommended that Partners verify files requested for audit or review are complete, including all communications and notifications between Partners' staff and appellants. This Recommendation was issued because Partners did not submit the Consumer Contact logs with the appeal files. These logs are often the only documentation that demonstrate staff are taking internal steps (e.g., oral notifications, outreach/assistance, phone calls from appellants, etc.) that are compliant with appeal requirements. Partners did not submit the Consumer Contact Logs again this year. CCME continues to advocate to maintain these documents as a part of the appeal record.

Once Consumer Contact Logs were obtained from Partners, the review of the 25 appeal files was completed and errors were noted in the oral, invalid, expedited, and withdrawn appeal files. These errors impacted almost half of the appeal files reviewed. Outside of these issues, all other standard and expedited appeals were acknowledged and resolved timely and within the requirements.

Figure 7 shows Partners met 85% of the grievance and appeals standards and provides a comparative to the previous EQR.

Figure 7: Grievances and Appeals Comparative Findings

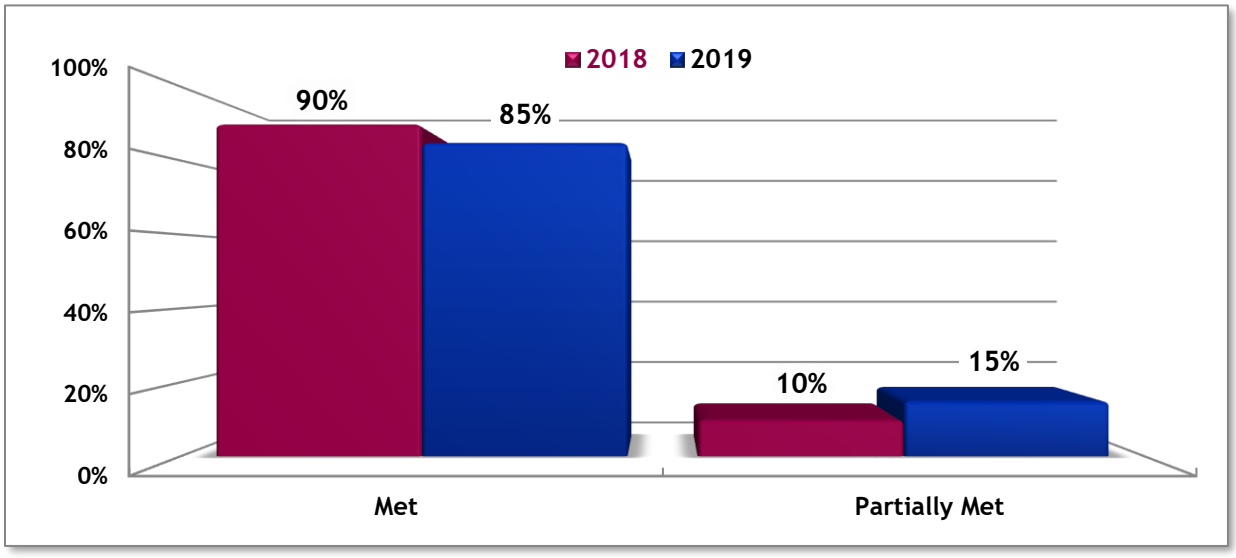


Table 24: Grievances and Appeals

Section	Standard	2019 Review
Appeals	The procedure for filing an appeal;	Partially Met
	Other requirements as specified in the contract.	Partially Met
	The PIHP applies the appeal policies and procedures as formulated.	Partially Met

Strengths

- Partners implemented the 2018 grievance EQR Recommendations.
- Staff were well versed in the requirements of processing appeals.

Weaknesses

- The Timing Section in Policy and Procedure 6.00U Grievance Management Policy discusses the process Partners follows when Partners extends the grievance resolution timeframe. However, this information does not include the requirement that Partners will notify the grievant of the grievant within two days.
- 83% of the grievance files submitted for this EQR indicated the grievances were “high priority”. The review of these files and feedback from the staff during the Onsite

discussion showed there is a disconnect between the process staff follow when identifying and acting on these type of grievances, and Policy and Procedure 6.00U, Grievance Management Policy.

- Partners' Policy and Procedure 13.04U, Clinical Utilization Management Appeals, *Provider Operations Manual* and *Member Handbook* are inconsistent when defining who can file an appeal.
- Partners' *Provider Operations Manual* and *Member Handbook* state Partners' form is required. Requiring this form is more restrictive than Policy and Procedure 13.04U, *NC Medicaid Contract* and the federal regulations governing appeals.
- Policy and Procedure 13.04U, Clinical Utilization Management Appeals, the *Provider Operations Manual*, and *Member Handbook* incorrectly state that, when Partners denies a request to expedite an appeal, Partners gives notification of the "the member's right to request reconsideration of the decision." The requirement, per *42 CFR § 438.410 (c)(2)* and *42 CFR § 438.408(c)(2)(ii)*, is when Partners denies a request to expedite an appeal, the enrollee must be notified of their right to file a grievance.
- Policy and Procedure 13.04U incorrectly states, "for expedited appeal request, written notification to the member of the decision occurs within 3 calendar days of the receipt of the appeal request." The required timeframe for this notification is 72 hours.
- Policy and Procedure 13.04U does not include the requirement to notify a member of their right to file a grievance against Partners when Partners extends the appeal resolution timeframe.
- Policy and Procedure 13.04U does not describe steps staff should follow when processing and resolving appeals that are invalid or withdrawn.
- The Consumer Contact Logs were not submitted as part of the appeal files in the last two EQRs. These logs are often the only documentation that capture steps that are required when staff are processing appeals.
- The EQR of the 25 appeal files showed compliance issues were noted in the oral, expedited, invalid, and withdrawn appeal files. These errors impacted almost half of the appeal files reviewed.

Corrective Action

- Revise the *Provider Operations Manual* and *Member Handbook* to clarify that any written request can initiate the appeals process.

- Include in Policy and Procedure 13.04U the steps staff should follow when processing and resolving appeals that are invalid or withdrawn. Include in these steps the expectations for mailing written notifications that acknowledge and resolve invalid and withdrawn appeals.

- Develop and document an appeal monitoring process that includes compliance monitoring of oral, invalid, expedited, and withdrawn appeal files. As a part of this monitoring, ensure Consumer Contact logs are reviewed for accuracy, legibility, completeness, and compliance with Partners' policies and procedures, *NC Medicaid Contract*, and federal regulations.

Recommendations

- In the grievance Policy and Procedure, Section J. Timing of Policy and Procedure 6.00U, include the information that Partners will send written notice of the extension to the grievance resolution timeframe to the grievant within two days.

- Develop and document a monitoring process that reviews "high priority" grievances and whether staff identify these grievances and take appropriate actions in compliance with Policy and Procedure 6.00U, Grievance Management Policy.

- Revise Partners' Policy and Procedure 13.04U, *Provider Operations Manual*, and *Member Handbook* to clearly and consistently state, "the Enrollee, legally responsible person, or a Provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent, may file a PIHP internal appeal." This revision will bring these documents into compliance with *NC Medicaid Contract, Attachment M, G.1* and the *42 CFR § 438.402(c)(1)(ii)*.

- Revise Policy and Procedure 13.04U, the *Provider Operations Manual*, and *Member Handbook* to state that, when Partners denies a request to expedite an appeal, the enrollee is notified of their right to file a grievance.

- Revise Policy and Procedure 13.04U to consistently state that written notification to the member of the decision occurs within 72 hours.

- Add to Policy and Procedure 13.04U the requirement to notify a member of their right to file a grievance against Partners when Partners extends the appeal resolution timeframe.

- Ensure Consumer Contact Logs are maintained as a part of the appeal record and submitted as a part of any documentation audit, review, or monitoring.

G. Delegation

CCME's review of Delegation functions included a review of the *Delegation Program Description*, the submitted Delegate List, Delegation Contracts, and Delegation Monitoring materials. Partners' staff provided additional information during the Onsite interview.

During the previous EQR, CCME provided one Recommendation. Partners partially addressed the Recommendation by revising the *Delegation Program Description*, though further revision is needed, as described in the current Recommendation.

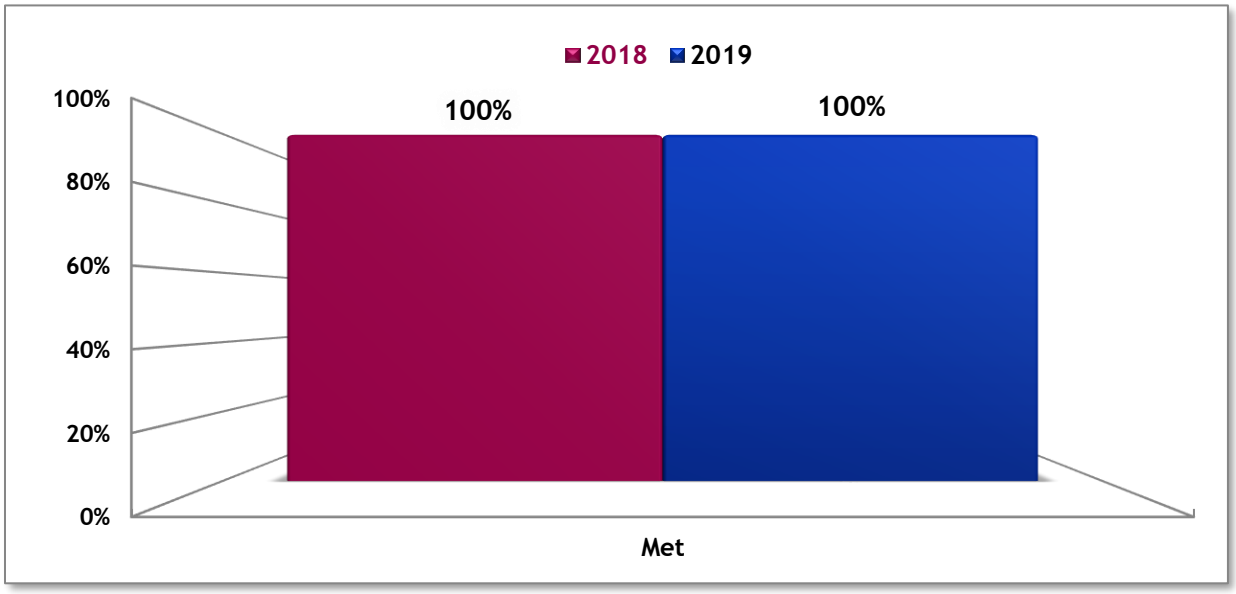
Partners reported four delegated entities during the EQR review time frame, as evidenced in Table 25. The delegation agreement with Vaya for call coverage ended on June 30, 2019. A delegation agreement with Cardinal Innovations Healthcare for "back-up and rollover Screening, Triage and Referral (STR) call center services as needed" was effective July 1, 2019. Partners conducted a Pre-Delegation Assessment prior to the inception of the Delegation Agreement with Cardinal.

Partners' contract with BHM was effective July 1, 2012, and a Business Associates Agreement (BAA) was added effective July 1, 2015. A contract amendment addressing Performance Monitoring and Failure to Perform was fully executed as of November 22, 2019. The contract and BAA with PREST & Associates LLC were effective November 1, 2017 and ended on October 31, 2019. Partners does not delegate any credentialing functions.

Table 25: Delegated Entities

Delegated Entities	Service
BHM Healthcare Solutions	Peer Review
Prest & Associates (ended 10/31/2019)	Peer Review
Cardinal Innovations (effective 07/01/19)	Call Coverage (Overflow and Non-Overflow); STR functions
Vaya Health (ended 6/30/2019)	Call Coverage (Overflow and Non-Overflow); STR functions

Figure 8: Delegation Comparative Findings



Strengths

- During the EQR review period, Partners had current delegation contracts and BAAs with the four named delegates.
- Partners receives monthly reports from delegates and held regular meetings with Vaya staff to monitor calls and to discuss and resolve any issues.
- Partners conducted a Pre-Delegation Assessment prior to the inception of the Delegation Agreement with Cardinal.

Weaknesses

- Partners revised the *Delegation Program Description* to include the *NC Medicaid Contract, Attachment B, Section 11.1.2* language regarding the requirement for an annual monitoring. Partners retained the language that states, "If the Delegate is URAC accredited and maintains that accreditation the annual assessment is not required." Further, Partners added language that, "If the delegate is NCQA accredited and maintains that accreditation, then the above audit items #2 & 3 are not required." This language is incorrect as the *NC Medicaid Contract* requires all delegates to be assessed at least annually, irrespective of accreditation status.
- Partners did not submit the annual assessments for the delegates until CCME specifically requested them, including one that was requested again during the Onsite review. One assessment had the typed name of a Partners' staff member, but the assessment was not signed and did not include the time frame covered by the assessment.

Recommendations

- Revise the *Delegation Program Description* to indicate all delegates will be assessed at least annually, irrespective of accreditation status. See *NC Medicaid Contract Attachment B, section 11.1.*

- For Delegation Assessments, include the time frame covered by the assessment, the date the assessment was completed, and the date signed by the Partners' staff member.

- For the EQR, submit the "results of the most recent monitoring activities, including annual evaluations/assessments, and indicate to which committee(s) delegate monitoring is reported", as indicated on the *External Quality Review Materials Requested for Desk Review* document.

H. Program Integrity

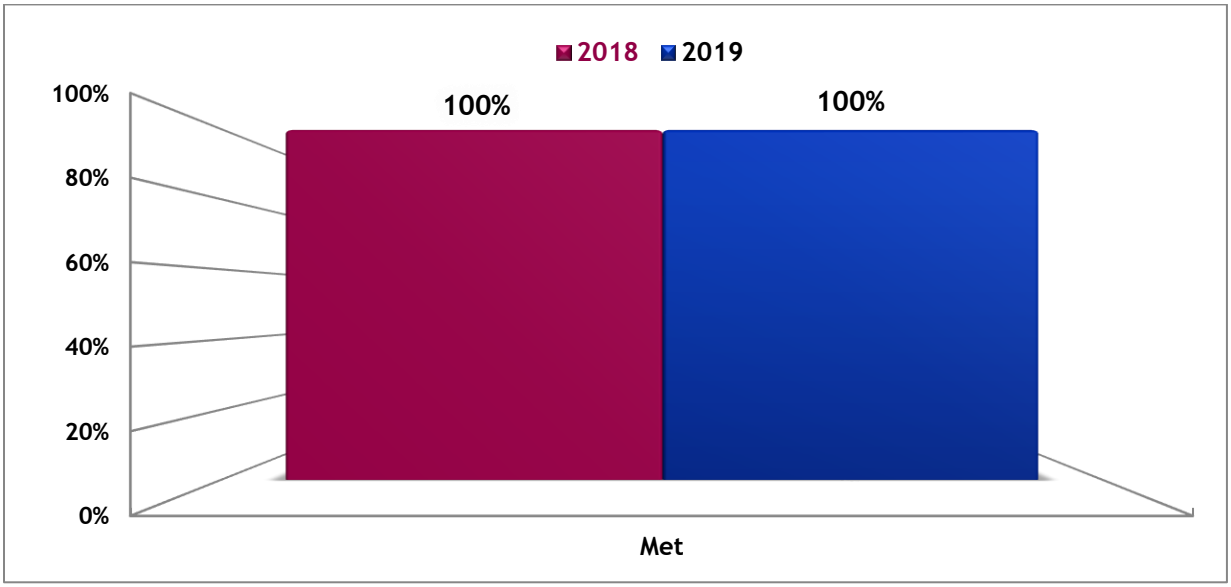
The Program Integrity (PI) EQR involves an assessment of Partners' compliance with federal and state regulations regarding PI functions. A Desk Review of Partners' documentation was conducted, and included review of Partners' policies, procedures, training materials, organizational charts, job descriptions, committee meeting minutes and reports, provider agreements, enrollment application, workflows, *Provider Operations Manual*, employee handbook, newsletters, conflict of interest forms and the *Compliance Plan*. Telepresence Onsite interviews were conducted with the Compliance and Program Integrity Managers to discuss the findings within the Desk Materials and PI files.

There were several Recommendations from the previous 2018 EQR. The Recommendations centered around contractual language that was missing from Partners' policies and procedures. While Partners did add some of the contractual requirements to their Departmental Procedural Guidelines, their website, and *Member Handbook*, CCME again recommends that their PI policies and procedures reflect their contractual requirements to ensure consistent information and compliance by Partners.

A sample of 15 PI files for the period of March 1, 2019 through February 29, 2020 were selected from a universe of files and submitted by Partners. These PI files were reviewed and found to be compliant with *NC Medicaid Contract* requirements. There were no cases of suspected enrollee fraud during the review period.

Figure 9 shows Partners met 100% of the Program Integrity standards in the 2018 and 2019 EQRs.

Figure 9: Program Integrity Findings



Strengths

- Partners is actively working to improve their training program for PI via their educational sub-committee.
- Partners takes a comprehensive data mining approach by receiving allegations from other departments such as quality management and grievances.

Weaknesses

- Timeliness requirements for initiating a preliminary investigation are not outlined in any policy and/or procedure.
- There is no policy or procedure that cites all the required information needed when referring cases of suspected provider and enrollee fraud to NC Medicaid.
- Partners' PI policies and procedures do not outline the requirements when there are changes in Partners' FAMS users.
- There is no policy or procedure that clearly states the timeliness requirements for reporting all current FAMS-users.
- Partners' PI policies and procedures do not state the timeliness requirements for lifting payment suspension.
- There is no language in Partners' PI policies and procedures that clearly states the required timeframes regarding imposing payment suspensions.

- No PI policy and procedure assures Partners will not take administrative action regarding allegations of suspected fraud against any providers without prior written approval from the NC Medicaid Program Integrity Department or the MFCU/MID.
- No policy or procedure states that reporting fraud, waste and abuse will not affect or interfere with the enrollee's access to care.

Recommendations

- Include in a PI policy and procedure the timeframe requirements for initiating a preliminary investigation.
- Include in a PI policy and procedure all the required information needed when referring suspected cases of provider and enrollee fraud to NC Medicaid in a PI policy and procedure.
- Include language in a PI policy and procedure clearly stating the timeliness requirements for reporting changes in Partners' NCID holders/FAMS users.
- Include language in a PI policy and procedure clearly stating the timeliness requirements for reporting all current NCID holders/FAMS-users at Partners.
- Include in a PI policy and procedure language clearly stating the timeliness requirements for lifting the payment suspension of providers.
- Include in a PI policy and procedure language regarding the required timeframes related to imposing payment suspensions.
- Include in a PI policy and/or procedure that the PIHP will not take administrative action regarding allegations of suspected fraud against any Providers referred to the NC Medicaid Program Integrity Department due to allegations of suspected fraud without prior written approval from the NC Medicaid Program Integrity Department or the MFCU/MID.
- Include in a PI policy and procedures that reporting fraud, waste, and abuse does not affect or interfere with enrollee's access to care.

I. Financial Services

In reviewing Partners' financial operations for the EQR review, the CCME implemented a Desk Review of the following documentation:

- Financial policies and procedures
- Audited financial statements, compliance reports, and footnotes dated June 30, 2019
- Balance sheet and income statements dated January 31, 2020 and February 29, 2020

- Medicaid monthly financial reports for January and February 2020
- Claims processing aging reports, as well as claims processing procedures
- Finance Department staffing structure
- Fiscal year budget ordinance for 2019-2020
- Budget to actual expenses report for Medicaid for January and February 2020
- Administrative Cost Allocation Plan Fiscal Year 2020
- Medicaid risk reserve bank statements for January and February 2020

CCME also reviewed deficiencies from prior EQRs to determine if they were corrected.

After reviewing Partners' Desk Review materials, a virtual Onsite interview was held. In addition to the standardized desk review inquiries, CCME asked interview questions in the following areas:

- Policies and procedures
- Staffing changes in finance
- Plans for computer upgrades or changes
- Financial review and monitoring
- Budget variances and development
- Any audit findings/corrective action plans

The previous EQR identified the need for two policy enhancements. The needed revisions related to adding language to Policy 4.11, Records Retention and Disposition. The first Recommendation was to reflect 10 years retention of all Medicaid records. This Recommendation was implemented, and the policy was updated on September 27, 2019. The second Recommendation was to add the five-business day requirement after receipt of capitation requirement to Policy 3.14, Management of Restricted Risk Reserve. This Recommendation was implemented, and the policy updated on September 27, 2019.

Per the EQR of Partners' financial records, Partners demonstrates ongoing financial stability through their audit report, net asset balance, and financial ratios. Partners' audit report for June 30, 2019 received an overall unqualified audit opinion on financial statements, which indicates that their auditors believe that their audited financial statements present fairly, in all material respects the financial position of Partners.

Partners exceeded the contract benchmarks for current ratio and Medical Loss Ratio (MLR). Partners' Medicaid current ratio is 1.03 total with a total current ratio of 1.20 in January 2020. The Medicaid current ratio is 1.03 total with a total current ratio of 1.19 for February

2020. The benchmark is 1.00. Partners' MLR, including Health Care Quality Indicators (HCQI) activities is 91.69% and 92.17% for January and February 2020, respectively. The benchmark is 85%. Medicaid total assets as of January 31, 2020 are $91,565,417 and $93,715,213 for February 29, 2020. Partners' net assets position was $113,203,473 as of June 30, 2019.

Partners meets the requirement in *42 CFR § 433.32(a)* for maintaining an appropriate accounting system (Great Plains). Partners uses Great Plains 2015 but anticipated upgrading to 2019 with the next fiscal year.

Partners meets the minimum record retention of ten years as required by *NC Medicaid Contract Section 8.3.2*. Partners' Procedure 4.11, Records Retention and Disposition, addresses Partners' plan for record storage, and Partners' stated during the interview that they are following the North Carolina Department of Health and Human Services' (DHHS) records retention schedule, with the exception of certain instances where they keep records longer than the state requires. Some examples of this include grants, claims, and invoices.

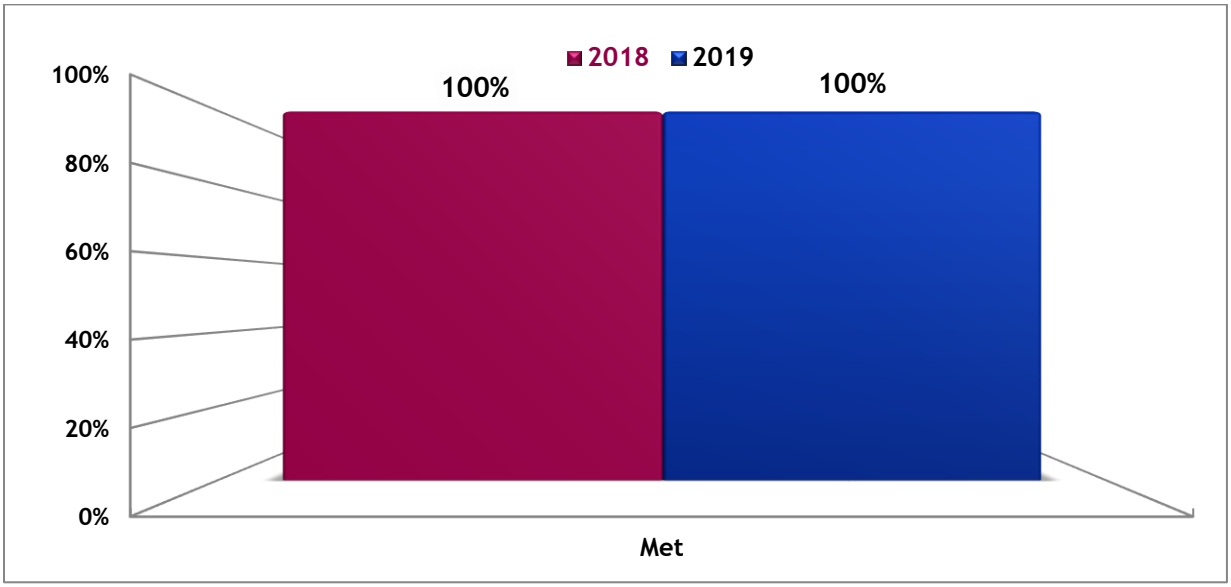
All finance procedures reviewed by CCME had review dates within the past year. Staff are notified via email and by communication in meetings, as well as the company newsletter, if there are procedures which require review.

Partners' Cost Allocation Plan meets the requirements for allocating the administrative costs between Medicaid, non-Medicaid, federal, state, and local entities based on revenue as required by *42 CFR § 433.34*. There were no costs disallowed per the audit report and Onsite interview. Annually, Partners submits a cost allocation plan to NC Medicaid to determine the percentage to be used monthly for allocation of Medicaid's share of administrative costs. The administrative expenses are separated monthly via the NC Medicaid financial reporting spreadsheet. Partners' Medicaid funds are properly segregated through the chart of accounts in the general ledger of Great Plains and Partners' Procedure 3.00, Accounting by Funding Source, addresses the segregation of funds by funding source.

Partners' Medicaid risk reserve account meets the minimum requirement of 2% of the capitation payment per month required by *NC Medicaid Contract, Section 1.9*. Partners has reached 12.8% of their required percentage of annualized capitation maximum (15%) as of February 29, 2020, with a balance of $40,545,709. Once the capitation payment is received from NC Medicaid, Partners calculates the risk reserve payment, which is reviewed by the Director of Finance and paid electronically to NC Capital Management Trust by Finance staff within five business days of the capitation payment (typically made within one day). All deposits were timely, and there were no unauthorized withdrawals. Partners provided CCME with bank statements demonstrating the risk reserve balance and deposits, which were made timely. Partners documents their risk reserve process in Policy 3.14, Management of Restricted Risk Reserve.

Figure 10 shows the Finance scores for Partners in the 2018 and 2019 EQRs.

Figure 10: Financial Services Comparative Findings



Strengths

- Partners typically makes their risk reserve payment within one day of receipt of the capitation period (standard is five business days).
- Partners has a detailed dashboard for their executive leadership team that serves as a management tool.

Weaknesses

- Policy and Procedure 3.00, Accounting by Funding Source, does not specify the due date of DHHS NC Medicaid Financial Reports.
- Policy and Procedure 3.00, Accounting by Funding Source, does not specify the 85% standard for Medical Loss Ratio reporting.
- Per the Onsite discussion, Partners does not submit to NC Medicaid a cost allocation plan with Medicaid percentage of costs calculated, only a description of its methodology.

Recommendations

- Revise Policy 3.00, Accounting by Funding Source, to reflect that monthly Medicaid reporting is due to NC Medicaid by the 20th of the month.
- Revise Policy 3.00, Accounting by Funding Source, to reflect that the Medical Loss Ratio standard is 85%.
- On an annual basis, submit to NC Medicaid a formal cost allocation plan with its estimated percentage of Medicaid and State administrative costs.

J. Encounter Data Validation

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

The scope of the EQR Encounter Data Validation review, guided by the CMS Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid by Partners for the period of January 2018 through December 2018. All claims paid by Partners should be submitted and accepted as a valid encounter to NC Medicaid. Our approach to the review included:

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

Results and Recommendations

Issue: Recipient Id

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

Resolution:

Partners should check their claims processing system and data warehouse to ensure the Recipient Id that is recognizable by the State is being captured appropriately. One possible solution is to review how Partners validates the recipient information in the system against GEF, and create exception reports to flag potential issues for manual review. Partners should also double check their 837 encounter creation process and encounter data extract process to make sure data was not lost or manipulated during transformation.

Issue: Billing Provider ID

A valid billing provider NPI number is required in order to properly adjudicate a claim. This issue only occurred in the Professional claims involving one providers.

Resolution:

The issue occurred involving claims that was submitted manually through the portal. The provider appears to have been loaded into the system initially with an incorrect NPI number. The issue has since been corrected. However, some claims still paid while the incorrect information was in the system, leading to incorrect encounter data submission. And while this problem seems isolated and highly likely occur with 837 transactions (since the NPI number

submitted on the 837 by the provider would not have matched the incorrect NPI number in Partners' system), Partners should review data validation rules and how provider information get validated and captured in the system during provider enrollment.

Issue: Provider Taxonomy

Provider Taxonomy codes were not consistently populated with a valid code. This information is key for passing the front end edits put in place by the State and to effectively price the claim. This impacts pricing since NCTracks is expecting the correct combination of NPI, Taxonomy and Procedure code. When values were populated, the Taxonomy code did not always match up with the Taxonomy values enrolled in NCTracks for the Billing and/or Rendering Provider. These errors result in denials by NC Medicaid that must be corrected and resubmitted.

Resolution:

As outlined in their ISCA response, Partners has a process in place to review 835 files and correctly resubmit encounters to the State that were denied due to invalid or missing Taxonomy. Partners should continue to follow their current process as well as monitor the front end edits in the local system to prevent these errors at the point of claim submission to ensure they are working as intended. The encounter data reviewed and NC Medicaid check write report reflects significant improvement compared to 2016 and 2017, so we know the process in place is making a positive impact.

Issue: Diagnosis Codes

The principal diagnosis was populated for 100% of the claims, which show a notable improvement compared to 2018. Additionally, Partners made great progress in capturing additional Diagnosis codes. Consequently, many Institutional and Professional claims now carry multiple Diagnosis codes, suggesting improvements in medical coding practices. However, most claims do not show additional Diagnosis codes.

Resolution:

The missing additional Diagnosis codes do not exceed the threshold outlined in the Data Quality Standards Table above, as there is no explicit figure for additional diagnosis. However, additional Diagnosis code should be populated with high frequency and Partners should continue to remind providers to code additional behavioral health diagnoses when appropriate. Separately, NC Medicaid will need to work with the PIHPs and CSRA to determine what additional non-behavioral health Diagnosis codes should be submitted and accepted when available. Currently, NCTracks will deny any encounter with a non behavioral health diagnosis regardless of the position of the Diagnosis code value (i.e. primary, secondary, tertiary, etc.). There are behavioral health services provided by the PIHPs that require medical services and medical Diagnosis codes. Partners will need to work collaboratively with the state and Alpha to ensure they can capture and report all Diagnosis codes once NCTracks has been updated to accept.

Issue: Procedure Codes

The Procedure code for Institutional claims should be populated 99% of the time. In the encounter data provided, 57% of claims contained a value in the Procedure code field. Adjusting for Revenue codes that do not require corresponding Procedure codes, this figure increases to 98%. Additionally, some Professional claims had invalid Procedure codes.

Resolution:

Overall, there has been a notable improvement in the quality of data as Partners just barely missed meeting the Data Quality Standards threshold target for Procedure codes (>99%). Procedure codes, when populated, were almost always valid. Partners should continue to monitor and make sure that Procedure codes submitted by providers are valid. In case of Institutional claims, encourage providers to code procedures when appropriate. Partners does a commendable job of denying outpatient Institutional claims when certain Revenue codes are submitted without a Procedure code (e.g. Revenue code '0450'.) 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 Procedure codes so that services that were rendered can be identified (e.g. submitting a Procedure code when billing Revenue code '0250'.)

Conclusion

Based on the analysis of Partners' encounter data, we have concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues were noted with both Institutional and Professional encounters. Based on Partners' ISCA response, overview of the Alpha system, and limited number of data anomalies, HMS believes that 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 in nature. Therefore, Partners should review and take corrective action to resolve the issues identified above.

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

ATTACHMENTS

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

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

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

April 20, 2020

Mr. Rhett Melton
Chief Executive Officer
Partners Behavioral 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 2019 External Quality Review (EQR) of Partners Behavioral Management (Partners) is being initiated. The review will be conducted by us, The Carolinas Center for Medical Excellence (CCME), and is a contractual requirement. The review will include both a desk review (at CCME) and a two-day onsite visit at Partners' office in Gastonia, North Carolina that will address all contractually required services.

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

The CMS EQR protocols can be found at:

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

The CCME EQR review team plans to conduct the onsite visit at Partners on **July 29, 2020** through **July 30, 2020**. For your convenience, a tentative agenda for the two-day review is enclosed.

In preparation for the desk review, the items on the enclosed **Desk Materials List** are to be submitted electronically, and are due no later than **April 27, 2020**. As indicated in item 40 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 by the aforementioned deadline.

Further, as indicated on item 42 of the Desk Materials List, Encounter Data Validation (EDV) will also be part of this review. Our subcontractor, Health Management Systems (HMS) will be evaluating this component. Please read the documentation requirements for this section carefully and make note of the submission instructions, as they differ from the other requested materials.

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

The location for the file transfer site is: https://eqro.thecarolinascenter.org

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 5
Cc: Monica Hamlin, NC Medicaid Contract Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager

External Quality Review 2019

MATERIALS REQUESTED FOR DESK REVIEW

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

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

3. Current Medical Director and Medical Staff job descriptions.

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

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

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

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

8. List of new services added to the provider network in the past 12 months (March 2019 through February 2020) by provider.

9. Network turnover rate for the past 12 months (March 2019 through February 2020) including a list of providers that were terminated for cause and list of providers that did not have their contracts renewed. For five providers termed in the last 12 months (March 2019 through February 2020), who were providing service to enrollees at the time of the termination notice, submit the termination letter sent to or from the provider, and the notification (of provider termination) letters sent to three consumers who were seeing the provider at the time of the provider termination notice.

10. List of providers credentialed/recredentialed in the last 12 months (March 2019 through February 2020). Include the date of approval of initial credentialing and the date of approval of recredentialing.

11. A current provider manual and provider directory.

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

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

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

15. Minutes of committee meetings for the months of March 2019 through February 2020 for all committees reviewing or taking action on enrollee-related activities. For example, quality committees, quality subcommittees, credentialing committees, compliance committee, etc.

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

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

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

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

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

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

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

22. A copy of the complete Appeals log for the months of March 2019 through February 2020. Please indicate on the log appeal type (standard or expedited), the service appealed, the date the appeal was received, the resolution date, and if the resolution timeframe was extended, who requested the extension. Also include on the log those appeals that were withdrawn or deemed invalid.

23. A copy of the complete Grievances log for the months of March 2019 through February 2020. Please indicate on the log the nature of the grievance, the date received, and the date resolved. If the grievance resolution timeframe was extended, please include who requested the extension.

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

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

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

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

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

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

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

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

32. Please provide an excel spreadsheet with a list of enrollees that have been placed in the TCLI program since April 2016. Please indicate on that list the individuals in In Reach, the individuals transitioned to the community, the individuals currently receiving Care Coordination, the individuals connected to services and list the services they are receiving, the individuals choosing to remain in ACH and the services they are receiving.

33. 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 Individual Support Plans in which the services and supports reflect participant assessed needs and life goals
Proportion of beneficiaries reporting they have a choice between providers.	Proportion of Individual Support Plans that address identified health and safety risk factors
Percentage of level 2 and 3 incidents reported within required timeframes.	Percentage of participants reporting that their Individual Support Plan has the services that they need
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.	Percentage of beneficiaries who received appropriate medication.
Percentage of medication errors resulting in medical treatment.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.

Required information includes the following for each measure:

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

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

c. Reporting frequency and format;

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

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

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

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

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

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

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

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

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

36. Data, Dashboards and/or reports for the Transition to Community Living Initiative (e.g., numbers of in-reach completed, housing slots filled, completed transitions, numbers of enrollees in supported employment, numbers of enrollees receiving ACT, Supported Employment, Peer Support Services, Community Support Team, Psychosocial Rehabilitation, etc. for the period March 2019 through February 2020.

37. Call performance statistics for the period of March 2019 through February 2020, including average speed of answer, abandoned calls, and average call/handle time for customer service representatives (CSRs).

38. Provide copies of the following files:

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

        i. Insurance:

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

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

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

iii. Ownership disclosure information/form.

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

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

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

ii. Insurance:

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

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

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

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

v. Ownership disclosure information/form.

c. Ten MH/SU, ten I/DD and five TCLI files medical necessity approvals made from March 2019 through February 2020, including any medical information and approval criteria used in the decision. Please select MEDICAID ONLY files and submit the entire file.

d. Ten MH/SU, ten I/DD and five TCLI files medical necessity denial files for any denial decisions made from March 2019 through February 2020. Include any medical information and physician review documentations used in making the denial determination. Please include all correspondence or notifications sent to providers and enrollees. Please select MEDICAID ONLY files and submit the entire file.

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

39. Provide the following for Program Integrity:

a. File Review: Please produce a listing of all active files during the review period (March 2019 through February 2020) including:
   i. Date case opened
   ii. Source of referral
   iii. Category of case (enrollee, provider, subcontractor)
   iv. Current status of the case (opened, closed)
b. Program Integrity Plan and/or Compliance Plan.
c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
d. Workflow of process of taking complaint from inception through closure.
e. All 'Attachment Y' reports collected during the review period.
f. All 'Attachment Z' reports collected during the review period.
g. Provider Manual and Provider Application.
h. Enrollee Handbook.
i. Subcontractor Agreement/Contract Template.
j. Training and educational materials for the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
k. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse.
l. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors, and employees.
m. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other State or Federal agency.
n. Code of Ethics and Business Conduct.
o. Internal and/or external monitoring and auditing materials.
p. Materials pertaining to how the PIHP captures and tracks complaints.
q. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
   i. NC Medicaid approved reporting templates.
r. Sample Data Mining Reports.
s. NC Medicaid Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
t. Monthly reports of NCID holders/FAMS-users in PIHP.

u. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
v. Corrective action plans including any relevant follow-up documentation.
w. Policies/Procedures for:
    i. Program Integrity
    ii. HIPAA and Compliance
    iii. Internal and external monitoring and auditing
    iv. Annual ownership and financial disclosures
    v. Investigative Process
    vi. Detecting and preventing fraud
    vii. Employee Training
    viii. Collecting overpayments
    ix. Corrective Actions
    x. Reporting Requirements
    xi. Credentialing and Recredentialing Policies
    xii. Disciplinary Guidelines

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

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

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

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

w. Any finance Corrective Action Plan

x. Detailed medical loss ratio calculation, including the following requirements under *42 CFR § 438.8*:

   i. Total incurred claims

   ii. Expenditures on quality improvement activities

   iii. Expenditures related to PI requirements under §438.608

   iv. Non-claims costs

   v. Premium revenue

   vi. Federal, state, and local taxes, and licensing and regulatory fees

   vii. Methodology for allocation of expenditures

   viii. Any credibility adjustment applied

   ix. The calculated MLR

   x. Any remittance owed to State, if applicable

   xi. A comparison of the information reported with the audited financial report required under *42 CFR § 438.3(m)*

   xii. The number of member months

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

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

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

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

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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2019

MATERIALS REQUESTED FOR ONSITE

1. QIC and GCQI Committee minutes for the months of March 2020 through June 2020.
2. UM Committee minutes for the months of March 2020 through June 2020.
3. Documentation of NC Medicaid approval of the practice of conducting a site visit via electronic means, as described in Policy/Procedure 8.08, Unlicensed Site Review, section 5. (Also, please see Provider Services Standard 3.2 from the last EQR.)
4. Flow chart of credentialing/recredentialing processes if you already have a flowchart. (Please do not create a new flow chart.)
5. Documentation of Partners' contact with licensing boards regarding supervision contracts. (Please see Provider Services Standard 3.1.2 from the last EQR.)
6. Documentation of Partners' contact with:
   a. the NC Medical Board (NCMB) to verify that Partners can assume there is a current collaborative practice agreement in place for PAs;
   b. the NCMB to verify that the NCMB conducted PSV of education for all physicians licensed prior to 08/01/10;
   c. the NC Board of Nursing to verify that Partners can assume there is a current collaborative practice agreement/supervision plan in place for NPs.
7. Credentialing or recredentialing items for the representative sample of providers identified on the *Partners Supplemental Documentation list*, for information obtained during the credentialing/recredentialing process.
8. Annual Delegation Assessment of Vaya for July 2018 – June 2019.
9. Annual Delegation Assessment of BHM.
10. Annual Delegation Assessment of Prest.
11. MCO Provider Sanctions Grid referenced in *Policy/Procedure 8.21N, MCO-Issued Provider Sanctions*.
12. Partners' NC Medicaid Waiver Annual Report Performance Measures Excel file (for the most recent available Fiscal Year).
13. PASRRs/RSVPs for all TCLI members submitted for this EQR.
14. For any TCLI members submitted for this EQR that accessed TYSR funds, any documentation demonstrating the papertrail and tracking throughout the TYSR process (e.g., referral to access TYSR funds, income verification, supervisor approval, economic worksheets, receipts, TYSR tracking information, etc.)

NOTE: Please see Partners Supplemental Documentation list for additional documentation needed. All items can be uploaded on the CCME File Transfer Site (folder 43. Other Info):

https://eqro.thecarolinascenter.org

C. Attachment 3: EQR Validation Worksheets

- Mental Health (b Waiver) Performance Measures Validation Worksheet
    - Readmission Rates for Mental Health
    - Readmission Rates for Substance Abuse
    - Follow-up after Hospitalization for Mental Illness
    - Follow-up after Hospitalization for Substance Abuse
    - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
    - Mental Health Utilization –Inpatient Discharge and Average Length of Stay
    - Mental Health Utilization
    - Identification of Alcohol and Other Drug Services
    - Substance Abuse Penetration Rate
    - Mental Health Penetration Rate
- Innovations (c Waiver) Performance Measures Validation Worksheet
    - Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals
    - Proportion of Individual Support Plans that address identified health and safety risk factors
    - Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need
    - 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
    - Number and percentage of deaths where required LME/PIHP follow-up interventions were completed, as required
    - Percentage of medication errors resulting in medical treatment
    - Percentage of beneficiaries who received appropriate medication
    - Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required
- Performance Improvement Project Validation Worksheet
    - Promoting follow-up within 7 days of discharge from a community hospital, state psychiatric hospital, and facility based crisis service for mental health treatment
    - Promoting follow-up within 7 days of discharge from a community hospital, state psychiatric hospital, state ADACTs, and detox/facility based crisis services for substance use disorder treatment
    - Physical health/primary care physician (PCP) referrals to behavioral health
    - Reduce Emergency Department utilization of active members

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS HEALTH MANAGEMENT**
Name of PM:	**READMISSION RATES FOR MENTAL HEALTH**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	07/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS HEALTH MANAGEMENT**
Name of PM:	**READMISSION RATES FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	07/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS HEALTH MANAGEMENT**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	07/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS HEALTH MANAGEMENT**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	07/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS HEALTH MANAGEMENT**
Name of PM:	**INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	07/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS HEALTH MANAGEMENT**
Name of PM:	**MENTAL HEALTH UTILIZATION- INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	07/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS HEALTH MANAGEMENT**
Name of PM:	**MENTAL HEALTH UTILIZATION**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	07/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS HEALTH MANAGEMENT**
Name of PM:	**IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	07/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS HEALTH MANAGEMENT**
Name of PM:	**SUBSTANCE ABUSE PENETRATION RATE**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	07/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**PARTNERS HEALTH MANAGEMENT**
Name of PM:	**MENTAL HEALTH PENETRATION RATE**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	07/20

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations Measures Validation Worksheet

PLAN NAME	**PARTNERS HEALTH MANAGEMENT**
Name of PM	**INNOVATIONS MEASURE: ISP NEEDS AND LIFE GOALS**
Reporting Year	2019
Review Performed	07/20

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**PARTNERS HEALTH MANAGEMENT**
Name of PM	**INNOVATIONS MEASURE: ISP HEALTH AND SAFETY RISK FACTOR**
Reporting Year	2019
Review Performed	07/20

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**PARTNERS HEALTH MANAGEMENT**
Name of PM	**INNOVATIONS MEASURE: ISP SERVICES NEEDED**
Reporting Year	2019
Review Performed	07/20

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**PARTNERS HEALTH MANAGEMENT**
Name of PM	**INNOVATIONS MEASURE: CHOICE BETWEEN PROVIDERS**
Reporting Year	2019
Review Performed	07/20

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**PARTNERS HEALTH MANAGEMENT**
Name of PM	**INNOVATIONS MEASURE: CARE COORDINATOR OFFERS SERVICES AVAILABLE**
Reporting Year	2019
Review Performed	07/20

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**PARTNERS HEALTH MANAGEMENT**
Name of PM	**INNOVATIONS MEASURE: LEVEL 2/3 INCIDENTS REPORTED WITHIN REQUIRED TIMEFRAME**
Reporting Year	2019
Review Performed	07/20

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**PARTNERS HEALTH MANAGEMENT**
Name of PM	**INNOVATIONS MEASURE: DEATHS WHERE INTERVENTIONS WERE COMPLETED AS REQUIRED**
Reporting Year	2019
Review Performed	07/20

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**PARTNERS HEALTH MANAGEMENT**
Name of PM	**INNOVATIONS MEASURE: MEDICATION ERRORS**
Reporting Year	2019
Review Performed	07/20

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**PARTNERS HEALTH MANAGEMENT**
Name of PM	**INNOVATIONS MEASURE: RECEIVED APPROPRIATE MEDICATION**
Reporting Year	2019
Review Performed	07/20

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**PARTNERS HEALTH MANAGEMENT**
Name of PM	**INNOVATIONS MEASURE: INCIDENTS REFERRED TO THE DIVISION OF SOCIAL SERVICES**
Reporting Year	2019
Review Performed	07/20

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

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

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

VALIDATION SUMMARY

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

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

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

OVERALL VALIDATION

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

AVERAGE VALIDATION PERCENTAGE & AUDIT DESIGNATION
100% FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

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

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

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

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

Component / Standard (Total Points)	Score	Comments
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	There are several remeasurements with interim review.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis of data is provided and follow up interventions are documented.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology and specification revisions are documented.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	Rate was improving and then decreased for the two most recent remeasurements. ***Recommendation: Continue peer support and provider engagement interventions to determine if they are impacting follow up.***
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Improvement was not documented for most recent remeasurement.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not calculated as sampling is not being used.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score		Steps	Possible Score	Score
Step 1				Step 6		
1.1	5	5		6.4	5	5
1.2	1	1		6.5	1	1
1.3	1	1		6.6	5	5
Step 2				Step 7		
2.1	10	10		7.1	10	10
Step 3				Step 8		
3.1	10	10		8.1	5	5
3.2	1	1		8.2	10	10
Step 4				8.3	1	1
4.1	5	5		8.4	1	1
4.2	1	1		Step 9		
Step 5				9.1	5	5
5.1	NA	NA		9.2	1	0
5.2	NA	NA		9.3	NA	NA
5.3	NA	NA		9.4	NA	NA
Step 6				Step 10		
6.1	5	5		10.1	NA	NA
6.2	1	1		Verify	NA	NA
6.3	1	1				

Project Score	**84**
Project Possible Score	**85**
Validation Findings	**99%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**PARTNERS HEALTH MANAGEMENT**
Name of PIP:	**PROMOTING FOLLOW-UP WITHIN 7 DAYS OF DISCHARGE FROM A COMMUNITY HOSPITAL, STATE PSYCHIATRIC HOSPITAL, STATE ADACTS, AND DETOX/FACILITY BASED CRISIS SERVICES FOR SUD TREATMENT**
Reporting Year:	2019
Review Performed:	2020

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

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

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

Component / Standard (Total Points)	Score	Comments
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	There are several remeasurements.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis of data is provided and follow up interventions are documented.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology and measure revisions are documented.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	The rates improved initially and then declined for the latest remeasurements. ***Recommendation: Continue interventions focused on low provider engagement to determine the impact on SUD follow-up rates.***
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement in most recent remeasurements.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not calculated as sampling is not being used.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score		Steps	Possible Score	Score
Step 1				Step 6		
1.1	5	5		6.4	5	5
1.2	1	1		6.5	1	1
1.3	1	1		6.6	5	5
Step 2				Step 7		
2.1	10	10		7.1	10	10
Step 3				Step 8		
3.1	10	10		8.1	5	5
3.2	1	1		8.2	10	10
Step 4				8.3	1	1
4.1	5	5		8.4	1	1
4.2	1	1		Step 9		
Step 5				9.1	5	5
5.1	NA	NA		9.2	1	0
5.2	NA	NA		9.3	NA	NA
5.3	NA	NA		9.4	NA	NA
Step 6				Step 10		
6.1	5	5		10.1	NA	NA
6.2	1	1		Verify	NA	NA
6.3	1	1				

Project Score	**84**
Project Possible Score	**85**
Validation Findings	**99%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**PARTNERS HEALTH MANAGEMENT**
Name of PIP:	**PHYSICAL HEALTH/PRIMARY CARE PHYSICIAN (PCP) REFERRALS TO BEHAVIORAL HEALTH- NON-CLINICAL**
Reporting Year:	2019
Review Performed:	2020

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

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

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

Component / Standard (Total Points)	Score	Comments
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	There were several remeasurement periods in the report**.**
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis of data is provided and follow up interventions are documented.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	New methodology has been used for the last several remeasurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	There was a new baseline in 2018 and the rate was around 14% and then dropped to 8.2% in the most recent remeasurement. ***Recommendation: Conduct analysis to determine if unknown barriers exist for referrals; determine if initiatives for referrals are appropriate; gather information from PCPs on reasons for lack of referrals*.**
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement in latest rate.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not calculated as sampling is not being used.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	84
Project Possible Score	85
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**PARTNERS HEALTH MANAGEMENT**
Name of PIP:	**REDUCE ED UTILIZATION OF ACTIVE MEMBERS**
Reporting Year:	2019
Review Performed:	2020

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions to address barriers are listed in the report including connecting with community-based providers, SDOH screening, value based contracting, and others.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses were performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly and accurately.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Baseline and repeat measurements have occurred.

Component / Standard (Total Points)	Score	Comments
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis of data is provided and follow up interventions are documented.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology was consistent.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not met**	Initial increase (non improvement) occurred, and then the rate decreased but it still above baseline. ***Recommendation: Continue to explore new interventions that will help high ED utilizing members to seek appropriate services.***
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to analyze.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not calculated as sampling is not being used.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score		Steps	Possible Score	Score
Step 1				Step 6		
1.1	5	5		6.4	5	5
1.2	1	1		6.5	1	1
1.3	1	1		6.6	5	5
Step 2				Step 7		
2.1	10	10		7.1	10	10
Step 3				Step 8		
3.1	10	10		8.1	5	5
3.2	1	1		8.2	10	10
Step 4				8.3	1	1
4.1	5	5		8.4	1	1
4.2	1	1		Step 9		
Step 5				9.1	5	5
5.1	NA	NA		9.2	1	0
5.2	NA	NA		9.3	NA	NA
5.3	NA	NA		9.4	NA	NA
Step 6				Step 10		
6.1	5	5		10.1	NA	NA
6.2	1	1		Verify	NA	NA
6.3	1	1				

Project Score	84
Project Possible Score	85
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

D. Attachment 4: Tabular Spreadsheet

CCME PIHP Data Collection Tool

Plan Name:	**Partners**
Collection Date:	2019

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A. General Approach to Policies and Procedures						
1. The PIHP has in place policies and procedures that impact the quality of care provided to Enrollees, both directly and indirectly.	X					For the EQR of policies and procedures, Partners submitted 201 policies and procedures, 11 program descriptions/plans, 13 standalone policies, and a Master Tracking List. Review of the Master Tracking List when compared to the program descriptions/plans submitted showed some disconnect. 11 program descriptions/plans were submitted with the policies and procedures, but the Master Tracking List shows 12 program descriptions/plans and, in a separate folder, Partners uploaded 16 program descriptions/plans. Policy and Procedure 1.09U, indicates, "Each procedure and program description/plan is reviewed initially and then at least annually by the Department Director/Designee." However, at least one of Partners' program description/plan (Partners' Disaster Plan) has not been reviewed in two years. During the Onsite, staff explained that some program descriptions/plans follow a different process for annual review than is outlined in Policy and Procedure 1.09U. Policy and Procedure 1.09U, Policies, Procedures, Program Descriptions and Plans, Approval and Maintenance, describes the process for the creation, annual review, revision and maintenance of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Partners' policies, procedures, program descriptions and plans. The procedure indicates that Master Lists include comprehensive information, such as the "document title, category, and reference number, responsible department, original approval date, and all subsequent review/approval dates." However, the Master Lists submitted for this EQR contain only the title, number and category of each policy and procedure and do not include the subsequent review and approval dates. Staff explained the history of policy and procedure revision is now tracked separately from the Master Lists. It was also noted that Policy and Procedure 1.09U requires the chronology of policy and procedure revisions to be captured in the footer of each policy and procedure. This process was abandoned by Partners in 2018. During the Onsite, staff confirmed the agency's internal drive maintains a separate list of policy and procedure revision dates and all previous versions of policies and procedures. ***Recommendations: Revise Policy and Procedure 1.09U to accurately reflect Partners' current process for tracking revisions of all policies and procedures. Include in this revision, an accurate description of the process Partners follows to annually review all program descriptions/plans.***
I. B. Organizational Chart / Staffing						
1. The PIHP's resources are sufficient to ensure that all health care products and services required by the State of North Carolina are provided to enrollees. At a minimum, this includes designated staff performing in the following roles:						
1.1 A full time administrator of day-to-day business activities;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities.	X					Dr. Stanton serves as Partners' Chief Medical Officer (CMO) and Dr. Edwards joined Partners' medical staff as the AMD in June 2019. Both physicians have identical job descriptions. It was recommended in the previous EQR that departmental oversight by the CMO is reflected on the Organizational Chart. This Recommendation was implemented, but the current Organizational Chart does not reflect the departmental involvement or oversight by Dr. Edwards. During the Onsite, while staff could describe Dr. Edwards' functions at Partners, there is no documentation to show which departments or functions he supports. ***Recommendation: Revise the Organizational Chart to include the AMD in the departments he supports.***
2. Operational relationships of PIHP staff are clearly delineated.	X					
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all PIHP staff positions, including those that are required by NC Medicaid.	X					
I. C. Confidentiality						
1. The PIHP formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					
2. The PIHP provides HIPAA/confidentiality training to new employees and existing staff.	X					During the Onsite, staff explained confidentiality training of new staff occurs in the first two days of the new staff's employment and prior to exposure to Protected Health Information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Procedure 2.15U, Employee Training and Support further indicates that Partners provides "initial orientation and training for all employees before assuming assigned roles and responsibilities" and that this initial orientation includes training on confidentiality and other regulatory compliance topics.
I D. Management Information Systems						
1. Enrollment Systems						
1.1 The PIHP capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Partners has standard processes in place for enrollment data updates. WellSky uploads the daily and quarterly GEF files to the AlphaMCS enrollment system. Partners uses the monthly 820 Capitation file along with the GEF and monthly 834 file to reconcile PMPM payment and to identify discrepancies between the eligibility and payment processes.
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					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.
1.3 The PIHP's enrollment system member screens store and track enrollment and demographic information.	X					Partners' vendor WellSky loads the GEF file on a daily basis. Partners also loads the GEF file to a local data warehouse for reporting. Summary reports compare the total number of records from each database to identify any discrepancies. Partners also compares the eligibility data to the 820 Capitation file on a monthly basis and discrepancies that are identified are then, investigated.
2. Claims System						
2.1 The PIHP processes provider claims in an accurate and timely fashion.	X					The majority of claims received are electronic or through the Provider Web Portal. Less than 1% of claims that are submitted by providers are received via paper. Approximately 95.6% of Institutional

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						and 99.3% of Professional claims are auto-adjudicated. Auto-adjudication is performed daily. Partners pends claims that have a billed amount higher than $5,000. Hospital Outpatient claims and professional claims with a POS for ED are also pended. The pended claims are manually reviewed by the Quality Review Analyst for accuracy prior to approval or denial. Claims that require medical review are pended and sent to Partners' CMO for approval or denial. Claims pended for medical review are completed within seven days.
2.2 The PIHP has processes and procedures in place to monitor, review and audit claims staff.	X					Partners has processes in place to monitor and audit claims staff. Partners audits a random sample of at least 3% of all claims processed on a weekly basis. Paper claims are included in the random sample of 3%. Partners audits 7% of COB claims. All claims higher than $5,000 are audited.
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. The PIHP has the capability of receiving and storing ICD-10 procedure codes on an 837 Institutional file.		X				Revenue codes and DRG codes are captured in the AlphaMCS system. DRG codes can be submitted via the Provider Web Portal. The revenue codes and DRG are also included for encounter data submission reporting. For Institutional claims, up to 25 ICD-10 diagnosis codes are captured received via the Provider Web Portal and up to 29 ICD-10 diagnosis codes are captured electronically. For Professional claims, up to 12 ICD-10 diagnosis codes are captured electronically and via the Provider Web Portal. Partners does not capture ICD-10 procedure codes on the AlphaMCS system or via the Provider Web Portal. ***Corrective Action: Update Partners' AlphaMCS system and Provider Web Portal to be able to capture the ICD-10 procedure codes.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 The PIHP's claim system screens store and track claim information and claim adjudication/payment information.	X					Teleconference review of the claim system screens identified the capture of adjudication/payment information for the claims.
3. Reporting						
3.1 The PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					The enrollment and claims data in the AlphaMCS database from WellSky is mirrored into local databases on a daily basis. Partners uses the AlphaMCS system, internal databases, and Reports Manager to generate reports. Partners' reporting database contains enrollment and claims data since 2012.
3.2 The PIHP has processes in place to back up the enrollment and claims data repositories.	X					Partners has processes in place that backup the enrollment and claims data in the AlphaMCS system on a daily and weekly basis A disaster recovery 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 submits up to 29 ICD-10 diagnosis codes on Institutional and up to 12 ICD-10 diagnosis codes on Professional encounters to NCTracks. Partners includes DRG codes on encounter data submissions. Partners does not include ICD-10 procedure codes on encounter data submissions. Partners includes procedure codes and revenue codes for certain lab, drug, or radiology services on encounter data submissions. ***Corrective Action: Update Partners' encounter data submission process to be able to submit ICD-10 procedure codes present on an 837I.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2 The PIHP has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					Partners uses an internally developed report based on the 835 response file to identify denied encounters and the reason for denial. Partners also uses the NC Medicaid Adam Holtzman's paid and denied report for additional information on the denied encounters.
4.3 PIHP has policies and procedures in place to reconcile and resubmit encounter data denied by NC Medicaid.	X					Partners has clear processes in place to address denied encounter data submissions. ISCA documentation shows workflows and procedures for encounter data submissions to NC Medicaid.
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 that is responsible for working on the denied encounters. The encounter data acceptance rate has been consistent with last year's observations. 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					Policy and Procedure 8.26U, Provider Credentialing, Policy and Procedure 8.27, Selection and Retention of Network Providers, and the *Credentialing Program Description* address the credentialing and recredentialing processes.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	X					The *Credentialing Committee Charter* and the *Credentialing Program Description* provide details on the composition and responsibilities of the Credentialing Committee. The *Credentialing Program Description* states "...the CMO chairs the credentialing committee, reviews and approves Providers' credentialing files that meet criteria for participation as delegated by the CR Committee." There is no alternate chair or reference to a coverage plan if the CMO is absent or otherwise unable to chair the meeting. Dr. Edwards chaired the December 2019 committee meeting, and, during Onsite discussion, Partners staff confirmed Dr. Edwards will chair the meeting if Dr. Stanton should be absent. The *Credentialing Program Description* states, "The function of signing-off on each completed credentials review sheet may be delegated to the Assistant CMO and/or Clinical Director, if needed." Partners staff confirmed there is no "Assistant CMO" and this is referencing Dr. Edwards, AMD. The *Credentialing Committee Charter* lists "membership position description" and "member Name". The *Credentialing Committee Charter* submitted for the EQR was revised May 15, 2019, but it includes some individuals who are no longer on the committee. ***Recommendations:*** • ***Revise the Credentialing Program Description and any other documents that reference the "Assistant CMO" to reflect the correct title ("Associate Medical Director").*** • ***To reflect the coverage plan if the CMO is absent, revise the Credentialing Program Description and any other documents that reference the Chair of the Credentialing Committee, to indicate the committee meetings are chaired by the CMO or designee.*** • ***Update the Credentialing Committee Charter to include and maintain current membership.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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. The following issues were identified from the file review.
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					At the last EQR, no supervision contract was found in the file of providers with "Associate" licensure, such as LPC-A (which is now LMHCA) or LCSW-A, or in the file of a provider who is an LPA. No credentialing or recredentialing files for Physician Assistants (PAs) were submitted for the last EQR. This issue was discussed at the EQR Onsite in October 2018 and CCME issued a *Recommendation* in the report for that EQR. No credentialing or recredentialing files for practitioners with "associate" licensure, or files for LPAs, and no initial credentialing files for PAs were submitted for this EQR. At CCME's request, Partners submitted documentation of their contact with the licensing boards regarding this matter. Only the Marriage and Family Therapy board indicated they collect the supervision contracts. During Onsite discussion, Partners staff indicated that credentialing staff was not instructed until March 2020 to begin collecting supervision contracts for practitioners with "associate" licensure and for LPAs. Partners indicated they rely on the NCMB for the supervision arrangements for PAs, though they could not provide any documentation from the NCMB to verify that the NCMB collects those. In fact, the NCMB website states, in part, "The primary

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						supervising physician and the PA must sign and date the supervisory arrangement, keep it on file at all practice sites and make it available to the Board if requested." The *Credentialing Program Description* dated 10/11/2019 submitted for the EQR does not include the requirement for supervision agreements to be collected for practitioners with "associate" licensure, for LPAs, or for Supervisory Agreement documentation to be collected for PAs. ***Recommendation: Revise the Credentialing Program Description and the credentialing/recredentialing processes to include the requirement to collect documentation of the supervision agreement for practitioners with "associate" licensure and for LPAs, and to collect the Supervisory Arrangement documentation for PAs. See NC Medicaid Contract Attachment O.***
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					The NCMB has confirmed that they do not conduct PSV of education or board certification (they only conduct random checks). The American Board of Medical Specialties (ABMS) and the American Board of Psychiatry and Neurology (ABPN) conduct PSV of education. The Educational Commission for Foreign Medical Graduates (ECFMG) also conducts PSV of education. The initial credentialing files of three physicians were submitted for the file review for the current EQR. The file of one physician (who is not board certified and does not have ECFMG certification) does not contain verification of education. Partners staff noted that this physician was licensed before August 1, 2010, the effective date on which the NCMB implemented their "expedited license application process". Partners assumes the NCMB conducted PSV of this physician's license, since she was licensed prior to August 1, 2010.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						However, Partners does not believe they have confirmed with the NCMB and could not produce any documentation to support this assumption is correct. ***Recommendation: Contact the NCMB to confirm that the NCMB conducted PSV of education for all physicians licensed prior to August 1, 2010. If confirmation is received, maintain the documentation. Otherwise, Partners remains responsible for conducting PSV of education for physicians who are not board certified or do not have ECFMG certification.***
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					
3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.8 Query of the National Practitioner Data Bank (NPDB) ;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); and query of the State Exclusion List;	X					No PSV of the *State Exclusion List* was included in the submitted initial credentialing file for one agency, but was provided upon CCME's request.
3.1.10 Query for the System for Awards Management (SAM);	X					
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	X					
3.1.14 Names of hospitals at which the physician has admitting privileges, if any	X					
3.1.15 Ownership Disclosure is addressed.	X					Partners obtains ownership information during the application process. However, staff confirmed during Onsite discussion that Partners does not ask LIP applicants if they have "agents or managing employees" such as EFT Transfer employees. The *NC Medicaid Contract Attachment O, #5* states, "Applicants must identify (by name, social security number, date of birth and address) all persons with an ownership or control interest of the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						entity as defined at *42 CFR § 455.101.*" *NC Medicaid Contract Attachment O, #6 states,* "Applicants must furnish PIHP a list of the names, dates of birth, social security numbers and addresses of all managing employees as defined at *42 CFR § 455.101...*". The *NC Medicaid Contract, Attachment B*, Section *1.13* addresses the requirements of *42 CFR § 455.106* and *42 CFR § 455.434* surrounding Disclosure of Criminal Convictions and Criminal Background Checks of Providers and Persons with Controlling Interest. The *NC Medicaid Contract, Attachment B, Section 1.14.4* states the PIHP "shall check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider, including the State Exclusion List, HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the System of Award Management (SAM) no less frequently than monthly to ensure that PIHP does not pay Federal funds to excluded persons or entities in accordance with *42 CFR § 455.436*. PIHP shall also develop and implement policies and procedures for appropriate collection and maintenance of disclosure information." ***Recommendation:*** ***Revise the Credentialing Program Description and the credentialing/recredentialing processes for LIPs to include the requirement to:*** • ***collect the identifying information, and*** • ***conduct the required exclusion and criminal background checks*** ***for persons with an ownership or control interest in the provider, and agents and managing employees of the provider, as outlined in the NC Medicaid Contract and the CFRs.***
3.1.16 Criminal background Check	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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. The following issues were identified in the file review.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					See Comments in "Standard 3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees." During the current EQR, Partners included one file for a PA in the recredentialing files submitted for review. The PSV of the PA license was included, but the Supervisory Arrangement documentation was not in the file. Partners staff confirmed they do not obtain the Supervisory Arrangement documentation for PA applicants. They instead, "rely on the licensing board as the primary source to verify license compliance and good standing with licensing requirements."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Partners did not contact the NCMB to confirm if the NCMB collects Supervisory Arrangement documentation. The FAQ section on the NCMB website states, "The primary supervising physician and the PA must sign and date the supervisory arrangement, keep it on file at all practice sites and make it available to the Board if requested." This implies the NCMB does not collect the Supervisory Arrangement documentation. ***Recommendation: Revise the Credentialing Program Description and the credentialing/recredentialing processes to include the requirement to collect documentation of the supervision agreement for practitioners with "associate" licensure and for LPAs, and to collect the Supervisory Arrangement documentation for PAs. See NC Medicaid Contract Attachment O.***
4.2.3 Valid DEA certificate; and/or CDS certificate	X					
4.2.4 Board certification if claimed by the applicant;	X					One physician's application indicates he is board certified, but the PSV from the American Board of Medical Specialists (ABMS) indicates the certification expired in 2007. Board certification is not required for credentialing, but the physician was not contacted for clarification regarding the discrepancy.
4.2.5 Malpractice claims since the previous credentialing event;	X					
4.2.6 Practitioner attestation statement;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event; and query of the State Exclusion List;	X					No PSV of the *State Exclusion List* was included in the submitted files for two agencies, but was provided upon CCME's request.
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 Query of the Social Security Administration's Death Master File	X					
4.2.12 Query of the NPPES;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					
4.2.14 Ownership Disclosure is addressed.	X					See details in "Comments" in *Standard 3.1.15 Ownership Disclosure* in this document. ***Recommendation:*** ***Revise the Credentialing Program Description and the credentialing/recredentialing processes for LIPs to include the requirement to:*** • ***collect the identifying information, and*** • ***conduct the required exclusion and criminal background checks*** ***for persons with an ownership or control interest in the provider, and agents and managing employees of the provider, as outlined in the NC Medicaid Contract and the CFRs.***
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					The Credentialing Committee considers factors including "flags" as identified in the *Credentialing Program Description*, quality of care concerns, and information from Partners' Program Integrity.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 8.21N, MCO-Issued Provider Sanctions, addresses sanctions issued "based on identified areas of risk and/or serious quality of care identified issues." Policy 6.04, Quality of Care Concerns, "identifies potential concerns that might indicate a Quality of Care (QOC) Concern, the steps to resolution, and how Partners BHM reports and uses the information regarding QOCConcerns." (*sic*)
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					
II B. Adequacy of the Provider Network						
1. The PIHP maintains a network of providers that is sufficient to meet the health care needs of enrollees and is consistent with contract requirements.	X					Policy and Procedure 8.22U, Network Program Scope, and Policy and Procedure 8.27, Selection and Retention of Network Providers, address network sufficiency. Policy and Procedure 8.24, Out of Network Consumer Specific Agreements states, "in the event that a Partners enrollee has a medically necessary need for behavior health of intellectual/developmental disability services that are not available through an in-network provider an out of network consumer specific agreement may be required." The Network Development Cross Functional Team provides reports at Network Management Committee meetings.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 Enrollees have a Provider location within a 30 – mile distance of 30 minutes' drive time of their residence. Rural areas are 45 miles and 45 minutes. Longer distances as approved by NC Medicaid are allowed for facility based or specialty providers.	X					The 30 miles/30 minutes and 45 miles/45 minutes standards are detailed on several pages of the *Provider Operations Manual* and in Partners' Policy and Procedure 8.00, Access and Availability Standards. At the last EQR, Partners had a gap for Medicaid-funded Opioid Treatment. The *2019 Community Mental Health, Substance Use and Developmental Disabilities Services Network Adequacy and Accessibility Analysis* states, "Partners was able to close gaps in the provider network for Opioid Treatment services during the last fiscal year... through the recruitment of Office Based Opioid Treatment Providers, expansion of existing Opioid Treatment providers, and distribution of CURES funding." The *2019 Network Adequacy and Accessibility Analysis* indicates choice and access standards were not met for Medicaid-funded Substance Abuse-Comprehensive Outpatient Treatment Program (SA-COT) services. Partners submitted an *Exception Request*, which NC DHHS approved through January 31, 2020. A memo from NC Medicaid dated February 26, 2020 states, "After review, it appears that Partners has taken the necessary actions to resolve the gap for SA Comprehensive Outpatient Treatment Program and no longer requires an exception request." During Onsite discussion, Partners staff reported additional SA-COT programs were being developed, but progress was halted due to delays in obtaining licensure due to the pandemic.
1.2 Enrollees have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the enrollee may utilize an out-of-network specialist with no benefit penalty.	X					The Partners' *Member Handbook* addresses "What if I need a specialty provider?" on page 15, and addresses out-of-network providers on page 22.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 The sufficiency of the provider network in meeting enrollee demand is formally assessed at least annually.	X					Partners conducts an annual *Network Adequacy and Accessibility Analysis*, as required by NC Medicaid.
1.4 Providers are available who can serve enrollees with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					During Onsite discussion for the current EQR, Partners' staff indicated they gather information regarding foreign languages spoken, diverse populations served, and clinical expertise and specialty areas on the *Credentialing Initiation Form*. That information is then loaded into Alpha and is populated into the Provider Directory on the website. The *Provider Operations Manual* states, "Providers must offer language interpretation services by telephone and/or in person as needed. TDD (telecommunication devices for the deaf) must also be made available by providers for persons who have impaired hearing or a communication disorder." The Continuously Recruited Services section on the Partners' website notes, "Partners is searching for bilingual therapists for every county in the catchment area. The primary need is for Spanish and Hmong speaking therapists." The *Provider Operations Manual* indicates providers are required to develop a Cultural Competence Plan. The manual includes a link to the Cultural Competency page of the Partners' website, which includes the Partners' Cultural Competence Plan, and a "sample Cultural Competency Plan template to aid in the development of the required Cultural Competency Plan." During Onsite discussion, Partners' staff reported the provider's Cultural Competence Plan is part of the routine monitoring process.
1.5 The PIHP demonstrates significant efforts to increase the provider network when it is identified as not meeting enrollee demand.	X					The "Continuously Recruited Services" section on the Partners' website lists service needs by county. Partners uses the Request for Proposal (RFP) or Request for Information (RFI) process based on identified needs.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Provider Accessibility						
2.1 The PIHP formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					The *Provider Operations Manual* informs providers of their responsibility to "provide services in accordance with access standards and appointment wait times as noted in the general conditions of the procurement contract." Policy and Procedure 8.22U, Network Program Scope, states, "The Quality Improvement Committee (QIC) provides oversight of access and availability by reviewing various reports related to access and availability goals at least quarterly.", and indicates "Corrective actions are implemented when performance is continually outside the set performance standards." During Onsite discussion, Partners' staff reported they have used a "mystery shopper" process in the past regarding first responder and crisis response. They recently used a "mystery shopper" process for Assertive Community Treatment (ACTT), Community Support Team (CST), and Intensive In-Home (IIH) providers, around the issue of avoidable Emergency Department visits.
II C. Provider Education						
1. The PIHP formulates and acts within policies and procedures related to initial education of providers.	X					Training and orientation of network providers is described in Policy and Procedure 8.13U, Participating Provider Relations Program. New providers receive the orientation packet link, which includes the telephone number and email address of their designated provider relations representative. During Onsite discussion, Partners' staff reported the Provider Network Department has two trainers who provide training to providers. The *Provider Orientation Toolkit* is a 4 page document with summary information and website links regarding the AlphaMCS Provider Portal, the Appeals Process, Claims, Housing, Zixmail, Incidents, Grievances, Complaints or Concerns, Utilization Management, and a variety of other topics.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Initial provider education includes:						Information regarding the following standards is included in the *Provider Operations Manual*, and/or on the Partners' website unless otherwise noted.
2.1 PIHP purpose and mission;	X					
2.2 Clinical Practice Standards;	X					The *Provider Operations Manual* references the Clinical Practice Guidelines and provides a link to the guidelines on the Partners' website. The *Provider Operations Manual* states, "It is expected that all network providers will follow the below guidelines and requirements as delineated in contracts."
2.3 Provider responsibilities;	X					Provider responsibilities are outlined throughout the *Provider Operations Manual*.
2.4 PIHP closed network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability.	X					
2.5 Access standards related to both appointments and wait times;	X					Access standards are addressed in the *Provider Operations Manual* and in Partners' Policy and Procedure 8.00, Access and Availability Standards. However, section II.A. of the procedure states "Emergency Services: Providers must provide face-to-face emergency care within no more than two hours and fifteen minutes after the request for emergency care is received by provider staff from the LME/MCO or directly from the consumer; the Provider must provide face-to-face care immediately for life threatening emergencies."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Per *NC Medicaid Contract Attachment S,* "Providers must provide face-to-face emergency services within two hours after a request for emergency care is received by Provider staff from the PIHP or directly from an Enrollee; the Provider must provide face-to-face emergency care immediately for life threatening emergencies;" During Onsite discussion, Partners' staff indicated they have two hours and fifteen minutes in their procedure because this is the timeframe they are required to report on "to the State". The CCME reviewer reiterated that the EQR is based on EQR standards and CFR and NC Medicaid Contract requirements, and the NC Medicaid Contract requirement is two hours (not two hours and fifteen minutes). Partners' staff was referred to NC Medicaid if they wish to further discuss the disparity. ***Recommendation: Correct Partners' Policy and Procedure 8.00, Access and Availability Standards, to reflect the NC Medicaid Contract Attachment S requirement that providers provide face-to-face emergency services within two hours (not two hours and fifteen minutes).***
2.6 Authorization, utilization review, and care management requirements;	X					
2.7 Care Coordination and discharge planning requirements;	X					
2.8 PIHP dispute resolution process;	X					
2.9 Complaint investigation and resolution procedures;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.10 Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements;	X					
2.11 Enrollee rights and responsibilities	X					
2.12 Provider program integrity requirements that include how to report suspected fraud, waste and abuse, training requirements as outlined in the False Claims Act, and other State and Federal requirements.	X					The *Provider Operations Manual* and the *Provider Orientation Toolkit* include how to report suspected fraud, waste, and abuse. The Reporting Fraud, Waste, and Abuse webpage on the Partners website includes definitions and examples of fraud, waste, and abuse, Tips to Prevent Health Care Fraud and Abuse, and information about how to report fraud or abuse. The webpage lists the tollfree phone number for the Partners Regulatory Compliance Alert Line and provides a link to the Partners Online Alert Line, which is a link to a form on EthicsPoint.
3. The PIHP provides ongoing education to providers regarding changes and/or additions to its programs, practices, enrollee benefits, standards, policies, and procedures.	X					The Partners website offers extensive training information for providers, including a Provider Knowledge Base section and a Training Academy section. An "Event Calendar" is also posted on the website. Provider Communication Bulletins and Provider Alerts are posted on the website. Information is shared with the Provider Council at the monthly meetings, which are open to all providers. Provider Forum webinars are conducted quarterly. Videos, slides, and handouts from previous forums are posted on the website. Provider Alerts are sent via email to communicate time-sensitive information. Before Medicaid Transformation was paused, Partners collaborated with NC Medicaid on transition of care training. Partners has continued to have frequent conversations with provider network groups, including a quarterly hospital forum.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II D. Clinical Practice Guidelines for Behavioral Health Management						
1. The PIHP develops clinical practice guidelines for behavioral health management of its enrollees that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Partners adopted Clinical Practice Guidelines from the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry. The adopted guidelines are approved by the Partners' Quality Improvement Committee (QIC) and its subcommittee, the Clinical Advisory Committee. Policy and Procedure 13.09, Practice Guidelines, details the process of researching, developing or adopting, and monitoring the guidelines.
2. The PIHP communicates the clinical practice guidelines for behavioral health management and the expectation that they will be followed for PIHP enrollees to providers.	X					The *Provider Operations Manual* informs providers about the Clinical Practice Guidelines, provides a link to the Clinical Practice Guidelines on the Partners' website, and conveys the expectation that care will be provided in accordance with the guidelines. The Clinical Practice Guidelines on the Partners' website have guidelines in sections, based on the population being treated (e.g., Adult Mental Health, Child Mental Health, Substance Use Disorders, etc.)
II E. Continuity of Care						
1. The PIHP monitors continuity and coordination of care between providers.	X					Coordination between providers is part of the required NC Provider Monitoring Process for PIHPs.
II F. Practitioner Medical Records						
1. The PIHP formulates policies and procedures outlining standards for acceptable documentation in the Enrollee medical records maintained by providers.	X					The *Provider Operations Manual* includes a "Medical Records Requirements" section that contains the requirements outlined in the *NC Medicaid Contract*. Partners' Policy and Procedure 8.25, Practitioner Medical Records, "outlines minimum standards for acceptable documentation in the enrollee records maintained by practitioners."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP monitors compliance with medical record documentation standards through formal periodic medical record audit and addresses any deficiencies with the providers.	X					Policy and Procedure 8.25, Practitioner Medical Records, indicates medical record documentation compliance is part of the routine monitoring process. During Onsite discussion, Partners confirmed this and noted that, if records do not meet documentation standards, a Plan of Correction is required.
3. The PIHP has a process for handling abandoned records, as required by the contract.	X					Policy and Procedure 4.11, Record Retention and Disposition, addresses the *NC Medicaid Contract, Attachment B, Section 8.2.1* requirements for abandoned medical records.

III. ENROLLEE SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III A. Enrollee Rights and Responsibilities						
1. The PIHP formulates policies outlining enrollee rights and procedures for informing enrollees of these rights.	X					Policy and Procedure 7.01U, Consumer Rights and Responsibilities, outlines enrollee rights and responsibilities and the process for notifying enrollees of these rights.
2. Enrollee rights include, but are not limited to, the right:	X					Information regarding enrollee rights and the following standards is listed in Policy and Procedure 7.01U, Consumer Rights and Responsibilities, the *Member Handbook*, the *Provider Operations Manual*, and the Partners' website.
2.1 To be treated with respect and due consideration of dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.3 To participate in decisions regarding health care;						
2.4 To refuse treatment;						
2.5 To be free from any form of restraint of seclusion used as a means of coercion, discipline, convenience, or retaliation;						
2.6 To request and receive a copy of his or her medical record, except as set forth in 45 C.F.R. §164.524 and in N.C.G.S. § 122C-53(d), and to request that the medical record be amended or corrected in accordance with 45 CFR Part 164.						
2.7 Of enrollees who live in Adult Care Homes to report any suspected violation of their enrollee rights, to the appropriate regulatory authority as outlined in NCGS§ 131-D21.						
III B. Enrollee PIHP Program Education						
1. Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid waiver managed care program which they are contractually entitled, including:	X					Policy 7.05, Consumer Member Engagement Relations, explains that "within 14 days after a member schedules an appointment for services, Front Desk staff will use the New Member report generated in the AlphaMCS to mail a Welcome Letter which contains written information on Partners, Medicaid managed care and state funded services access, and how to view the *Member Handbook*, Rights and Responsibilities, and the Notice of Privacy Practices." Three individual sub-standards have recommendations explained with each sub-standard.
1.1 A description of the benefits and services provided by the PIHP and of						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
any limitations or exclusions applicable to covered services. These descriptions must have sufficient detail to ensure the Enrollees understand the benefits to which they are entitled and may include a web link to the PIHP Benefit Plan. This includes a descriptions of all Innovations Waiver services and supports;						
1.2 Benefits include access to a 2nd opinion from a qualified health care professional within the network, or arranges for the enrollees to obtain one outside the network, at no cost to the enrollee;						Receiving a second opinion is included as an enrollee right and is explained on page 15 of the *Member Handbook*.
1.3 Updates regarding program changes;						Getting information about changes in benefits, services or providers is included as an enrollee right.
1.4 A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;						EPSDT benefits are explained in the *Member Handbook* on page 20. Procedures for obtaining other benefits are described throughout the *Member Handbook*.
1.5 An explanation of the Enrollee's responsibilities and rights and protection as set forth in *42 CFR § 438.100*;						
1.6 An explanation of the Enrollee's rights to select and change Network Providers						Choosing and changing providers is discussed in the *Member Handbook* on pages 21-22.
1.7 The restrictions, if any, on the enrollee's right to select and change Network Providers						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.8 The procedure for selecting and changing Network Providers						
1.9 Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request);						Corrective Action was completed during last EQR to add the field for "provider accepting new patients" to the printed and online *Provider Directory*. All required fields were present in both the printed and online *Provider Directory* for this review.
1.10 The non-English languages, if any, spoken by each Network Provider;						In the previous EQR, it was recommended to rename the field "Languages supported" in the printed *Provider Directory* to indicate if it is the provider-spoken language or interpretation services available. It is renamed "Languages Spoken" in both the online and printed *Provider Directory*.
1.11 The extent to which, and how, after-hours and emergency coverage are provided, including:						
1.11.1 What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services in accordance with *42 CFR § 438.114* and *EMTALA*;						The *Member Handbook* explains emergency conditions/services and post stabilization services on page 15. Specifically, post stabilization services are explained as, "You are entitled to post stabilization services after treatment for an emergency medical condition. Post stabilization services are covered services related to an emergency medical condition, provided after you are stabilized. These services are intended to maintain, improve, or resolve your medical condition so that you can be safely discharged or transferred. They may be provided by Crisis Recovery Centers or a community walk-in center."
1.11.2 The fact that prior authorization is not required for emergency services;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.11.3 The process and procedures for obtaining Emergency Services, the use of 911 telephone services or the equivalent;						The *Member Handbook* explains on page 15, "If you have a life-threatening, physical health emergency, call 911. You can also go to the nearest Emergency Room. You do not need to call the Access to Care Call Center before calling 911. During a behavioral health emergency, call 1-888-235-HOPE (4673) anytime, every day. A behavioral health emergency is also called a crisis. A behavioral health crisis is serious but may not require a visit to the emergency room".
1.11.4 The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract;						Corrective Action from the previous EQR to "add locations at which post stabilization services are furnished" was completed and is in the *Member Handbook* on page 16. The chart titled "Crisis Recovery Centers in the Partners' Area" provides three locations in Cleveland, Gaston, and Iredell counties.
1.11.5 A statement that, subject to the provisions of the NC Medicaid contract, the Enrollee has a right to use any hospital or other setting for Emergency care;						The *Member Handbook* on page 15 indicates Emergency services locations include any Emergency Department.
1.12 The PIHP's policy on referrals for Specialty Care to include cost sharing, if any, and how to access Medicaid benefits that are not covered under the NC Medicaid contract;						The process for referral to a specialty provider is explained on page 15 of the *Member Handbook* as, "Members can speak to their current provider or call Access to Care at 1-888-235-HOPE (4673) to learn about available specialty care. The use of certain network specialists is restricted and is based on medical necessity. Partners staff can review medical necessity criteria with you and help with a referral."
1.13 Any limitations that may apply to services obtained from Out-of Network Providers, including disclosures of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of Network Providers, and the procedures for						The *Member Handbook* explains in page 22, "You may need services from a provider not contracted as part of Partners' Provider Network, or not located in the nine counties Partners serves. If you receive Medicaid, this is OK. Partners will work with the provider to make sure they are able to offer the services you need. However, if you start the service before Partners authorizes it, you may be responsible for paying for this service. The cost for the service will

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
obtaining authorization for such services.						not be more than the in-network cost for the same service. Ask the provider to make sure they received authorization before you start services. Crisis or emergency services do not require prior approval".
1.14 How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost-sharing;						
1.15 Procedures for obtaining out-of-area or out-of-state coverage of services, if special procedures exist;						Out-of-area and out-of-network are explained in the *Member Handbook* on page 22. How to attain out-of-state services is not specifically explained. Reference: *NC Medicaid Contract 6.9.1 (n)*. ***Recommendation: Within the Member Handbook, add a definition and explanation of out-of-state services and the procedure for obtaining that service if needed.***
1.16 Information about medically necessary transportation services by the department of Social Services in each county;						Transportation services for each county is displayed in a chart on page 22 of the *Member Handbook*.
1.17 Identification and explanation of State laws and rules Policies regarding the treatment of minors;						
1.18 The enrollee's right to recommend changes in the PIHP's policies and services						This is addressed on page 10 of the *Member Handbook*.
1.19 The procedure for recommending changes in the PIHP's policies and services;						
1.20 The Enrollee's right to formulate Advance Directives;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.21 The Enrollee's right to file a grievance concerning non-actions, and the Enrollee's right to file an appeal if PIHP takes an action against an Enrollee;						
1.22 The accommodations made for non-English speakers, as specified in *42 CFR § 438.10(c)(5);*						
1.23 Written information shall be made available in the non-English languages prevalent in the PIHP's services area.						The *Member Handbook* on page 4 explains translation services and materials are available in Braille, large print, audio, and any non-English language.
1.24 The availability of oral interpretation service for non-English languages and how to access the service;						The *Member Handbook* explains to call the Access to Care number to be connected to interpretation services.
1.25 The availability of interpretation of written information in prevalent languages and how to access those services						
1.26 Information on how to report fraud and abuse; and						
1.27 Upon an Enrollee's request, the PIHP shall provide information on the structure and operation of the agency and any physician incentive plans.						
1.28 Information on grievance, appeal and fair hearing procedures and information specified in CFR §438.10 (g).						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.	X					The annual mailing is available in English and Spanish. It is mailed to all current members each year, usually in October, and explains how to access online and request printed copies of any materials. The letter example in the Desk Materials was dated November 15, 2019.
3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in CFR 438.10 (f) (61) and 438.10 (g) at least 30 days before calendar days before the intended effective date of the change; and (2) . termination of their provider within fifteen (15) calendar days after PIHP receives notice that NC Medicaid or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.	X					Page 17 of the *Member Handbook* states, "If a Medicaid service benefit is added or changed, you will be notified in writing thirty calendar days before the change happens." When a provider is terminating from the network, Partners' process is to notify enrollees within 15 days. The EQR included a review of files with voluntary provider termination, with termination for cause, and termination due to the provider's death. All terminated provider files met review criteria.
4. Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation of prevalent non-English languages as required by the contract.	X					In the previous EQR, there was a Recommendation, "Enrollee written materials must use a font size no smaller than 12 point, per *42 CFR § 438.10(d)(6)(ii)*, and large print is no smaller than 18 point, per *42 CFR § 438.10(d)(3)*. Include this reference in a marketing and communications policy and/or procedure for enrollee-written materials and verify these are implemented." For the current review, Partners confirmed this reference is not in any policy or procedure, but all enrollee-written materials are no smaller than 12 point font, and all large print materials are no smaller than 18 point font. ***Recommendation: Include reference in a marketing and communications policy and/or procedure for enrollee-written materials to be produced in a font no smaller than 12 point font, and large print no smaller than 18 point font.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. The PIHP maintains and informs Enrollees of how to access a toll-free vehicle for 24-hours Enrollee access to coverage information from the PIHP, including the availability of free oral translation services for all languages and care management services such as crisis interventions.	X					
III C. Behavioral Health and Chronic Disease Management Education						
1. The PIHP enables each enrollee to choose a Provider upon enrollment and provides assistance as needed.	X					
2. The PIHP informs enrollees about the behavioral health education services that are available to them and encourages them to utilize these benefits.	X					Page 28 of the *Member Handbook* includes a section with links to various member resources. The Members section of the Partners' website has a Resources section with three main categories: Print Materials, Housing & Transport, and Resources. Partners' Training Academy posts upcoming events online. The June Provider Forum presented member classes and groups and community trainings (on Training Academy). Partners' Training Academy is not explained in the *Member Handbook* and would be a great reference to members. Reference: *NC Medicaid Contract Section 6.12*. ***Recommendation: Explain the Partners' Training Academy and post a link to the Training Academy in the Member Handbook.***
3. The PIHP tracks the participation of enrollees in the behavioral health education services.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III D. Call Center						
1. The PIHP provides customer services that are responsible to the needs of the Enrollees and their families. Services include:	X					Partners has several policies and procedures addressing customer service needs of their enrollees. The main policies and procedures reviewed include, 10.00U Access to Care Timeliness Standards, 10.01U Clinical Decision Support Tools, 10.02U Access to Community Crisis Services, 10.04U Access to Care Documentation of the Triage Process, 10.09 Access to Care Inter-Rater Reliability, 10.03U Access to Care Member Health and Safety, and 10.08U Steps of the Triage Process.
1.1 Respond appropriately to inquiries by enrollees and their family members (including those with limited English proficiency);	X					Policy and Procedure 10.08U, Steps of the Triage Process, guides Access to Care staff to respond appropriately to members. Members with limited English are helped with interpretation services from Pacific Solutions, Fluent Interpreting, on the phone with Partners' staff.
1.2 Connect enrollees, family members and stakeholders to crisis services when clinically appropriate;	X					The triage process used in the Access to Care Department and Policy and Procedure 10.02U, Access to Care Community Crisis Services, guides staff to connect callers to crisis services when needed.
1.3 Provide information to enrollees and their family members on where and how to access behavioral health services;	X					The *Member Handbook* provides clear information about access to services and the Access to Care team refers callers to specific areas of this handbook when appropriate.
1.4 Train its staff to recognize third-party insurance issues, recipient appeals, and grievances and to route these issues to the appropriate individual;	X					
1.5 Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;	X					
1.6 Process referrals twenty-four (24) hours per day, seven (7) days per week; 365 days per year; and	X					Partners has a contract with Cardinal Innovations, effective July 1, 2019, for call overflow and non-overflow coverage. Access to Care data is presented at the Partners' Quality Improvement Committee meetings. Partners meets or exceeds standards for speed of answer,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						call blockage, and call abandonment rates consistently. Partners explained at the Onsite that the most challenging metric is answering the calls in less than 30 seconds, although they consistently meet this metric. With Access to Care staff working from home during the pandemic, each call connection takes longer than answering from the call center.
1.7 Process Call Center linkage and referral requests for services twenty-four (24) hours per day, seven (7) days per week, 365 days per year.	X					Partners has a couple of different levels to answer the call. First, if there is a Qualified Professional (QP) available, they answer. If no QP is available, calls are answered in this order, based on staff availability: a Licensed Professional, member of the eligibility team, or it will roll over to Cardinal Innovations. If Cardinal answers, they take care of any immediate urgent needs. If somebody needs to be scheduled, they put it on a document and notify Partners by email. A Partners' staff member calls the person back, schedules the appointment, and enters all the information in the AlphaMCS system.

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV A. The Quality Improvement (QI) Program						
1. The PIHP formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to enrollees.	X					Partners' *Quality Management Plan & Program Description* outlines the QI program, including goals, structure, scope, and methodology directed at improving enrollee health care quality.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.			X			In the 2017 EQR, this standard had a Recommendation that was not implemented for the 2018 EQR. In the 2018 EQR, this standard had a *Corrective Action to "Initiate a process to proactively and routinely monitor provider adherence to Clinical Practice Guidelines throughout the provider network. Offer technical assistance when needed."* The 2018 EQR Corrective Action Plan (CAP) was approved based on the Partners' statement, "Internal Quality Assurance: Audit outcomes regarding provider compliance with clinical guidelines will be reviewed quarterly in CAC and QIC as a standing quarterly agenda item. Timeline: Completion of new process (e.g., within the first quarter, target-March 31, 2019)." Provider compliance was not reviewed in the CAC meeting minutes from April 2019 through January 2020 or in the QIC meeting minutes from March 2019 through February 2020. There was not a new monitoring process in place within the first quarter, ending March 31, 2019. Although, this was not the monitoring process that was explained during the Onsite interview, page two of Policy and Procedure 13.09, Practice Guidelines states, "D. Monitoring of provider use and implementation of approved Clinical Practice Guidelines is done in a variety of ways: • Focused audits by Utilization Reviews • Routine review of Service Authorization Requests • Peer review activities • Quality of Car Committee Activities • Medical record audits by the Provider Network Department • Program Integrity staff perform intensive monitoring in some cases" The *Clinical Practice Guidelines (CPG's) At A Glance* table found on page 31 *of the QIC Meeting Packet February 2020* includes the two Relias reporting measures that will be monitored for each guideline.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Baseline monitoring for these three Clinical Practice Guidelines was reported to QIC at the May 2020 QIC meeting, which is after the review period for the current EQR. The monitoring process for provider clinical practice guidelines is in place now, but baseline data was reported after the current EQR review period. ***Corrective Action: Update Policy 13.09, Practice Guidelines, to reflect the current process for monitoring provider practice guidelines using the Relias reports explained during the Onsite and in the May 2020 QIC minutes. Continue with monitoring using the Relias reports. Submit the next Relias provider clinical practice guideline monitoring report data that follows the baseline report, showing discussion in CAC and QIC for that quarterly standing agenda item. Include the monitoring results in the Quality Management Program Annual Evaluation.***
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Partners has a policy in place for detecting over and underutilization, Policy and Procedure 13.06 Detecting Over and Under-Utilization.
4. The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.			X			The 2018 EQR revealed, *"The Quality Assurance / Quality Improvement Program Evaluation 2016-17* documents reflect no improvement is needed for enrollee satisfaction survey measures, although, there was no discussion documented in QIC or GCQI committee minutes that arrives at this decision." The 2018 EQR Recommendation included, "Create a process for committee discussion regarding lower scoring Enrollee survey measures for the purpose of identifying steps to improve these measures. Capture discussion and next steps within QIC minutes." Partners addresses this in the status of REC documents: "Complete Discussions, opportunities, and actions captured/tracked in QIC; QI Annual Work Plan and Organizational Quality Activities Plan or OQAP."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						For the current review, Partners identified two ECHO Survey measures to work on (page 62 of the May 2019 QIC Meeting Packet). There is no evidence showing discussion of implementing interventions for the two chosen lower scoring ECHO Survey items from page 62 of the May 2019 QIC Meeting Packet. *The Quality Management Plan & Program Description* explains communication of survey results on page 29 but does not explain the process Partners uses to make improvements to lower scoring survey responses. *The Organizational Quality Activities Plan "OQOP" SFY: 2019-2020* has a Survey Activity table on page 16. The table has activities for four surveys, including the ECHO Survey. All surveys are missing tasks for implementing interventions related to the recommendations and reporting back to QIC on updates from the implemented interventions. ***Corrective Action: Implement interventions for lower scoring enrollee survey items related to QIC recommendations from the survey results. Show this on a PDSA or formal tracking project process. If improvement is addressed through Partners' Access to Care and MH/SU Care Coordination Departments, bring updates back to QIC for discussion and recommendations for changes needed to the interventions and document on the PDSA or formal tracking project you implement.***
5. The PIHP reports the results of the enrollee satisfaction survey to providers.	X					June 2019 QIC meeting minutes state, "ECHO Survey – Bill Rankin reported that the ECHO Survey has been posted to the external website along with recommendations for further action." ECHO Survey results and other enrollee survey results were reported to GQIC.
6. The PIHP reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the	X					A summary of the results of the ECHO Survey was given at the May 2019 QIC meeting with analysis of next steps on two identified areas: one from the Child ECHO Survey and one from the Adult ECHO Survey.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
impact of measures taken to address those quality problems that were identified.						
7. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, time frame for implementation and completion, and the person(s) responsible for the project(s).	X					
IV B. Quality Improvement Committee						
1. The PIHP has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The QIC is charged with oversight of the QI program at Partners.
2. The composition of the QI Committee reflects the membership required by the contract.	X					QIC is comprised of Partners' staff, CFAC members, GCQI members, and provider members. Reported information flows from CFAC and GCQI meetings to QIC. Every meeting had a quorum. Several QIC members had poor attendance, including one CFAC member and three Partners' staff members. One CFAC member never attended. One Partners staff member was absent four times and a proxy attended the other seven meetings. Another Partners' staff member attended twice, was absent three times, and had a proxy six times. Another Partners' staff member only attended one meeting. GCQI was comprised of a fluctuating count of between 14 and 21 voting members from March 2019 through June 2020. There were seven quarterly meetings held during this time frame. At each meeting, all voting members listed on each meeting minutes were present, resulting in a quorum for all meetings. ***Recommendation: Consider adjusting QIC membership when members cannot attend the majority of the meetings.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The QI Committee meets at regular intervals.	X					There were monthly QIC meetings held from March 2019 through February 2020. As planned, meetings were not held in July 2019 and January 2020. GCQI meetings were held quarterly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Complete and detailed meeting minutes were maintained for QIC and GCQI from March 2019 through February 2020.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					(b) and (c) Waiver measures included all necessary documentation, and measures are reported according to specifications.
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					
3. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					Four projects were validated with High Confidence in reported results. Recommendations from last EQR were implemented.
IV E. Provider Participation in Quality Improvement Activities						
1. The PIHP requires its providers to actively participate in QI activities.	X					The 2018 EQR had a Recommendation to "Implement and document a process that monitors the submission of provider QIPs to Partners". This recommendation was followed. Partners' IT created a Share File for providers to submit QIP Projects, which are then discussed in Global CQI Committee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Page 171 of the November 2019 *Provider Operations Manual* explains "Providers should demonstrate a Continuous Quality Improvement (CQI) process by identifying Quality Improvement Projects per fiscal year (July-June)." Page 2 of the December GCQI minutes states, "all providers who have submitted their three projects; 52% of providers have submitted these projects." Onsite discussion revealed that all except one provider submitted their QIPs for this year.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Partners is completing the first year of the current provider QIP process. During the year, Partners provided technical assistance around what a QIP is and what the expectations are for the providers.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					The *Quality Management Program Annual Evaluation* covers the period of July 2018 through June 2019. This document gives an overview and analysis of the QM program, the QIPs and informal quality projects, access and availability standards, satisfaction evaluations, and other initiatives. Areas within each item addressed are goal, status/ evaluation, issue/barriers, interventions, and goal to continue or not continue for the next fiscal year.
2. The annual report of the QI program is submitted to the QI Committee and to the PIHP Board of Directors.	X					The *Quality Management Program Annual Evaluation* is reviewed by the QM Director, CMO, QIC, and Board of Directors.

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. The Utilization Management (UM) Program						
1. The PIHP formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					While the *UM Plan* is updated annually, there are several areas within the plan that were not updated. For example, the addition of Rutherford County to Partners' catchment area in July 2019. Additionally, the process for identifying and intervening with over and underutilized services did not have the level of detail and impact that was described by staff during the Onsite. ***Recommendation: Revise the Utilization Management Plan to update Partners' catchment area. Include more detail describing the process Partners follows for identifying and intervening with over and underutilized services.***
1.1 structure of the program;	X					Partners' *Utilization Management Plan* provides an outline of the UM program structure. While the CMO provides UM oversight, the CCO provides direct supervision of clinical operations.
1.2 lines of responsibility and accountability;	X					The *Utilization Management Plan* describes the UM Department's purpose, scope, structure, components, and staffing qualifications. The lines of responsibility and accountability are illustrated in the Organizational Chart.
1.3 guidelines / standards to be used in making utilization management decisions;		X				Partners' process for making UM decisions is outlined in Policy and Procedure 13.15U, Utilization Management Screening and Review. Partners uses an "Administrative Approval" process for some of their pass-through services. However, this process is not included in any policy and procedure. This process was evident in the file review and details provided by staff during the Onsite. Moreover, Policy and Procedure 13.15U Utilization Management Screening and Review, states that "initial clinical review is conducted by UM Reviewers who hold an active, unrestricted license

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						in the State of North Carolina", yet the "Administrative Approval" process results is completed by unlicensed staff. ***Corrective Action: Detail the "Administrative Approval" process in policies and procedures. Update Policy and Procedure 13.15U, to reflect the use of non-clinical, unlicensed staff in the "Administrative Approval" process.***
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 consideration of new technology;	X					Partners has Policy and Procedure 13.14, Utilization Management Criteria, that defines the processes for review of request that includes the consideration of new technology
1.6 the appeal process, including a mechanism for expedited appeal;	X					Details regarding the appeals process is described in Policy and Procedure 13.04U, Clinical Utilization Management Appeals.
1.7 the absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					Partners has Policy and Procedure, 3.02U, Business Practices/Financial Incentives, that prohibits employees and contractors from accepting financial incentives of any type based on the utilization of services.
1.8 mechanisms to detect underutilization and overutilization of services.	X					Outlined in Policy and Procedure 13.06, Detecting Overutilization and Under Utilization, are the details of how claims data is reviewed quarterly to determine over utilization and underutilization of services. During the Onsite, Partners provided ample detail on how they use different reports to discover over and underutilization of services. When these discoveries are made, the information is reported to the UM/UR Committee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Partners' Board of Directors provides overall governance and oversight, including the UM Program and its implementation. The Chief Medical Officer provides oversight of medical decision making, clinical supervision, and oversight. The Medical Department includes an Associate Medical Director, a Chief Clinical Officer, and a Pharmaceutical Contractor. The Pharmaceutical Contractor provides consultation services to support Partners' efforts in preparing for the NC Tailored plan.
3. The UM program design is reevaluated annually, including Provider input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					The review of approved SARs showed providers submitted out of date documentation to support their service request. For example, in two files, SARs were approved even though the Comprehensive Clinical Assessments were over four years old and both enrollees had experienced significant changes in their housing and health statuses. ***Recommendation: Continue to collaborate with Provider Network, I/DD, MH/SU and TCLI Departments to ensure documentation submitted with SARs adequately reflects the enrollee's current clinical needs.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
4. Utilization management standards/criteria are consistently applied to all enrollees across all reviewers.	X					Partners conducts inter-rater reliability review (IRR) at least biannually. The IRR benchmark for UM Care Managers is 85%. A process is in place for UM Managers who do not meet the benchmark to include re-resting and based on the initial score, re-training.
5. Emergency and post stabilization care is provided in a manner consistent with contract and federal regulations.	X					
6. Utilization management standards/criteria are available for Providers.	X					
7. Utilization management decisions are made by appropriately trained reviewers	X					The review of MH/SU SARs found 16% did not include the credentials of the UM Reviewer that rendered the approval. The review of the denied SARs also found 16% of MH/SU service request files did not include the UM Reviewer credentials. *NC Medicaid Contract 8.2.2.1.e* requires *'The name and credentials of the individual conducting the review.* ***Recommendation: Develop, document, and implement a monitoring process that ensures the credentials of clinicians rendering service authorization approvals are consistently documented in the service authorization request files.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
8. Initial utilization decisions are made promptly after all necessary information is received	X					
9. Denials						
9.1 A reasonable effort that is not burdensome on the enrollee or the provider is made to obtain all pertinent information prior to making the decisions to deny services	X					
9.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.		X				The review of I/DD denial SARs found 80% (9) files that did not include the full signature and credentials used to render the decision to deny services. *NC Medicaid Contract 8.2.2.1.f,* require "The name, signature, and credentials of the individual who made the decision to deny, reduce, or terminate authorization for the requested service." ***Corrective Action: Develop, document, and implement a monitoring process that ensures the credentials of clinicians rendering service authorization denials are consistently documented in all SARs, as required by NC Medicaid Contract, Section 8.2.2.1.***
9.3 Denial decisions are promptly communicated to the provider and enrollee and include the basis for the denials of service and the procedure for appeal	X					
V C. Care Coordination						
1. The PIHP utilizes care coordination techniques to ensure comprehensive, coordinated care for enrollees with	X					Partners has the *Mental Health/Substance Use Care Management Program Description* and the *Intellectual/ Developmental Disabilities Care Management Program Description* in place that describes its Care Management and Care Coordination processes. Enrollees with

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
complex health needs or high-risk health conditions.						complex health needs and high-risk health conditions are identified in policies and procedures. Partners also has Policy and Procedure 9.01, Care Management Outreach and Follow-Up with High-Risk Enrollees, that outlines the efforts made to provide outreach to high-risk enrollees.
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					The MH/SU Care Coordination Program Description, the I/DD Program Description, and the Complex Case Management Program Description provide an overview of process by which enrollees with special needs are identified.
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					Partners has Policy and Procedure 11.21, I/DD Support Planning, that describes the process for the development of a Comprehensive individual support plan (ISP). Moreover, Policy and Procedure 9.07, MH/SU Care Management, governs the treatment plan development for MH/SU enrollees.
2.5 Quality monitoring and continuous quality improvement;	X					Partners has a detailed quality monitoring plan in place in the Comprehensive Case Management Plan and Program Description, the I/DD Program Description, and the Complex Case Management Program Description.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.6 Determination of which Behavioral Health Services are medically necessary:	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					Partners has Policy and Procedure 9.02, Care Management Collaborative Discharge Planning, in place that that describes discharge planning and coordination of care activities. To support discharge planning, Partners has Care Coordinators located at specified hospitals and crisis centers, who participate in the discharge planning. This creates a seamless process as the enrollee is discharged from the hospital or an inpatient facility.
2.8 Coordinate care with each enrollee's provider;	X					
2.9 Provide follow-up activities for enrollees;		X				Partners has policies and procedures that outline the role of the Care Coordinator, which includes ensuring that follow-up activities are provided. However, little guidance is provided in MH/SU policies and procedures to ensure consistent follow up by Care Coordinators. The need for this guidance was clear in the MH/SU. ***Corrective Action: Revise MH/SU Care Coordination policies and procedures to better define documentation requirements to include:*** • ***Timely submission of documentation into the TruCare platform*** • ***Transfer of enrollees from a Care Coordinator to another Care Coordinator, region, department, or PIHP and the content expectations of the transfer documentation*** • ***The expected steps Care Coordinators follow when they are having difficulty locating and engaging enrollees in Care Coordination*** • ***Discharging enrollees and the content expectations for those discharge notes***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Clinical Coverage Policy 8P, L. Failure to Use Services, outlines required steps and notifications that PIHPs must follow when an Innovations member is not accessing services and at risk of losing their Innovations slot. These requirements are not listed in any I/DD policy and procedures. ***Recommendation: Include the required steps and notification outlined in Clinical Coverage 8P, L. Failure to Use Services in an I/DD policy and procedure.***
2.10 Ensure privacy for each enrollee is protected.	X					
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					Partners' Policy and Procedure 11.16, I/DD Care Manager Monitoring of Plan Implementation, outlines the monitoring responsibility of the I/DD Care Manager. The procedure does not include information about the monitoring of Home and Community-Based Services (HCBS). The *I/DD Care Management Program Description* includes information about monitoring HCBS in residential settings but does not recognize Day Support and Supported Employment as a part of those HCBS. There was also no reference to Day Support and Supported Employment in the *HCBS Monitoring Checklist* used to capture HCBS monitoring information by I/DD Care Coordinators. ***Recommendation: Add details to Policy and Procedure 11.16 regarding HCBS monitoring to include the use of the required State Monitoring Checklist. Ensure that the I/DD Care Management Program Description is updated to include Day Support and Supported Employment as a part of HCBS.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The PIHP applies the Care Coordination policies and procedures as formulated.		X				The EQR of MH/SU found inconsistencies in staff documentation. There were patterns of blank notes, late progress notes, large gaps in notes (as much as six months), blank discharge notes, and abrupt endings in Care Coordination notes with no reference to discharging or transferring the enrollee from Care Coordination. The review of I/DD documentation showed the same type of inconsistency, but to smaller degree. The I/DD Department has improved upon their internal documentation processes, including the use of checklists, and this improvement was noted in the files reviewed. Compliance issues within the I/DD files showed gaps in notes (as much as five months), late progress notes, and delays in coordinating services when an enrollee's was transferred to another PIHP. ***Corrective Action: Develop, document, and implement a data-driven monitoring plan that routinely reviews I/DD and MH/SU documentation entered into TruCare. The monitoring plan should identify:*** • ***the frequency of monitoring*** • ***departmental benchmarks for compliance*** • ***how and when outcomes of monitoring are captured, reviewed, and reported.*** ***The monitoring plan should include:*** • ***routine review of timeliness of activities (e.g., documentation of completed activities, follow up activities, HCBS monitoring, etc.)*** • ***quality and completeness of Care Coordinator documentation*** • ***quality and completeness of Care Coordination documentation around transferring and discharging enrollees from Care Coordination.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. D Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					Partners has Policy and Procedure 9.08, Mental Health and Substance Use (MHSU) Care Coordination- Transition to Community Living (TCL) a DOJ Initiative, that provides an overview of TCLI requirements and the function of the TCLI staff. The *TCLI How to Manual* provides details and the role of each TCLI staff. The document also includes the *Transition to Community Living Checklist* with detailed information for completion.
2.1 Care Coordination activities occur as required.	X					
2.2 Person Centered Plans are developed as required.	X					
2.3 Assertive Community Treatment, Peer Support, 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					Assertive Community Treatment (ACT), Peer Support Services (PS), and Supportive Employment Services (SE) are offered to enrollees when appropriate. TCLI staff discussed employment options during In-Reach. Enrollees with ACTT who expressed interested in employment had goals related to employment activities.

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					Partners has Policy and Procedure 9.08, Mental Health and Substance Use (MHSU) Care Coordination- Transition to Community Living (TCL) a DOJ Initiative, that discusses the mechanism to provide one-time transitional support. During last year's EQR, it was recommended that Policy and Procedure 9.08, Mental Health and Substance Use (MHSU) Care Coordination -Transition to Community Living and U.S. Department of Justice (TCL-DOJ) Initiative, to describe how to access these funds. The policy and procedure was updated, but lack the detail on how to access TYSR funds. ***Recommendation: Add to Policy and Procedure 9.08, detail describing the process staff follow to access TYSR funds for TCLI enrollees.***
2.5 QOL Surveys are administered timely.	X					Policy and Procedure 9.08, Mental Health and Substance Use (MHSU) Care Coordination- Transition to Community Living (TCL) a DOJ Initiative, provides the time frames for the administration of the *Quality of Life (QOL) Surveys*. The *TCLI How to Manual* outlines the staff responsible for completing the QOL survey and steps to take once the QOL survey is completed.
3. Transition, diversion and discharge processes are in place for TCLI enrollees as outlined in the DOJ Settlement and DHHS Contract.	X					Policy and Procedure 9.08, Mental Health and Substance Use (MHSU) Care Coordination- Transition to Community Living (TCL) a DOJ Initiative, outlines staff roles and responsibility during the diversion process. The process of transition, diversion and discharge after housing is outlined in more detail in the *TCLI How to Manual*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to NC Medicaid within the time frames determined by NC Medicaid.	X					TCLI data is reported as required and reports were provided for the Desk Review.
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					Information related to TCLI can be found on the Partners' website from the main page by clicking mental health->transition to community living. The page includes detail information about TCLI and the contact information of the TCLI Supervisor.
6. A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.		X				The EQR of TCLI files found inconsistencies in staff documentation. For example, while TCLI staff during the Onsite described an expectation for timely submission of contact notes as three calendar days. However, at least 75 of the progress notes were entered beyond that time frame. One note was more than 300 days late. There was also a pattern in the TCLI files reviewed of blank progress notes, blank discharge notes, large gaps in progress notes (nine months or more), and abrupt endings to TCLI Care Coordination interventions with no reference to discharge or transfer. The TCLI file review showed three Quality of Life Surveys had not been completed and at least four In Reach Tools were either missing or incomplete. For example, one enrollee was referred to TCLI in August 2019 yet the In-Reach tool was not completed for two months. No progress notes indicated the reason for the delay.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Corrective Action: Develop, document, and implement a data-driven monitoring plan that routinely reviews I/DD and MH/SU documentation entered into TruCare. The monitoring plan should identify: • *the frequency of monitoring* • *departmental benchmarks for compliance* • *how and when outcomes of monitoring are captured, reviewed, and reported.* *The monitoring plan should include:* • *routine review of timeliness of activities (e.g., documentation of completed activities, In Reach activities, etc.)* • *quality and completeness of Care Coordinator documentation (e.g., Quality of Life surveys),* • *quality and completeness of Care Coordination documentation around transferring and discharging enrollees from Care Coordination.*

VI. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy and Procedure 6.00U is the primary policy and procedure describing Partners' process for resolving grievances.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 Definition of a grievance and who may file a grievance;	X					
1.2 The procedure for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					The Timing Section in Policy and Procedure 6.00U, Grievance Management Policy, discusses the process Partners follows when Partners extends the grievance resolution timeframe. However, this information does not include the requirement that Partners will notify the grievant of the extension within two days. ***Recommendations: Include in Section J. Timing of Policy and Procedure 6.00U, Partners will send written notice of the extension to the grievance resolution timeframe to the grievant within two days.***
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a grievance log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Policy & Procedure 4.11 Record Retention and Disposition details Partners' process and timeframe retention of grievance files.
2. The PIHP applies the grievance policy and procedure as formulated.	X					Partners provided 20 grievance files selected by CCME from their Medicaid grievance log. Two of the files submitted appeared to be grievances around State-funded services and so were not reviewed. In the review of the remaining 18 grievance files provided by Partners, all grievances were acknowledged and resolved within the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						required timeframes. Resolution notices contained detailed steps Partners took to resolve each grievance. Fifteen of the 18 files, or 83%, were indicated to be "high priority". Partners' grievance policy identifies an accelerated process for resolving grievances that are "high priority". These are typically grievances that are escalated due to immediate threats of harm, clients' rights issues, or serious quality of care issues. Policy and Procedure 6.00U requires staff to take immediate action (within 72 hours) to address the concerns. During the Onsite, staff were surprised that such a large portion of the grievance file sample was marked "high priority". They indicated only a small portion of grievances are escalated to "high priority" status. Further, review of files showed no actions were documented by staff within 72 hours in the majority of the "high priority" files. Given these findings are not congruent with Partners' grievance policy and procedure, CCME recommends Partners closely monitors the "high priority" grievance process. Monitoring should look at how and when grievances are identified as "high priority" and whether staff are clearly documenting in the grievance file the immediate actions taken to address concerns. This monitoring can also provide valuable grievance data to support the effectiveness of the "high priority" grievance process. ***Recommendation: Develop and document a monitoring process that reviews "high priority" grievances and whether staff identify these grievances and take appropriate actions in compliance with Policy and Procedure 6.00U, Grievance Management Policy.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Grievances are tallied, patterns, trends and compliance data are reported in the *Quality Improvement, Quality of Care, Consumer and Family Advisory,* and *Human Rights Committees*.
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					
VI. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					Policy and Procedure 13.04U, Clinical Utilization Management Appeals is the primary procedure that governs Partners' appeals process.
1.1 The definitions an appeal and who may file an appeal;	X					Partners' Policy and Procedure 13.04U, Clinical Utilization Management Appeals, *Provider Operations Manual* and *Member Handbook* are inconsistent when defining who can file an appeal. Per *NC Medicaid Contract, Attachment M, G.1* and the *42 CFR § 438.402(c)(1)(ii)*, "with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee." Policy and Procedures 13.04U correctly states, "Partners BHM allows an authorized representative to act on behalf of the member or provides help to any member (or member's LRP) who requests assistance in filing an appeal." However, this information is contradicted in other places within the procedure. For example, the first section of the procedure, I. Timeframe, describes the timeframe for processing an appeal begins "when Partners receives the appeals "from the member/LRP (or the provider acting upon the member's behalf and with the 's/LRP's member's written consent to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						do so." There is no reference to other stakeholders serving as representatives during the appeal process. ***Recommendation: Revise Partners' Policy and Procedure 13.04U, Provider Operations Manual, and Member Handbook to clearly and consistently state, "the Enrollee, legally responsible person, or a Provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent, may file a PIHP internal appeal." This revision will bring these documents into compliance with NC Medicaid Contract, Attachment M, G.1 and the 42 CFR § 438.402 (c)(1)(i).***
1.2 The procedure for filing an appeal;		X				It was recommended in last year's EQR that Partners clarify in the *Provider Operations Manual* and *Member Handbook* that any written request for an appeal can initiate the appeal process and Partners' *Request for Reconsideration Review Form* is not required. This Recommendation was not addressed and the *Provider Operations Manual* and *Member Handbook* still state Partners' form is required. For example, the *Provider Operations Manual* states that to request an appeal, the appellant "must complete and return the Partners' Reconsideration Review Request." This practice was also found within the appeal file review. This requirement by Partners is more restrictive than the *NC Medicaid Contract* and Partners' appeals policy. ***Corrective Action: Revise the Provider Operations Manual and Member Handbook to clarify that any written request can initiate the appeals process.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay	X					Policy and Procedure 13.04U, Clinical Utilization Management Appeals, *the Provider Operations Manual*, and *Member Handbook* incorrectly state that, when Partners denies a request to expedite an appeal, Partners gives notification of the "the member's right to request reconsideration of the decision." The requirement, per *42 CFR § 438.410(I)(2) and § 438.408(I)(2)(ii)*, is when Partners denies a request to expedite an appeal, the enrollee must be notified of their right to file a grievance. It was also evident in the review of expedited appeal files, appellants were not notified of their right to file a grievance. There is also an error in Policy and Procedure 13.04U regarding the timeframe for providing written notification of an expedited appeal resolution to the enrollee. The correct timeframe is outlined in Section V.B of the policy and procedure. However, under Section VI.A, the policy and procedure states, "For expedited appeal request, written notification to the member of the decision occurs within 3 calendar days of the receipt of the appeal request." *The NC Medicaid Contract, Attachment M* and *42 CFR § 438.408(b)(3)* require notification within 72 hours. ***Recommendations:*** • ***Revise Policy and Procedure 13.04U, the Provider Operations Manual, and Member Handbook to state that, when Partners denies a request to expedite an appeal, the enrollee is notified of their right to file a grievance.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						• ***Revise Policy and Procedure 13.04U to consistently state that written notification to the member of the decision occurs within 72 hours.***
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					In previous EQR, a Corrective Action was issued addressing missing language in Policy and Procedure 13.04U, Clinical Utilization Management Appeals, regarding the requirements around extending the appeal resolution timeframe. Partners addressed this Corrective Action and added language to their policy and procedure but missed the requirement to notify of the enrollee of their right to file a grievance. *42 CFR § 438.408l(2)(ii)* requires that, when Partners extends the timeframe for resolving an appeal, the enrollee is notified of their right to file a grievance against Partners. ***Recommendation: Add to Policy and Procedure 13.04U the requirement to notify a member of their right to file a grievance against Partners when Partners extends the appeal resolution timeframe.***
1.6 Written notice of the appeal resolution as required by the contract;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.7 Other requirements as specified in the contract.		X				In the previous EQR, CCME recommended that Partners include in Policy and Procedure 13.04U, the steps staff should follow when processing appeals that are invalid or withdrawn. This Recommendation was not addressed by Partners. Policy and Procedure 13.04U, requires that "Partners acknowledges receipt of the appeal in writing via a letter to the appellant dated the next working day" and "for all appeals, regardless of the final decision, Partners BHM sends written notification to the aforementioned parties". However, review of the appeal files showed staff did not consistently provide written notifications to appellants when processing invalid or withdrawn appeals. This provide further evidence that staff need procedural guidance to ensure a consistent and fair process is followed. ***Corrective Action: Include in Policy and Procedure 13.04U the steps staff should follow when acknowledging, processing, and resolving appeals that are invalid or withdrawn. Include in these steps the timeframe for mailing written notifications that acknowledge and resolve invalid and withdrawn appeals.***
2. The PIHP applies the appeal policies and procedures as formulated.		X				In previous EQR, CCME recommended that Partners "verify files requested for any audit or review are complete, including all communications and notifications between Partners' staff and appellants." This Recommendation was issued because Partners did not submit the Consumer Contact logs with the appeal files requested. These logs are often the only documentation that capture steps that are required when staff are processing appeals (e.g., oral notifications, outreach/assistance, phone calls from appellants, etc.) Partners did not submit the Consumer Contact Logs again this year.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Ensure Consumer Contact Logs are maintained as a part of the appeal record and submitted as a part of any documentation audit, review, or monitoring. Once Consumer Contact Logs were obtained from Partners, the review of the 25 appeal files was completed. Compliance issues were noted in the oral, expedited, invalid, and withdrawn appeal files. These errors impacted almost half of the appeal files reviewed. <u>Oral Appeals</u> • In all three of the oral, expedited appeals reviewed staff obtained a written appeal request after the oral, expedited appeal was submitted. A written request is not required after an oral, expedited request is submitted per Partners' policy and procedure, which states, "Orally requested expedited appeals do not require written follow-up per 42 CFR § 438.402 3 (ii)." There was staff documentation within one file that indicated Partners was requiring the form, "I informed her I needed Recon form to complete Appeal from start to finish." • In all three of the oral, standard appeal files reviewed, staff did not acknowledge the Oral appeals within one business day. Partners' appeal policy and procedure requires appeal acknowledgements to be sent "the next working day following receipt for the appeal for written and oral requests." • Staff did not consistently capture the date and time an oral, expedited appeal was received. Therefore, there was no documentation confirming the appeal was processed within 72 hours, as is required by Partners' appeal policy and procedure, federal regulations, and the *NC Medicaid Contract*. <u>Denied requests to expedite appeals</u> • In the three files where Partners denied the request for an expedited appeal, appellants were not notified of their right to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						file a grievance against Partners. This is required by *42 CFR § 438.410(l)(2)*. <u>Invalid Appeals</u> • In both of the invalid appeal files reviewed, there was no documentation within the Consumer Contact Logs explaining why the appeals were invalid. • In both of the invalid appeal files reviewed, no appeal acknowledgements or appeal resolution notifications were sent to the appellants. These notifications are required by Partners' Policy and Procedure 13.04U, *42 CFR § 438.406(b)(1), 42 CFR § 438.408(a)* and *Attachment M* of Partners' *NC Medicaid Contract*. • In both of the invalid appeal files reviewed, there was no evidence staff provided any assistance in obtaining information that would have made the appeals valid. Reasonable assistance is required by *42 CFR § 438.406(a)*. <u>Withdrawn Appeals</u> • In all three of the withdrawn appeals reviewed, no appeal resolution notifications were sent to the appellant. Per Partners' appeals procedure, "For all appeals, regardless of the final decision, Partners BHM sends written notification to the aforementioned parties". This notification is required to include six elements listed in section VI.F of the appeal policy. • In one of the withdrawn appeals, staff informed the guardian a subsequent authorization for PRTF services was approved and "there are no dates left to be reconsidered on this appeal". However, the dates authorized in the subsequent authorization were different from those appealed, leaving 18 days of PRTF still appealable. • One withdrawn appeal was noted to be "administratively withdrawn" but there is no definition or formal procedure for administratively withdrawing appeals.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Corrective Action: Develop and document an appeal monitoring process that includes compliance monitoring of oral, invalid, expedited, and withdrawn appeal files. As a part of this monitoring, ensure Consumer Contact logs are reviewed for accuracy, legibility, completeness, and compliance with Partners' policies and procedures, NC Medicaid Contract, and federal regulations.
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. Delegation						
1. The PIHP has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Partners currently has an executed Delegation Agreement with two delegates (BHM and Cardinal Innovations). Two other Delegation Agreements (Prest & Associates and Vaya Health) ended in 2019. Delegation Agreements include BAAs with those delegates that have access to Protected Health Information (PHI).
2. The PIHP conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the PIHP if	X					Partners completed a Pre-Delegation Assessment before the inception of the Delegation Agreement with Cardinal. At the previous EQR, Partners received the Recommendation to "Revise the *Delegation Program Description* to comply with *NC*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
the PIHP were directly performing the delegated functions.						*Medicaid Contract Attachment B, section 11.1.2* language regarding monitoring the subcontractor's performance on an ongoing basis, at least annually…" Partners added this contract language to the *Delegation Program Description*, but retained the language stating, "If the Delegate is URAC accredited and maintains that accreditation the annual assessment is not required." Further, Partners added language stating, "If the Delegate is NCQA accredited and maintains that accreditation, then the above audit items # 2 & 3 are not required." This is in direct conflict with the *NC Medicaid Attachment B, section 11.1.2* language requiring the PIHP to "monitor the subcontractor's performance on an ongoing basis, at least annually." The *NC Medicaid Contract* does not exempt accredited delegates from annual monitoring. Partners failed to submit the annual assessments as requested on the *EQR Materials Requested for Desk Review*. CCME staff requested the annual assessments on the *Onsite Request List*. The form Partners then submitted for Vaya was actually the "Delegation Assessment 2017-2018" submitted for the last EQR. During the Onsite visit, CCME staff again requested the annual assessment for Vaya for July 2018 through June 2019. In response, Partners submitted an unsigned, undated Delegation Assessment and the Quality Improvement Committee (QIC) meeting packet for the September 3, 2019 meeting, including the Rollover Call report (showing Partners' calls that rolled over to Vaya) for July 2018 through June 30, 2019. The *Delegation Program Description* states, "The outcome of each Delegates (*sic*) Annual Assessment is reviewed by the QIC and feedback is provided to each Delegate." During Onsite discussion, Partners' staff indicated this occurs in August of each year for the Access Department (though this year, QIC reviewed the delegate monitoring on September 3, 2019). Partners' staff presented the *BHM Healthcare Solutions 2019 Utilization and Quality Management*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Program description at the November 4, 2019 QIC meeting and presented an overview of BHM at the December 3, 2019 QIC meeting. ***Recommendations:*** • ***Revise the Delegation Program Description to indicate all delegates will be assessed at least annually, irrespective of accreditation status.*** • ***For Delegation Assessments, include the timeframe covered by the assessment, the date the assessment was completed, and the date signed by the Partners' staff member.*** • ***For the EQR, submit the "results of the most recent monitoring activities, including annual evaluations/assessments, and indicate to which committee(s) delegate monitoring is reported", as indicated on the External Quality Review Materials Requested for Desk Review document.***

VIII. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII A. General Requirements						
1. PIHP shall be familiar and comply with Section 1902(a)(68) of the Social Security Act, *42 CFR § 438.455* and *1000* through *1008*, as applicable, including proper payments to Providers and methods for detection of fraud and abuse.	X					This requirement is addressed in the Regulatory Compliance Program Description/Plan and the Program Integrity Provider Monitoring/Auditing Protocol.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents', and subcontractors,' compliance with the requirements of this Section 14 of the NC Medicaid contract.	X					
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					
VIII B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with 42 C.F.R. 438.608 that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the NC Medicaid Contract Administrator on an annual basis.	X					This requirement is addressed in the Regulatory Compliance Program Description/Plan. The last annual review of the *Compliance Plan* took place on 9/27/2019, within the review period. During the onsite, the PIHP confirmed submission to NC Medicaid via Share File during the measurement period and also shared a screenshot of the transmission as evidence.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of 42 C.F.R. 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					
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	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
Compliance Officer or the PIHP Contract Administrator. In addition, PIHP shall identify a primary point of contact within the Special Investigations Unit to receive and respond to data requests from MFCU/MID. The MFCU/ MID will copy the PIHP Contract Administrator on all such requests.						
4. PIHP shall participate in quarterly Program Integrity meetings with NC Medicaid Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').	X					
5. PIHP shall send staff to participate in monthly meetings with Division Program Integrity staff, either telephonically or in person at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.						
6. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
7. The Division recognizes that the scope of the PIHP's Regulatory Compliance Committee includes issues beyond those related to Program Integrity. Within seven (7) business days of a request by the Division, PIHP shall also make portions of the PIHP's Regulatory Compliance and Program Integrity minutes relating to Program Integrity issues available for review, but the PIHP may, redact other portions of the minutes not relating to Regulatory Compliance or Program Integrity issues.	X					
8. PIHP's written Compliance Plan shall, at a minimum include:						
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(66) of the Social Security Act;	X					
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing, and development of corrective action initiatives;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 promptly 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 Division as provided in Section 13.2 – Monetary Penalties.	X					

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

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid-standardized elements or NC Medicaid-approved template;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available database or other search mechanism.	X					
11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.	X					This requirement is addressed in the Regulatory Compliance Program Description/Plan and the Participating Provider Disputes policy and procedure.
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected NC Medicaid within five (5) business days of final determination of the findings.	X					Last year, it was recommended that Partners create a formal policy and procedure to address this requirement. This Recommendation was not addressed by Partners. ***Recommendation: Include in a PI policy and procedure the timeframe requirements for initiating a preliminary investigation.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
All case records shall be stored electronically by PIHP.						
13. In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						This requirement is not addressed in any policy or procedure. In the previous EQR, a Recommendation was made to include this requirement and its subparts in a policy or procedure. This Recommendation was not addressed by Partners. While the files reviewed for this EQR contained this information, it is again recommended that Partners include all the required information needed when referring a case of suspected provider fraud to NC Medicaid in a PI policy and procedure. ***Recommendation Include in a PI policy and procedure all the required information needed when referring a case of suspected provider fraud to NC Medicaid.***
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	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
dates of suspected intentional misconduct;						
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					
13.6 All communications between PIHP and the Provider concerning the conduct at issues, 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					
13.8.1 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.8.2 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					
13.8.3 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					
13.8.4 Information on Biller/Owner;	X					
13.8.5 Additional Provider Locations that are related to the allegations;	X					
13.8.6 Legal and Administrative Status of Case.	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:						This requirement is not addressed in any policy or procedure. In the previous EQR, a Recommendation was made to include this requirement and its subparts in a policy/procedure. This Recommendation was not addressed by Partners. While the files reviewed for this EQR did not include cases of enrollee fraud, waste, and abuse, it is again recommended that Partners include all the required information needed when referring a case to NC Medicaid in a PI policy and procedure. ***Recommendation: Include in a PI policy and procedure all the required information needed when referring a suspected case of enrollee fraud to NC Medicaid.***
14.1 The Enrollee's name, birth date, and Medicaid number;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.2 The source of the allegation;	X					
14.3 The nature of the allegation, including the timeframe of the allegation in question;	X					
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	X					
14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;	X					
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					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
16. PIHP shall use the NC Medicaid Fraud and Abuse Management System (FAMS) or a NC Medicaid approved alternative data mining technology solution to detect and prevent fraud, waste, and abuse in managed care.	X					
17. If PIHP uses FAMS, PIHP shall work with the NC Medicaid designated Administrator to submit appropriate claims data to load into the NC Medicaid Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	X					According to the FAMS reports submitted for the review period, two users were added in December 2019 and one user was removed in January 2019. Post-onsite, the PIHP provided the emails that evidence the transmission of notification of changes to the FAMS users to NC Medicaid within the measurement period. In the previous EQR, it was recommended that Partners include contractual requirements around FAMS user in a policy and procedure. This Recommendation was not addressed by Partners. ***Recommendation: Include language in a PI policy and procedure clearly stating the timeliness requirements for reporting changes in Partners' NCID holders/FAMS-users.***
18. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month or the next business day if the 10th day is a non-business day (i.e. weekend or State or PIHP holiday). Section 9.8 Fraud and Abuse Reports. In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to NC Medicaid Program	X					Partners reports its FAMS users to NC Medicaid each month. In the previous EQR, it was recommended that Partners include contractual timeliness requirements for reporting current FAMS users in a policy/procedure. This Recommendation was not was not addressed by Partners. ***Recommendation: Include language in a PI policy and procedure clearly stating the timeliness requirements for reporting Partners' current NCID holders/FAMS-users.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to NC Medicaid Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting 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 Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.	X					This requirement is not addressed in any policy or procedure. In the previous EQR, the Recommendation was made to include this requirement and its subparts in a policy/procedure. This Recommendation was not addressed by Partners. ***Recommendation: Include in a PI policy and procedure language clearly stating the timeliness requirements for lifting the payment suspension of providers.***
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					There is no language in Partners' PI policies and procedures that clearly states the required timeframes related to imposing payment suspensions. In the previous EQR, the Recommendation was made to include this requirement and its subparts in a policy/procedure. This Recommendation was not addressed by Partners. ***Recommendation: the required timeframes related to imposing payment suspensions.***
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					This requirement is not addressed in any policy or procedure. In the previous EQR, the Recommendation was made to include this requirement and its subparts in a policy and procedure. This Recommendation was not addressed by Partners. ***Recommendation: Include in a PI policy and/or procedure that the PIHP will not take administrative action regarding allegations of suspected fraud against any Providers referred to the NC Medicaid Program Integrity Department due to allegations of suspected fraud without prior written approval from the NC Medicaid Program Integrity Department or the MFCU/MID.***
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	X					This requirement is addressed in the Provider Monitoring policy and on the enrollee-facing webpage for fraud, waste, and abuse: https://www.partnersbhm.org/fraud-and-abuse/ . Additionally, the PIHP updated the *Member Handbook* to include language pertaining to enrollee quality of care. In the previous EQR, there was a recommendation set for Partners to include a statement in a PI policy and procedure that reporting fraud, waste and abuse will not affect or interfere with an enrollee's access to care. This Recommendation was not addressed by Partners. ***Recommendation: Include in a PI policy and procedures that reporting fraud, waste, and abuse does not affect or interfere with enrollee's access to care.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
access to care or with any such ongoing investigation being conducted by NC Medicaid, MFCU/MID or other oversight agency.						
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.	X					

X. FINANCIAL SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IX. Financial						
1. The PIHP has policies and systems in-place for submitting and reporting financial data.	X					This requirement is addressed in Policy and Procedure 3.00, Accounting by Funding Source. ***Recommendation: Revise Policy 3.00, Accounting by Funding Source, to reflect that monthly Medicaid reporting is due to NC Medicaid by the 20th of the month.***
2. The PIHP has and adheres to a cost allocation plan that meets the requirements of *42 CFR § 433.34*.	X					This requirement is addressed in Policy and Procedure 3.00, Accounting by Funding Source. ***Recommendation: On an annual basis, submit to NC Medicaid a formal cost allocation plan with its estimated percentage of Medicaid and State administrative costs.***
3. PIHP maintains detailed records of the administrative costs and expenses incurred as required by the *NC Medicaid Contract*.	X					Administrative costs are recorded to their natural expense account and are separated by funding source on the NC Medicaid monthly financial reports.
4. Maintains an accounting system in accordance with *42 CFR § 433.32(a).*	X					Partners uses Microsoft GP Dynamics version 2015. During the interview, they indicated that they are evaluating a software upgrade to version 2019.
5. The PIHP follows a record retention policy of retaining records for ten years. (*NC Medicaid Contract, Section 8.3.2* and *Amendment 4, Section 31).*	X					This requirement is addressed in Policy and Procedure 4.11, Records Retention and Disposition. For Medicaid records, Partners follows the state guidelines in the Records Retention and Disposition Schedule for LME-APSM 10-6, with some exceptions where they retain records longer.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution in accordance with *NC Medicaid Contract*.	X					Partners maintains their restricted risk reserve account at NC Capital Management Trust. They provided bank statements for January and February 2020. These balances agree with the January and February 2020 Medicaid reports. The February 2020 balance was $40,545,709 (12.8% of capitation reached).
7. The required minimum balance of the Risk Reserve Account meets the requirements of the *NC Medicaid Contract*.	X					This requirement is addressed in Policy and Procedure 3.14, Management of Restricted Risk Reserve. Per the interview, the deposits were all made on time and in the correct amounts, and there were no withdrawals in the current review period.
8. All funds received by PIHP are accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as required by the *NC Medicaid Contract*.	X					This requirement is addressed in Policy and Procedure 3.00, Accounting by Funding Source. To ensure that they are correctly coded, the general ledger accounts are coded in segments by funding source. Partners provided a copy of their general ledger chart of accounts as well as a breakdown of the segments of the chart of account segments.
9. The Medical Loss Ratio (MLR) meets the requirements of *42 CFR § 438.8* and the *NC Medicaid Contract*.	X					This requirement is addressed in Policy and Procedure 3.00, Accounting by Funding Source. However, the 85% requirement is not mentioned. ***Recommendation: Revise Policy and Procedure 3.00, Accounting by Funding Source, to reflect that the Medical Loss Ratio standard is 85%.***

E. Attachment 5: Encounter Data Validation Report

Partners Health Management

Encounter Data Validation Report

performed on behalf of

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

August 19, 2020

Prepared By:

hms

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

Table of Contents

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Background

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

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

Overview

The scope of our review, guided by the CMS Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid by Partners for the period of January 2018 through December 2018. All claims paid by Partners should be submitted and accepted as a valid encounter to NC Medicaid. Our approach to the review included:

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

Review of Partners' ISCA response

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

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

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

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

Looking at claims with dates of service in 2018, Partners submitted 1,363,466 unique encounters to the State. To date, less than 1% of all encounters submitted have not been corrected and accepted by NC Medicaid.

2018	Submitted	Initally Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	75,313	74,414	88	811	1%
Professional	1,288,153	1,276,806	9,646	1,701	0%
Total	1,363,466	1,351,220	9,734	2,512	0%

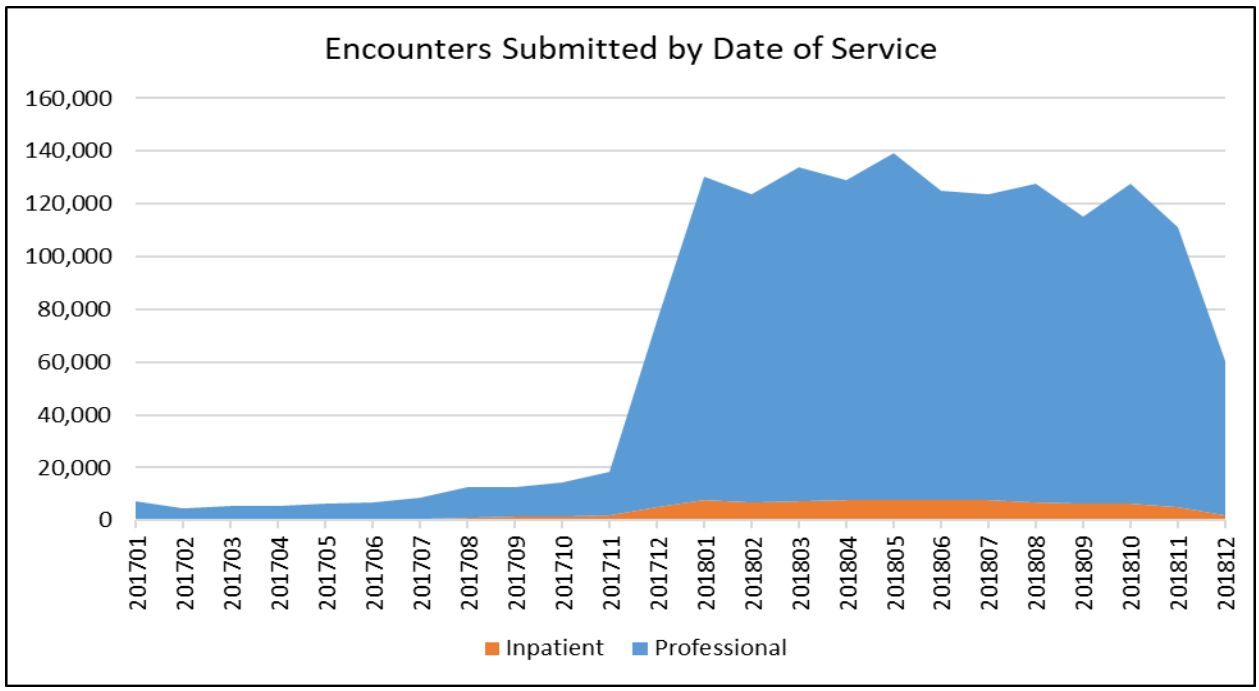
Compared to claims submitted in 2017, Partners has decreased the number of initial denials and total number of outstanding denials for claims submitted in 2018. According to Partners' response and review of NC Medicaid 's acceptance report, 31% of all outstanding and ongoing denials are still related to invalid Taxonomy codes for the billing and rendering Provider. Partners' strategy to continue to reduce, correct and resubmit encounter denials includes the following steps:

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

As a result of their strategy, denied claims from 2017 that were reported in the EDV review last year has decreased from 4% (55,566 claims) to less than 1% (1,044 claims).

Analysis of Encounters

The analysis of encounter data evaluated whether Partners submitted complete, accurate, and valid data to NC Medicaid for all claims paid between January 1, 2018 through December 31, 2018. Partners pulled all claims adjudicated and submitted to NC Medicaid during 2018 and sent to HMS via SFTP. This included more than 1.5 million Professional claims and just over 92,000 Institutional claims. Data transmitted included voids and resubmissions for previously denied claims, so the numbers do not reconcile back to the metrics reported in the ISCA response.



In order to evaluate the data, HMS ingested the 837I and 837P data extracts, and loaded them to a consolidated database. After data onboarding was completed, HMS applied proprietary, internally designed data analysis logic within SAS to review each data element, focusing on the data elements defined as required. Our logic evaluates the presence of data in each field within a record as well as whether the value for the field is within accepted standards. Results of these checks were compared with general expectations for each data field and to the CMS standards adopted for encounter data. The Table below depicts the specific data expectations and validity criteria applied.

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Recipient ID	Should be valid ID as found in the State's eligibility file. Can use State's ID unless State also accepts Social Security Number.	100% valid
Recipient Name	Should be captured in such a way that makes separating pieces of name easy. Expect data to be present and of good quality	85% present. Lengths should vary, but there should be at least some last names of >8 digits and some first names of < 8 digits, validating that fields have not been truncated. Also, a high percentage

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
		of names should have at least a middle initial.
Recipient Date of Birth	Should not be missing and should be a valid date.	< 2% missing or invalid
MCO/PIHP ID	Critical Data Element	100% valid
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	95% valid
Attending Provider ID	Should be an enrolled provider listed in the provider enrollment file (will accept the MD license number if it is listed in the provider enrollment file).	> 85% match with provider file using either provider ID or MD license number
Provider Location	Minimal requirement is county code, but zip code is strongly advised.	> 95% with valid county code > 95% with valid zip code (if available)
Place of Service	Should be routinely coded, especially for physicians.	> 95% valid for physicians > 80% valid across all providers
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% nonmissing and valid on physician or other applicable provider type claims (e.g., other practitioners)
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid codes (using International Statistical Classifications of Diseases, Ninth Revision, Clinical Modification [ICD-10-CM] lookup tables) for practitioner providers (not including transportation, lab, and other ancillary providers)
Other Diagnosis	This is not expected to be coded on all claims even with applicable	90% valid when present

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

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

Encounter Accuracy and Completeness

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

Table: Evaluation of Key Fields

Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	1,645,653	100.00%	1,645,634	99.99%	1,645,634	99.99%	1,645,634	99.99%
Recipient Name	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%
Recipient Date of Birth	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%
MCO/PIHP ID	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%
Provider ID	1,645,653	100.00%	1,645,636	99.99%	1,645,636	99.99%	1,645,636	99.99%
Attending/Rendering Provider ID	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%
Provider Location	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%
Place of Service	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%
Specialty Code / Taxonomy - Billing	1,645,653	100.00%	1,644,944	99.96%	1,644,944	99.96%	1,644,944	99.96%
Specialty Code / Taxonomy - Rendering / Attending	1,645,653	100.00%	1,645,383	99.98%	1,645,383	99.98%	1,645,383	99.98%
Principal Diagnosis	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%
Other Diagnosis	218,037	13.25%	218,037	13.25%	218,037	13.25%	218,037	13.25%
Dates of Service	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%
Unit of Service (Quantity)	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%	1,645,653	100.00%
Procedure Code	1,626,102	98.81%	1,625,910	98.80%	1,625,910	98.80%	1,625,910	98.80%
Procedure Code Modifier	550,491	33.45%	550,491	33.45%	550,491	33.45%	550,491	33.45%
Patient Discharge Status Code Inpatient	92,437	100.00%	92,437	100.00%	92,437	100.00%	92,437	100.00%
Revenue Code	92,437	100.00%	92,436	99.99%	92,436	99.999%	92,436	99.99%

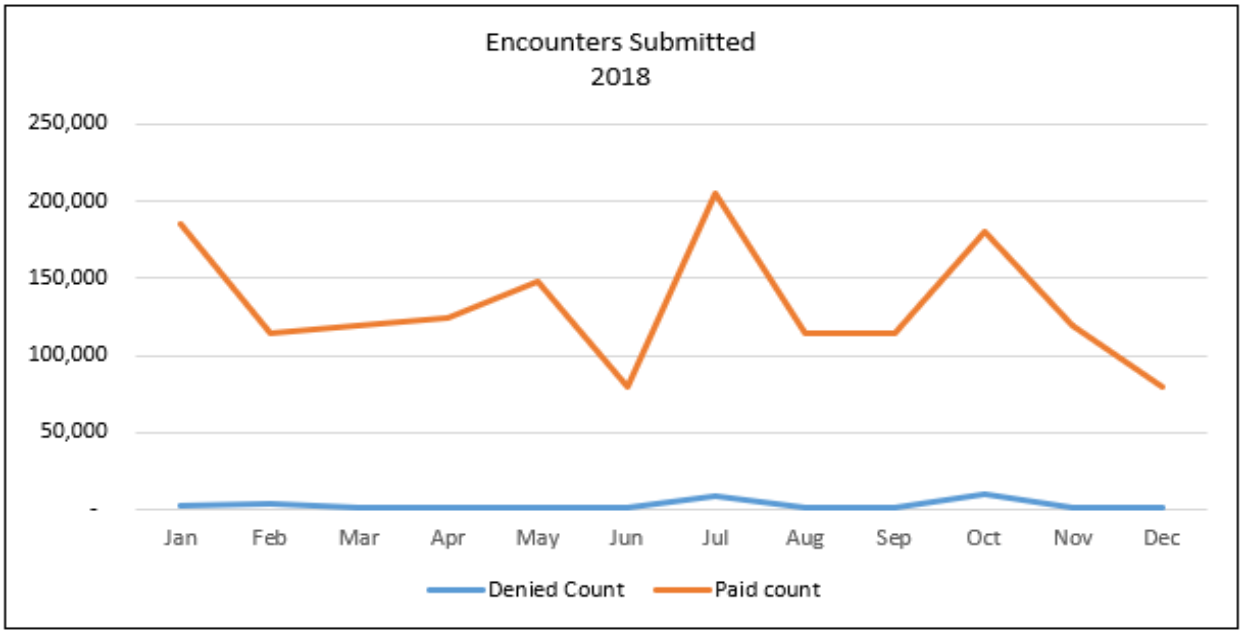
Overall, Partners has significantly improved the quality and accuracy of the encounter data submitted compared to last year's review of 2017 claims. Institutional claims contained complete and valid data in 16 of the 18 key fields (89%) with noted issues for Revenue Code and Procedure Code. The Revenue Code was incorrect on one claim. The value submitted was a Procedure code rather than a Revenue code. In addition, 1,866 lines were missing Procedure codes on Institutional charges where the Revenue code alone is insufficient for identifying the service. Room & board type of charges were excluded for this analysis.

Professional encounter claims submitted contained complete and accurate data in 11 of the 16 key Professional fields (93%). Provider Id was populated with incorrect values on 19 claims while 17 claims contained incorrect Recipient Id. The Provider Id should be populated 100% of the time with a 10 digit

numeric NPI number. Recipient Id should also be populated 100% of the time with the 10 digit alpha numeric Medicaid Id. In addition, 979 claims contained incorrect Taxonomy codes. 709 of these were billing provider Taxonomy codes, while 270 rendering provider Taxonomy codes were invalid. Taxonomy code field should be populated 100% of the time with a 10 digit alpha numeric Taxonomy code. Lastly, 192 claims contained invalid Procedure codes. Procedure code field must be populated 100% of the time with a valid CPT or HCPCS Procedure code.

Encounter Acceptance Report

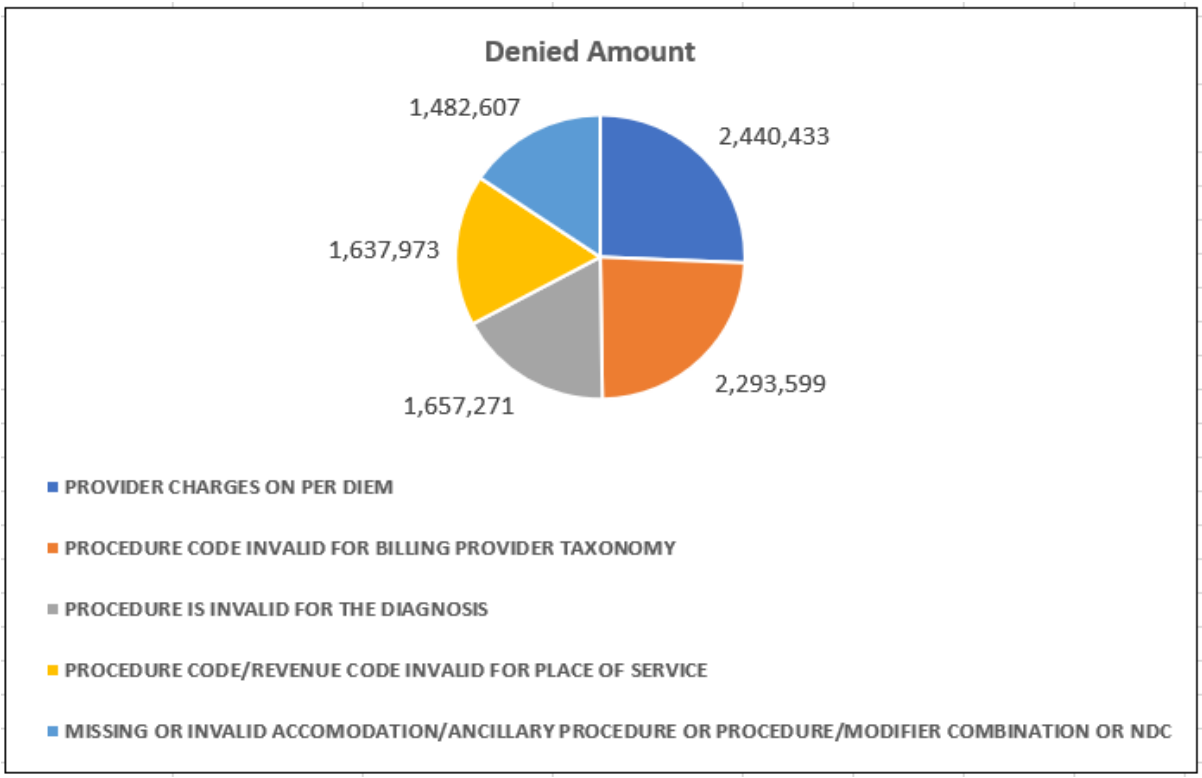
In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each LME/MCO. The report is tracked by check write which made it difficult to tie back to the ISCA response and submitted encounter files since only the Date of Service for each is available. During the 2018 weekly check write schedule, Partners submitted a total of 1,583,678 encounters to NC Medicaid. On average, 2% of all encounters submitted were denied. Less than 1% of claims denied are still outstanding -- the rest have been reviewed, resubmitted, and accepted by NC Medicaid.

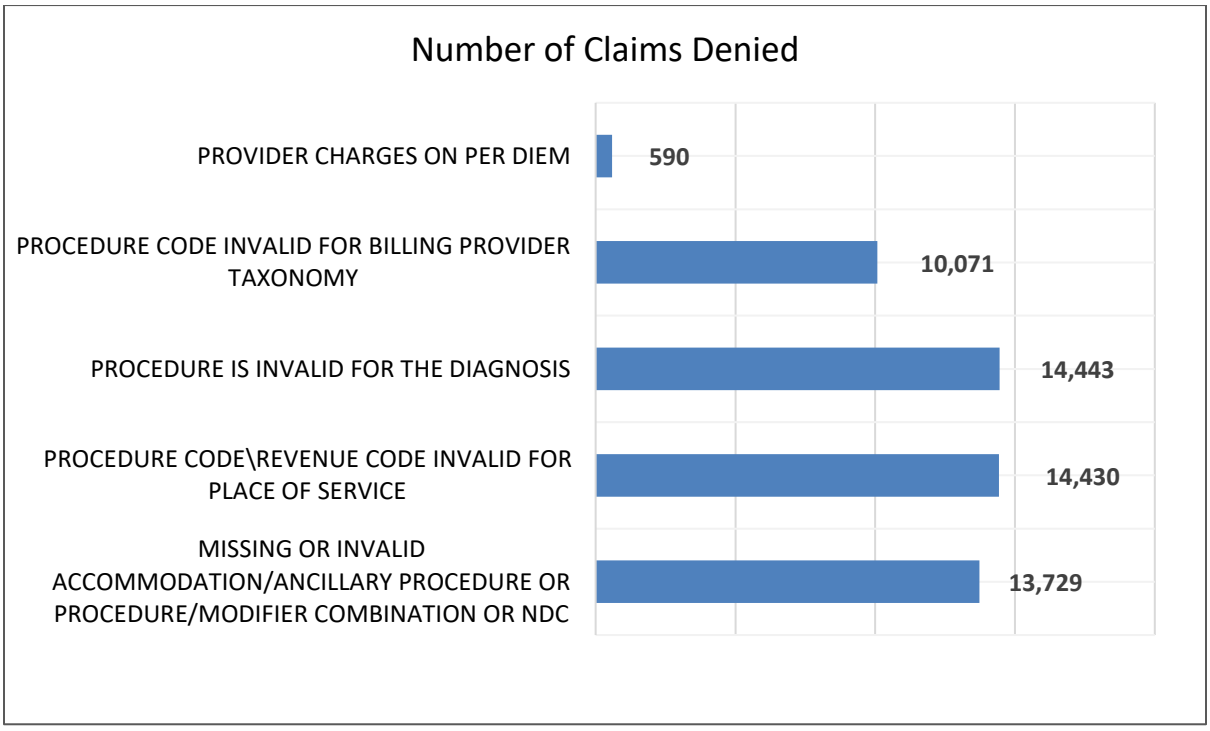


Evaluation of the top denials for Partners' encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis above. Encounters were denied primarily for:

- Provider charges on per diem
- Procedure code invalid for billing provider Taxonomy
- Procedure is invalid for the diagnosis
- Procedure code/Revenue code invalid for place of service missing or invalid accommodation/ancillary procedure or procedure/modifier combination or NDC

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





Results and Recommendations

Issue: Recipient Id

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

Resolution:

Partners should check their claims processing system and data warehouse to ensure the Recipient Id that is recognizable by the State is being captured appropriately. One possible solution is to review how Partners validates the recipient information in the system against GEF, and create exception reports to flag potential issues for manual review. Partners should also double check their 837 encounter creation process and encounter data extract process to make sure data was not lost or manipulated during transformation.

Issue: Billing Provider ID

A valid billing provider NPI number is required in order to properly adjudicate a claim. This issue only occurred in the Professional claims involving one providers.

Resolution:

The issue occurred involving claims that was submitted manually through the portal. The provider appears to have been loaded into the system initially with an incorrect NPI number. The issue has since been corrected. However, some claims still paid while the incorrect information was in the system, leading to incorrect encounter data submission. And while this problem seems isolated and highly likely occur with 837 transactions (since the NPI number submitted on the 837 by the provider would not have matched the incorrect NPI number in Partners' system), Partners should review data validation rules and how provider information get validated and captured in the system during provider enrollment.

Issue: Provider Taxonomy

Provider Taxonomy codes were not consistently populated with a valid code. This information is key for passing the front end edits put in place by the State and to effectively price the claim. This impacts pricing since NCTracks is expecting the correct combination of NPI, Taxonomy and Procedure code. When values were populated, the Taxonomy code did not always match up with the Taxonomy values enrolled in NCTracks for the Billing and/or Rendering Provider. These errors result in denials by NC Medicaid that must be corrected and resubmitted.

Resolution:

As outlined in their ISCA response, Partners has a process in place to review 835 files and correctly resubmit encounters to the State that were denied due to invalid or missing Taxonomy. Partners should continue to follow their current process as well as monitor the front end edits in the local system to prevent these errors at the point of claim submission to ensure they are working as intended. The encounter data reviewed and NC Medicaid check write report reflects significant improvement compared to 2016 and 2017, so we know the process in place is making a positive impact.

Issue: Diagnosis Codes

The principal diagnosis was populated for 100% of the claims, which show a notable improvement compared to 2018. Additionally, Partners made great progress in capturing additional Diagnosis codes. Consequently, many Institutional and Professional claims now carry multiple Diagnosis codes, suggesting improvements in medical coding practices. However, most claims do not show additional Diagnosis codes.

Resolution:

The missing additional Diagnosis codes do not exceed the threshold outlined in the Data Quality Standards table above, as there is no explicit figure for additional diagnosis. However, additional Diagnosis code should be populated with high frequency and Partners should continue to remind providers to code additional behavioral health diagnoses when appropriate. Separately, NC Medicaid will need to work with the PIHP and CSRA to determine what additional non-behavioral health Diagnosis codes should be submitted and accepted when available. Currently, NCTracks will deny any encounter with a non behavioral health diagnosis regardless of the position of the Diagnosis code value (i.e. primary, secondary, tertiary, etc.). There are behavioral health services provided by the PIHPs that require medical services and medical Diagnosis codes. Partners will need to work collaboratively with the state and Alpha to ensure they can capture and report all Diagnosis codes once NCTracks has been updated to accept.

Issue: Procedure Codes

The Procedure code for Institutional claims should be populated 99% of the time. In the encounter data provided, 57% of claims contained a value in the Procedure code field. Adjusting for Revenue codes that do not require corresponding Procedure codes, this figure increases to 98%. Additionally, some Professional claims had invalid Procedure codes.

Resolution:

Overall, there has been a notable improvement in the quality of data as Partners just barely missed meeting the Data Quality Standards threshold target for Procedure codes (>99%). Procedure codes, when populated, were almost always valid. Partners should continue to monitor and make sure that Procedure codes submitted by providers are valid. In case of Institutional claims, encourage providers to code procedures when appropriate. Partners does a commendable job of denying outpatient Institutional claims when certain Revenue codes are submitted without a Procedure code (e.g. Revenue code '0450'.) 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 Procedure codes so that services that were rendered can be identified (e.g. submitting a Procedure code when billing Revenue code '0250'.)

Conclusion

Based on the analysis of Partners' encounter data, we have concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues were noted with both Institutional and Professional encounters. Based on Partners' ISCA response, overview of the Alpha system, and limited number of data anomalies, HMS believes that 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 in nature. Therefore, Partners should review and take corrective action to resolve the issues identified above.

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

Appendix 1

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
00001	HDR BEG DOS INVLD/ > TCN DATE	DENY
00002	ADMISSION DATE INVALID	DENY
00003	HDR END DOS INVLD/ > TCN DATE	DENY
00006	DISCHARGE DATE INVALID	PAY AND REPORT
00007	TOT DAYS CLM GTR THAN BILL PER	PAY AND REPORT
00023	SICK VISIT BILLED ON HC CLAIM	IGNORE
00030	ADMIT SRC CD INVALID	PAY AND REPORT
00031	VALUE CODE/AMT MISS OR INVLD	PAY AND REPORT
00036	HEALTH CHECK IMMUNIZATION EDIT	IGNORE
00038	MULTI DOS ON HEALTH CHECK CLM	IGNORE
00040	TO DOS INVALID	DENY
00041	INVALID FIRST TREATMENT DATE	IGNORE
00044	REQ DIAG FOR VITROCERT	IGNORE
00051	PATIENT STATUS CODE INVALID	PAY AND REPORT
00055	TOTAL BILLED INVALID	PAY AND REPORT
00062	REVIEW LAB PATHOLOGY	IGNORE
00073	PROC CODE/MOD END-DTE ON FILE	PAY AND REPORT
00076	OCC DTE INVLD FOR SUB OCC CODE	PAY AND REPORT
00097	INCARCERATED - INPAT SVCS ONLY	DENY
00100	LINE FDOS/HDR FDOS INVALID	DENY
00101	LN TDOS BEFORE FDOS	IGNORE
00105	INVLD TOOTH SURF ON RSTR PROC	IGNORE
00106	UNABLE TO DETERMINE MEDICARE	PAY AND REPORT

00117	ONLY ONE DOS ALLOWED/LINE	PAY AND REPORT
00126	TOOTH SURFACE MISSING/INVALID	IGNORE
00127	QUAD CODE MISSING/INVALID	IGNORE
00128	PROC CDE DOESNT MATCH TOOTH #	IGNORE
00132	HCPCS CODE REQ FOR REV CODE	IGNORE
00133	HCPCS CODE REQ BILLING RC 0636	IGNORE
00135	INVL POS INDEP MENT HLTH PROV	PAY AND REPORT
00136	INVLD POS FOR IDTF PROV	PAY AND REPORT
00140	BILL TYPE/ADMIT DATE/FDOS	DENY
00141	MEDICAID DAYS CONFLICT	IGNORE
00142	UNITS NOT EQUAL TO DOS	PAY AND REPORT
00143	REVIEW FOR MEDICAL NECESSITY	IGNORE
00144	FDOS AND TDOS MUST BE THE SAME	IGNORE
00146	PROC INVLD - BILL PROV TAXON	PAY AND REPORT
00148	PROC\REV CODE INVLD FOR POS	PAY AND REPORT
00149	PROC\REV CD INVLD FOR AGE	IGNORE
00150	PROC CODE INVLD FOR RECIP SEX	IGNORE
00151	PROC CD/RATE INVALID FOR DOS	PAY AND REPORT
00152	M/I ACC/ANC PROC CD	PAY AND REPORT
00153	PROC INVLD FOR DIAG	PAY AND REPORT
00154	REIMB RATE NOT ON FILE	PAY AND REPORT
00157	VIS FLD EXAM REQ MED JUST	IGNORE
00158	CPT LAB CODE REQ FOR REV CD	IGNORE
00164	IMMUNIZATION REVIEW	IGNORE
00166	INVALID VISUAL PROC CODE	IGNORE
00174	VACCINE FOR AGE 00-18	IGNORE

00175	CPT CODE REQUIRED FOR RC 0391	IGNORE
00176	MULT LINES SAME PROC, SAME TCN	IGNORE
00177	HCPCS CODE REQ W/ RC 0250	IGNORE
00179	MULT LINES SAME PROC, SAME TCN	IGNORE
00180	INVALID DIAGNOSIS FOR LAB CODE	IGNORE
00184	REV CODE NOT ALLOW OUTPAT CLM	IGNORE
00190	DIAGNOSIS NOT VALID	DENY
00192	DIAG INVALID RECIP AGE	IGNORE
00194	DIAG INVLD FOR RECIP SEX	IGNORE
00202	HEALTH CHECK SHADOW BILLING	IGNORE
00205	SPECIAL ANESTHESIA SERVICE	IGNORE
00217	ADMISSION TYPE CODE INVALID	PAY AND REPORT
00250	RECIP NOT ON ELIG DATABASE	DENY
00252	RECIPIENT NAME/NUMBER MISMATCH	PAY AND REPORT
00253	RECIP DECEASED BEFORE HDR TDOS	DENY
00254	PART ELIG FOR HEADER DOS	PAY AND REPORT
00259	TPL SUSPECT	PAY AND REPORT
00260	M/I RECIPIENT ID NUMBER	DENY
00261	RECIP DECEASED BEFORE TDOS	DENY
00262	RECIP NOT ELIG ON DOS	DENY
00263	PART ELIG FOR LINE DOS	PAY AND REPORT
00267	DOS PRIOR TO RECIP BIRTH	DENY
00295	ENC PRV NOT ENRL TAX	IGNORE
00296	ENC PRV INV FOR DOS	IGNORE
00297	ENC PRV NOT ON FILE	IGNORE
00298	RECIP NOT ENRL W/ THIS ENC PRV	IGNORE

00299	ENCOUNTER HMO ENROLLMENT CHECK	PAY AND REPORT
00300	BILL PROV INVALID/ NOT ON FILE	DENY
00301	ATTEND PROV M/I	PAY AND REPORT
00308	BILLING PROV INVALID FOR DOS	DENY
00313	M/I TYPE BILL	PAY AND REPORT
00320	VENT CARE NO PAY TO PRV TAXON	IGNORE
00322	REND PROV NUM CHECK	IGNORE
00326	REND PROV NUM CHECK	PAY AND REPORT
00328	PEND PER 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