CCME

2022 External Quality Review

PARTNERS HEALTH MANAGEMENT

Submitted: April 14, 2023

Prepared on behalf of
North Carolina Medicaid

Table of Contents

EXECUTIVE SUMMARY

The *Balanced Budget Act of 1997* requires State Medicaid Agencies that contract with Prepaid Inpatient Health Plans (PIHPs) to evaluate their compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358 (42 CFR § 438.358)*. This review determines the level of performance demonstrated by Partners. This report contains a description of the process and the results of the 2022 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the North Carolina Medicaid (NC Medicaid).

Goals of the review are to:

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

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

A. Overall Findings

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

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

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

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

B. Overall Recommendations

The following provides a global or high-level summary of the status of the Recommendations and Corrective Action items from the 2021 EQR and the findings of the 2022 EQR. Specific Recommendations and Corrective Actions are detailed in each section of this report.

Administration

42 CFR § 438.224 and 42 CFR § 438.242

In the 2022 EQR, Partners again met 100% of the Administrative standards and no Weaknesses were identified. The review showed Partners was able to maintain their very high encounter data acceptance rate despite an increase in claim submissions due to the inclusion of five additional counties. Partners is also working with NC Medicaid to reduce the number of denied claims due to duplicate claims and taxonomy related issues.

Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

In Partners' 2021 EQR of Credentialing/Recredentialing, there were no items requiring Corrective Action and one Recommendation was issued. Partners addressed the Recommendation, adding the (Initial, Recredentialing, monthly) query of the *NC DHHS Excluded Provider List* to the checklist of Primary Source Verification and monitoring table in the *Credentialing Program Description*.

In the 2022 EQR, Partners met 100% of the Credentialing/Recredentialing standards, with no identified Weaknesses, Corrective Action items or Recommendations. Per the direction of the North Carolina Department of Health and Human Services (NC DHHS), credentialing has now shifted from the PIHPs completing credentialing and recredentialing to the PIHPs verifying credentialing completed by NCTracks. Partners completed the in-process credentialing and recredentialing files in May 2022, with the final Credentialing Committee meeting occurring on June 15, 2022.

Quality Improvement

42 CFR § 438.330

In the 2021 EQR, Partners met 100% of the Quality Improvement (QI) standards, resulting in no Corrective Actions. There were three Recommendations regarding the assessment of interventions and consideration for additional interventions to improve PIP rates, which were validated in the High Confidence range. Partners was Fully Compliant for (b) Waiver and (c) Waiver PMs, but one (b) Waiver PM showed a decline in rate compared to the previous measurement year. CCME issued a Recommendation for monitoring to determine if rates with substantial improvement or decline represent trends or anomalies in the PMs. All Recommendations were implemented in the 2022 EQR.

For the 2022 EQR, Partners met 100% of the standards, resulting in no Corrective Actions. All PIPs were validated in the High Confidence range with Recommendations issued for four PIPs related to the lack of rate improvement. Partners was Fully Compliant for (b) Waiver and (c) Waiver PMs. The (b) Waiver measure rates from this year were compared to last year and there were four measurements with substantial declines (greater than 10%) and four measurements with substantial improvement (greater than 10%). A Recommendation was issued to continue monitoring (b) Waiver performance measure rates to determine if rates with substantial improvement or decline represent a continued trend or an irregularity in the PMs. The five (c) Waiver measures were above the State benchmark of 85%.

Utilization Management

42 CFR § 438.208

In the 2021 EQR, Partners met 100% of the UM standards and received one Recommendation related to incorrect information in the *Innovations Member and Family Handbook*. In the 2022 EQR, CCME reviewed the *Innovations Member and Family Handbook* and found the handbook was revised to correctly reflect the exceptions to the $135,000 limit of the Innovations Waiver cost and the current counties in Partners' catchment area.

In the 2022 EQR, a few anomalies were identified in the enrollee file review and discussed during the Onsite. One I/DD file showed a 22-year-old enrollee had an

Oppositional Defiant Disorder diagnosis, a childhood disorder, listed in the enrollee's Individual Support Plan and demographic sheet. This same enrollee transferred from Gaston County to Mecklenburg County, and Partners could not provide evidence of the notification to the Department of Social Services as required by Partners' *NC Medicaid Contract, Section 4.6*. In one TCL file, Partners was not able to locate the enrollee's 24-month Quality of Life survey. Staff reported during the Onsite, the 24-month survey was overlooked during a transition from one Care Coordinator to another. CCME is recommending Partners take steps to prevent these oversights including reviewing diagnoses within enrollees' treatment plans as a part of the plan update and revision, documenting a process for notifying the appropriate Department of Social Services when changes occur that impact enrollee's Medicaid eligibility, and enhancing the current enrollee file review process to include review of the timely completion and filing of all Quality of Life surveys.

Grievances and Appeals

42 CFR § 438, Subpart F, 42 CFR 483.430

In the 2021 EQR, Partners met 100% of the Grievance and Appeal standards. CCME issued no Corrective Actions. One Recommendation was issued to address a concern noted in the *Member Handbook*. This Recommendation was implemented, and the *Member Handbook* was updated with the term "grievance/complaint" throughout as the term for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination."

In the 2022 EQR, Partners met 100% of the Grievance and Appeal standards. No Corrective Actions or Recommendations were issued.

All 2022 Grievance files were compliant with Partners' Policy and Procedure 6.00, Grievance/Complaint Coordination and Resolution, the *NC Medicaid Contract*, and the federal regulations. Onsite discussion regarding four files concentrated on Partners' internal follow up after the written *Notice of Resolution letter* was issued. The Partners follow up involved many different departments for a cross functional approach for completing the investigations for those Grievances.

The 2022 Appeal file review was similar to the 2021 file review in terms of compliance, completeness, and detail of staff documentation. No compliance issues were noted in the 2022 EQR Appeal file review. All reviewed Appeal files were compliant with Policy and Procedure 13.04, Clinical Utilization Management Appeals, the *NC Medicaid Contract*, and the federal regulations. During the Onsite discussion, Partners staff attributed the compliance success to the focused Appeals monitoring process and staff attention to detail in their documentation.

Program Integrity

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

In the 2021 EQR, Partners met 100% of Program Integrity (PI) Standards with no identified Weaknesses, Corrective Actions, or Recommendations.

In the 2022 EQR, Partners again met 100% of PI standards, resulting in no Corrective Actions and one Recommendation. The review found one Special Investigation Unit (SIU) investigation that was not initiated during the required timeframe as stated in *NC Medicaid Contract Section 14.2.8*. CCME is recommending that Partners develop a process that ensures allegations received by mail are initiated in the required timeframes.

During the 2022 EQR Onsite, Partners shared in the past year they have added new cybersecurity tools and obtained cybersecurity certifications to improve IT security. Additionally, Partners' SIU has added an exit interview process as part of the overpayment assessment. This allows providers the opportunity to gain a clearer understanding of the findings from the investigation and has also reduced the number of disputes from providers.

Encounter Data Validation

Based on the analysis of Partners' encounter data, it has been concluded that the data submitted to NC Medicaid is complete and accurate. Some 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, Aqurate believes that some of the errors are isolated cases that can be mitigated in the future by reviewing and modifying data validation rules, as necessary.

Overall, Partners has shown continued improvements in the quality of encounter data, and this is consistent with the reductions seen in the rate of denials on first time encounter submissions. However, some of the errors noted above are critical data elements as identified by CMS and NC Medicaid. Therefore, Partners should review and take steps to resolve the issues identified above.

For the next review period, Aqurate is recommending that the encounter data from NCTracks be reviewed to verify encounters that pass front end edits and are adjudicated to either a paid or denied status. Additionally, Partners should monitor the volume of denied claims pending re-submission to ensure there is no backlog. The goal is to ensure that Partners is reporting all paid claims as encounters to NC Medicaid.

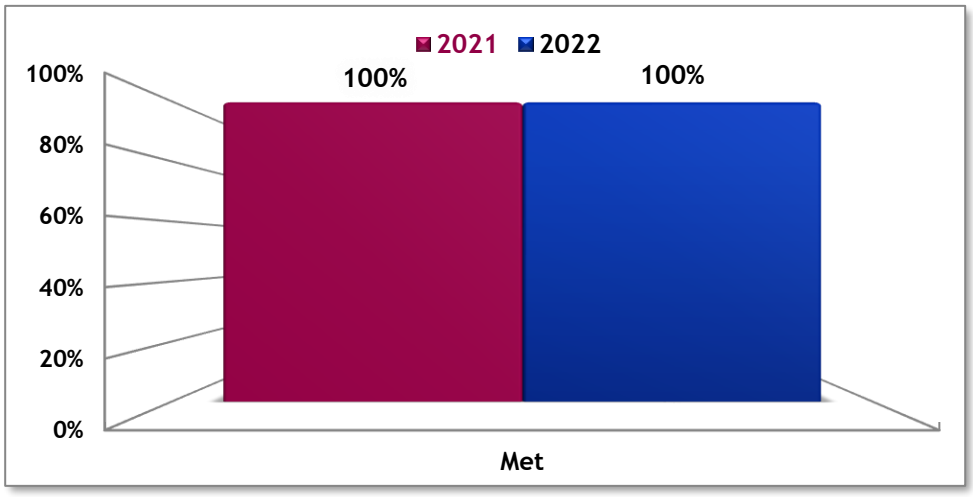
Corrective Actions and Recommendations from Previous EQR

During the previous EQR, all standards scored as "Met" and no Corrective Action issued. Additional details regarding Partners' 2021 Recommendations, the PIHP's response, and evidence, or lack thereof, of PIHP implementation of the 2021 Recommendations are detailed in each section of this report.

Conclusions

Overall, Partners has met the requirements set forth in its contract with NC Medicaid. The 2022 Annual EQR shows that Partners has achieved a "Met" score for 100% of the standards reviewed. As the following chart indicates, none of the standards were scored as "Partially Met" or "Not Met." *Figure 1, Annual EQR Comparative Results*, provides an overview of the scoring of the current annual review as compared to the findings of the 2021 review.

Figure 1: Annual EQR Comparative Results



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

Table 1: Partners' 2022 Overall Strengths, Weaknesses, Recommendations and Corrective Actions

	Strengths	Weaknesses	Recommendations
Quality	b) Waiver Measures included all necessary documentation, and measures were reported according to specifications.	The Initial NC TOPPS Interview PIP showed a decline in indicator rates.	***Recommendation: Initial NC TOPPS Interview PIP - Monitor interventions and consider focusing efforts on two or three primary interventions that are likely to have impact on improving the rate for initial NC-TOPPS interviews completed.***
	(c) Waiver Measures met or exceeded State benchmark rates.	The Registry of Unmet Needs PIP showed a decline in indicator rates.	***Recommendation: Registry of Unmet Needs PIP- Determine if additional services need to be established and offered to increase engagements based on member needs.***
	All PIPs were in the High Confidence range.	The Opioid-Initiated Engagement PIP showed a decline in indicator rates.	***Recommendation: Increase Opioid-Initiated Engagement PIP- Consider focusing efforts on two or three primary interventions that are likely to have impact on improving the rate for Opioid-dependent members receiving services.***
	Partners reported they exceeded their Care Coordination departmental benchmarks in the past quarter regarding timeliness of progress notes and engagement with enrollees.	The Initiation & Engagement of Substance Use Members PIP showed a decline in indicator rates.	***Recommendation: Initiation & Engagement of Substance Use Members PIP- Consider focusing efforts on two or three primary interventions that are likely to have impact on improving the rate for SUD members receiving services.***

	Strengths	Weaknesses	Recommendations
	Partners worked to improve the content detail in their Grievance *Notice of Resolution letters*.	Follow-Up after Hospitalization for Mental Illness and Follow-Up After Hospitalization for Substance Abuse showed a substantial decline from the previous year's rate.	***Recommendation: Continue to monitor (b) Waiver performance measure rates to determine if rates with substantial improvement or decline represent a continued trend or an irregularity in the performance measures***
	Partners has implemented a focused Appeals monitoring process that focuses on routine and complex Appeals including oral, invalid, expedited, and withdrawn Appeals.	Review of one I/DD Care Coordination file showed a 22 year-old enrollee had an Oppositional Defiant Disorder diagnosis, a childhood disorder, listed in the enrollee's Individual Support Plan and demographic sheet.	***Recommendation: Ensure diagnoses within enrollee's treatment plans are routinely reviewed and updated as a part of any treatment plan revision.***
	In the past year, Partners has added new cybersecurity tools and obtained cybersecurity certifications to improve IT security.	In one TCL file the 24-month Quality of Life survey could not be located by staff. It was reported during the Onsite, the 24-month survey was overlooked during a transition of the enrollee between Partners' Care Coordinators.	***Recommendation: Enhance the current enrollee file review process to include review of the timely completion and filing of all Quality of Life surveys.***
Timeliness	Partners is working with NC Medicaid to reduce the number of denied claims due to duplicate claims and taxonomy related issues.		
	Partners launched a new Utilization Management electronic system that will be able to automate many processes for Appeals.		

	Strengths	Weaknesses	Recommendations
Access to Care	Partners has a Provider Help Desk with a dedicated toll-free number.	Review of one I/DD file showed the enrollee transferred from Gaston County to Mecklenburg County and Partners could not provide evidence of the notification to the Department of Social Services, as required by *NC Medicaid Contract, Section 4.6.*	***Recommendation: Develop and document a process by which notifications to the Department of Social Services are issued when changes occur that impact enrollee's Medicaid eligibility. Ensure the language and process are compliant with NC Medicaid Contract, Section 4.6.***
	Direct phone numbers and email addresses for various provider network personnel are listed on the Partners website.		
	New participating providers receive a Welcome Packet that includes the seven-page *Provider Orientation Toolkit* and a Welcome Letter "which includes the telephone number and email addresses of their designated provider relations representative."		
	Partners has developed specialized teams in Care Coordination to help better serve enrollees with complex care needs.		
	Partners' SIU has added an exit interview process as part of the overpayment assessment. This allows providers the opportunity to gain a clearer understanding of the findings from the investigation and has also reduced the number of disputes from providers.		

METHODOLOGY

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

On January 13. 2023, CCME sent notification to Partners that the annual EQR was being initiated (see *Attachment 1*). This notification included:

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

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

The review consisted of two segments. The first was a Desk Review of materials and documents received from Partners on February 21, 2023, and reviewed by CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. Also included in the Desk Review was a review of Credentialing, Grievance, Utilization, Care Coordination, and Appeal files.

The second segment of the EQR is typically a two-day, Onsite review conducted at the PIHP's offices. However, due to COVID-19, this Onsite was conducted through a teleconference platform on March 16, 2023. This Onsite visit focused on areas not covered in the Desk Review and those needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's onsite activities included:

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

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

FINDINGS

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

A. Administration

42 CFR § 438.208

Information Systems Capabilities Assessment

The review of Partners' system capabilities involved the use of the Information Systems Capabilities Assessment (ISCA) tool and review of supporting documentation such as Partners' claim audit reports, enrollment workflows, and Partners' Information Technology (IT) staffing patterns. This system analysis is completed as specified in the Centers for Medicare and Medicaid Services (CMS) External Quality Review protocol. During the Onsite discussion, Partners staff provided an enrollment and claims systems overview. Questions regarding the ISCA tool were discussed with Partners staff during the Onsite review.

In the 2021 EQR, Partners met 100% of the Administration EQR standards, and no Recommendations or Corrective Actions were issued.

Table 2: 2021 EQR Administration Findings

2021 EQR Administration Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
2022 EQR Follow up: No Recommendations or Corrective Actions were issued in the 2021 Administrative EQR.		

Partners uses the Alpha+ system provided by Alphaind to process member enrollment, claims, submit encounters, and generate reports. No significant changes have taken place with the Alpha+ claims and enrollment system.

For the 2022 EQR, Aqurate reviewed the ISCA tool and supporting documentation submitted by Partners, which outlined Partners' processes for enrollment data in the Alpha+ enrollment system. During the Onsite review, Partners provided a demonstration of the Alpha+ enrollment system. This demonstrated system capabilities included

maintenance of the member's enrollment history and the capture of member demographic information.

The documentation provided indicates a daily upload of the Global Eligibility File (GEF) created by NCTracks into the Alpha+ system. There is a one-day lag in the data. A weekly full file is received that contains a complete list of all Medicaid eligible members, regardless of when records were updated, that can be used to update missing eligibility segments. The enrollment team receives a daily copy of the Alpha+ production database daily to support reporting needs. Summary reports are produced to compare total records from each database and to research any discrepancies. Monthly, cumulative eligibility data are compared against the 820 file, discrepancies are investigated and necessary adjustments are made. In August of 2022, NCTracks started sending 837 files to replace the GEF files; however, this does not impact the 2022 EQR findings.

During the Onsite discussion, Partners clarified staff could manually update the eligibility data in the Alpha+ system in cases where the GEF had incorrect information. Partners stores the Medicaid identification number (ID) received on the GEF. Documentation provided with the ISCA tool indicated members may have multiple Medicaid IDs, but all IDs link to the same unique Client ID. The unique Client ID is retained, and historical information is moved to Unique ID to ensure a single member does not have duplicate records.

The historical claims for the member are also merged into the Unique member ID. During the Onsite system demonstration, Partners' staff displayed the enrollment information is viewable and captured within Alpha+. Partners' enrollment counts for the past three years are presented in Table 3.

Table 3: Enrollment Counts

2019	2020	2021
156,412	178,199	93,847

Partners experienced a significant decrease (Approx 69%) in enrollment from December 2020 to July 2021 due to a transition of membership to the NC Medicaid Managed Care plans. Partners received additional membership from Cabarrus, Union, Stanly, Forsyth and Davie counties between September 2021 and December 2021. This increased the membership by about 70% from July 2021 to December 2021. This is still a more than 47% decrease in overall membership since the prior year.

Partners' authorizations and claims are processed in the Alpha+ system. A review of Partners' processes for collecting, adjudicating and reporting claims was conducted

through a review of its ISCA response and supporting documentation provided. A demonstration of Partners' Provider web claims entry portal and the Alpha+ claims processing system was performed during the Onsite.

Partners receives claims from three methods: 837 electronic file, provider web portal and paper claims. During the Onsite discussion, Partners stated they receive paper claims from new providers who have not been set up in Alpha+. Table 4 details the percentage of 2021 claims received via the three methods.

Table 4: Percent of claims with 2021 dates of service that were received via Electronic (HIPAA, Provider Web Portal) or Paper forms.

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

Partners adjudicates claims daily. Approximately 95.61% of Institutional claims and 95.42% of professional claims were auto adjudicated. Partners receives the inbound 835 files daily and the Adam Holtzman reports. Reports are generated by the IT team to reconcile the 835 files with the Adam Holtzman reports.

Partners can capture up to 25 ICD-10 Diagnosis codes via the provider web portal and up to 29 ICD-10 Diagnosis codes via the HIPAA files for Institutional claims. For Professional claims, the plan has the ability to receive and store up to 12 ICD-10 Diagnosis codes on both the provider web portal and via HIPAA files. Partners can capture ICD-10 Procedure codes and Diagnosis Related Groups (DRGs), if they are submitted on the claim.

Partners conducts daily random audits of 3% of Professional claims and approximately 10% of Institutional claims. Partners also conducts focused audits on Coordination of Benefits (COB) and claim overrides. Paper claims are included in the daily random audit. Partners conducts manual review of Emergency Department (ED) claims and claims over $5,000. A pended claims report is generated daily for a claims processor to review and manually approve or deny claims. Partners also audits claims processed by newly hired claims examiners, and the tasks performed by them are monitored and audited by a claims supervisor.

The breakdown of encounter data acceptance/denial rates by claim service detail counts was provided for encounters submitted in 2020 and 2021 and the breakdown is displayed in Table 5.

Table 5: Volume of 2020 and 2021 Submitted Encounter Data

2021	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	94,380	633	284	95,297
Professional	1,452,037	3905	893	1,456,835
2020	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	78,871	208	139	79,218
Professional	1,300,619	3,920	91	1,304,630

Partners has a 99.92% acceptance rate for both Professional and Institutional encounters with dates of service in 2021. Due to county realignment, members who receive Medicaid or State-funded Services for intellectual or developmental disabilities, mental health or substance abuse disorders from Cabarrus, Union, Stanly, Forsyth, and Davie counties were enrolled as of September 1st, 2021. Partners was able to maintain their very high encounter data acceptance rate even though there was a 12.16% increase in claims volume from the prior year due to the inclusion of the five counties. Partners experienced issues related to onboarding more providers with different contract rates causing an increase in time to resolve related claims and encountered challenges with data not matching with data in the state system. Partners also observed an increase in denials due to taxonomy differences due to adoption of new taxonomy codes. Partners stated they are still working through some taxonomy code related denials backlog.

Based on data review and discussion during the Onsite, Partners provided the top three denial reasons for encounters submitted to NCTracks:

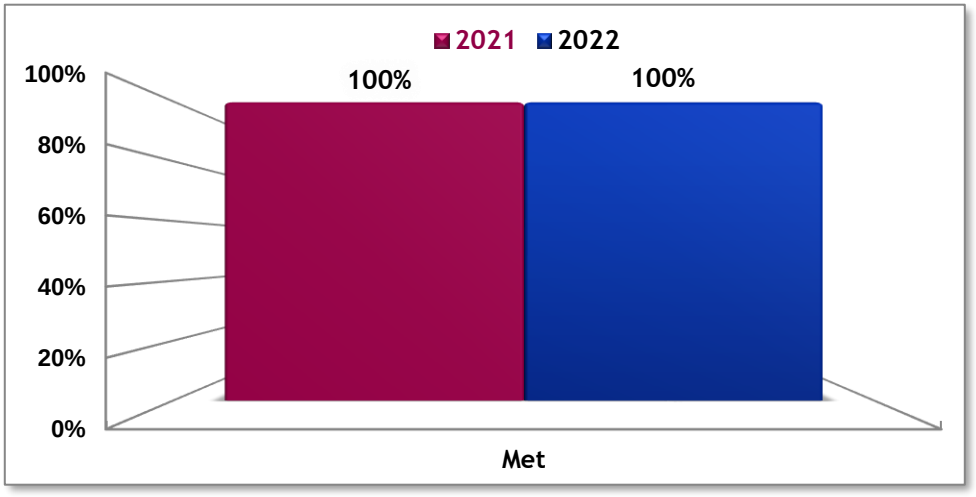
- Possible duplicate same provider, same procedure, overlapping dates of service
- Procedure code invalid for billing provider taxonomy
- Duplicate service or procedure

On average, Partners submits an encounter within nine days from the time of adjudication to NC Medicaid. It takes approximately 49 days to correct and resubmit an encounter to NC Medicaid. As stated in the ISCA, Partners has 2,108 Institutional and

5,903 Professional encounters that are still awaiting resubmission as of February 11, 2023. Although this is a significant increase from 2022, it is due to the issues caused by the acquisition of the five counties as well as denials due to retroactive rate changes on claims. Partners exceeds the NC Medicaid standards for encounter submissions and has less than 0.8% denial rate of their encounter data submissions.

Figure 2 demonstrates Partners met all of the standards in the 2021 and 2022 Administration EQRs.

Figure 2: Administration Findings



Strengths

- Partners was able to maintain their very high encounter data acceptance rate even though there was an increase in claim submissions due to the inclusion of five additional counties.
- Partners is working with NC Medicaid to reduce the number of denied claims due to duplicate claims and taxonomy related issues.

B. Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

The Provider Services EQR for Partners included Credentialing and Recredentialing as well as a discussion of provider education and network adequacy. CCME reviewed relevant policies and procedures, the *Credentialing Program Description (CPD)*, the *Credentialing Committee Charter Revised 01/18/22 (CCC),* credentialing/recredentialing files, a sample of Credentialing Committee meeting minutes, and select items on the Partners website. Partners staff provided additional information during an Onsite interview.

In the 2021 EQR, Partners met 100% of the Credentialing/Recredentialing standards, resulting in no Corrective Actions. CCME issued one Recommendation, which Partners addressed, as evidenced in Table 6 below.

Table 6: 2021 EQR Provider Services Findings

2021 EQR Credentialing/Recredentialing findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
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.	***Recommendation: Revise the CPD and any other documents that reference the PSVs conducted during the credentialing, recredentialing, or monthly monitoring processes to clearly include the NC DHHS Excluded Provider List. See NC Medicaid Contract, Attachment B, Section 1.14.4.***	**Y**
2022 EQR Follow up: In this 2022 EQR, Partners added the (Initial, Recredentialing, monthly) query of the *NC DHHS Excluded Provider List* to the checklist of Primary Source Verification and monitoring items in the table in the *Credentialing Program Description*.		

In the 2022 EQR, Partners met 100% of the Credentialing/Recredentialing standards, with no identified Weaknesses, Corrective Actions, or Recommendations. Per the direction of the North Carolina Department of Health and Human Services (NC DHHS), credentialing has now shifted from the PIHPs completing credentialing and recredentialing to the PIHPs verifying credentialing completed by NCTracks. Partners completed the in-process credentialing and recredentialing files in May 2022, with the Credentialing Committee disbanding after the June 15, 2022 meeting.

The *CPD*, the *CCC*, Policy and Procedure 8.26 Provider Credentialing, and Policy and Procedure 8.27, Selection and Retention of Network Providers, directed the credentialing and recredentialing processes. CCME's review of the credentialing and recredentialing files showed they were organized and contained appropriate information.

The *CPD* described the "Scope and Objectives of the Credentialing Program", provided definitions of relevant terms, and outlined details of the credentialing and recredentialing processes. The *CCC* and the *CPD* provided information about the Credentialing Committee, which was composed of Partners employees and "representatives from the Provider community." Dr. Elizabeth Stanton, the former Chief Medical Officer (CMO) and a board-certified psychiatrist, or her designee, reviewed and approved "unflagged" credentialing applications and chaired the Credentialing

Committee. Dr. Stanton retired in early fall 2022 but was with Partners through the completion of credentialing/recredentialing.

The *CCC* lists the Membership Position Description for the Credentialing Committee Membership. Seven provider representatives and three Partners employees comprised the voting membership. The *CPD* defines a quorum as "greater than half of the filled positions of the voting membership." A quorum was present at the Credentialing Committee meetings for which minutes were submitted for this EQR.

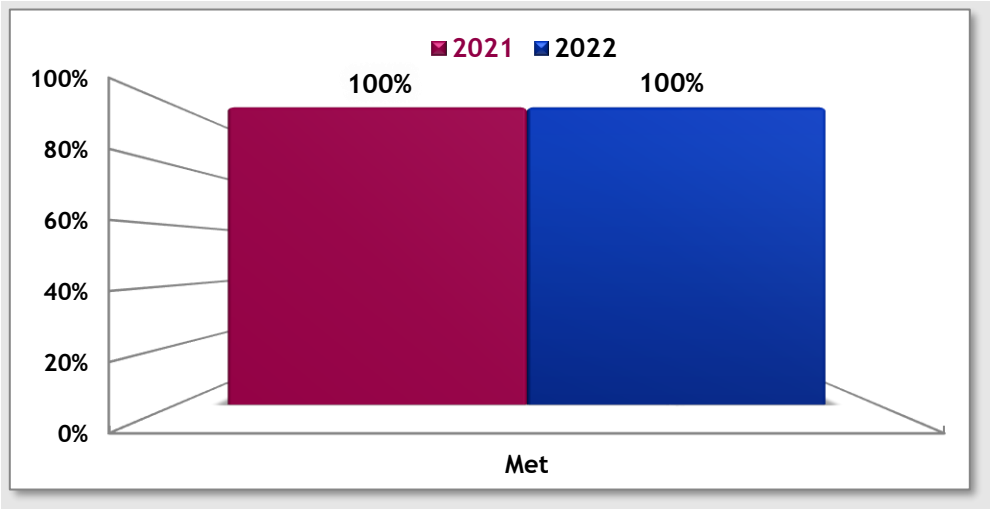
Policy and Procedure 8.13, Participating Provider Relations Program, includes information about the "Training and Orientation of Network Providers." New participating providers receive a Welcome Packet with a Welcome Letter "which includes the telephone number and email addresses of their designated provider relations representative." The packet includes the seven-page *Provider Orientation Toolkit* with "links to forms, manuals and documents that will assist providers in becoming acquainted and conducting business with Partners."

The COVID-19 flexibilities outlined in *NC Medicaid Contract Amendment #9* included a delay for the annual *Network Adequacy and Accessibility Analysis* (Gaps Analysis) report. CCME reviewed the most recent "gaps analysis", Partners' *Network Adequacy and Accessibility Analysis 2020-2021*, for the 2021 EQR. This report identified gaps in access/choice for Medicaid-funded Partial Hospitalization (PH), Facility-Based Crisis-Child, Non-Hospital Detox, and Psychiatric Residential Treatment Facility (PRTF). The report attributed the gaps in PH, Non-Hospital Detox, and PRTF to "updated access and choice specifications in January 2020." Partners filed *Exception Requests* for these four services with identified gaps but has still not heard if the Exception Requests were approved, and it is not clear if Exception Requests were still required.

During the Onsite interview, Partners staff reported they run and review monthly gaps reports and determine if they need to issue an RFI or RFP. Regarding the four gaps discussed at the last EQR, Partners staff reported only Facility-Based Crisis-Child continues to be a need, noting there is access in neighboring counties and Partners is "looking to expand to have one in our area." Partners staff reported a gap for Office-Based Opioid Treatment (OBOT) and noted there have been some issues related to service codes for opioid treatment, including providers not billing the correct codes for OBOT. Another need that may actually be related to incorrect service codes is halfway house.

Figure 3, Provider Services Comparative Findings, shows that 100% of the standards in the 2022 Credentialing/Recredentialing EQR were scored as "Met" and provides an overview of 2022 scores compared to 2021 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.
- New participating providers receive a Welcome Packet that includes the seven-page *Provider Orientation Toolkit* and a Welcome Letter "which includes the telephone number and email addresses of their designated provider relations representative."

C. Quality Improvement

42 CFR § 438.330

The 2022 Quality Improvement (QI) EQR included Performance Measures (PMs) and Performance Improvement Projects (PIPs) validation. CCME conducted a Desk Review of the submitted (b) and (c) Waiver Performance Measures (PMs) and a review of each PIP's *Quality Improvement Project (QIP) Form* for validation, using CMS standard validation protocols. An Onsite discussion clarified measurement rates for each of the areas.

In the 2021 EQR, Partners met 100% of the Quality standards and received three Recommendations related to the PIPs that were validated. The Recommendations and the status of implementation in the 2022 EQR are presented in Table 7.

Table 7: 2021 EQR PIP Recommendations

Project(s)	Recommendation	Recommendation Implemented in 2022 (Y/N/NA)
Initial NC TOPPS Interview	***Recommendation: Determine if additional interventions are needed to improve interview rates; assess the impact of other interventions and determine if continuation is beneficial to initial interview rates.***	**Y**
TCL Housing Loss Reduction	***Recommendation: Continue evaluation of services provided and determine if additional services might be beneficial for I/DD members***	**Y**
Registry of Unmet Needs	***Recommendation: Continue evaluation of services provided and determine if additional services might be beneficial for I/DD members.***	**Y**

For the current review, five projects were submitted, and all five were validated including: Initial NC TOPPS Interview, TCL Housing Loss Reduction, Registry of Unmet Needs, Increase Opioid-Initiated Engagement, and Initiation & Engagement of Substance Use Members.

Table 8 displays the PIP project title and interventions for the current review year.

Table 8: 2021 EQR PIP Interventions

Project(s)	Interventions
Initial NC TOPPS Interview	Produce individualized provider scorecards; Create a distribution list of NC-TOPPS Super Users; 1:1 meeting with providers for technical assistance; enhance the knowledge base of NC-TOPPS; .NC TOPPS workgroup webinar;
TCL Housing Loss Reduction	Visit TCL members monthly; Discuss each member monthly with service providers; Review eviction notices and County data; Increase communication with members and service providers; Address social determinants of health issues.
Registry of Unmet Needs	Development/Implementation of Long-term Community Support, Community Living and Supports, Day Supports, In-Home Skills building

Project(s)	Interventions
Increase Opioid-Initiated Engagement	Ongoing local housing initiatives and additional recovery support services; incentives for members that remain in treatment for 180 days; Provide training and technical assistance to providers; PSS (Peer Support Services) in the OTPs (Opioid Treatment Program) to help with engagement; office-based opioid treatment service;
Initiation & Engagement of Substance Use Members	Incentives for members that remain in treatment for 180 days training and technical assistance to providers on an ongoing basis; Educate the provider community about MAT; Ongoing local housing initiatives and recovery support services; report that includes providers' specific data regarding the engagement of services; communication with providers about flexibility codes

Performance Measure Validation

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

Table 9: (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 10: (c) Waiver Measures

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

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

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

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

(b) Waiver Measures Reported Results

These measures' rates as reported by Partners for FY 2021 and FY 2022 are included in the table that follows. In comparing the rates, Follow-Up after Hospitalization for Mental Illness showed a substantial decline of greater than 10% for the FBC population for seven-day follow-up (declined 26.8%) and 30-day follow-up (25.2%). For the PRTF population, the 30-day follow up rate declined 10.7%. For the Follow-Up After Hospitalization for Substance Abuse, the Detox and FBC population three-day follow up declined 10.8%, whereas the combined population showed a substantial improvement of 11.3% in the seven-day follow-up. Another measure with substantial improvement was Initiation and Engagement of Alcohol & Other Drug Dependence Treatment for 65+ year old with initiation improving 15.9% and engagement improving 23.1%. Additionally, Mental health penetration rates increased substantially (>10%) for several counties across several age groups.

The current rate in comparison to last year's rate is presented in Tables 11 through 20.

Table 11: A.1. Readmission Rates for Mental Health

30-day Readmission Rates for Mental Health	FY 2021	FY 2022	Change
Inpatient (Community Hospital Only)	10.9%	13.4%	2.50%
Inpatient (State Hospital Only)	0.0%	0.0%	0.00%
Inpatient (Community and State Hospital Combined)	11.2%	13.6%	2.40%
Facility Based Crisis	6.1%	11.5%	5.40%
Psychiatric Residential Treatment Facility (PRTF)	9.5%	16.9%	7.40%
Combined (includes cross-overs between services)	12.0%	15.0%	3.00%

Table 12: A.2. Readmission Rate for Substance Abuse

30-day Readmission Rates for Substance Abuse	FY 2021	FY 2022	Change
Inpatient (Community Hospital Only)	13.5%	12.2%	-1.30%
Inpatient (State Hospital Only)	4.3%	2.6%	-1.70%
Inpatient (Community and State Hospital Combined)	14.1%	12.7%	-1.40%
Detox/Facility Based Crisis	6.8%	12.3%	5.50%
Combined (includes cross-overs between services)	14.0%	16.3%	2.30%

Table 13: A.3. Follow-Up after Hospitalization for Mental Illness

Follow-up after Hospitalization for Mental Illness	FY 2021	FY 2022	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	42.2%	36.5%	-5.70%
Percent Received Outpatient Visit Within 30 Days	57.8%	52.8%	-5.00%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	92.6%	65.8%	**-26.80%**
Percent Received Outpatient Visit Within 30 Days	96.3%	71.1%	**-25.20%**
PRTF			
Percent Received Outpatient Visit Within 7 Days	38.3%	30.3%	-8.00%
Percent Received Outpatient Visit Within 30 Days	66.0%	55.3%	-10.70%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	42.8%	36.8%	-6.00%
Percent Received Outpatient Visit Within 30 Days	58.6%	53.3%	-5.30%

Table 14: A.4. Follow-Up After Hospitalization for Substance Abuse

Follow-up after Hospitalization for Substance Abuse	FY 2021	FY 2022	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	19.8%	24.8%	5.0%
Percent Received Outpatient Visit Within 30 Days	32.3%	34.3%	2.0%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	66.7%	55.9%	**-10.8%**
Percent Received Outpatient Visit Within 7 Days	66.7%	58.6%	-8.1%
Percent Received Outpatient Visit Within 30 Days	68.8%	62.9%	-5.9%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	28.6%	39.9%	**11.3%**
Percent Received Outpatient Visit Within 30 Days	39.1%	47.1%	8.0%

NR = Not reported

NA = not computed due to small denominator or missing data

Table 15: B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2021	FY 2022	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	41.4%	43.0%	1.60%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	26.5%	23.7%	-2.80%
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	38.7%	43.9%	5.20%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	20.4%	22.8%	2.40%
Ages 21–34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	53.2%	46.0%	-7.20%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	39.0%	34.2%	-4.80%
Ages 35–64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	45.9%	44.5%	-1.40%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	31.6%	30.1%	-1.50%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	30.9%	46.8%	**15.90%**
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	13.6%	36.7%	**23.10%**
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	47.3%	44.9%	-2.40%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	32.7%	31.0%	-1.70%

Table 16: D.1. Mental Health Utilization-Inpatient Discharges and Average Length of Stay

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY 2021	FY 2022	Change	FY 2021	FY 2022	Change
3–12	Male	0.2	1.1	0.9	28.8	38.9	10.1
	Female	0.3	2.8	2.5	15.8	23.9	8.1
	Total	0.2	1.8	1.6	21.2	30	8.8
13–17	Male	1.0	4.0	3.0	47.5	44.3	-3.2
	Female	2.5	7.9	5.4	19.9	31.8	11.9
	Total	1.8	5.7	3.9	28.1	36.7	8.6
18–20	Male	1.2	4.6	3.4	7.5	9.7	2.2
	Female	1.6	6.0	4.4	5.9	11.2	5.3
	Total	1.4	5.3	3.9	6.6	10.5	3.9
21–34	Male	3.0	5.4	2.4	8.1	9.5	1.4
	Female	1.5	3.9	2.4	8.3	8.7	0.4
	Total	1.9	4.5	2.6	8.3	9.1	0.8
35–64	Male	2.9	3.4	0.5	8.5	9.2	0.7
	Female	2.1	2.7	0.6	8.2	9.2	1.0
	Total	2.4	3.0	0.6	8.3	9.2	0.9
65+	Male	0.4	0.3	-0.1	22.5	17.5	-5.0
	Female	0.3	0.3	0.0	14.2	22.7	8.5
	Total	0.3	0.3	0.0	17.2	21.1	3.9
Unknown	Male	0.0	0.0	0.0	0.0	0.0	0.0
	Female	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0
Total	**Male**	**1.1**	**2.8**	**1.7**	**16.6**	**16.8**	**0.2**
	Female	**1.3**	**2.6**	**1.3**	**11.7**	**15.2**	**3.5**
	Total	**1.2**	**2.7**	**1.5**	**13.6**	**15.9**	**2.3**

Table 17: D.2. Mental Health Utilization -% of Members that Received at Least 1 Mental Health Service in the Category Indicated during the Measurement Period

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change
3-12	Male	11.90%	35.41%	23.51%	0.06%	0.33%	0.27%	0.37%	3.15%	2.78%	11.79%	34.43%	22.64%
	Female	10.32%	39.54%	29.22%	0.03%	0.61%	0.58%	0.10%	1.38%	1.28%	10.29%	39.26%	28.97%
	Total	11.13%	36.94%	25.81%	0.05%	0.43%	0.38%	0.24%	2.49%	2.25%	11.06%	36.22%	25.16%
13-17	Male	15.08%	41.45%	26.37%	0.26%	1.74%	1.48%	0.57%	2.81%	2.24%	14.96%	40.71%	25.75%
	Female	21.12%	55.71%	34.59%	0.37%	1.92%	1.55%	0.33%	1.95%	1.62%	21.06%	55.36%	34.30%
	Total	18.05%	47.73%	29.68%	0.32%	1.81%	1.49%	0.45%	2.43%	1.98%	17.96%	47.15%	29.19%
18-20	Male	9.06%	25.22%	16.16%	0.05%	0.24%	0.19%	0.05%	0.34%	0.29%	9.06%	25.13%	16.07%
	Female	12.91%	30.13%	17.22%	0.10%	0.32%	0.22%	0.03%	0.32%	0.29%	12.91%	29.97%	17.06%
	Total	11.06%	27.57%	16.51%	0.07%	0.28%	0.21%	0.04%	0.33%	0.29%	11.06%	27.44%	16.38%
21-34	Male	20.41%	31.85%	11.44%	0.22%	0.25%	0.03%	0.12%	0.37%	0.25%	20.39%	31.80%	11.41%
	Female	16.94%	36.31%	19.37%	0.14%	0.24%	0.10%	0.10%	0.24%	0.14%	16.94%	36.27%	19.33%
	Total	17.74%	34.54%	16.80%	0.16%	0.25%	0.09%	0.11%	0.29%	0.18%	17.73%	34.50%	16.77%

2022 External Quality Review

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change
35-64	Male	19.94%	27.87%	7.93%	0.20%	0.15%	-0.05%	0.11%	0.68%	0.57%	19.94%	27.75%	7.81%
	Female	23.69%	31.67%	7.98%	0.17%	0.15%	-0.02%	0.13%	0.40%	0.27%	23.68%	31.62%	7.94%
	Total	22.29%	30.09%	7.80%	0.18%	0.15%	-0.03%	0.12%	0.52%	0.40%	22.29%	30.02%	7.73%
65+	Male	7.70%	7.80%	0.10%	0.00%	0.01%	0.01%	0.02%	0.09%	0.07%	7.70%	7.73%	0.03%
	Female	8.25%	9.01%	0.76%	0.00%	0.01%	0.01%	0.01%	0.05%	0.04%	8.25%	8.99%	0.74%
	Total	8.07%	8.61%	0.54%	0.00%	0.01%	0.01%	0.01%	0.06%	0.05%	8.07%	8.57%	0.50%
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**	**14.06%**	**26.68%**	**12.62%**	**0.13%**	**0.34%**	**0.21%**	**0.29%**	**1.10%**	**0.81%**	**13.99%**	**26.39%**	**12.40%**
	Female	**15.94%**	**27.22%**	**11.28%**	**0.13%**	**0.27%**	**0.14%**	**0.12%**	**0.43%**	**0.31%**	**15.92%**	**27.14%**	**11.22%**
	Total	**15.14%**	**26.99%**	**11.85%**	**0.13%**	**0.30%**	**0.17%**	**0.20%**	**0.72%**	**0.52%**	**15.10%**	**26.82%**	**11.72%**

Table 18: D.3. Identification of Alcohol and Other Drug Services

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change
3–12	Male	0.02%	0.05%	0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.05%	0.03%
	Female	0.04%	0.12%	0.08%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.04%	0.12%	0.08%
	Total	0.03%	0.08%	0.05%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%	0.08%	0.05%
13–17	Male	0.89%	3.16%	2.27%	0.00%	0.05%	0.05%	0.12%	0.59%	0.47%	0.82%	2.71%	1.89%
	Female	0.71%	2.66%	1.95%	0.01%	0.06%	0.05%	0.02%	0.19%	0.17%	0.70%	2.50%	1.80%
	Total	0.80%	2.94%	2.14%	0.01%	0.06%	0.05%	0.07%	0.41%	0.34%	0.76%	2.61%	1.85%
18–20	Male	1.85%	5.18%	3.33%	0.11%	0.34%	0.23%	0.09%	0.34%	0.25%	1.83%	5.04%	3.21%
	Female	1.71%	4.01%	2.30%	0.14%	0.32%	0.18%	0.14%	0.32%	0.18%	1.70%	3.85%	2.15%
	Total	1.78%	4.62%	2.84%	0.12%	0.33%	0.21%	0.12%	0.33%	0.21%	1.76%	4.47%	2.71%
21–34	Male	7.11%	10.24%	3.13%	0.58%	0.85%	0.27%	0.63%	0.91%	0.28%	6.96%	9.91%	2.95%
	Female	6.42%	17.74%	11.32%	0.44%	1.45%	1.01%	0.79%	2.13%	1.34%	6.33%	17.22%	10.89%
	Total	6.58%	14.76%	8.18%	0.48%	1.21%	0.73%	0.76%	1.64%	0.88%	6.47%	14.32%	7.85%

2022 External Quality Review

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change
35–64	Male	7.20%	9.55%	2.35%	0.56%	0.88%	0.32%	0.41%	0.95%	0.54%	7.18%	9.31%	2.13%
	Female	6.02%	8.99%	2.97%	0.39%	0.41%	0.02%	0.52%	0.88%	0.36%	5.90%	8.77%	2.87%
	Total	6.46%	9.22%	2.76%	0.46%	0.61%	0.15%	0.48%	0.91%	0.43%	6.38%	8.99%	2.61%
65+	Male	0.97%	1.06%	0.09%	0.06%	0.08%	0.02%	0.06%	0.20%	0.14%	0.93%	0.92%	-0.01%
	Female	0.25%	0.36%	0.11%	0.01%	0.01%	0.00%	0.02%	0.03%	0.01%	0.23%	0.33%	0.10%
	Total	0.48%	0.59%	0.11%	0.03%	0.03%	0.00%	0.03%	0.09%	0.06%	0.45%	0.52%	0.07%
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**	**2.21%**	**5.47%**	**3.26%**	**0.16%**	**0.45%**	**0.29%**	**0.16%**	**0.57%**	**0.41%**	**2.18%**	**5.26%**	**3.08%**
	Female	**2.79%**	**6.40%**	**3.61%**	**0.18%**	**0.39%**	**0.21%**	**0.28%**	**0.68%**	**0.40%**	**2.74%**	**6.21%**	**3.47%**
	Total	**2.54%**	**6.00%**	**3.46%**	**0.17%**	**0.42%**	**0.25%**	**0.23%**	**0.63%**	**0.40%**	**2.50%**	**5.80%**	**3.30%**

Table 19: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change
	3-12			13-17			18-20			21-34		
Burke	0.02%	0.00%	-0.02%	1.05%	2.93%	1.88%	2.00%	2.55%	0.55%	7.48%	14.79%	7.31%
Cabarrus	*	0.07%	NA	*	2.00%	NA	*	3.09%	NA	*	9.09%	NA
Catawba	0.01%	0.00%	-0.01%	1.10%	2.71%	1.61%	2.12%	5.69%	3.57%	5.93%	12.29%	6.36%
Cleveland	0.05%	0.22%	0.17%	0.68%	3.28%	2.60%	1.96%	5.22%	3.26%	6.39%	12.74%	6.35%
Davie	*	0.00%	NA	*	5.24%	NA	*	3.30%	NA	*	10.53%	NA
Forsyth	*	0.05%	NA	*	2.69%	NA	*	3.95%	NA	*	7.64%	NA
Gaston	0.04%	0.05%	0.01%	1.21%	3.93%	2.72%	1.90%	4.68%	2.78%	6.02%	11.08%	5.06%
Iredell	0.00%	0.00%	0.00%	0.46%	2.44%	1.98%	1.86%	3.93%	2.07%	5.38%	10.49%	5.11%
Lincoln	0.04%	0.00%	-0.04%	0.84%	3.58%	2.74%	2.72%	7.17%	4.45%	8.80%	16.51%	7.71%
Rutherford	0.04%	0.00%	-0.04%	0.89%	1.88%	0.99%	2.97%	5.51%	2.54%	6.92%	15.20%	8.28%
Stanley	*	0.00%	NA	*	1.68%	NA	*	3.41%	NA	*	9.00%	NA
Surry	0.00%	0.00%	0.00%	0.38%	2.17%	1.79%	1.45%	1.35%	-0.10%	6.61%	11.85%	5.24%
Union	*	0.09%	NA	*	2.53%	NA	*	4.64%	NA	*	7.46%	NA
Yadkin	0.00%	0.33%	0.33%	0.56%	1.90%	1.34%	2.17%	2.78%	0.61%	7.47%	11.89%	4.42%

2022 External Quality Review

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change
	35-64			65+			Unknown			Total		
Burke	7.63%	10.41%	2.78%	0.81%	0.74%	-0.07%	0.00%	0.00%	0.00%	3.04%	6.62%	3.58%
Cabarrus	*	9.44%	NA	*	1.50%	NA	*	0.00%	NA	*	5.03%	NA
Catawba	7.42%	11.06%	3.64%	0.88%	0.66%	-0.22%	0.00%	0.00%	0.00%	2.64%	6.36%	3.72%
Cleveland	7.40%	10.09%	2.69%	0.98%	0.71%	-0.27%	0.00%	0.00%	0.00%	2.92%	6.35%	3.43%
Davie	*	8.28%	NA	*	0.94%	NA	*	0.00%	NA	*	5.28%	NA
Forsyth	*	7.51%	NA	*	0.98%	NA	*	0.00%	NA	*	4.58%	NA
Gaston	8.08%	10.57%	2.49%	0.80%	0.92%	0.12%	0.00%	0.00%	0.00%	2.91%	6.34%	3.43%
Iredell	6.07%	9.05%	2.98%	0.48%	0.81%	0.33%	0.00%	0.00%	0.00%	2.19%	5.41%	3.22%
Lincoln	8.77%	10.36%	1.59%	0.61%	0.42%	-0.19%	0.00%	0.00%	0.00%	3.47%	6.93%	3.46%
Rutherford	6.10%	8.20%	2.10%	0.75%	0.73%	-0.02%	0.00%	0.00%	0.00%	2.82%	5.84%	3.02%
Stanley	*	7.07%	NA	*	0.80%	NA	*	0.00%	NA	*	4.35%	NA
Surry	5.51%	6.14%	0.63%	0.47%	0.30%	-0.17%	0.00%	0.00%	0.00%	2.25%	4.22%	1.97%
Union	*	6.99%	NA	*	0.40%	NA	*	0.00%	NA	*	3.81%	NA
Yadkin	6.97%	7.78%	0.81%	0.60%	0.14%	-0.46%	0.00%	0.00%	0.00%	2.55%	4.70%	2.15%

** = Cabarrus, Davie, Forsyth, Stanly, and Union counties were part of Cardinal Innovations Healthcare's catchment area in 2021, so data for 2021 was not reported by Partners.*

Table 20: 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		
	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change
	3-12			13-17			18-20			21-34		
Burke	8.84%	29.09%	20.25%	15.99%	43.59%	27.60%	9.99%	19.75%	9.76%	12.56%	21.30%	8.74%
Cabarrus	*	19.00%	NA	*	35.65%	NA	*	25.05%	NA	*	20.50%	NA
Catawba	8.74%	26.45%	17.71%	17.47%	41.81%	24.34%	11.80%	29.03%	17.23%	13.04%	23.17%	10.13%
Cleveland	9.83%	29.01%	19.18%	17.66%	45.52%	27.86%	13.26%	29.86%	16.60%	16.27%	28.73%	12.46%
Davie	*	19.83%	NA	*	40.84%	NA	*	16.48%	NA	*	17.34%	NA
Forsyth	*	20.58%	NA	*	34.48%	NA	*	20.41%	NA	*	22.86%	NA
Gaston	9.46%	27.20%	17.74%	19.06%	45.47%	26.41%	13.39%	28.45%	15.06%	15.25%	24.68%	9.43%
Iredell	9.33%	23.70%	14.37%	18.41%	41.68%	23.27%	13.43%	25.41%	11.98%	13.58%	19.97%	6.39%
Lincoln	11.70%	27.25%	15.55%	22.14%	48.45%	26.31%	15.07%	28.29%	13.22%	15.82%	27.56%	11.74%
Rutherford	9.38%	25.44%	16.06%	17.43%	36.71%	19.28%	11.31%	23.62%	12.31%	16.91%	24.77%	7.86%
Stanly	*	26.14%	NA	*	40.60%	NA	*	25.00%	NA	*	21.70%	NA
Surry	9.92%	26.64%	16.72%	16.72%	42.75%	26.03%	9.27%	19.82%	10.55%	13.59%	20.02%	6.43%
Union	*	18.43%	NA	*	32.66%	NA	*	25.83%	NA	*	18.54%	NA
Yadkin	10.11%	32.33%	22.22%	16.28%	41.71%	25.43%	14.31%	27.78%	13.47%	12.30%	21.12%	8.82%

2022 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		
	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change
	35-64			65+			Unknown			Total		
Burke	19.85%	25.71%	5.86%	11.08%	10.97%	-0.11%	0.00%	0.00%	0.00%	12.97%	22.98%	10.01%
Cabarrus	*	22.78%	NA	*	8.65%	NA	*	0.00%	NA	*	20.10%	NA
Catawba	19.68%	26.57%	6.89%	10.57%	11.01%	0.44%	0.00%	0.00%	0.00%	13.10%	23.70%	10.60%
Cleveland	22.07%	27.91%	5.84%	11.07%	10.47%	-0.60%	0.00%	0.00%	0.00%	14.93%	25.07%	10.14%
Davie	*	17.46%	NA	*	6.75%	NA	*	0.00%	NA	*	17.06%	NA
Forsyth	*	23.80%	NA	*	8.78%	NA	*	0.00%	NA	*	20.13%	NA
Gaston	23.80%	29.39%	5.59%	11.57%	11.02%	-0.55%	0.00%	0.00%	0.00%	15.07%	25.58%	10.51%
Iredell	16.37%	20.34%	3.97%	8.37%	8.85%	0.48%	0.00%	0.00%	0.00%	12.98%	20.52%	7.54%
Lincoln	22.15%	25.95%	3.80%	12.74%	8.93%	-3.81%	0.00%	0.00%	0.00%	16.36%	24.17%	7.81%
Rutherford	19.77%	23.28%	3.51%	13.78%	12.57%	-1.21%	0.00%	0.00%	0.00%	14.53%	21.94%	7.41%
Stanly	*	24.83%	NA	*	12.95%	NA	*	0.00%	NA	*	22.63%	NA
Surry	16.12%	18.03%	1.91%	9.81%	8.99%	-0.82%	0.00%	0.00%	0.00%	12.67%	18.33%	5.66%
Union	*	20.55%	NA	*	6.37%	NA	*	0.00%	NA	*	17.81%	NA
Yadkin	16.33%	17.41%	1.08%	5.69%	7.44%	1.75%	0.00%	0.00%	0.00%	12.35%	19.53%	7.18%

** = Cabarrus, Davie, Forsyth, Stanly, and Union counties were part of Cardinal Innovations Healthcare's catchment area in 2021, so data for 2021 was not reported by Partners.*

(b) Waiver Validation Results

All measures received a validation score of 100% and were found Fully Compliant. The stored procedures have been updated to address NC Medicaid's most recent changes to the measures. Table 21 contains validation scores for each of the 10 (b) Waiver Performance Measures.

Table 21: (b) Waiver Performance Measure Validation Scores

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

(c) Waiver Measures Reported Results

Five (c) Waiver Measures were chosen for validation. The rates reported by Partners and the State benchmarks are displayed in *Table 22: (c) Waiver Measures Reported Results 2021 - 2022*. Documentation on data sources, data validation, source code, and calculated rate for the five measures was provided. Additionally, all rates exceeded the State Performance Benchmarks.

Table 22: (c) Waiver Measures Reported Results 2021-2022

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	636/636 = 100%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	1762/1762 = 100%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	121/130 = 93.08%	85%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	126/130 = 96.92%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	106/106 =100%	85%

* Latest reported rates are shown in Excel file submitted by Partners labeled “Innovation FY2022 Q4 Apr-Jun AnnualSemiAnnualQuarterly”

(c) Waiver Validation

All (c) Waiver Measures met the validation requirements and were Fully Compliant as shown in *Table 23, (c) Waiver Performance Measure Validation Scores*. The validation worksheets offer detailed information on validation and calculation steps for (c) Waiver Measures.

Table 23: (c) Waiver Performance Measures Validation Scores

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

Performance Improvement Project (PIP) Validation

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

- 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

PIP Validation Results

For this year's 2022 EQR, there were five PIPs submitted and all were validated. For the Initial NC TOPPS Interview, there was a decrease from August 2022 (38.4%) to September 2022 (37.2%). The goal is 80%. The TCL Housing Loss Reduction PIP report showed that the total who lost housing was 71 as of June 2022, and the percentage re-housed was 44%, which exceeds the comparison goal rate of 13%. The Registry of Unmet Needs PIP results indicated that the most recent quarterly rates showed a decline from July to September 2022 at 41% to 39% from October through December 2022. The goal rate is 48% for the percentage of IDD members on the registry of unmet needs engaged in services. The Increase Opioid-Initiated Engagement PIP had the indicator divided according to non-Medicaid and Medicaid individuals with opioid/abuse dependence diagnosis who initiated treatment who had two or more additional services within one to 34 days after the initial assessment. The goal is 79.21% for non-Medicaid. The results showed a decline from July through September 2022 at 64.8% to October through December 2022 at 62.69%. The goal is 87.58% for Medicaid, and the results showed improvement from 64.8% in July through September 2022 to 65.92% from October through December 2022. The Initiation & Engagement of Substance Use Members PIP examines the percentage of members who initiated treatment and had two or more additional substance use disorder services or MAT within one to 34 days of initiation of treatment. The results showed a slight decline from July through September 2022 at 33.98% to 33.19% from October through December 2022. The goal is 37.96%.

Table 24: PIP Summary of Validation Scores

Project Type	Project	2021 Validation Score	2022 Validation Score
Non Clinical	Initial NC TOPPS Interviews	73/74 = 99% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results
	TCL Housing Loss Reduction	73/74 = 99% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
Clinical	Registry of Unmet Needs Services	73/74 = 99% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results
	Opioid Engagement	79/79 =1 00% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results
	SUD Initiation and Engagement	79/79 = 100% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results

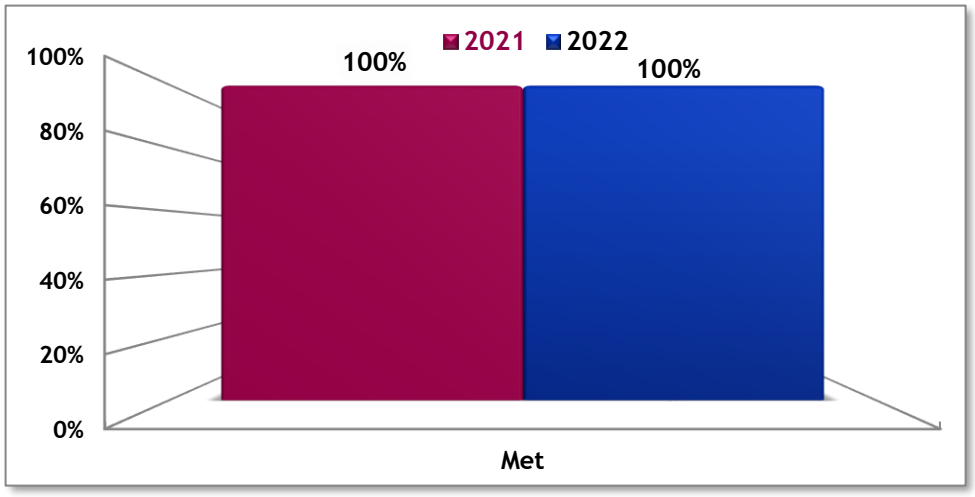
There are no Corrective Actions for the validated PIPS. For four of the five PIPs, there are Recommendations regarding the monitoring of interventions to identify wherein the most effective actions can be taken and initiation of new interventions to improve rates that showed a decline in the most recent remeasurement period. The project, section, reason, and Recommendations are displayed in Table 25 below.

Table 25: Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Initial NC TOPPS Interview	Was there any documented, quantitative improvement in processes or outcomes of care?	There was a decrease from August 2022 (38.4%) to September 2022 (37.2%). The goal is 80%.	Monitor interventions and consider focusing efforts on two or three primary interventions that are likely to have a high impact on improving the rate for initial NC-TOPPS interviews completed.
Registry of Unmet Needs	Was there any documented, quantitative improvement in processes or outcomes of care?	The most recent quarterly rates showed a decline from July-Sep 2022 at 41% to 39% during Oct-Dec 2022. The goal rate is 48% for the percentage of IDD members on the registry of unmet needs engaged in services.	Determine if additional services need to be established and offered to increase engagements based on member needs.
Increase Opioid-Initiated Engagement	Was there any documented, quantitative improvement in processes or outcomes of care?	The goal is 79.21% for non-Medicaid and the results showed a decline from Jul-Sep 2022 at 64.8% to Oct-Dec 2022 at 62.69%. The goal is 87.58% for Medicaid, and the results showed improvement from 64.8% in Jul-Sept 2022 to 65.92% in Oct-Dec 2022.	Consider focusing efforts on two or three primary interventions that are likely to have a high impact on improving the rate for Opioid-dependent members receiving services.
Initiation & Engagement of Substance Use Members	Was there any documented, quantitative improvement in processes or outcomes of care?	The results showed a slight decline from Jul-Sept 2022 at 33.98% to 33.19% in Oct-Dec 2022. The goal is 37.96%.	Consider focusing efforts on two or three primary interventions that are likely to have a high impact on improving the rate for SUD members receiving services.

Details of the validation activities for the PMs and PIPs and specific outcomes related to each activity may be found in *Attachment 3, CCME EQR Validation Worksheets*. As demonstrated in Figure 4, Partners met all the Quality Improvement standards in the 2022 EQR.

Figure 4: Quality Improvement Comparative Findings



Strengths

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

Weaknesses

- Four out of five PIPs showed a decline in indicator rates.
- Follow-Up after Hospitalization for Mental Illness and Follow-Up after Hospitalization for Substance Abuse showed a substantial decline from the previous year's rate.

Recommendations

- Initial NC TOPPS Interview PIP - Monitor interventions and consider focusing efforts on two or three primary interventions that are likely to have high impact on improving the rate for initial NC-TOPPS interviews completed.
- Registry of Unmet Needs PIP - Determine if additional services need to be established and offered to increase engagements based on member needs.

- Increase Opioid-Initiated Engagement PIP- Consider focusing efforts on two or three primary interventions that are likely to have high impact on improving the rate for Opioid-dependent members receiving services.

- Initiation & Engagement of Substance Use Members PIP - Consider focusing efforts on two or three primary interventions that are likely to have high impact on improving the rate for Substance Use Disorder (SUD) members receiving services.

- Continue to monitor (b) Waiver performance measure rates to determine if rates with substantial improvement or decline represent a continued trend or an irregularity in the performance measures.

D. Utilization Management

42 CFR § 438.208

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

In the 2021 EQR, Partners met 100% of the UM standards and received one Recommendation related to incorrect information in the *Innovations Member and Family Handbook*. Table 26 outlines the 2021 findings and CCME's follow-up in the 2022 EQR regarding Partners' implementation of that Recommendation.

Table 26: 2021 EQR Utilization Management Findings

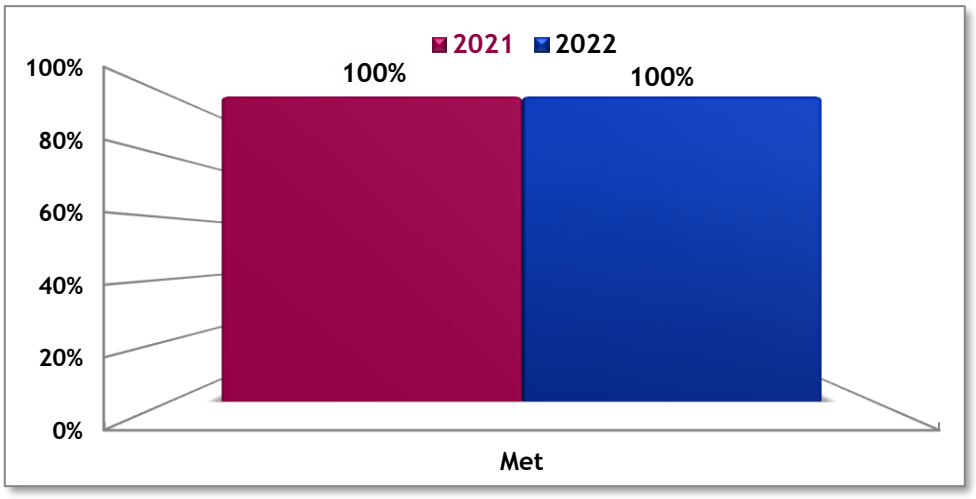
2021 EQR Utilization Management Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Quality monitoring and continuous quality improvement;	***Recommendations: Revise the Innovations Member and Family Handbook to provide consistent information regarding NC Innovations Waiver Cost Limits and exceptions. Include in the manual all of the counties within Partners' current catchment area.***	**Y**
2022 EQR Follow up: In the 2022 EQR, the review of the *Innovations Member and Family Handbook* applicable to PIHP enrollees showed the handbook was revised. All of the counties in Partners' catchment area are now identified in the handbook and the handbook contains a list of the exceptions to the Innovations Waiver cost limit.		

In the 2022 EQR, a thorough review of Partners' documentation was conducted and no major issues were identified. However, a few enrollee file anomalies were identified in the file review and discussed during the Onsite. One I/DD file showed a 22-year-old enrollee had an Oppositional Defiant Disorder diagnosis, a childhood disorder, listed in the enrollee's Individual Support Plan and demographic sheet. This same enrollee transferred from Gaston County to Mecklenburg County, and Partners could not provide evidence of the notification to the Department of Social Services. Per Partners' *NC Medicaid Contract, Section 4.6*, "PIHP shall notify the applicable county Department of Social Services within five (5) business days after PIHP becomes aware of changes to an Enrollee's circumstances that may affect eligibility, including but not limited to changes in address of Enrollee and death of Enrollee."

In two TCL files, no Quality of Life surveys could initially be located by Partners. One TCL file was an enrollee transferred from another PIHP and staff reported those surveys were not provided in the transfer. In the second file, staff were able to locate the 11-month Quality of Life survey during the Onsite but not the 24-month survey. Staff reported during the Onsite the 24-month survey was overlooked during a transition between Care Coordinators. Overall, the file review showed a pattern of good engagement by Care Coordination with enrollees and their legal guardians, face-to-face monitoring using telehealth platforms and contact notes were compliant with the timeframe for submission of notes as required by Partners' policies and procedures. Partners also reported they exceeded their departmental benchmarks in the past quarter regarding timeliness of progress notes and engagement with enrollees. This was evident in the review of enrollee files.

Figure 5 shows 100% of the UM standards were scored as "Met" in the 2022 EQR and compares those to the 2021 EQR UM score.

Figure 5: Utilization Management Comparative Findings



Strengths

- Partners has developed specialized teams in Care Coordination to help better serve enrollees with complex care needs.
- Partners reported they exceeded their departmental benchmarks in the past quarter regarding timeliness of progress notes and engagement with enrollees.

Weaknesses

- Review of one I/DD file showed a 22-year-old enrollee had an Oppositional Defiant Disorder diagnosis, a childhood disorder, listed in the enrollee's Individual Support Plan and demographic sheet. This same I/DD file showed the enrollee transferred from Gaston County to Mecklenburg County, and Partners could not provide evidence of the notification to the Department of Social Services, as required by *NC Medicaid Contract, Section 4.6*.
- In one TCL file, the 24-month Quality of Life survey could not be located by staff. It was reported during the Onsite, the 24-month survey was overlooked during a transition of the enrollee between Partners' Care Coordinators.

Recommendations

- Ensure diagnoses within enrollee's treatment plans are routinely reviewed and updated as a part of any treatment plan revision.
- Develop and document a process by which notifications to the Department of Social Services are issued when changes occur that impact enrollee's Medicaid eligibility. Ensure the language and process are compliant with *NC Medicaid Contract, Section 4.6*.
- Enhance the current enrollee file review process to include review of the timely completion and filing of all Quality of Life surveys.

E. Grievances and Appeals

42 CFR § 438, Subpart F

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

In the 2021 EQR, Partners met 100% of the Grievance and Appeal standards. CCME issued no Corrective Actions. One Recommendation was issued to address a documentation

concern noted primarily in the *Member Handbook*. In the 2022 EQR, Partners again met 100% of the Grievance and Appeal standards, resulting in no Corrective Actions or Recommendations.

Grievances

In the 2021 EQR, Partners received no Corrective Actions and one Recommendation. Table 27 outlines the Recommendation and whether it was addressed by Partners.

Table 27: 2021 EQR Grievances Findings

2021 EQR Grievance Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
1.1 Definition of a Grievance and who may file a Grievance;	***Recommendations: Revise the Member Handbook to reflect one consistent term for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination".***	**Y**
2022 EQR Follow up: The *Member Handbook* uploaded to the Desk Materials and available to members on the Partners' website is updated throughout with the term "grievance/complaint" as the term for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination."		

The 2022 EQR included a review of 10 Grievance files. All files were compliant with Partners' Policy and Procedure 6.00, Grievance/Complaint Coordination and Resolution Policy, the *NC Medicaid Contract*, and the federal regulations.

There were two files that had a similar Grievance at the same Psychiatric Residential Treatment Facility (PRTF), reported less than two weeks apart. The Onsite discussion included a follow-up from Partners after the resolutions. Partners involved many different departments for a cross-functional approach for investigating both Grievances, including follow-up after the written Notice of Resolution letters were mailed.

Another two similar files involved the same Alternative Family Living (AFL) facility that was in the process of changing ownership. Both Grievances were received the same day and resolved in a similar way. The Onsite discussion focused on the outcome of the ownership change and the fact that the new owner was licensed as an AFL facility and services continued under the new ownership name.

Appeals

In the 2021 EQR of Appeals, CCME issued no Recommendations and no Corrective Actions. Table 28 outlines there were no Recommendations or Corrective Actions issued.

Table 28: 2021 EQR Appeal Findings

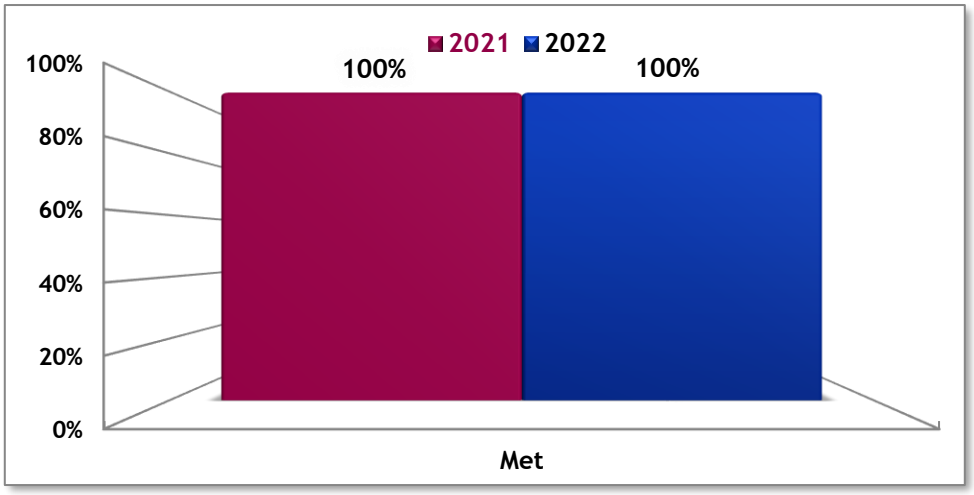
2021 EQR Appeals Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
2022 EQR Follow up: There were no Corrective Actions or Recommendations issued in the 2021 EQR of Appeals.		

The 2022 EQR review of 10 Appeal files was similar to the 2021 file review in terms of compliance, completeness, and detail of staff documentation. No compliance issues were noted in the 2022 EQR Appeal file review. All reviewed Appeal files were compliant with Policy and Procedure 13.04, Clinical Utilization Management Appeals, the *NC Medicaid Contract*, and the federal regulations.

CCME's review found the data in the Appeals Log to be consistent with the data in the Appeal files. All required notifications were issued timely, including written and verbal notifications. The Chief Medical Officer (CMO) was consulted on Appeals involving concerns around enrollee health and safety. The documentation in the Contact Log was formatted in a clear and easy to understand way.

Partners' staff attributed the compliance success to the focused Appeals monitoring process and staff attention to detail in their documentation. Partners reported they "strive to monitor 90% of the special Appeal cases and have monitored nearly 100% of the special cases in the past year."

Figure 6: Grievances and Appeals Comparative Findings



Strengths

- Partners worked to improve the content detail in their Grievance *Notice of Resolution letters*.
- Partners launched a new Utilization Management electronic system that will be able to automate many processes for Appeals.
- Partners has implemented a focused Appeals monitoring process that focuses on routine and complex Appeals including oral, invalid, expedited, and withdrawn Appeals.

F. Program Integrity

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

The 2022 Program Integrity EQR for Partners encompassed a thorough Desk Review of Prepaid Inpatient Health Plan (PIHP) Program Integrity (PI) functions. Partners' policies and procedures related to Special Investigative Unit (SIU) investigations, Provider Overpayments and aspects of compliance were evaluated. The EQR also included a review of PI staffing, workflows, reports, training materials, committee charters, data mining processes, and 10 SIU case files investigated during the period under review. There was an Onsite discussion with Partners' Chief Compliance and Performance Officer, Compliance Director, Legal Officer, Program Integrity, and Information Technology staff to address questions related to Partners' PI functions.

In the 2021 EQR, Partners met 100% of the PI standards. There were no Recommendations or Corrective Actions issued.

Table 29: 2021 EQR Provider Services Findings

2021 EQR Program Integrity Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
2022 EQR Follow up: No Corrective Actions or Recommendations were issued in the 2021 Program Integrity EQR.		

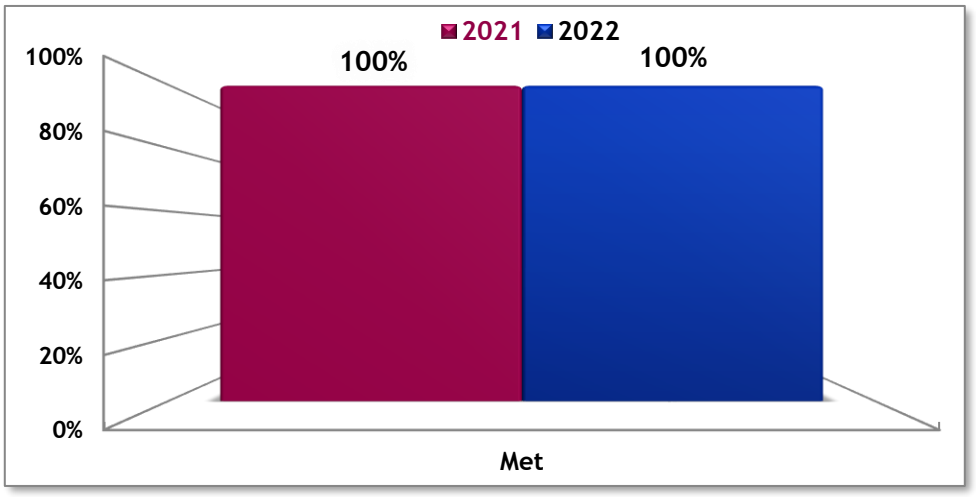
In the 2022 EQR, review of Partners' Organizational Chart showed several changes in the Compliance and Legal Affairs Departments. Partners has created a Compliance Director position that is currently held by its Privacy Officer. Additionally, the Internal Auditor (Controller) role was shifted from Legal Affairs to Business Operations to better align the duties and responsibilities of the position. Currently, Partners is recruiting for two Health Information Management (HIM) positions. Partners has increased routine monitoring and auditing of its Information Technology (IT) systems. This monitoring has reduced the number of phishing emails and has assisted Partners in identifying those staff persons

more prone to opening and responding to high risk emails. During the Onsite, Partners also shared they obtained an auditing protocol that will increase security controls and protect sensitive data.

For this EQR, CCME reviewed 10 SIU case files for compliance, including timeliness of investigations and to ensure all required elements are documented in referrals to NC Medicaid. The review found one SIU case file that was not initiated 32 days after receipt. *NC Medicaid Contract Section 14.2.8* requires PIHPs to initiate preliminary investigations within 10 business days of receipt of a potential allegation. CCME is recommending that Partners develop a process that will ensure allegations received by mail are initiated within 10 business days.

Figure 7, Program Integrity Comparative Findings, shows 100% of the standards in the 2022 PI EQR were scored as "Met" and provides a comparison to 2021 PI EQR scores.

Figure 7: Program Integrity Comparative Findings



Strengths

- In the past year, Partners has added new cybersecurity tools and obtained cybersecurity certifications to improve IT security.
- Partners' SIU has added an exit interview process as part of the overpayment assessment. This allows providers the opportunity to gain a clearer understanding of the findings from the investigation and has also reduced the number of disputes from providers.

Weaknesses

- The review of SIU case files found one file where the investigation was initiated outside of the required timeframe of 10 business days.

Recommendations

- Develop and document a process that will ensure allegations received via mail are triaged and investigations initiated within the required timeframe according to *NC Medicaid Contract, Section 14.2.8,* and Partners' PID Internal and External Reporting Guide.

G. Encounter Data Validation

The scope of the review, guided by the Centers for Medicare and Medicaid Services (CMS) External Quality Review Protocol for Encounter Data Validation focused on measuring the data quality and completeness of claims and submitted to NC Medicaid by Partners for the period of January through December 2021. All claims paid by Partners are expected to be submitted and accepted as a valid encounter to NC Medicaid. The approach to the review included:

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

Results and Recommendations

Issue: Other Diagnosis Codes

The Principal Diagnosis code was populated for 100% of the claims. However, less than 18% of all encounter records show at least one valid Other Diagnosis code. Given that Partners currently reports the maximum number of Diagnosis codes accepted by NCTracks, the low figure suggests that many providers may not be reporting the Other Diagnosis codes. A closer examination reveals that some providers never report the Other Diagnosis code. This issue is particularly acute for Professional encounters where only about 13% of all claims had at least one Other Diagnosis code.

Recommendation:

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

Issue: Procedure Codes

The Procedure code for all claims should be populated 99% of the time. For the current review period, only 54% of Institutional claim line items contained a valid value in the Procedure code field where one is needed to identify the service that was provided.

Recommendation:

Overall, there has been a notable improvement in the quality of data as Partners barely missed meeting the Data Quality Standards threshold target for Procedure codes. Procedure codes were populated 96.76% of the time, and in each instance, a valid value was present. However, for Institutional claims, the figure drops significantly to 54.29%.

Conclusion

Based on the analysis of Partners' encounter data, it has been concluded that the data submitted to NC Medicaid are complete and accurate. Some 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, Aqurate believes that some of the errors are isolated cases that can be mitigated in the future by reviewing and modifying data validation rules, as necessary. Overall, Partners has shown continued improvements in the quality of encounter data and this is consistent with the reductions seen in the rate of denials on first-time encounter submissions. However, some of the errors noted above are critical data elements as identified by CMS and NC Medicaid. Therefore, Partners should review and take steps to resolve the issues identified above.

For the next review period, Aqurate is recommending that the encounter data from NCTracks be reviewed to verify encounters that pass front end edits and are adjudicated to either a paid or denied status. Additionally, Partners should monitor the volume of denied claims pending re-submission to ensure there is no back log. The goal is to ensure that Partners is reporting all paid claims as encounters to NC Medicaid.

ATTACHMENTS

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

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

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

January 13, 2023

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

Dear Mr. Melton,

At the request of the North Carolina Medicaid (NC Medicaid) this letter serves as notification that the 2022 External Quality Review (EQR) of Partners Health Management (Partners) is being initiated. The review will be conducted by us, The Carolinas Center for Medical Excellence (CCME), and is a contractual requirement. The review will include both a Desk Review (at CCME) and a one-day, virtual Onsite that will address contractually required services.

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

The CMS EQR protocols can be found at:

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

Due to COVID-19 and the issuance of the contractual flexibilities issued by the State outlined in Contract Amendment #11, the 2022 EQR will be a focused review. The focus of this review will be on Partner's Corrective Actions from the previous EQR and Partners' functions that impact enrollee health and safety. Similarly, for the 2022 EQR, the two-day Onsite previously performed at Partners' offices will be conducted during a one-day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **March 16, 2023**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

In preparation for the Desk Review, the items on the enclosed **Desk Materials List** are to be submitted electronically. **Please note that, to facilitate a timely review, there are three items on the Desk Materials List (items 9, 10, and 19.a) that should be submitted by no later than January 20, 2023,** and the remaining items are due by no later than **February 21, 2023**. Also, as indicated in item 20 of the Desk Materials List, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted with the other Desk Materials on **February 21, 2023**.

All 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

Also, please note that for this year's upload of Encounter Data (item 21), the data should be uploaded into the folder labelled "EDV" within CCME's secure documentation portal along with all other EQR materials.

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 6

Cc: Emily Bridgers, Partners Health Management Waiver Contract Manager
Monica Hamlin, NC Medicaid Waiver Contract Manager
Deb Goda, NC Medicaid Associate Director, Behavioral Health and IDD
Christean Hunter, NC Medicaid Quality Management Specialist

Partners Health Management

Focused External Quality Review 2022

MATERIALS REQUESTED FOR DESK REVIEW

****Please note that the lists requested in items 9, 10, and 19.a must be uploaded by no later than January 20, 2023. The remainder of items must be uploaded by no later than February 21, 2023.**

1. Copies of all current policies and procedures, as well as a complete index which includes policy and procedure name, number, and department owner. The date of the addition/review/revision should be identifiable on each policy/procedure. *(Please do not embed files within word documents.)*
2. Organizational Chart of all staff members including names of individuals in each position including their degrees, licensure, and any certifications required for their position. Include any current vacancies. In addition, please include any positions currently filled by outside consultants/vendors.
3. Description of major changes in operations such as expansions, new technology systems implemented, etc. Include any major changes to PIHP functions related to COVID-19.
4. A summary of the status of all Corrective Action items from the previous External Quality Review. Please include evidence of Corrective Action implementation.
5. List of providers credentialed/recredentialed in the last 12 months (January 2021 through December 2022). Include the date of approval of initial credentialing and the date of approval of recredentialing.
6. A description of the Quality Improvement, Utilization Management, and Care Coordination Programs. Include a Credentialing Program Description and/or Plan, if applicable.
7. Minutes of committee meetings for the following committees:
   a) Credentialing (for the three most recent committee meetings)
   b) UM (for the three most recent committee meetings)
8. Membership lists and a committee matrix for all committees, including the professional specialty of any non-staff members. Please indicate which members are voting members. Include the required quorum for each committee.
9. **By January 20, 2023, a copy of the complete Appeal log for the months of January 2021 through December 2022. Please indicate on the log: the appeal type (standard, expedited, extended, withdrawn, or invalid), the service appealed, the date the appeal was received, and the date of the appeal resolution notification.

10. **By January 20, 2023, a copy of the complete Grievances log for the months of January 2021 through December 2022. Please indicate on the log: the nature of the grievance, the date received, and the date of the grievance resolution notification.

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

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

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

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

15. For Care Coordination enrollee files, please provide:

    a. three MH/SU Care Coordination enrollee files (two active since 2020 and one recently discharged)
    b. three I/DD Care Coordination enrollee files (two active since 2020 and one recently discharged)
    c. four TCL Care Coordination enrollee files (one active since 2020, one who received In-Reach, one who transitioned to the community and recently discharged).

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

16. Information regarding the following selected Performance Measures:

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

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

Required information includes the following for each measure:

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

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

c. Reporting frequency and format;

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

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

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

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

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

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

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

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

18. Provide copies of the following files:

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

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

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

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

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

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

            i. 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).

            ii. Ownership disclosure information/form.

    c. Recredentialing files for the four most recently credentialed practitioners (as listed below)
        - One licensed practitioner who is joining an already contracted agency
        - One non-MD, Licensed Independent Practitioner (i.e., clinician who will have their own contract)
        - One physician
        - One practitioner with an associate licensure (e.g., LCSW-A, LMFT-A, etc.)

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

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

i. Proof of original credentialing date and all recredentialing dates, including the current recredentialing (this is usually a letter to the provider, indicating the effective date).
ii. Insurance:
   A. Proof of all required insurance, or a signed and dated statement/waiver/attestation from the practitioner/agency indicating why specific insurance coverage is not required.

   B. For practitioners joining already-contracted agencies, include copies of the proof of insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.
      i. 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).
      ii. Site visit/assessment reports if the provider has had a quality issue or a change of address.
      iii. Ownership disclosure information/form.

19. Provide the following for Program Integrity:
   a. ****<u>File Review</u>:** Please produce a listing of all active files during the review period (January 2021 through December 2022) by January 20, 2023. The list should include the following information:
      i. Date case opened
      ii. Source of referral
      iii. Category of case (enrollee, provider, subcontractor)
      iv. Current status of the case (opened, closed)
   b. Program Integrity Plan and/or Compliance Plan.
   c. Workflow of process of taking complaint from inception through closure.
   d. All 'Attachment Y' reports collected during the review period.
   e. All 'Attachment Z' reports collected during the review period.
   f. Provider Manual and Provider Application.
   g. Enrollee Handbook.
   h. 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.
   i. 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.

j. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors, and employees.
k. 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.
l. Code of Ethics and Business Conduct.
m. Internal and/or external monitoring and auditing materials.
n. Materials pertaining to how the PIHP captures and tracks complaints.
o. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
    i. NC Medicaid approved reporting templates.
p. Sample Data Mining Reports.
q. Monthly reports of NCID holders/FAMS-users in PIHP.
r. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
s. Corrective action plans including any relevant follow-up documentation.

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

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

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

21. Provide the following for Encounter Data Validation (EDV):
    a. Include all adjudicated claims (paid and denied) from January 1, 2021 – December 31, 2021. 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 CCME 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 CCME.
    b. Provide a report of all paid claims by service type from January 1, 2021 – December 31, 2021. 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 also be submitted via CCME's SFTP. If you have any questions, please contact Kathy Niblock at kniblock@thecarolinascenter.org.

B. Attachment 2: EQR Validation Worksheets

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

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

- Performance Improvement Project Validation Worksheet
    - Initial NC TOPPS Interview
    - TCL Housing Loss Reduction
    - Registry of Unmet Needs
    - Increase Opioid-Initiated Engagement
    - Initiation & Engagement of Substance Use Members

CCME Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Readmission Rates for Mental Health**
Reporting Year:	**2022**
Review Performed:	**2023**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Readmission Rates for Substance Abuse**
Reporting Year:	**2022**
Review Performed:	**2023**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Follow-Up after Hospitalization for Mental Illness**
Reporting Year:	**2022**
Review Performed:	**2023**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Follow-Up after Hospitalization for Substance Abuse**
Reporting Year:	**2022**
Review Performed:	**2023**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	Data sources and programming logic were documented.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to denominator specifications.
NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**
Reporting Year:	**2022**
Review Performed:	**2023**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Mental Health Utilization- Inpatient Discharged and Average Length of Stay**
Reporting Year:	**2022**
Review Performed:	**2023**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Mental Health Utilization**
Reporting Year:	**2022**
Review Performed:	**2023**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Identification of Alcohol and Other Drug Services**
Reporting Year:	**2022**
Review Performed:	**2023**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Substance Abuse Penetration Rate**
Reporting Year:	**2022**
Review Performed:	**2023**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Mental Health Penetration Rate**
Reporting Year:	**2022**
Review Performed:	**2023**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Innovations Measure Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC**
Reporting Year:	**2022**
Review Performed:	**2023**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Proportion of beneficiaries reporting they have a choice between providers. IW D10**
Reporting Year:	**2022**
Review Performed:	**2023**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Percentage of level 2 and 3 incidents reported within required timeframes. IW G2**
Reporting Year:	**2022**
Review Performed:	**2023**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Percentage of beneficiaries who received appropriate medication. IW G5**
Reporting Year:	**2022**
Review Performed:	**2023**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Partners**
Name of PM:	**Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8**
Reporting Year:	**2022**
Review Performed:	**2023**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Partners**
Name of PIP:	**INITIAL NC TOPPS INTERVIEW**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan?	**MET**	Data analysis plan is included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by month.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	There was a decrease from August 2022 (38.4%) to September 2022 (37.2%). The goal is 80%. ***Recommendations: Monitor interventions and consider focusing efforts on two or three primary interventions that are likely to have high impact on improving the rate for initial NC-TOPPS interviews completed***.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Partners**
Name of PIP:	**TCL HOUSING LOSS REDUCTION**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by month.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The TCL Housing Loss Reduction PIP report showed that the total who lost housing was 71 as of June 2022; the percentage re-housed was 44% which exceeds the comparison goal rate of 13%.
9.2 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to the interventions such as: Visit TCL members monthly; Discuss each member monthly with service providers; Review eviction notices and County data; Increase communication with members and service providers; Address social determinants of health issues.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	79
Project Possible Score	79
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Partners**
Name of PIP:	**REGISTRY OF UNMET NEEDS**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan?	**MET**	Data analysis plan is included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by quarter.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The most recent quarterly rates showed a decline from July-Sep 2022 at 41% to 39% during Oct-Dec 2022. The goal rate is 48% for the percentage of IDD members on the registry of unmet needs engaged in services. ***Recommendation: Determine if additional services need to be established and offered to increase engagements based on member needs.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Partners**
Name of PIP:	**OPIOID ENGAGEMENT**
Reporting Year:	**2022**
Review Performed:	**2023**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by quarter.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The goal is 79.21% for non-Medicaid and the results showed a decline from Jul-Sep 2022 at 64.8% to Oct-Dec 2022 at 62.69%. The goal is 87.58% for Medicaid, and the results showed improvement from 64.8% in Jul-Sept 2022 to 65.92% in Oct-Dec 2022. ***Recommendations: Consider focusing efforts on two or three primary interventions that are likely to have high impact on improving the rate for Opioid-dependent members receiving services.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement in rate
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Partners**
Name of PIP:	**INITIATION AND ENGAGEMENT OF SUBSTANCE USE MEMBERS**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan?	**MET**	Data analysis plan is included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by quarter.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The results showed a slight decline from Jul-Sept 2022 at 33.98% to 33.19% in Oct-Dec 2022. The goal is 37.96%. ***Recommendations: Consider focusing efforts on two or three primary interventions that are likely to have high impact on improving the rate for SUD members receiving services.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling not utilized.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

C. Attachment 3: Tabular Spreadsheet

CCME PIHP Data Collection Tool

Plan Name:	**Partners**
Collection Date:	2022

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A 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. The GEF files are loaded daily into the Alpha+ system. Partners uses the monthly 820 capitation file in combination with the GEF and 834 files to reconcile current and retroactive payments. Member demographics and historical enrollment information are stored in the system.
1.2 The PIHP is able to identify and review any errors found during, or as a result, of the State enrollment file load process.	X					During the Onsite, Partners indicated reports are generated that identify discrepancies between the GEF file and existing information.
1.3 The PIHP's enrollment system member screens store and track enrollment and demographic information.	X					During the Onsite review, Partners demonstrated the Alpha+ enrollment screens and their capability to store demographic information. All historical data for members is stored and merged under one unique member ID.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Claims System						
2.1 The PIHP processes provider claims in an accurate and timely fashion.	X					The greatest portion of claims received are electronic on a HIPAA file or through the provider web portal. Very few claims from new providers who have not gained access to the Alpha+ system are received via paper claims (approximately less than 0.1%). For claims received in 2021, Approximately 95.61% of Institutional claims and 95.42% of professional claims are auto adjudicated on a nightly basis.
2.2 The PIHP has processes and procedures in place to monitor, review and audit claims staff.	X					Partners stated staff conduct daily random audits of 3% of Professional claims and approximately 10% of Institutional claims. Partners also conducts focused audits on Coordination of Benefits (COB) and claim overrides. Paper claims are included in the daily random audit. Partners explained they conduct manual review of Emergency Department (ED) claims and claims over $5,000. A pended claims report is generated daily for a claims processor to review and manually approve or deny claims. Partners also audits new hire claims examiners, and the tasks performed by them are monitored and audited by a claims supervisor.
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					During the Onsite, Partners demonstrated the Alpha+ claims system and capabilities to receive and store all ICD-10 Diagnosis codes. Partners indicated ICD-10 Procedure codes, Revenue codes and DRG codes are captured in the Alpha+ system electronically and via the provider web portal. Up to 25 ICD-10 Diagnosis codes are captured via the web portal and up to 29 ICD-10 Diagnosis codes are captured via HIPAA files for Institutional claims. For Professional encounters, up to 12 ICD-10 Diagnosis codes are captured via the web portal and HIPAA files.

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					During the Onsite review, Partners demonstrated their provider web portal, claim system screens, and claim adjudication/payment information. Partners demonstrated their claim systems ability to capture all the ICD-10 Diagnosis codes, Diagnosis Related Groups (DRGs), Revenue codes, CPT/HCPCS, ICD-10 Procedure codes and adjudication information.
3. Reporting						
3.1 The PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Partners captures all required ICD-10 Diagnosis codes and is capable of capturing additional procedures, DRGs, and Revenue codes are submitted on the claims. Partners stores the DRG and ICD-10 Procedure codes for reporting.
3.2 The PIHP has processes in place to back up the enrollment and claims data repositories.	X					During the Onsite discussion, Partners stated they have processes in place to back up their data warehouse on a daily basis. A business continuity plan was provided along with the ISCA tool.
4. Encounter Data Submission						
4.1 The PIHP has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	X					Partners can submit up to 29 ICD-10 Diagnosis codes on Institutional encounters and up to 12 ICD-10 Diagnosis codes on Professional encounters to NCTracks.

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					During the Onsite discussion, Partners stated they review an internally generated Encounter Claims Reconcile Report to ensure all outgoing claims on an 837 encounter file are received on the incoming 835 file. Partners uses the 835-encounter response file to identify and reconcile the returned 835 information with the claims paid to providers in the Alpha+ system. The DMA Paid/Denied spreadsheets along with the outgoing 837 encounter files and incoming 835 response files are used to investigate discrepancies, correct issues, and submit missing or corrected encounters.
4.3 PIHP has policies and procedures in place to reconcile and resubmit encounter data denied by NC Medicaid.	X					Partners loads the incoming 835 file into a SQL database to identify denied encounters by denied reason, taxonomy, and member. Partners uses this data to research the claim and identify the necessary correction. If additional information is needed, then Partners uses the NCTRACKS Paid and Denied spreadsheets. Partners has an encounter acceptance rate of approximately 99.2%. Partners has been able to maintain a very high encounter acceptance rate. This was observed in last year's EQR review as well. Partners clarified they enrolled members who receive Medicaid or State-funded Services for intellectual or developmental disabilities, mental health or substance abuse disorders from Cabarrus, Union, Stanly, Forsyth, and Davie counties in 2021.
4.4 The PIHP has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to NC Medicaid.	X					Partners' Claims department staff and an IT Business analyst are responsible for working on the encounter claims research, correction, and resubmission process. Partners' staff was able to speak to encounter data submissions and reconciliation process.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II A. Credentialing and Recredentialing						
1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					The *Credentialing Program Description* (*CPD*) and several policies and procedures addressed the credentialing and recredentialing processes. The *CPD* described the "Scope and Objectives of the Credentialing Program", provided definitions of relevant terms, and outlined details of the credentialing and recredentialing processes.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	X					The *Credentialing Committee Charter* (*CCC)* summarized the committee's purpose, responsibilities, committee meeting logistics, and composition of the committee membership. The *CPD* states "The Credentialing Committee is responsible for making independent decisions about applications for credentialing, recredentialing and sanctions as set forth in Section XXI of the Credentialing Program Description." The *CPD* described the Credentialing Committee as "a peer review body composed of a cross-functional team of representatives internal and external to the organization that represent the range of practitioners that participate in the network." The Credentialing Committee was chaired by the Chief Medical Officer (CMO) or designee. Dr. Stanton, the former CMO, retired in early fall 2022 but was with Partners through the completion of credentialing/recredentialing. The *CPD* defined "flagged" and "unflagged" applications. The approval of unflagged applications was delegated to the CMO. The submitted Credentialing Committee meeting minutes include the lists of "unflagged" applications approved by the CMO and reflect committee discussion of, and decisions regarding, "flagged" applications.

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.
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
3.1.3 Valid DEA certificate; and/or CDS certificate	X					
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					

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

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

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					
4.2.14 Ownership Disclosure is addressed.	X					
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					The *CPD* states, "Credentialing Committee review also includes review of provider performance data, including but not limited to findings of quality management/quality improvement activities, utilization management activities, and member/provider complaints/grievances." The submitted recredentialing files include a "Practitioner Profiling – PGHM Performance Indicators/Quality of Care Concerns" section. The reviewed Credentialing Committee meeting minutes reflect the committee's consideration of these kinds of "flags"/issues/ concerns.
5. The PIHP formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the PIHP for serious quality of care or service issues.	X					Policy and Procedure 8.21, MCO-Issued Provider Sanctions, addresses sanctions issued "based on identified areas of risk and/or serious quality of care identified issues." Policy and Procedure 6.04, Quality of Care Concerns, "identifies potential concerns that might indicate a Quality of Care (QOC) Concern, the steps to resolution, and how Partners reports and utilizes the information regarding QOC Concerns."
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					

III. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III. Quality Improvement						
III. A Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					All (c) Waiver Measures were above the State benchmark rates. The overall validation scores for all Performance Measures (PMs) were in the Fully Compliant range, with an average validation score of 100% across the 10 (b) Waiver Measures and the five (c) Waiver Measures. Follow-Up after Hospitalization for Mental Illness showed a substantial decline of greater than 10% for the FBC population for seven-day follow-up (declined 26.8%) and 30-day follow-up (25.2%). For the PRTF population, the 30-day follow up rate declined 10.7%. For the Follow-Up After Hospitalization for Substance Abuse, the Detox and FBC population three-day follow up declined 10.8%, whereas the combined population showed a substantial improvement of 11.3% in the seven-day follow-up. Another measure with substantial improvement was Initiation and Engagement of Alcohol & Other Drug Dependence Treatment for 65+ year old with initiation improving 15.9% and engagement improving 23.1%. Mental health penetration rates increased substantially (>10%) for several counties across several age groups. ***Recommendation: Continue to monitor (b) Waiver performance measure rates to determine if rates with substantial improvement or decline represent a continued trend or an irregularity in the PMs.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III. B Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					Partners submitted five projects for this 2022 EQR. These five were validated: • Initial NC TOPPS Interview • TCL Housing Loss Reduction • Registry of Unmet Needs • Increase Opioid-Initiated Engagement • Initiation & Engagement of Substance Use Members
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					All five validated Performance Improvement Projects (PIPs) scored in the High Confidence range, although four PIPs had errors. See Recommendations below. ***Recommendations:*** • ***Initial NC TOPPS Interview - Monitor interventions and consider focusing efforts on two or three primary interventions that are likely to have high impact on improving the rate for initial NC-TOPPS interviews completed.*** • ***Registry of Unmet Needs - Determine if additional services need to be established and offered to increase engagements based on member needs.*** • ***Increase Opioid-Initiated Engagement - Consider focusing efforts on two or three primary interventions that are likely to have high impact on improving the rate for Opioid-dependent members receiving services.*** • ***Initiation & Engagement of Substance Use Members - Consider focusing efforts on two or three primary interventions that are likely to have a high impact on improving the rate for Substance Use Disorder (SUD) members receiving services.***

IV. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. A Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					Partners' *Mental Health/Substance Use (MHSU) Care Management Program Description* and *Intellectual and Developmental Disabilities (I/DD) Care Management Program Description* outline the various techniques, functions, and interventions employed by the Care Management Departments to coordinate care for enrollees with complex or high-risk needs.
2. The care 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					Partners' *Mental Health/Substance Use (MHSU) Care Management Program Description* outlines the process and criteria for assessing enrollees with special healthcare needs.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					Partners' *Intellectual and Developmental Disabilities (I/DD) Care Management Program Description* identifies a primary role and responsibility of I/DD Care Managers is, "facilitating person centered planning to include convening the member, the member's family, key providers, the Community Navigator, others, and developing the Individual Support Plan (ISP)".
2.5 Quality monitoring and continuous quality improvement;	X					Partners' Policy and Procedure 11.30, NC Innovations: Case Record Review, provides a detailed description of the process, frequency, and targeted compliance ratings for reviewing enrollee Care Management records for compliance and potential areas of quality improvement.
2.6 Determination of which Behavioral Health Services are medically necessary;	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					
2.10 Ensure privacy for each Enrollee is protected.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					In the 2022 EQR, a thorough review of Partners' documentation was conducted and no major issues were identified. A few enrollee file anomalies were identified in the file review and discussed during the Onsite. One I/DD file showed a 22-year-old enrollee had an Oppositional Defiant Disorder diagnosis, a childhood disorder, listed in the enrollee's Individual Support Plan and demographic sheet. This same enrollee transferred from Gaston County to Mecklenburg County, and Partners could not provide evidence of the notification to the Department of Social Services. Per Partners' *NC Medicaid Contract, Section 4.6*, "PIHP shall notify the applicable county Department of Social Services within five (5) business days after PIHP becomes aware of changes to an Enrollee's circumstances that may affect eligibility, including but not limited to changes in address of Enrollee and death of Enrollee." ***Recommendation: Ensure diagnoses within enrollee's treatment plans are routinely reviewed and updated as a part of any treatment plan revision.*** ***Develop and document a process by which notifications to the Department of Social Services are issued when changes occur that impact enrollee's Medicaid eligibility. Ensure the language and process are compliant with NC Medicaid Contract, Section 4.6.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. B Transition to Community Living Initiative						
1. Transition to Community Living (TCL) functions are performed by appropriately licensed, or certified, and trained staff.	X					Partners' Policy and Procedure 9.08, Mental Health and Substance Use (MHSU) Care Management-Transitions to Community Living, details the roles and required credentials for In-Reach Specialists, Transition Coordinators, Housing Coordinators, and TCL Care Managers.
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					
2.1 Care Coordination activities occur, as required.	X					
2.2 Person Centered Plans are developed as required.	X					
2.3 Assertive Community Treatment, Peer Support, Supported Employment, Community Support Team, Psychosocial Rehabilitation, and other services as set forth in the DOJ Settlement are included in the individual's transition, if applicable.	X					Care Management staff participate in weekly and biweekly meetings with providers working with TCL enrollees, such as Assertive Community Treatment Team (ACTT) providers. These routine meetings are listed in the TCL How-To-Manual.
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					
2.5 QOL Surveys are administered timely.	X					Partners' Policy and Procedure 9.08, Mental Health and Substance Use (MHSU) Care Management-Transitions to Community Living describes the required timeframes for implementation of Quality of Life (QOL) surveys.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Transition, diversion and discharge processes are in place for TCL members as outlined in the DOJ Settlement and *DHHS Contract*.	X					Partners' Transition to Community Living Initiative How-to-Manual details the processes in place for TCL transition, diversion, and discharge processes.
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.	X					
5. The PIHP will develop a TCL communication plan for external and internal stakeholders providing information on the TCL initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					
6. A review of files demonstrates the PIHP is following appropriate TCL policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	X					In two TCL files, no Quality of Life surveys could initially be located by Partners. One TCL file was an enrollee transferred from another PIHP and staff reported those surveys were not provided in the transfer. In the second file, staff were able to locate the 11-month Quality of Life survey during the Onsite, but not the 24-month survey. Staff reported during the Onsite the 24-month survey was overlooked during a transition between Care Coordination. ***Recommendations: Enhance the current enrollee file review process to include review of the timely completion and filing of all Quality of Life surveys.***

V. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy and Procedure 6.00, Grievance/Complaint Coordination and Resolution Policy, is the primary policy and procedure describing Partners' processes for resolving Grievances.
1.1 Definition of a grievance and who may file a grievance;	X					In the 2021 EQR, CCME issued a Recommendation for Partners to revise the *Member Handbook* to reflect one consistent term for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination." The *Member Handbook* uploaded to the Desk Materials and available to members on the Partners' website is updated throughout with the term "grievance/complaint" as the term for "an expression of dissatisfaction about any matter other than an Adverse Benefit Determination."
1.2 The procedure for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a grievance log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Policy and Procedure 6.00, Grievance/Complaint Coordination and Resolution Policy, details Partners' process and required timeframe for retention of Grievance files.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP applies the grievance policy and procedure as formulated.	X					The 2022 EQR included a review of 10 Grievance files. All files were compliant with Partners' Policy and Procedure 6.00, Grievance/ Complaint Coordination and Resolution Policy, *the NC Medicaid Contract*, and the federal regulations. There were two files that had a similar Grievance at the same Psychiatric Residential Treatment Facility (PRTF), reported less than two weeks apart. The Onsite discussion included the follow-up Partners did after the resolutions. Partners involved many different departments for a cross functional approach for investigating both Grievances including follow up after the written *Notice of Resolution letters* were mailed. There were two other files that were also similar that involved the same Alternative Family Living (AFL) facility that was in the process of changing ownership. Both Grievances were received the same day and resolved in a similar way. The Onsite discussion focused on the outcome of the ownership change and the fact that the new owner was licensed as an AFL facility and services continued under the new ownership name.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Grievances are tallied and analyzed for patterns, trends, and compliance. Grievance data is reported in the Quality Improvement, Quality of Care, Consumer and Family Advisory, and Client Rights committee meetings.
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					Policy and Procedure 13.04, Clinical Utilization Management Appeals, is the primary policy and procedure that governs Partners' Appeals process.
1.1 The definitions an appeal and who may file an appeal;	X					
1.2 The procedure for filing an appeal;	X					
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The PIHP applies the appeal policies and procedures as formulated.	X					The 2022 EQR review of 10 Appeal files was similar to the 2021 file review in terms of compliance, completeness, and detail of staff documentation. No compliance issues were noted in the 2022 EQR Appeal file review. All reviewed Appeal files were compliant with Policy and Procedure 13.04, Clinical Utilization Management Appeals, the *NC Medicaid Contract*, and the federal regulations. CCME's review of the Appeals Log found the data to be consistent with the data in the Appeal files. All required notifications were issued timely, including written and verbal notifications. The Chief Medical Officer (CMO) was consulted on Appeals involving concerns around enrollee health and safety. The documentation in the Contact Log was in a clear and easy to understand format. Partners' staff attributed the compliance success to the focused Appeals monitoring process and staff attention to detail in their documentation. Partners reported they, "strive to monitor 90% of the special Appeal cases and have monitored nearly 100% of the special cases in the past year."
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					Since the 2021 EQR, Partners has implemented a focused Appeals monitoring process that focuses on routine and complex Appeals including oral, invalid, expedited, and withdrawn Appeals.
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					

VI. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI A. General Requirements						
1. PIHP shall be familiar and comply with *Section 1902 (a)(68)* of the *Social Security Act*, *42 CFR § 438.455* and *1000* through *1008*, as applicable, including proper payments to providers and methods for detection of fraud and abuse.	X					
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					
VI B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with *42 CFR § 438.608* that is designed to guard against fraud and abuse.	X					Partners' *Regulatory Compliance Program Description/Plan* includes a detailed description of the Compliance Program.

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 CFR 438.608* and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under NC Medicaid Contract in accordance with *42 CFR § 438.608(a)(1)(iv).*	X					Partners has established a Regulatory Compliance Committee that is chaired by the Chief Compliance & Performance Officer and co-chaired by the Compliance Director.
3. PIHP shall establish and implement a special investigations or program integrity unit.	X					Partners' Special Investigative Unit (SIU) reviews allegations of fraud, waste, and abuse (FWA). Since the last EQR, there have been no staff changes in this unit.
4. PIHP's written Compliance Plan shall, at a minimum include:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.1 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					The *Regulatory Compliance Program Description/Plan* contains information regarding the method for training and educating staff, providers, and Board of Directors on FWA policies and procedures. During the Onsite, Partners gave a detailed description of the training offered to staff and providers by the SIU.
4.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing, and development of corrective action initiatives;	X					
4.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					
4.4 The PIHP supplies all data in a uniform format provided by NC Medicaid and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by the Division as provided in *NC Medicaid Contract Section 13.2-Monetary Penalties.*	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. In accordance with *42 CFR § 438.608 (a)(vii),* PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under *NC Medicaid Contract*, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under *NC Medicaid Contract*; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month.	X					Partners has staff dedicated to addressing internal monitoring and auditing of compliance risks. Since the last EQR, the Internal Auditor has shifted from the Office of Legal Affairs to Business Operations. During the Onsite, staff explained that the shift occurred to better align the position with outlined duties and responsibilities.
6. PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					
6.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure.	X					Partners has a workflow that details the process of taking a complaint from inception through closure. A review of the *SIU Case List* found Partners accepted 122 referrals for PI review. Of these 122 referrals, 84 have been closed and 38 are in-process or pending action. For this EQR, 10 PI case files were reviewed, five were closed investigations, including two merged case files. During the Onsite, Partners stated the cases that were merged are still in process. The remaining five case files were open, including two files where the investigation has concluded, and overpayments are being collected.
6.3 In accordance with Attachment Y - Audits/Self-Audits/investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					Partners' *Provider Self-audit Protocol* describes the process providers follow to complete self-audits and report results of self-audits. This information is also included in the *Provider Operations Manual*.
6.4 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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6.5 Process for handling self-audits and challenge audits.	X					
6.6 Process for using data mining to determine leads.	X					Partners' *Program Integrity Department Data Mining Guidelines* outlines the data mining and analytics efforts used to identify and generate investigative leads. Two of 10 SIU cases reviewed in this EQR showed the lead was derived from data analytics reports.
6.7 Process for informing PIHP employees, subcontractors, and providers regarding the *False Claims Act.*	X					
6.8 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					
6.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid-standardized elements or a NC Medicaid-approved template;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6.10 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					
7. 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.	X					
8. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					In this EQR, 10 SIU case files were reviewed for compliance with *NC Medicaid Contract* requirements. The review found one PI file where the investigation was initiated 32 days after Partners received the allegation. According to the Case Detail summary, the allegation was mailed and received by Partners on August 15, 2022, but the case was not initiated until September 28, 2022. *NC Medicaid Contract Section 14.2.8* states, the "PIHP shall initiate a preliminary investigation within 10 business days of receipt of a potential allegation of fraud." This 10-day timeframe to initiate an investigation is also required by Partners' *PID Internal and External Reporting Guide*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						During the Onsite, Partners described the process by which mailed allegations are distributed to the appropriate SIU staff. However, this process does not take into account lags in staff time distributing or opening SIU mail. CCME is recommending Partners document the process by which mail is distributed to SIU staff and ensure a back up plan is in place for when staff are out. ***Recommendation: Develop and document a process that will ensure allegations received via mail are triaged and investigations initiated within the required timeframe according to NC Medicaid Contract, Section 14.2.8 and Partners' PID Internal and External Reporting Guide.***
9. 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:						For this EQR, two of 10 SIU case files reviewed contained a referral to NC Medicaid for possible FWA. This referral contained all of the information required on the NC Medicaid approved template. A review of Partners' *Attachment Y Report* found Partners referred seven cases of potential FWA to NC Medicaid in the past year.
9.1 Subject (name, Medicaid provider ID, address, provider type);	X					
9.2 Source/origin of complaint;	X					
9.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation:	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated; and dates of suspected intentional misconduct;	X					
9.5 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					
9.6 All communications between PIHP and the Provider concerning the conduct at issue, when available.	X					
9.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					
9.8 Total Sample Amount of Funds Investigated per Service Type	X					
9.8.1 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					
9.8.2 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.8.3 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					
9.8.4 Information on Biller/Owner;	X					
9.8.5 Additional Provider Locations that are related to the allegations;	X					
9.8.6 Legal and Administrative Status of Case	X					
10. 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.	X					
11. 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					Partners' monthly NCID holders/FAMS-users report showed no changes in FAMS users during the review period.
12. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP.	X					

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. 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 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					
2. Upon receipt of a payment suspension notice from NC Medicaid Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of NC Medicaid Program Integrity's suspension and lasting until PIHP is notified by NC Medicaid Program Integrity in writing that the suspension has been lifted.	X					
3. PIHP shall provide to NC Medicaid all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					
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.	X					

D. Attachment 4: Encounter Data Validation Report

Table of Contents

This page intentionally left blank.

Background

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

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

Overview

The scope of the review, guided by the Centers for Medicare and Medicaid Services (CMS) External Quality Review Protocol for Encounter Data Validation focused on measuring the data quality and completeness of claims and submitted to NC Medicaid by Partners for the period of January through December 2021. All claims paid by Partners are expected to be submitted and accepted as a valid encounter to NC Medicaid. The approach to the review included:

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

Review of Partners' ISCA response

The review of Partners' ISCA response was focused on section V. Encounter Data Submission. NC Medicaid requires each PIHP to submit their encounter data for all paid claims on a weekly basis via 837 Institutional and Professional transactions. The companion guides follow the standard ASC X12 transaction set with a few modifications to some segments. For example, the PIHP must submit their provider number and paid amount to NC Medicaid in the Contract Information CN104 and CN102 segment of Claim Information Loop 2300.

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

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

Looking at claims with dates of service in 2021, Partners submitted 1,552,132 unique encounters to the State. To date, 0.08% of all encounters submitted have not been corrected and accepted by NC Medicaid.

2021	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	95,297	94,380	633	284	0.30%
Professional	1,456,835	1,452,037	3,905	893	0.06%
Total	1,552,132	1,546,417	4,538	1,177	0.08%

Over the years, Partners has improved their encounter submission process, increasing their acceptance rate and quality of encounter data year over year. The table below shows the latest overall acceptance rate of 0.08%, well above NC Medicaid's expectations.

Year of Service	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
2017	1,347,304	1,297,629	45,028	4,647	0.34%
2018	1,363,466	1,351,220	9,734	2,512	0.18%
2019	1,446,496	1,437,955	8,230	311	0.02%
2020	1,383,848	1,379,490	4,128	230	0.02%
2021	1,552,132	1,546,417	4,538	1,177	0.08%

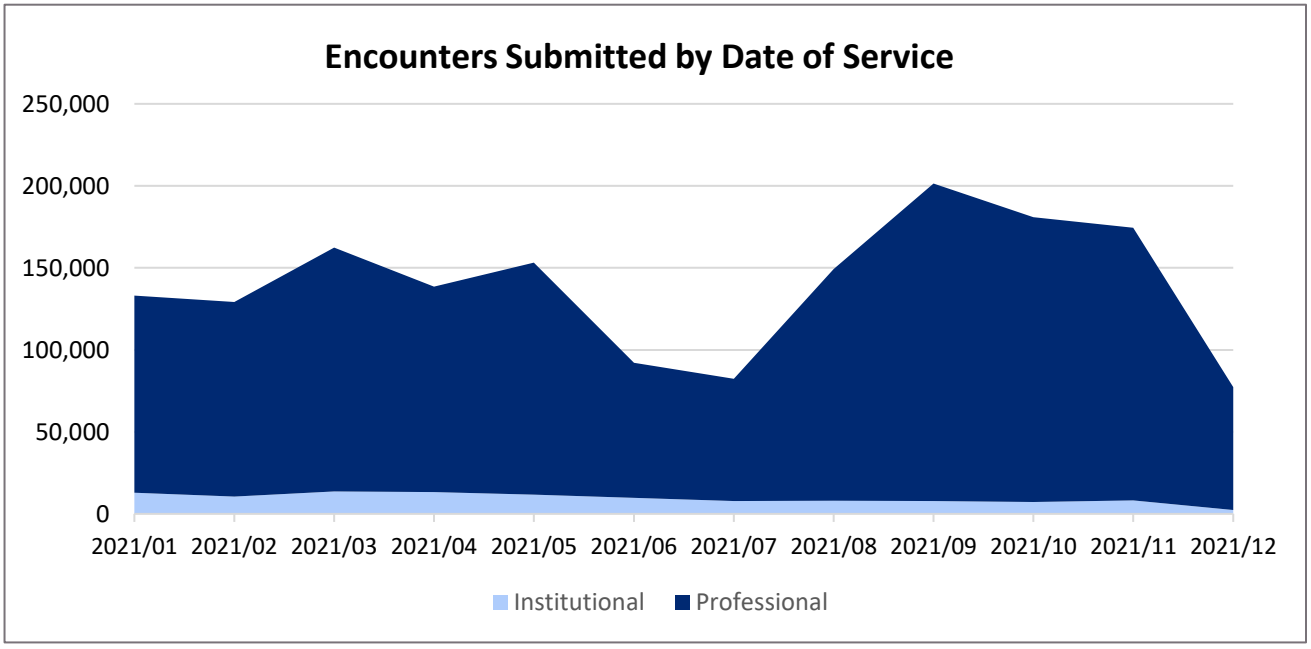
Compared to claims submitted in prior years, Partners continued to decrease the total number of initial denials and outstanding denials each year. There is a slight increase in denials due to the increase in claims received when Partners received members from five new counties. This required onboarding of new providers and ensuring correct payment rates. According to Partners' response and review of NC Medicaid 's acceptance report, most of the outstanding and ongoing denials are

related to suspected duplicates related to a timing issue in submitting adjusted encounters before the prior encounter records have been voided in NCTracks. Partners' strategy to continue to reduce, correct, and resubmit encounter denials includes the following steps:

- Ensure replacement claims are submitted after the voided encounters are sent
- Reviewing service codes with modifiers for accuracy and confirm that modifiers are billed appropriately
- Adding additional adjudication edits to Alpha+ (i.e., all submitted Diagnosis codes)
- Provider education guidelines
- Rebilling corrected encounter denials
- Working with the State to correct the provider upload issues

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 through December 31, 2021. Partners pulled all claims adjudicated and submitted to NC Medicaid during 2021 and sent to Aqurate via Secure File Transfer Protocol (SFTP). This included 1,560,701 Professional and over 113,543 Institutional claim line items for a total of 1,674,244 encounters submitted. Data transmitted included voids and resubmissions for previously denied claims, so the numbers do not reconcile back to the metrics reported in the ISCA response.



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

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Recipient ID	Should be valid ID as found in the State's eligibility file. Can use State's ID unless State also accepts Social Security Number.	100% valid. Medicaid IDs are 9 numeric long followed by 1 alpha.
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 may 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.
Recipient Date of Birth	Should not be missing and should be a valid date.	Existence of a valid date
PIHP ID	Critical Data Element	100% valid for PIHP
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	10 digits
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. 10 digits
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 Standard UB POS

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% non-missing and valid on physician or other applicable provider type claims (e.g., other practitioners). This is the taxonomy code and is a standard code set.
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid ICD codes for practitioner providers. Codes should be within standard ICD 9 and 10 code sets. ICD-9s have generally stopped appearing on files for current records.
Other Diagnosis	This is not expected to be coded on all claims even with applicable provider types but should be coded with a fairly high frequency.	90% valid when present. Codes should be within standard ICD 9 and 10 code sets. ICD-9s have generally stopped appearing on files for current records.
Dates of Service	Dates should be evenly distributed across time.	Valid date Dates spread throughout reporting year.
Unit of Service (Quantity)	The number should be routinely coded.	The number should be routinely coded. Current Procedural Terminology (CPT) code is in 99200–99215 or 99241–99291 range.
Procedure Code	Critical Data Element	There should be a wide range of procedures appropriate for the services covered by the PIHP
Procedure Code Modifier	Important to separate out surgical procedures/ anesthesia/assistant surgeon, not applicable for all procedure codes.	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.”	Expect a variety of values, with "Discharge to Home" being most common, and includes "Still-in" and transfers
Revenue Code	If the facility uses a UB04 claim form, this should always be present	Valid code is present

Encounter Accuracy and Completeness

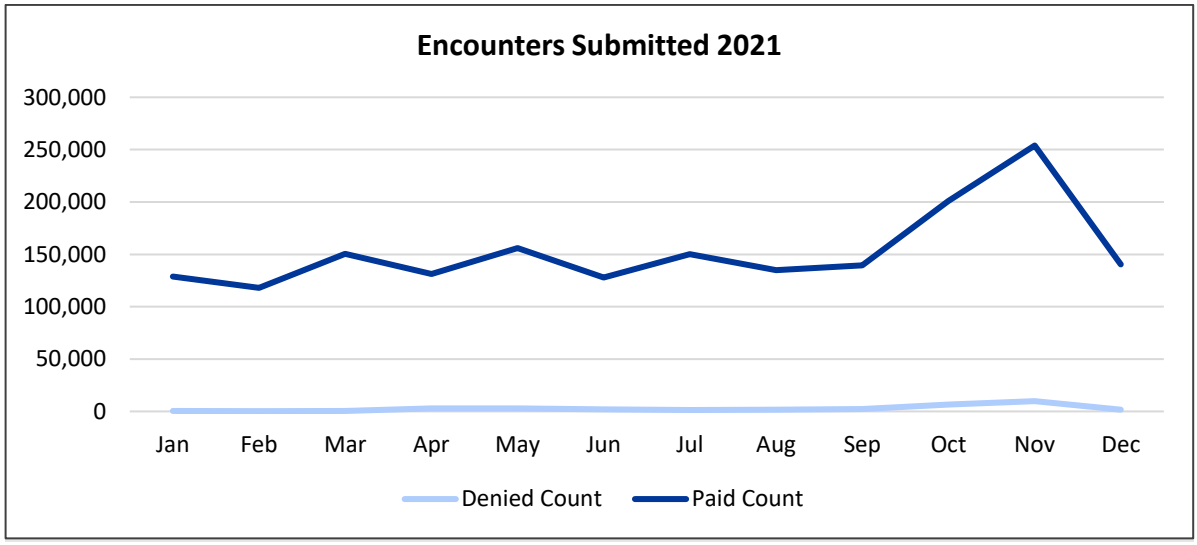
The table below outlines the key fields that were reviewed to determine if information was present, whether the information was the correct type and size and whether the data populated was valid. Although the complete data set was analyzed and all data values validated, the fields below are key fields for properly pricing 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	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%
Recipient Name	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%
Recipient Date of Birth	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%
PIHP ID	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%
Provider ID	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%
Attending/Rendering Provider ID	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%
Provider Location	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%
Place of Service	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%
Specialty Code / Taxonomy - Billing	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%
Specialty Code / Taxonomy - Rendering / Attending	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%
Principal Diagnosis	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%
Other Diagnosis	312,311	17.14%	312,311	17.14%	312,311	17.14%	312,311	17.14%
Dates of Service	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%	1,822,385	100.00%
Unit of Service (Quantity)	1,798,873	98.71%	1,798,873	98.71%	1,798,873	98.71%	1,798,873	98.71%
Procedure Code	1,763,305	96.76%	1,763,305	96.76%	1,763,305	96.76%	1,763,305	96.76%
Procedure Code Modifier	943,386	51.77%	943,386	51.77%	943,386	51.77%	943,386	51.77%
Patient Discharge Status Code Inpatient	129,227	99.99%	129,227	99.99%	129,227	99.99%	129,227	99.99%
Revenue Code	129,243	100.00%	129,243	100.00%	129,243	100.00%	129,243	100.00%

Overall, there were some inconsistencies in the data. Institutional claims contained complete and valid data in 13 of the 17 key fields (76.47%). In 2021, the Procedure code was present only for 54.29% of the encounters. Over 70.67% of all institutional claims contain Other Diagnosis codes. It was identified that the Units of Service field was populated only 81.81%. Partners explained that the claims came in with units, but they are adjudicated with zero units due to being denied as non-covered ancillary services. The Procedure Code Modifier was populated only 21.31%. Professional encounter claims submitted contained complete and accurate data in 13 of the 15 key professional fields (86.67%). The Other Diagnosis code was present in only 13.5% of all Professional claims. The Procedure Code Modifier was populated only 54.09%.

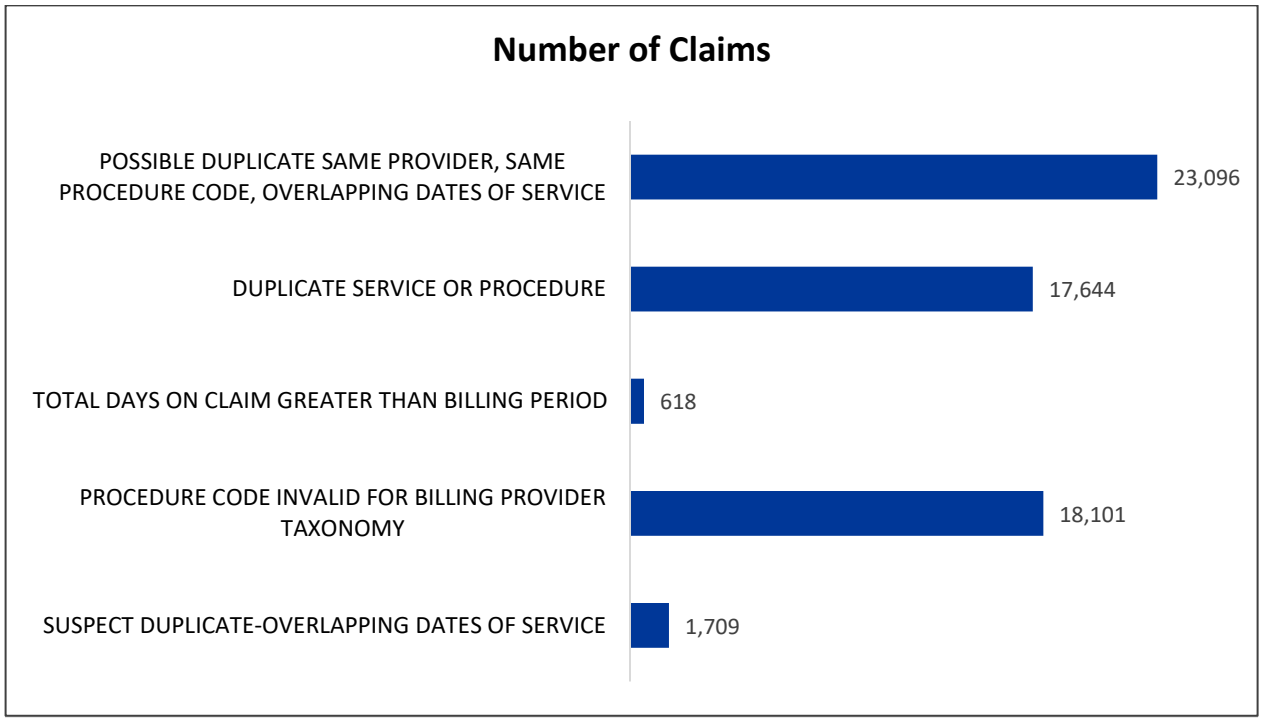
In addition to performing evaluation of the encounter data submitted, the Aqurate analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by Check Write which made it difficult to tie back to the ISCA response and submitted encounter files since only the Date of Service for each is available. During the 2021 weekly Check Write schedule, Partners submitted a total of 1,864,368 encounters to NC Medicaid. On average, 0.29% of all encounters submitted were initially denied. About 0.08% of denied claims are still outstanding, and the rest have been reviewed, resubmitted, and accepted by NC Medicaid.

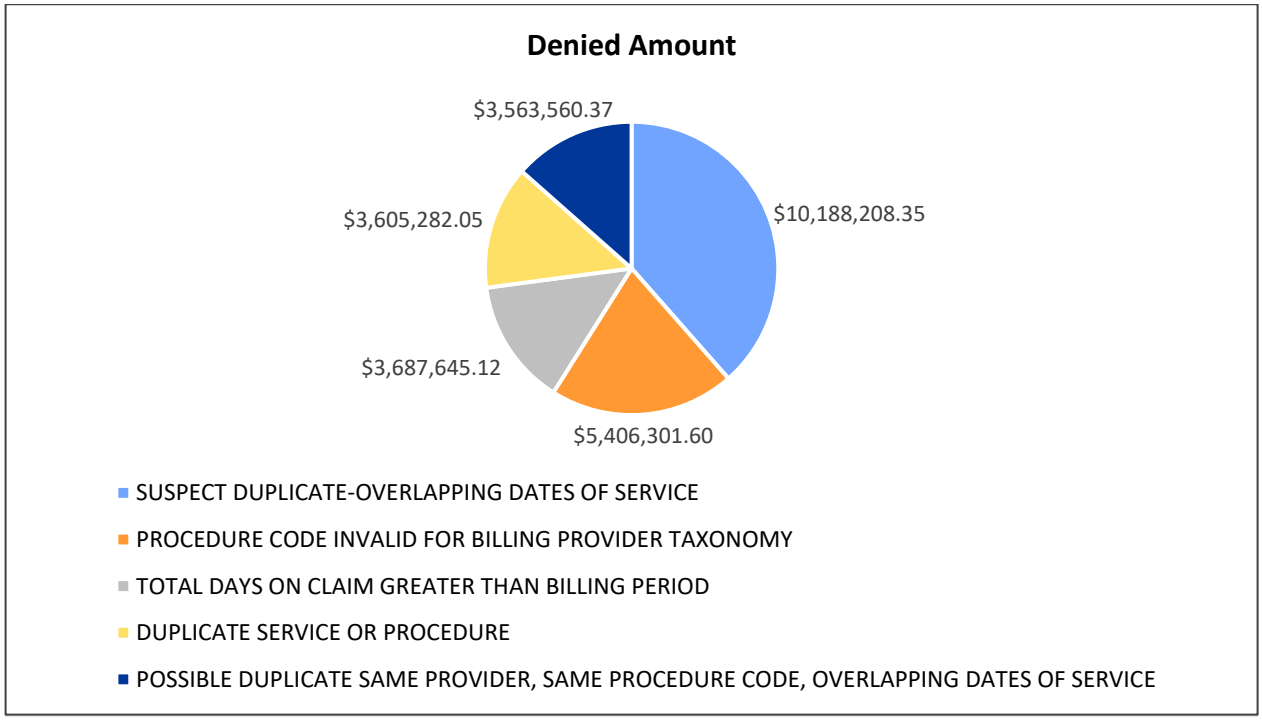


Evaluation of the top denials for Partners encounters correlates with the data deficiencies identified by the Aqurate analyst in the Key Field analysis above. Encounters were denied primarily for:

- Possible duplicate same provider, same procedure, overlapping dates of service
- Procedure code invalid for billing provider taxonomy
- Duplicate service or procedure
- Suspect duplicate-overlapping dates of service
- Total days on claim greater than the billing period

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





Results and Recommendations

Issue: Other Diagnosis Codes

The Principal Diagnosis code was populated for 100% of the claims. However, less than 18% of all encounter records show at least one valid Other Diagnosis code. Given that Partners currently reports the maximum number of Diagnosis codes accepted by NCTracks, the low figure suggests that many providers may not be reporting the Other Diagnosis codes. A closer examination reveals that some providers never report the Other Diagnosis code. This issue is particularly acute for Professional encounters where only about 13% of all claims had at least one Other Diagnosis code.

Recommendation:

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

Issue: Procedure Codes

The Procedure code for all claims should be populated 99% of the time. For the current review period, only 54% of Institutional claim line items contained a valid value in the Procedure code field where one is needed to identify the service that was provided.

Resolution:

Overall, there has been a notable improvement in the quality of data as Partners barely missed meeting the Data Quality Standards threshold target for Procedure codes. These codes were populated 96.76% of the time, and in each instance, a valid value was present. However, for Institutional claims, the figure drops significantly to 54.29%.

Conclusion

Based on the analysis of Partners' encounter data, it has been concluded that the data submitted to NC Medicaid are complete and accurate. Some 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, Aqurate believes that some of the errors are isolated cases that can be mitigated in the future by reviewing and modifying data validation rules, as necessary. Overall, Partners has shown continue improvements in the quality of encounter data and this is consistent with the reductions seen in the rate of denials on first time encounter submissions. However, some of the errors noted above are critical data elements as identified by CMS and NC Medicaid. Therefore, Partners should review and take steps to resolve the issues identified above.

For the next review period, Aqurate is recommending that the encounter data from NCTracks be reviewed to verify encounters that pass front end edits and are adjudicated to either a paid or denied status. Additionally, Partners should monitor the volume of denied claims pending re-submission to ensure there is no back log. 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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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