



**The State of North Carolina
Division of Medical Assistance**

External Quality Review

2010 Annual Technical Report

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Executive Summary

The Balanced Budget Act of 1997 (BBA) requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with 42 Code of Federal Regulations (CFR) 438.358 were aggregated and analyzed. The following report contains a description of the process and a discussion of the findings of the 2010 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the North Carolina Department of Health and Human Services, Division of Medical Assistance (DMA).

The process used for the 2010 EQR was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) titled Validating Performance Improvement Projects and Validating Performance Measures. The review included a desk review of documents submitted by Piedmont Behavioral Healthcare (PBH), a teleconference to discuss the preliminary findings, and a review of the corrective action plans.

Findings

The performance improvement projects (PIP) submitted for validation included:

- Decrease admission rate to Psychiatric Residential Treatment Facilities (PRTF) and/or inpatient for consumers discharged from residential level III placement.
- Improve community tenure for enrollees with multi systemic therapy (MST) and in-home services (IHS).
- Improve provider incident reporting through the State's Incident Reporting Improvement System (IRIS).
- Improve provider compliance with Coordination of Benefits (COB) and sliding fee schedules.

The validation scores for the four projects ranged from 84 percent to 100 percent of the total points possible. One project scored in the "High Confidence" range, while the remaining three scored in the "Confidence" range of the final audit designations.

The following performance measures (PM) were designated by DMA for review during the 2010 EQR activities:

- PM #25: Readmit to Inpatient Mental Health Facility.¹
- PM #28: Follow-up after Hospitalization for Mental Illness.
- PM #29: Mental Health Utilization.
- PM #30: Identification of Alcohol and other Drug Services.
- PM #31: Follow-up after Hospitalization for Substance Abuse.²
- PM #33: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (AOD).

Using the current 2010 HEDIS® Specifications, except where noted, all six measures were found to be fully compliant.

¹ Not an official HEDIS® measure.

² Not an official HEDIS® measure. Adapted based on PI #28 Follow-up after Hospitalization for Mental Illness.

As a part of the EQR activities, CCME performed an Information System Capabilities Assessment (ISCA) based on documentation submitted by PBH on an ISCA worksheet and other documentation provided by PBH.³ This third party review was conducted to assess PBH's ability to meet the State guidelines for the delivery of health care services, health care data collection, and such reporting as is required by DMA. Timeliness guidelines are in place and reasonable, with compliance monitored and 90 percent of claims meeting the 30-day guidelines and 99 percent of claims meeting the 180-day guidelines. PBH adequately demonstrated their ability to track enrollment and demographic data and support external and internal data reporting. CCME's review found PBH's Information System to fully meet the ISCA specifications.

Conclusion and Recommendations

Results of the 2010 EQR found PBH to be in compliance with the contractual and federal regulations for their performance improvement projects and performance measures. CCME recommended the following corrective action plans.

- *Improve provider incident reporting through the State's Incident Reporting Improvement System (IRIS)*
 - Revise the documentation so that the intervention table reflects only the interventions that have been implemented or are planned to be implemented.
- *PM #31: Follow-up After Hospitalization for Substance Abuse*
 - Correct the reference date used to calculate age. The date should be the discharge date.
 - Corrected report should be resubmitted to the State.
- *PM #33: Initiation and Engagement of AOD*
 - Correct the reference date used to calculate age. The date should be the end of the measurement year.
 - Corrected report should be submitted to the State.

³ This assessment protocol was developed by CMS as Appendix Z of the External Quality Review Activity protocols. Version 1.0 dated May 1, 2002 was used.

Background

The Balanced Budget Act of 1997 (BBA) requires that a state which contracts with a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) conduct an External Quality Review (EQR) of each entity. In January 2003, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to specify the requirement for external quality reviews of a Medicaid MCO/PIHP. In this final rule, federal regulation requires that external quality reviews include three mandatory activities: validation of performance improvement projects, validation of plan performance measures, and compliance monitoring. In addition, federal regulations allow states to require optional activities which include validation of encounter data, administration and validation of consumer and provider surveys, calculation of additional performance measures, and conduction of performance improvement projects and quality of care studies. After completing the required activities, a detailed technical report is submitted to the state. This report describes the data aggregation and analysis and the way in which conclusions were drawn as to the quality, timeliness, and access to the care furnished by the plans. The report also contains the plan's strengths and weaknesses; comparative information about all plans; recommendations for improvement; and the degree to which the plan has addressed the quality improvement recommendations made during the prior year's review.

In May 2008, the Division of Medical Assistance (DMA) for the State of North Carolina contracted with The Carolinas Center for Medical Excellence (CCME), an external quality review organization (EQRO), to conduct the EQR of Piedmont Behavioral Healthcare (PBH). The contract between CCME and DMA stipulates that the activities included in the 2008 EQR will only include the three mandatory activities; the optional activities are not required. For 2009 and 2010 only the validation activities were required.

Piedmont Behavioral Healthcare is a managed behavioral health plan that operates in a five-county area of North Carolina. The program operates under the combined authorities of sections 1915 (b) and 1915 (c) of the Social Security Act. It allows the state to restrict freedom of choice of providers and mandate that Medicaid recipients enroll in and receive any needed mental health, developmental disabilities, and substance abuse services through a single managed care entity; offer home and community-based services as an alternative to care in an intermediate care facility for persons with mental retardation; restrict the program to specific geographic areas; and reinvest savings into additional services for Medicaid recipients.

The current PIHP contract requires the plan to have an overall quality improvement program; submit annual reports of consumer and provider satisfaction surveys; and provide HEDIS data and DMA measures which include utilization data, complaints, grievance reports, and 1915 (c) waiver enrollee data. The contract requires that the plan develop and implement performance improvement projects. DMA's Quality Evaluation and Health Outcomes section conducts quarterly meetings with the PIHP's Quality Management staff regarding the performance improvement project design and progress, EQR activities, performance monitoring reporting, identified trends, follow-up initiatives or action plans, and any other quality-related topics of concern.

EQR Activities

The process used by CCME for the EQR activities was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid MCO/PIHP and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects. The contract between CCME and DMA does not allow for any optional activities.

PMs and PIPs Validation Process and Scoring Overview

A standardized process to perform EQR activities has been developed and is used by CCME. The process balances the subjective and objective parts of the review in order to provide the best quality review that is fair to the plan but provides the State with real information on how the plan is operating.

An overview of the process and scoring used in the 2010 review of PBH is provided below, beginning with the Performance Improvement Projects followed by the overview of the process and scoring for the Performance Measures.

Performance Improvement Projects

The validation protocol, as adapted by CCME, is broken down into three activities:

1. Assessing the Study Methodology.
2. Verifying Study Findings.
3. Evaluating Overall Validity and Reliability of Study Results.

Activities one and three were performed on the four projects submitted by PBH, while activity two is not a part of the contracted services for the current North Carolina EQR contract and was not considered for any of the projects submitted.

Activity one has ten steps, and each step has questions that relate to its theme. Each of these components has a point value assigned (1, 5, or 10) based upon the importance of the component to the validity of the project, with higher point values assigned to the more important components. These steps, components, and point assignments are provided in the table below.

Step	Description	Total Points
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
1.2	Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	1
1.3	Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	1

Step	Description	Total Points
2	Review The Study Question(s)	
2.1	Was/were the study question(s) stated clearly in writing?	10
3	Review Selected Study Indicator(s)	
3.1	Did the study use objective, clearly defined, measurable indicators?	10
3.2	Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	1
4	Review The Identified Study Population	
4.1	Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	5
4.2	If the MCO/PIHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	1
5	Review Sampling Methods	
5.1	Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	5
5.2	Did the MCO/PIHP employ valid sampling techniques that protected against bias? <i>Specify the type of sampling or census used:</i>	10
5.3	Did the sample contain a sufficient number of enrollees?	5
6	Review Data Collection Procedures	
6.1	Did the study design clearly specify the data to be collected?	5
6.2	Did the study design clearly specify the sources of data?	1
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
6.4	Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	5
6.5	Did the study design prospectively specify a data analysis plan?	1
6.6	Were qualified staff and personnel used to collect the data?	5
7	Assess Improvement Strategies	
7.1	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	10
8	Review Data Analysis And Interpretation Of Study Results	

Step	Description	Total Points
8.1	Was an analysis of the findings performed according to the data analysis plan?	5
8.2	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	10
8.3	Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	1
8.4	Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	1
9	Assess Whether Improvement Is “Real” Improvement	
9.1	Was the same methodology as the baseline measurement used when measurement was repeated?	5
9.2	Was there any documented, quantitative improvement in processes or outcomes of care?	1
9.3	Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)?	5
9.4	Is there any statistical evidence that any observed performance improvement is true improvement?	1
10	Assess Sustained Improvement	
10.1	Was sustained improvement demonstrated through repeated measurements over comparable time periods?	5

During the activity one review, each component is assessed to what degree the project meets that component. There are four degrees to which a component can score. A component that fully meets the criteria without issue is assigned a “Met” score and receives the full point value. A component that partially meets the criteria is assigned a “Partially Met” score and receives just half the point value (rounded up)⁴. A component that fails to meet the criteria is assigned a “Not Met” score and receives none of the points for that component. Finally, a component that does not apply to a particular project is assigned an “NA” score, and those points are not counted against the project in the final audit calculation.

Once all components have been scored for a project, the validation process moves to activity three, where all scores are summarized and a final audit designation is assigned to the project. To assign the audit designation for a project, a final “Validation Finding” is calculated by dividing the score the project actually received by the total possible points and then multiplying by 100. This percentage of points earned is then used to assign the final “Audit Designation” as described in the following table.

⁴ A score of “Partially Met” is not available for components with 1 point value assigned to them.

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

Performance Measures

The validation protocol for Performance Measures, as adapted by CCME, is broken down into six sections:

1. General Measure Elements
2. Denominator Elements
3. Numerator Elements
4. Sampling Elements
5. Reporting Elements
6. Validation Summary

The first five sections have individual components on which each measure is judged based on the information submitted by the plan. Each of these components has a point value assigned (either 5 or 10) based upon the importance of the component to the validity of the project, with higher point values assigned to the more important components. These individual components and their assigned point values are provided in the table below.

Section	Description	Total Points
G	General Measure Elements	
G1	Documentation: Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	10
D	Denominator Elements	
D1	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	10
D2	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).	5
N	Numerator Elements	
N1	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.	10

Section	Description	Total Points
N2	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).	5
N3	Medical Record Abstraction Only - If medical record abstraction was used, documentation/tools were adequate.	5
N4	Hybrid Only - If hybrid method was used, the integration of administrative and medical record data was adequate.	5
N5	Medical Record Abstraction or Hybrid - If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	5
S	Sampling Elements (only used with medical record abstraction or hybrid method)	
S1	Sample was unbiased.	5
S2	Sample treated all measures independently.	5
S3	Sample size and replacement methodologies met specifications.	5
R	Reporting Elements	
R1	Was the measure reported accurately?	10
R2	Was the measure reported according to State specifications?	5

For each of the components listed above, the degree to which the plan meets each component is assessed. There are four degrees to which a component can score. A component that fully meets the criteria without issue is assigned a "Met" score and receives the full point value. A component that partially meets the criteria is assigned a "Partially Met" score and receives a portion of the point value dependent on the severity of issue(s) found, with the maximum point being half the full point value of the section (rounded up to the next whole number). A component that fails to meet the criteria is assigned a "Not Met" score and receives none of the points. Finally, a component that does not apply to a particular measure is assigned an "NA" score and does not count against the measure in the final audit calculation.

Once all components have been scored for a measure, the validation process moves to the last section, where all scores are summarized and a final audit designation is assigned. To assign the audit designation for a measure, a final "Validation Finding" is calculated by dividing the total number of points received during the validation by the total possible points, then multiplying by 100. The percentage earned is then used to assign the final "Audit Designation" as described in the following table.

Audit Designation Possibilities	
Fully Compliant	Measure was fully compliant with State specifications. <i>Validation findings must be 86%–100%.</i>
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. <i>Validation findings must be 70%–85%.</i>
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. <i>Validation findings below 70% receive this mark.</i>
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

Validation Conclusions

The validation process offers DMA and the plan an independent view of how the plan is operating and how it is improving the care the organization provides to its members. Out of this independent review, conclusions are established for the individual measures and projects that were reviewed. These conclusions typically fall into one of two categories: suggestions or recommendations.

Suggestions are items found during the review that, if changed by the plan, can help improve processes and/or documentation for a project or measure. The issues with these items are not severe enough to introduce bias or make the project or measure invalid.

Recommendations are items found during the review that the plan should change because they have the potential to drastically alter results or hinder the improvement process. The conclusions cited in PBH's EQR for 2010 are summarized below beginning with the plan's Performance Improvement Projects followed by the conclusions for the plan's Performance Measures. General strengths and weakness are discussed at the end of each section.

Process Improvement Projects

The four projects submitted for review by PBH were all evaluated and judged to have sound study designs that do not introduce bias, and each promotes improvement in the four respective project topics. Any recommendations identified in the review of the projects documentation are noted with that project. Summaries of these conclusions follow with detailed explanations available in the report *Piedmont Behavioral Healthcare: 2010 Performance Improvement Project Report* found in Appendix A.

DECREASE ADMISSION RATE TO PRTF AND/OR INPATIENT FOR CONSUMERS DISCHARGED FROM RESIDENTIAL LEVEL III PLACEMENT

This project scored 79 points out of 90 possible points for a final validation finding of 88 percent, categorizing this project in the *Confidence* range. In comparison to the year prior, this project dropped from the *High Confidence* range due to the lack of improvement being shown. The lack of improvement was noted as being partially caused by changes in policy and the State budget which caused an increase in the number of higher level admissions. The recommendations for this project are as follows:

- **STUDY QUESTION:** As with the previous review, no direct study question is included in the project documentation. Partial language is included that can be revised to make correct study questions (“reducing in length of stay... and admission to community based services ...”). This statement needs to be reworded into multiple questions or statements as needed to fully clarify the scope of the study. These statement(s) should be clear and be specific towards the intervention versus outcome/indicator relationship. For example, “Does doing ‘x’ reduce the likelihood of admission to PRTF?” CCME recommends adjusting the statement in the documentation to be worded as a question, breaking up as necessary into multiple questions, and being specific about the intervention and outcome the question is directed towards.
- **DOCUMENTED IMPROVEMENT:** Project indicator did not improve during the last remeasurement. Changes in the budget and policy may have contributed to the lack of improvement. With the results potentially biased outside the control of the plan it is recommended that the project continue as planned.

IMPROVE COMMUNITY TENURE FOR ENROLLEES WITH MULTI SYSTEMIC THERAPY (MST) AND IN-HOME SERVICES (IHS)

This project scored 91 out of 91 points, earning all points available and a validation finding of 100 percent, and thus a *High Confidence* audit designation. This is consistent with the score from last year’s review which was also 100 percent. But unlike last year’s review, this year a complete review was done since this was the second year for the project and improvement could be assessed. No areas for improvement were noted with the project.

IMPROVE PROVIDER INCIDENT REPORTING THROUGH THE STATE’S INCIDENT REPORTING IMPROVEMENT SYSTEM (IRIS)

Earning 52 out of 62 points, this project scored an 84 percent validation rating and a *Confidence* audit designation. This is a new project for validation as well as for the plan. The main issue found was the documentation of interventions as discussed below:

- **INTERVENTIONS:** The interventions table in the project documentation seems to be more of a log of what is happening with IRIS, rather than specific interventions that the plan is implementing to increase timely submission. CCME recommends that the documentation be revised so that the intervention table reflects only interventions that have been implemented or are planned to be implemented. The other information should be placed elsewhere in the documentation.

IMPROVE PROVIDER COMPLIANCE WITH COORDINATION OF BENEFITS (COB) AND SLIDING FEE SCHEDULES

This new project received 87 out of 99 total points, for a finding of 88 percent and a designation of *Confidence*. Issues were found relating to the plan's documentation of the sample size and the methodology used to create it. Some of these issues were noted in the project documentation and are in the process of being corrected:

- **SAMPLING TECHNIQUE:** Documentation for the original baseline does not include any information about how the sample size was determined. CCME recommends adding the rationale for the sample size selected for the project including statistical elements like the margin of error being used to determine the sample size.
- **SAMPLE SIZE:** The original sample did not have a sufficient number in the sample. This issue was addressed in the documentation and the methodology has changed including the size of the sample. CCME recommends the plan ensure that the revised sample size is large enough for the population being studied. Justify using this size in the documentation by specifically describing the process used to determine it.
- **NUMERICAL PRESENTATION:** The plan identified a problem with the small sample size which could bias the results. CCME recommends throwing out the initial baseline measurement and using the next measurement as the baseline. This will provide better comparisons and will prevent the change in methodology from influencing future decisions.

Strengths and Weaknesses Identified During PIP Review

Strengths	An increased focus on general documentation was noted.
Weaknesses	Study questions were not always present in the project documentation. Improvements in documentation of sampling methodology and interventions should be looked at.

2010 Validation Summary: Performance Improvement Projects

Performance Improvement Project	Score	Possible Score	Validation Finding	Recommendations
Decrease admission rate to PRTF and/or inpatient for consumers discharged from residential level III placement	79	90	Confidence	Adjust the statements in the documentation and word as a question. Break the statement up as necessary into multiple questions and be specific about the intervention and outcome the question is directed towards.
Improve community tenure for enrollees with multi systemic therapy (MST) and in-home services (IHHS)	91	91	High Confidence	None
Improve provider incident reporting through the State's Incident Reporting Improvement System (IRIS)	52	62 ⁵	Confidence	Revise the documentation so that the intervention table reflects only the interventions that have been implemented or are planning to be implemented.
Improve provider compliance with Coordination of Benefits (COB) and sliding fee schedules	87	99	Confidence	<p>Add the rationale for the sample size selected including statistical elements like the margin of error being used to determine the sample size.</p> <p>Ensure that the sample size is large enough for the population being studied.</p> <p>Throw out the initial baseline measurement and use the next measurement as the baseline for the project.</p>

⁵ This project was relatively new and, therefore, certain sections of the review did not apply at this time.

Performance Measures

Six performance measures were selected by DMA and submitted by PBH for review. Comments can be split into two categories: recommendations and suggestions. Recommendations are direct corrections for issues identified through the review that affected the scoring for that measure. Suggestions, if given, are minor observations that were identified but did *not* have a direct effect on scoring and thereby no effect on the final audit designation.

As a part of the EQR activities, CCME performed an Information System Capabilities Assessment (ISCA) based on documentation submitted by PBH on an ISCA worksheet and other documentation provided by PBH.⁶ This third party review was conducted to assess PBH's ability to meet the State guidelines for the delivery of health care services, health care data collection, and such reporting as is required by DMA. Timeliness guidelines are in place and reasonable, with compliance monitored and 90 percent of claims meeting the 30-day guidelines and 99 percent of claims meeting the 180-day guidelines. PBH adequately demonstrated their ability to track enrollment and demographic data and support external and internal data reporting. CCME's review found PBH's Information System to fully meet the ISCA specifications.

Much improvement has been made since the previous reviews on how the measures are documented in general and in the source program code for each measure. In general all measures were graded as *Fully Compliant* with scores ranging from 87 percent to 100 percent.

The findings of the Performance Measure reviews are summarized here, with more details included in the report *Piedmont Behavioral Healthcare: 2010 Performance Measurement Validation Report* found in Appendix B.

Measure Specific Recommendations

PM #25: Readmit to Inpatient Mental Health Facility

This non HEDIS® measure scored 55 out of 55 available points, earning a rating of 100 percent, and received a final audit designation of *Fully Compliant*. The measure is based upon specifications / definitions found in the contract that PBH has with DMA. This measure was not rated in last year's review. No recommendations were identified.

PM #28: Follow-up after Hospitalization for Mental Illness

This measure scored a 100 percent rating and thus received a *Fully Compliant* final audit designation. This measure maintained a 100 percent rating from the last year's review. No recommendations were identified for this measure.

PM #29: Mental Health Utilization

This measure scored 55 out of 55 earning 100 percent of the available points, and received a final audit designation of *Fully Compliant*. This year's review saw improvement over the previous review

⁶ This assessment protocol was developed by CMS as Appendix Z of the External Quality Review Activity protocols. Version 1.0 dated May 1, 2002 was used.

(87.3 percent, *Fully Compliant*), with corrections made to how age was calculated. No recommendations were identified in this year's review.

PM #30: Identification of Alcohol and other Drug Services

This measure received 55 out of 55 points to score 100 percent and a final audit designation of *Fully Compliant*. This measure saw improvement over the previous review year's result which was 87.3 percent and a final audit designation of *Fully Compliant*. Corrections to their method of age calculation were made. No recommendations were identified in this year's review.

PM #31: Follow-up After Hospitalization for Substance Abuse⁷

This measure received 48 out of 55 points available or 87 percent, and was given a *Fully Compliant* final audit designation. An issue was noted this year regarding the way the inclusion age was being implemented and thus did not maintain its 100 percent score from last year's review, but did retain the *Fully Compliant* rating. The noted issues are described below:

- **DENOMINATOR:** It appears that most of the performance measure specifications for the denominator are being followed. However, the inclusion criteria should be six years and older as of the *date of discharge*, the code appears to base the age calculation on the date the report is ran instead of the discharge date. CCME recommends that the reference date used to calculate age be corrected. The date should be the discharge date.
- **REPORTING:** Because of the error in the inclusion criteria, the report could be inaccurate. CCME recommends that the reference date be corrected and the corrected report be resubmitted to the State.

PM #33: Initiation and Engagement of AOD

This measure received 48 out of 55 points in the review earning 87 percent of the points and an audit designation of *Fully Compliant*. An issue was noted this year regarding the way the measure was calculating age. This caused a loss of points from last year's review, but the measure remained in the same audit designation of *Fully Compliant*. The issues identified with their recommendations are noted below:

- **DENOMINATOR:** It appears that most of the performance measure specifications for the denominator are being followed. However, the calculation of age appears to be using the date the report is ran as a reference date instead of the end of the measurement year as required in the specifications. CCME recommends correcting the reference date used to calculate age. The date should be the end of the measurement year.
- **REPORTING:** Because of the error in the age calculation, minor differences may be present in the reported data strata. CCME recommends correcting the age calculation so that the strata will be reported correctly and the corrected report should be resubmitted to the State.

⁷ Non-HEDIS® measure based on PM #28 – Follow-up After Hospitalization for Mental Illness.

Strengths and Weaknesses Identified During PM Review

Strengths	Better and increased use of documentation in the source code was noted.
Weaknesses	Incorrect usages of dates in the coding of the specifications.

2010 Validation Summary: Performance Measures

PERFORMANCE MEASURE	Score	Possible Score	Validation Finding	Recommendations
PM #25: Readmit to Inpatient Mental Health Facility	55	55	100% Fully Compliant	NONE
PM #28: Follow-up after Hospitalization for Mental Illness	55	55	100% Fully Compliant	NONE
PM #29: Mental Health Utilization	55	55	100% Fully Compliant	NONE
PM #30: Identification of Alcohol and other Drug Services	55	55	100% Fully Compliant	NONE
PM #31: Follow-up After Hospitalization for Substance Abuse	48	55	87% Fully Compliant	Correct the reference date used to calculate age. The date should be the discharge date. Corrected report should be resubmitted to the State.
PM #33: Initiation and Engagement of AOD	48	55	87% Fully Compliant	Correct the reference date used to calculate age. The date should be the end of the measurement year. Corrected report should be submitted to the State.

Elements Requiring Corrective Action Plans

Based on the review process done for the PIPs and PMs submitted by PBH, CCME identified elements requiring corrective action. These elements have direct impact on the accuracy or validity of the respective measure or project and needs to be addressed by the plan for correction.

It is CCME's suggestion that PBH write a corrective action plan for the project *Improve Provider Incident Reporting through the State's Incident Reporting Improvement System (IRIS)* denoted in RED in the respective table above. The recommendations cited in the other projects should be reviewed, but a formal action plan is not deemed necessary unless so directed by the State.

CCME has determined that a corrective action plan should be written for the two measures that scored the lowest in the validation review (PM #31 and PM #33) and are denoted in RED in the table above. It is also CCME's recommendation that these measures be resubmitted once the corrective actions have been completed. Corrective action is not necessary for the other measures that were reviewed.

Response to PBH's Corrective Action Plan

Piedmont Behavioral Healthcare submitted their Corrective Action Plan as directed by the results of the EQR. CCME has reviewed and accepted their plans in full. The following table summarizes the corrections that were implemented by PBH.

2010 Corrective Action Plan Summary

Project or Measure	Recommendation	Corrective Action Plan	Status
Performance Improvement Project			
Improve provider incident reporting through the State's Incident Reporting Improvement System (IRIS)	Revise the documentation so that the intervention table reflects only the interventions that have been implemented or are planned to be implemented.	The table has been revised to reflect only the interventions that have been implemented.	Approved

2010 Corrective Action Plan Summary

Project or Measure	Recommendation	Corrective Action Plan	Status
Decrease admission rate to PRTF and/or inpatient for consumers discharged from residential level III placement	Adjust the statements in the documentation and word as a question. Break the statement up as necessary into multiple questions and be specific about the intervention and outcome the question is directed towards.	The statements were adjusted to word as a question.	Recommended but not formally requested as a corrected action.
Improve provider compliance with Coordination of Benefits (COB) and sliding fee schedules	Throw out the initial baseline measurement and use the next measurement as the baseline for the project.	Added statement in the analysis section under Opportunities stating the next measurement will replace the previous baseline.	Recommended but not formally requested as a corrected action.
Performance Measures			
PM #31: Follow-up After Hospitalization for Substance Abuse	Correct the reference date used to calculate age. The date should be the discharge date.	Reference date to calculate age has been changed to the discharge date.	Approved
	Corrected report should be resubmitted to the State.	Report was reran and submitted to the State.	Approved
PM #33: Initiation and Engagement of AOD	Correct the reference date used to calculate age. The date should be the end of the measurement year.	The reference date was changed to calculate age at the end of the measurement year.	Approved
	Corrected report should be submitted to the State.	Report was reran and submitted to the State.	Approved

Appendix A: PBH 2010 PIP Validation Report



The State of North Carolina
Division of Medical Assistance

Piedmont Behavioral Healthcare

2010 Performance Improvement Project Validation Report

SEPTEMBER 2010



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Executive Summary

As the External Quality Review Organization (EQRO) for the Division of Medical Assistance (DMA) for the State of North Carolina, The Carolinas Center for Medical Excellence (CCME) conducted an independent review of four Performance Improvement Projects (PIPs) to verify Piedmont Behavioral Healthcare's (PBH) compliance with the regulations in the Balanced Budget Act (BBA) that govern Medicaid managed care programs as described in federal regulations.¹ CCME used the protocol developed by the Centers for Medicare & Medicaid Services (CMS) titled *Validating Performance Improvement Projects: A protocol for use in conducting Medicaid external quality review activities* to review the projects designated by DMA.

Overview of Evaluation Activities

The review was performed based on documentation submitted for each PIP by PBH, which included:

- a narrative description of the project including an analysis of the project performed up to the time of submission,
- a completed PIP Submission Worksheet as laid out in the CMS protocol.

The CMS protocol validates criteria for the following parts of each project:

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

This validation process provides an assessment of the overall study design to ensure that the project is methodologically sound.

Summary of Findings

Piedmont Behavioral Healthcare submitted the following four projects for review:

- Decrease admission rate to Psychiatric Residential Treatment Facilities (PRTF) and/or inpatient for consumers discharged from residential level III placement.
- Improve community tenure for enrollees with multi systemic therapy (MST) and in-home services (IHS).
- Improve provider incident reporting through the State's Incident Reporting Improvement System (IRIS).
- Improve provider compliance with Coordination of Benefits (COB) and sliding fee schedules.

¹ Title 42 of the Code of Federal Regulations, part 438 et seq.



All four projects were validated; one project scored in the “High Confidence” range, while the remaining three scored in the “Confidence” range of the final audit designations. The validation scores for the four projects ranged from 84 percent to 100 percent of the total points possible for each project. Further explanation of these findings is included later in the report as well as a detailed account within the *CCME EQR PIP Validation Worksheet* for each project located in the appendix report.



Validation Scoring Overview

The validation protocol, as adapted by CCME, is divided into three activities:

1. Assessing the Study Methodology.
2. Verifying Study Findings.
3. Evaluating Overall Validity and Reliability of Study Results.

Activities one and three were performed on the four projects submitted by PBH, while activity two is not part of the contracted services for the current North Carolina EQR contract and was not considered for any of the projects submitted.

Activity one has ten steps and each step has questions that relate to its theme. Each of these components has a point value assigned (1, 5, or 10) based upon the importance of the component to the validity of the project, with higher point values assigned to the more important components. These steps, components, and point assignments are provided in the table below.

STEP	DESCRIPTION	TOTAL POINTS
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
1.2	Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	1
1.3	Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	1
2	Review The Study Question(s)	
2.1	Was/were the study question(s) stated clearly in writing?	10
3	Review Selected Study Indicator(s)	
3.1	Did the study use objective, clearly defined, measurable indicators?	10
3.2	Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	1
4	Review The Identified Study Population	
4.1	Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	5
4.2	If the MCO/PIHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	1
5	Review Sampling Methods	



5.1	Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	5
5.2	Did the MCO/PIHP employ valid sampling techniques that protected against bias? <i>Specify the type of sampling or census used:</i>	10
5.3	Did the sample contain a sufficient number of enrollees?	5
6	Review Data Collection Procedures	
6.1	Did the study design clearly specify the data to be collected?	5
6.2	Did the study design clearly specify the sources of data?	1
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
6.4	Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	5
6.5	Did the study design prospectively specify a data analysis plan?	1
6.6	Were qualified staff and personnel used to collect the data?	5
7	Assess Improvement Strategies	
7.1	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	10
8	Review Data Analysis And Interpretation Of Study Results	
8.1	Was an analysis of the findings performed according to the data analysis plan?	5
8.2	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	10
8.3	Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	1
8.4	Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	1
9	Assess Whether Improvement Is "Real" Improvement	
9.1	Was the same methodology as the baseline measurement used when measurement was repeated?	5
9.2	Was there any documented, quantitative improvement in processes or outcomes of care?	1
9.3	Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)?	5
9.4	Is there any statistical evidence that any observed performance improvement is true improvement?	1
10	Assess Sustained Improvement	
10.1	Was sustained improvement demonstrated through repeated measurements over comparable time periods?	5



During the activity one review, each component is assessed to what degree the project meets that component. There are four degrees to which a component can score. A component that fully meets the criteria without issue is assigned a “Met” score and receives the full point value. A component that partially meets the criteria is assigned a “Partially Met” score and receives just half the point value (rounded up)². A component that fails to meet the criteria is assigned a “Not Met” score and receives none of the points for that component. Finally, a component that does not apply to a particular project is assigned a “NA” score, and those points are not counted against the project in the final audit calculation.

Once all components have been scored for a project, the validation process moves to activity three, where all scores are summarized and a final audit designation is assigned to the project. To assign the audit designation for a project, a final “Validation Finding” is calculated by dividing the score the project actually received by the total possible points and then multiplying by 100. This percentage of points earned is then used to assign the final “Audit Designation” as described in the following table.

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. <i>Validation findings must be 90%–100%.</i>
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. <i>Validation findings must be 70%–89%.</i>
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. <i>Validation findings between 60%–69% are classified here.</i>
Reported Results NOT Credible	Major errors that put the results of the entire project in question. <i>Validation findings below 60% are classified here.</i>

² A score of “Partially Met” is not available for components with 1 point value assigned to them.



Project Conclusions and Recommendations

The four projects submitted for review by PBH were all evaluated and judged to have sound study designs that do not introduce bias, and each promotes improvement in the four respective project topics. Any recommendations identified in the review of the projects documentation are noted with that project. Further details of the review can be found in the *CCME EQR PIP Validation Worksheet* included in the appendix.

Decrease admission rate to PRTF and/or inpatient for consumers discharged from residential level III placement

This project scored 79 points out of 90 possible points for a final validation finding of 88 percent, categorizing this project in the *Confidence* range. In comparison to the year prior, this project dropped from the *High Confidence* range due to the lack of improvement being shown. The lack of improvement was noted as being partially caused by changes in policy and State budget which caused an increase in the number of higher level admissions. The recommendations for this project are as follows:

- **STUDY QUESTION:** As with the previous review, no direct study question is included in the project documentation. Partial language is included that can be revised to make correct study questions (“reducing in length of stay... and admission to community based services ...”). This statement needs to be reworded into multiple questions or statements as needed to fully clarify the scope of the study. These statement(s) should be clear and be specific towards the intervention versus outcome / indicator relationship. For example, “Does doing ‘x’ reduce the likelihood of admission to PRTF?” CCME recommends adjusting the statement in the documentation to be worded as a question, breaking up as necessary into multiple questions, and being specific about the intervention and outcome the question is directed towards.
- **DOCUMENTED IMPROVEMENT:** Project indicator did not improve during the last remeasurement. Changes in the budget and policy may have contributed to the lack of improvement. With the results potentially biased outside the control of the plan it is recommended that the project continue as planned.

Improve community tenure for enrollees with multi systemic therapy (MST) and in-home services (IHHS)

This project scored 91 out of 91 points, earning all points available to it and a validation finding of 100 percent, and thus a *High Confidence* audit designation. This is consistent with the score from last year’s review which was also 100 percent. But unlike last year’s review, this year a complete review was done since this was the second year for the project and improvement could be assessed. No areas for improvement were noted with the project.

Improve provider incident reporting through the State’s Incident Reporting Improvement System (IRIS)



Earning 52 out of 62 points, this project scored an 84 percent validation rating and a *Confidence* audit designation. This is a new project for validation as well as for the plan. The main issue found was the documentation of interventions as discussed below:

- **INTERVENTIONS:** The interventions table in the project documentation seems to be more of a log of what is happening with IRIS, rather than specific interventions that the plan is implementing to increase timely submission. CCME recommends that the documentation be revised so that the intervention table reflects only interventions that have been implemented or are planned to be implemented. The other information should be placed elsewhere in the documentation.

Improve provider compliance with Coordination of Benefits (COB) and sliding fee schedules

This new project received 87 out of 99 total points, for a finding of 88 percent and designation of *Confidence*. Issues were found relating to the plan's documentation of the sample size and the methodology used to create it. Some of these issues were noted in the project documentation and are in the process of being corrected:

- **SAMPLING TECHNIQUE:** Documentation for the original baseline does not include any information about how the sample size was determined. CCME recommends adding the rationale for the sample size selected for the project including statistical elements like the margin of error being used to determine the sample size.
- **SAMPLE SIZE:** The original sample did not have a sufficient number in the sample. This issue was addressed in the documentation and the methodology has changed including the size of the sample. CCME recommends the plan ensure that the revised sample size is large enough for the population being studied. Justify using this size in the documentation by specifically describing the process used to determine it.
- **NUMERICAL PRESENTATION:** The plan identified a problem with the small sample size which could bias the results being obtained. CCME recommends throwing out the initial baseline measurement and use the next measurement as the baseline. This will provide better comparisons and will prevent the change in methodology from influencing future decisions.



Piedmont Behavioral Healthcare 2008 Validation Summary: Performance Improvement Projects

PERFORMANCE IMPROVEMENT PROJECT	SCORE	POSSIBLE SCORE	VALIDATION FINDING	RECOMMENDATIONS
Decrease admission rate to PRTF and/or inpatient for consumers discharged from residential level III placement	79	90	<i>Confidence</i>	<ul style="list-style-type: none"> Adjust the statements in the documentation and word as a question. Break the statement up as necessary into multiple questions and be specific about the intervention and outcome the question is directed towards.
Improve community tenure for enrollees with multi systemic therapy (MST) and in-home services (IHS)	91	91	<i>High Confidence</i>	<ul style="list-style-type: none"> None
Improve provider incident reporting through the State's Incident Reporting Improvement System (IRIS)	52	62 ³	<i>Confidence</i>	<ul style="list-style-type: none"> Revise the documentation so that the intervention table reflects only the interventions that have been implemented or are planned to be implemented.
Improve provider compliance with Coordination of Benefits (COB) and sliding fee schedules	87	99	<i>Confidence</i>	<ul style="list-style-type: none"> Add the rationale for the sample size selected including statistical elements like the margin of error being used to determine the sample size. Ensure that the sample size is large enough for the population being studied. Throw out the initial baseline measurement and use the next measurement as the baseline for the project.

³ This project was relatively new and, therefore, certain sections of the review did not apply at this time.



Elements Requiring Corrective Action Plans

It is CCME’s suggestion that PBH write a corrective action plan for the project *Improve Provider Incident Reporting through the State’s Incident Reporting Improvement System (IRIS)* denoted in RED in the above table. The recommendations cited in the other projects should be reviewed, but a formal action plan is not deemed necessary unless so directed by the State.



Appendix: EQR PIP Validation Worksheets

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	Piedmont Behavioral Healthcare
Name of PIP	DECREASE ADMISSION RATE TO PRTF AND/OR INPATIENT FOR CONSUMERS DISCHARGED FROM RESIDENTIAL LEVEL III PLACEMENT
Validation Period	2009
Review Performed	8/10

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected through analysis of the enrollees' care and needs.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? (1)	MET	The plan addresses a broad spectrum of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	Plan does not exclude any one group from their project measurement or analysis.



STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	Score	Comments
2.1 Was/were the study question(s) stated clearly in writing? (10)	PARTIALLY MET	<p>As with the previous review, no direct study question is included in the project documentation. Partial language is included that can be revised to make a correct study questions (“reducing in length of stay... and admission to community based services ...”). This statement needs to be reworded into multiple questions or statements as needed to fully clarify the scope of the study. These statement(s) should be clear and specific towards the intervention versus outcome / indicator relationship.</p> <p><i>Example:</i> “Does doing ‘x’ reduce the likelihood of admission to PRTF?”</p> <p><u>RECOMMENDATION:</u> Adjust the statement in the documentation to be worded as a question, breaking up as necessary into multiple questions, and being specific about the intervention and outcome the question is directed towards.</p>
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	Score	Comments
3.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Project indicators are well defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Appropriate indicators are being used.
STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	Score	Comments
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? (5)	MET	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach	MET	Collection approach is based on claims and does appear to capture all



truly capture all enrollees to whom the study question applied? (1)		enrollees relevant to the project.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	Score	Comments
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	No sampling used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? (10) <i>Specify the type of sampling or census used:</i>	NA	No sampling used.
5.3 Did the sample contain a sufficient number of enrollees? (5)	NA	No sampling used.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	Score	Comments
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data used were clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Source data were clearly specified.
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	A systematic method appears to be used for data collection.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments should provide consistent and accurate data over time.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan is specified.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualified staff was used.



STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	Score	Comments
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Reasonable interventions were undertaken to address the barriers identified.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	Score	Comments
8.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was performed according to the analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were presented clearly and accurately.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Results include repeated measurements and factors that threaten measurement validity (policy / budget changes).
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	A narrative section of the analysis is included for each measurement period. This section summarizes the findings and interpretation of the data collected and discusses next steps.
STEP 9: Assess Whether Improvement Is “Real” Improvement		
Component / Standard (Total Score)	Score	Comments
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? (5)	MET	Same methodology was used.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	Project indicator did not improve in the last remeasurement. Changes in budget and policy from the State may have contributed to the lack of improvement. <i>RECOMMENDATION:</i> <i>With the results potentially biased outside the control of the plan it is recommended that the project continue as planned.</i>
9.3 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality	NA	No improvement to judge.



improvement intervention)? (5)		
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	NA	No improvement to judge.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	Score	Comments
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NOT MET	Sustained improvement was not demonstrated in remeasurement.

ACTIVITY 2

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



ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	5
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	0	NA
5.2	0	NA
5.3	0	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

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

Project Score	79
Project Possible Score	90
Validation Findings	88%



AUDIT DESIGNATION
CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. <i>Validation findings must be 90%–100%.</i>
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. <i>Validation findings must be 70%–89%.</i>
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. <i>Validation findings between 60%–69% are classified here.</i>
Reported Results NOT Credible	Major errors that put the results of the entire project in question. <i>Validation findings below 60% are classified here.</i>



CCME EQR PIP VALIDATION WORKSHEET

Plan Name	Piedmont Behavioral Healthcare
Name of PIP	IMPROVE COMMUNITY TENURE FOR ENROLLEES WITH MULTI SYSTEMIC THERAPY (MST) AND IN-HOME SERVICES (IIHS)
Validation Period	2009
Review Performed	8/10

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected through analysis of the enrollees' care and needs.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? (1)	MET	The plan addresses a broad spectrum of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	Plan does not exclude any one group from their measurement or analysis.
STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	Line Score	Comments
2.1 Was/were the study question(s) stated clearly in writing? (10)	MET	The documentation had a clear study statement.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	Score	Comments
3.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	The study's indicator is clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicator is appropriate.



STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	Score	Comments
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? (5)	MET	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? (1)	MET	Collection approach is claims based and appears to capture all enrollees relevant to the study.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	Score	Comments
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	No sampling used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? (10) <i>Specify the type of sampling or census used:</i>	NA	No sampling used.
5.3 Did the sample contain a sufficient number of enrollees? (5)	NA	No sampling used.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	Score	Comments
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data used were clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Source data were clearly specified.
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	Systematic method appears to be used for data collection.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments should provide consistent and accurate data over time.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan is specified.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualified staff was used.



STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	Score	Comments
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Appropriate interventions were used.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	Score	Comments
8.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were accurately presented.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Results include repeated measurements and factors that threaten measurement validity (policy / budget changes).
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	A narrative section of the analysis is included for each measurement period. This section summarizes the findings and interpretation of the data collected and discusses next steps.
STEP 9: Assess Whether Improvement Is “Real” Improvement		
Component / Standard (Total Score)	Score	Comments
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? (5)	MET	Methodology was changed from previous review, but an explanation was given as to why and all baseline measurements were recalculated.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	Improvement was documented.
9.3 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	MET	Improvement appears to be valid.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Improvement appears to be valid.



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

ACTIVITY 2

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

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS					
Summary of Aggregate Validation Findings and Summary					
	Possible Score	Score		Possible Score	Score
Step 1			Step 6		
1.1	5	5	6.4	5	5
1.2	1	1	6.5	1	1
1.3	1	1	6.6	5	5
Step 2			Step 7		
2.1	10	10	7.1	10	10
Step 3			Step 8		
3.1	10	10	8.1	5	5
3.2	1	1	8.2	10	10
Step 4			8.3	1	1
4.1	5	5	8.4	1	1
4.2	1	1	Step 9		
Step 5			9.1	5	5
5.1	0	NA	9.2	1	1
5.2	0	NA	9.3	5	5
5.3	0	NA	9.4	1	1
Step 6			Step 10		
6.1	5	5	10.1	0	NA
6.2	1	1			
6.3	1	1			
Project Score	91				
Project Possible Score	91				
Validation Findings	100%				



AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. <i>Validation findings must be 90%–100%.</i>
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. <i>Validation findings must be 70%–89%.</i>
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. <i>Validation findings between 60%–69% are classified here.</i>
Reported Results NOT Credible	Major errors that put the results of the entire project in question. <i>Validation findings below 60% are classified here.</i>



CCME EQR PIP VALIDATION WORKSHEET

Plan Name	Piedmont Behavioral Healthcare
Name of PIP	IMPROVE PROVIDER INCIDENT REPORTING THROUGH THE STATE'S INCIDENT REPORTING IMPROVEMENT SYSTEM (IRIS)
Validation Period	2009
Review Performed	8/10

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected through analysis of the new submission requirement.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? (1)	MET	The plan addresses a broad spectrum of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	Plan does not exclude any one group from their project measurement or analysis.
STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	Line Score	Comments
2.1 Was/were the study question(s) stated clearly in writing? (10)	MET	A study question is clearly stated for the project.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	Score	Comments
3.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Project is using a clearly defined measure.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicator is measuring process of care.



STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	Score	Comments
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? (5)	MET	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? (1)	MET	Collection approach is based on claims and does appear to capture all enrollees relevant to the project.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	Score	Comments
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? (10) <i>Specify the type of sampling or census used:</i>	NA	Sampling not used.
5.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not used.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	Score	Comments
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data used were clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Source data were clearly specified.
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	Systematic method appears to be used for data collection.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments should provide consistent and accurate data over time.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan is specified.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualified staff was used.



STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	Score	Comments
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	NOT MET	The interventions table in the project documentation seems to be more of a log of what is happening with IRIS instead of specific interventions that the plan is implementing to increase timely submission. <u>RECOMMENDATION:</u> <i>Revise the documentation so the intervention table reflects interventions that have been or are planned to be implemented.</i>
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	Score	Comments
8.1 Was an analysis of the findings performed according to the data analysis plan? (5)	NA	Project just beginning. Too early in process to judge.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	NA	Project just beginning. Too early in process to judge.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	NA	Project just beginning. Too early in process to judge.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	NA	Project just beginning. Too early in process to judge.
STEP 9: Assess Whether Improvement Is “Real” Improvement		
Component / Standard (Total Score)	Score	Comments
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? (5)	NA	Project just beginning. Too early in process to judge.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NA	Project just beginning. Too early in process to judge.
9.3 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	Project just beginning. Too early in process to judge.



9.4 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	NA	Project just beginning. Too early in process to judge.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	Score	Comments
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Project just beginning. Too early in process to judge.

ACTIVITY 2

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

ACTIVITY 3



EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	0	NA
5.2	0	NA
5.3	0	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

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

Project Score	52
Project Possible Score	62
Validation Findings	84%

AUDIT DESIGNATION
CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES

High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. <i>Validation findings must be 90%–100%.</i>
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. <i>Validation findings must be 70%–89%.</i>
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. <i>Validation findings between 60%–69% are classified here.</i>
Reported Results NOT Credible	Major errors that put the results of the entire project in question. <i>Validation findings below 60% are classified here.</i>



CCME EQR PIP VALIDATION WORKSHEET

Plan Name	Piedmont Behavioral Healthcare
Name of PIP	IMPROVE PROVIDER COMPLIANCE WITH COORDINATION OF BENEFITS (COB) AND SLIDING FEE SCHEDULES
Validation Period	2009
Review Performed	8/10

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected through analysis of the compliance standards.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? (1)	MET	The plan addresses a broad spectrum of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	Plan does not exclude any one group from their project measurement or analysis.
STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	Line Score	Comments
2.1 Was/were the study question(s) stated clearly in writing? (10)	MET	A study question is clearly stated for the project.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	Score	Comments
3.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Project is using clearly defined measures.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicators are measuring process of care.



STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	Score	Comments
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? (5)	MET	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? (1)	MET	Collection approach is based on claims and does appear to capture all enrollees relevant to the project.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	Score	Comments
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NOT MET	Documentation for the original baseline does not include any information about how the sample size was determined. <i>RECOMMENDATION:</i> <i>Add the rationale for the sample size selected for the project including statistical elements like the margin of error being used to determine the sample size.</i>
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? (10)	MET	Plan used a random sampling technique.
5.3 Did the sample contain a sufficient number of enrollees? (5)	PARTIALLY MET	The original sample did not have a sufficient number in the sample. This issue was addressed in the documentation and the methodology has changed including the size of the sample. <i>RECOMMENDATION:</i> <i>Ensure that the revised sample size is large enough for the population being studied. Justify using this size in the documentation by specifically describing the process used to determine it.</i>
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	Score	Comments
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data used were clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Source data were clearly specified.



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	Systematic method appears to be used for data collection.
6.4	Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments should provide consistent and accurate data over time.
6.5	Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan is specified.
6.6	Were qualified staff and personnel used to collect the data? (5)	MET	Qualified staff was used.
STEP 7: Assess Improvement Strategies			
	Component / Standard (Total Score)	Score	Comments
7.1	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Reasonable interventions have begun.
STEP 8: Review Data Analysis and Interpretation of Study Results			
	Component / Standard (Total Score)	Score	Comments
8.1	Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was performed according to the data analysis plan.
8.2	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	PARTIALLY MET	The plan identified a problem with the small sample size which could bias the results being obtained. <u>RECOMMENDATION:</u> <i>Throw out the initial baseline measurement and use the next measurement as the baseline for the project. This will provide better comparisons and will prevent the change in methodology from influencing future decisions.</i>
8.3	Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	The plan has recognized a problem with the sample methodology and sample size and has taken steps to correct.
8.4	Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	The plan has recognized a problem with the sample methodology and sample size and has taken steps to correct.



STEP 9: Assess Whether Improvement Is “Real” Improvement		
Component / Standard (Total Score)	Score	Comments
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? (5)	NA	Too early to judge.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NA	Too early to judge.
9.3 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	Too early to judge.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	NA	Too early to judge.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	Score	Comments
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Too early to judge.

ACTIVITY 2

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

ACTIVITY 3



EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	0
5.2	10	10
5.3	5	3
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

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

Project Score	87
Project Possible Score	99
Validation Findings	88%

AUDIT DESIGNATION

CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES

High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. <i>Validation findings must be 90%–100%.</i>
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. <i>Validation findings must be 70%–89%.</i>
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. <i>Validation findings between 60%–69% are classified here.</i>
Reported Results NOT Credible	Major errors that put the results of the entire project in question. <i>Validation findings below 60% are classified here.</i>



Appendix B: PBH 2010 PM Validation Report





The State of North Carolina
Division of Medical Assistance

Piedmont Behavioral Healthcare

2010 Performance Measurement Validation Report

SEPTEMBER 2010

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Executive Summary

As the External Quality Review Organization (EQRO) for the North Carolina Department of Health and Human Services, Division of Medical Assistance (DMA), The Carolinas Center for Medical Excellence (CCME) was contracted to conduct an independent review of seven Performance Measures (PMs) submitted by Piedmont Behavioral Healthcare (PBH) in compliance with the regulations in the Balanced Budget Act of 1997 (BBA) that govern Medicaid managed care programs as described in federal regulations.¹ CCME used the protocol developed by the Centers for Medicare & Medicaid Services (CMS) titled *Validating Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities* to review the measures designated by DMA.

Overview of Evaluation Activities

The review was performed based on documentation submitted for each measure by PBH and from DMA, which included:

- The performance measure report as submitted by PBH to DMA covering the 2009 calendar year.
- Source code used to calculate the measure's denominator and numerator.
- The reporting requirements as set forth in the contract between DMA and PBH.
- A completed PM Submission Worksheet as laid out in the CMS protocol.

Since the selected measures included the National Committee for Quality Assurance's (NCQA) *Healthcare Effectiveness Data and Information Set* (HEDIS®) measures calculated by PBH, documentation from NCQA's HEDIS® Specifications were also used to judge these measures.

The CMS protocol validates criteria for the following parts of each measure:

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

This validation process provides an assessment of the process that is used by PBH to calculate the required PMs and to ensure that these measures are correctly reported to DMA.

¹ Title 42 of the Code of Federal Regulations, part 438 et seq.

Summary of Findings

The following PMs were designated by DMA for review during the 2010 EQR activities:

- PM #25: Readmit to Inpatient Mental Health Facility.²
- PM #28: Follow-up after Hospitalization for Mental Illness.
- PM #29: Mental Health Utilization.
- PM #30: Identification of Alcohol and other Drug Services.
- PM #31: Follow-up after Hospitalization for Substance Abuse.³
- PM #33: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (AOD).

Except where noted above, review activities used the current 2010 HEDIS® Specifications.

The reviewed measures were validated and found to be mostly compliant overall. The final summary of audit designations for these measures was as follows:

- Six measures were scored **Fully Compliant**.
- No measures were scored **Substantially Compliant**.
- No measures were scored **Not Valid**.

These final scores are further explained later in the report as well as in the detailed accounts within the “CCME EQR PM Validation Worksheet” for each measure located in the appendix.

As a part of the EQR activities, CCME performed an Information System Capabilities Assessment (ISCA) based on documentation submitted by PBH on an ISCA worksheet and other documentation provided by PBH.⁴ This third party review was conducted to assess PBH’s ability to meet the State guidelines for the delivery of health care services, health care data collection, and such reporting as is required by DMA. Timeliness guidelines are in place and reasonable, with compliance monitored and 90 percent of claims meeting the 30 day guidelines and 99 percent of claims meeting the 180-day guidelines. PBH adequately demonstrated their ability to track enrollment and demographic data and support external and internal data reporting. CCME’s review found PBH’s Information System to fully meet the ISCA specifications.

² Not an official HEDIS® measure.

³ Not an official HEDIS® measure. Adapted based on PI #28 Follow-up after Hospitalization for Mental Illness.

⁴ This assessment protocol was developed by CMS as Appendix Z of the External Quality Review Activity protocols. Version 1.0 dated May 1, 2002 was used.

Validation Scoring Overview

The validation protocol, as adapted by CCME, is broken down into six sections:

4. General Measure Elements
5. Denominator Elements
6. Numerator Elements
7. Sampling Elements
8. Reporting Elements
9. Validation Summary

The first five sections have individual components on which each measure is judged based on the information submitted by the plan. Each of these components has a point value assigned (either 5 or 10) based upon the importance of the component to the validity of the project, with higher point values assigned to the more important components. These individual components and their assigned point values are provided in the table below.

Section	Description	Total Points
G	General Measure Elements	
G1	Documentation: Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	10
D	Denominator Elements	
D1	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	10
D2	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).	5
N	Numerator Elements	
N1	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.	10
N2	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).	5
N3	Medical Record Abstraction Only - If medical record abstraction was used, documentation/tools were adequate.	5
N4	Hybrid Only - If hybrid method was used, the integration of administrative and medical record data was adequate.	5



N5	Medical Record Abstraction or Hybrid - If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	5
S	Sampling Elements (only used with medical record abstraction or hybrid method)	
S1	Sample was unbiased.	5
S2	Sample treated all measures independently.	5
S3	Sample size and replacement methodologies met specifications.	5
R	Reporting Elements	
R1	Was the measure reported accurately?	10
R2	Was the measure reported according to State specifications?	5

For each of the components listed above, the degree to which the plan meets each component is assessed. There are four degrees to which a component can score. A component that fully meets the criteria without issue is assigned a “Met” score and receives the full point value. A component that partially meets the criteria is assigned a “Partially Met” score and receives a portion of the point value dependent on the severity of issue(s) found, with the maximum point being half the full point value of the section (rounded up to the next whole number). A component that fails to meet the criteria is assigned a “Not Met” score and receives none of the points. Finally, a component that does not apply to a particular measure is assigned a “NA” score and does not count against the measure in the final audit calculation.

Once all components have been scored for a measure, the validation process moves to the last section, where all scores are summarized and a final audit designation is assigned. To assign the audit designation for a measure, a final “Validation Finding” is calculated by dividing the total number of points received during the validation by the total possible points, then multiplying by 100. The percentage earned is then used to assign the final “Audit Designation” as described in the following table.

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. <i>Validation findings must be 86%–100%.</i>
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. <i>Validation findings must be 70%–85%.</i>
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. <i>Validation findings below 70% receive this mark.</i>
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.



Project Conclusions and Recommendations

Six performance measures were selected by DMA and submitted by PBH for review. The findings of these reviews are summarized here, with more details included with the “EQR PM Validation Worksheets” contained in the appendix of this report. Comments can be split into two categories: recommendations and suggestions. Recommendations are direct corrections for issues identified through the review that affected the scoring for that measure. Suggestions, if given, are minor observations that were identified but did *not* have a direct effect on scoring and thereby no effect on the final audit designation.

General Recommendations

Much improvement has been seen since previous reviews on how the measures are documented in general and in the source program code for each measure. In general all measures were graded as *Fully Compliant* with scores ranging from 87 percent to 100 percent.

Measure Specific Recommendations

PM #25: Readmit to Inpatient Mental Health Facility

This non HEDIS® measure scored 55 out of 55 available points, earning a rating of 100 percent, and received a final audit designation of *Fully Compliant*. The measure is based upon specifications / definitions found in the contract that PBH has with DMA. This measure was not rated in last year’s review. No recommendations were identified.

PM #28: Follow-up after Hospitalization for Mental Illness

This measure scored a 100 percent rating and thus received a *Fully Compliant* final audit designation. This measure maintained a 100 percent rating from the last year’s review. No recommendations were identified for this measure.

PM #29: Mental Health Utilization

This measure scored 55 out of 55 earning 100 percent of the available points, and received a final audit designation of *Fully Compliant*. This year’s review saw improvement over the previous review (87.3 percent, *Fully Compliant*), with corrections made to how age was calculated. No recommendations were identified in this year’s review.

PM #30: Identification of Alcohol and other Drug Services

This measure received 55 out of 55 points to score 100 percent and a final audit designation of *Fully Compliant*. This measure saw improvement over the previous review year’s result which was 87.3 percent and a final audit designation of *Fully Compliant*. Corrections to their method of age calculation were made. No recommendations were identified in this year’s review.



PM #31: Follow-up After Hospitalization for Substance Abuse⁵

This measure received 48 out of 55 points available or 87 percent, and was given a *Fully Compliant* final audit designation. An issue was noted this year regarding the way the inclusion age was being implemented and thus did not maintain its 100 percent score from last year's review, but did retain the *Fully Compliant* rating. The noted issues are described below:

DENOMINATOR: It appears that most of the performance measure specifications for the denominator are being followed. However, the inclusion criteria should be six years and older as of the *date of discharge*, the code appears to base the age calculation on the date the report is ran instead of the discharge date. CCME recommends that the reference date used to calculate age be corrected. The date should be the discharge date.

REPORTING: Because of the error in the inclusion criteria, the report could be inaccurate. CCME recommends that the reference date be corrected and the corrected report be resubmitted to the State.

PM #33: Initiation and Engagement of AOD

This measure received 48 out of 55 points in the review earning 87 percent of the points and an audit designation of *Fully Compliant*. An issue was noted this year regarding the way the measure was calculating age. This caused a loss of points from last year's review, but the measure remained in the same audit designation of *Fully Compliant*. The issues identified with their recommendations are noted below:

- **DENOMINATOR:** It appears that most of the performance measure specifications for the denominator are being followed. However, the calculation of age appears to be using the date the report is ran as a reference date instead of the end of the measurement year as required in the specifications. CCME recommends correcting the reference date used to calculate age. The date should be the end of the measurement year.
- **REPORTING:** Because of the error in the age calculation, minor differences may be present in the reported data strata. CCME recommends correcting the age calculation so that the strata will be reported correctly and the corrected report should be resubmitted to the State.

⁵ Non-HEDIS® measure based on PM #28 – Follow-up After Hospitalization for Mental Illness.



Piedmont Behavioral Healthcare 2010 Validation Summary: Performance Measures

PERFORMANCE MEASURE	SCORE	POSSIBLE SCORE	VALIDATION FINDING	RECOMMENDATIONS
PM #25: Readmit to Inpatient Mental Health Facility	55	55	100% Fully Compliant	NONE
PM #28: Follow-up after Hospitalization for Mental Illness	55	55	100% Fully Compliant	NONE
PM #29: Mental Health Utilization	55	55	100% Fully Compliant	NONE
PM #30: Identification of Alcohol and other Drug Services	55	55	100% Fully Compliant	NONE
PM #31: Follow-up After Hospitalization for Substance Abuse	48	55	87% Fully Compliant	<ul style="list-style-type: none"> Correct the reference date used to calculate age. The date should be the discharge date. Corrected report should be resubmitted to the State.
PM #33: Initiation and Engagement of AOD	48	55	87% Fully Compliant	<ul style="list-style-type: none"> Correct the reference date used to calculate age. The date should be the end of the measurement year. Corrected report should be submitted to the state.

Elements Requiring Corrective Action Plans

It is CCME's determination that a corrective action plan should be written for the two measures that scored the lowest in the validation review (PM #31 and PM #33) and are denoted in **RED** in the table above. It is also CCME's recommendation that these measures be resubmitted once the corrective actions have been completed. Corrective action is not necessary for the other measures that were reviewed.



Appendix: EQR PM Validation Worksheets

CCME EQR HEDIS® PM VALIDATION WORKSHEET

Plan Name	Piedmont Behavior Healthcare
Name of PM	PM #25 READMIT TO INPATIENT MH FACILITY
Validation Period	2009
Review Performed	8/10

METHODOLOGY FOR CALCULATING MEASURE		
Administrative	Medical Record Review	Hybrid

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Contract: Report the number and proportion of Medicaid Enrollees readmitted to inpatient psychiatric hospital care within 30 calendar days.

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	Documentation is appropriate and complete.



DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Data sources, based on ISCA review, are complete and 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	Based on current specifications in the DMA contract, the denominator adhered to all specifications.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	MET	Data sources, based on ISCA review, are complete and accurate.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years calculation, and adherence to specified time parameters).	MET	Based on current specifications in the DMA contract, the numerator adhered to all specifications.



NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	NA	Medical record abstraction not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	NA	Hybrid method not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	NA	Medical record abstraction or hybrid method not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	Audit Specifications	Validation	Comments
S1. Sampling	Sample was unbiased.	NA	No sampling used.
S2. Sampling	Sample treated all measures independently.	NA	No sampling used.
S3. Sampling	Sample size and replacement methodologies met specifications.	NA	No sampling used.

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



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	0	NA	NA
N4	0	NA	NA
N5	0	NA	NA
S1	0	NA	NA
S2	0	NA	NA
S3	0	NA	NA
R1	10	MET	10
R2	5	MET	5

Elements with higher weights have been selected because problems with those elements could result in larger problems in data validity or accuracy.

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

AUDIT DESIGNATION

FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES

Fully Compliant	Measure was fully compliant with State specifications. <i>Validation findings must be 86%–100%.</i>
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. <i>Validation findings must be 70%–85%.</i>
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. <i>Validation findings below 70% receive this mark.</i>
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.



CCME EQR HEDIS® PM VALIDATION WORKSHEET

Plan Name	Piedmont Behavior Healthcare
Name of PM	PM #28 FOLLOW UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS
Validation Period	2009
Review Performed	8/10

METHODOLOGY FOR CALCULATING MEASURE		
Administrative	Medical Record Review	Hybrid

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS® 2010 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	Documentation is appropriate and complete.

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Data sources, based on ISCA review, are complete and 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	Based on current 2010 HEDIS® specifications, the denominator adhered to all specifications.



NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	MET	Data sources, based on ISCA review, are complete and accurate.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years calculation, and adherence to specified time parameters).	MET	Based on current 2010 HEDIS® specifications, the numerator adhered to all specifications.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	NA	Medical record abstraction not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	NA	Hybrid method not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	NA	Medical record abstraction or hybrid method not used.



SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	Audit Specifications	Validation	Comments
S1. Sampling	Sample was unbiased.	NA	No sampling used.
S2. Sampling	Sample treated all measures independently.	NA	No sampling used.
S3. Sampling	Sample size and replacement methodologies met specifications.	NA	No sampling used.

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

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	0	NA	NA
N4	0	NA	NA
N5	0	NA	NA
S1	0	NA	NA
S2	0	NA	NA
S3	0	NA	NA
R1	10	MET	10
R2	5	MET	5

Elements with higher weights have been selected because problems with those elements could result in larger problems in data validity or accuracy.

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



AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. <i>Validation findings must be 86%–100%.</i>
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. <i>Validation findings must be 70%–85%.</i>
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. <i>Validation findings below 70% receive this mark.</i>
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.



CCME EQR HEDIS® PM VALIDATION WORKSHEET

Plan Name	Piedmont Behavior Healthcare
Name of PM	PM #29 MENTAL HEALTH UTILIZATION
Validation Period	2009
Review Performed	8/10

METHODOLOGY FOR CALCULATING MEASURE		
Administrative	Medical Record Review	Hybrid

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS® (SPECS)

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	Documentation is appropriate and complete.

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Data sources, based on ISCA review, are complete and 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	Based on current 2010 HEDIS® specifications, the denominator adhered to all specifications.



NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	MET	Data sources, based on ISCA review, are complete and accurate.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years calculation, and adherence to specified time parameters).	MET	Based on the 2010 HEDIS® specifications, the numerator adhered to all specifications.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	NA	Medical record abstraction not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	NA	Hybrid method not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	NA	Medical record abstraction or hybrid method not used.



SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	Audit Specifications	Validation	Comments
S1. Sampling	Sample was unbiased.	NA	No sampling used.
S2. Sampling	Sample treated all measures independently.	NA	No sampling used.
S3. Sampling	Sample size and replacement methodologies met specifications.	NA	No sampling used.

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

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	0	NA	NA
N4	0	NA	NA
N5	0	NA	NA
S1	0	NA	NA
S2	0	NA	NA
S3	0	NA	NA
R1	10	MET	10
R2	5	MET	5

Elements with higher weights have been selected because problems with those elements could result in larger problems in data validity or accuracy.

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



AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. <i>Validation findings must be 86%–100%.</i>
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. <i>Validation findings must be 70%–85%.</i>
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. <i>Validation findings below 70% receive this mark.</i>
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.



CCME EQR HEDIS® PM VALIDATION WORKSHEET

Plan Name	Piedmont Behavior Healthcare
Name of PM	PM #30 IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES
Validation Period	2009
Review Performed	8/10

METHODOLOGY FOR CALCULATING MEASURE		
Administrative	Medical Record Review	Hybrid

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS® (SPECS)

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	Documentation is appropriate and complete.

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Data sources, based on ISCA review, are complete and 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	Based on current 2010 HEDIS® specifications, the denominator adhered to all specifications.



NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	MET	Data sources, based on ISCA review, are complete and accurate.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years calculation, and adherence to specified time parameters).	MET	Based on the 2010 HEDIS® specifications, the numerator adhered to all specifications.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	NA	Medical record abstraction not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	NA	Hybrid method not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	NA	Medical record abstraction or hybrid method not used.



SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	Audit Specifications	Validation	Comments
S1. Sampling	Sample was unbiased.	NA	No sampling used.
S2. Sampling	Sample treated all measures independently.	NA	No sampling used.
S3. Sampling	Sample size and replacement methodologies met specifications.	NA	No sampling used.

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

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	0	NA	NA
N4	0	NA	NA
N5	0	NA	NA
S1	0	NA	NA
S2	0	NA	NA
S3	0	NA	NA
R1	10	MET	10
R2	5	MET	5

Elements with higher weights have been selected because problems with those elements could result in larger problems in data validity or accuracy.

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



AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. <i>Validation findings must be 86%–100%.</i>
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. <i>Validation findings must be 70%–85%.</i>
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. <i>Validation findings below 70% receive this mark.</i>
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.



CCME EQR HEDIS® PM VALIDATION WORKSHEET

Plan Name	Piedmont Behavior Healthcare
Name of PM	PM #31 FOLLOW UP AFTER HOSPITALIZATION FOR SUBSTANCE ABUSE
Validation Period	2009
Review Performed	8/10

METHODOLOGY FOR CALCULATING MEASURE		
Administrative	Medical Record Review	Hybrid

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Own Specs (Modeled after HEDIS® 2010 measure: <i>Follow Up After Hospitalization for Mental Illness</i>)

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	Documentation is appropriate and complete.



DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Data sources, based on ISCA review, are complete and 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).	PARTIALY MET	It appears that most of the performance measure specifications for the denominator are being followed. However, the inclusion criteria should be six years and older as of the <i>date of discharge</i> , the code appears to base the age calculation on the date the report is ran instead of the discharge date. <u>RECOMMENDATION:</u> <i>Correct the reference date used to calculate age. The date should be the discharge date.</i>

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	MET	Data sources, based on ISCA review, are complete and accurate.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years calculation, and adherence to specified time parameters).	MET	Based on the adapted 2010 HEDIS® specifications, the numerator adhered to all specifications.



NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	NA	Medical record abstraction not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	NA	Hybrid method not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	NA	Medical record abstraction or hybrid method not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	Audit Specifications	Validation	Comments
S1. Sampling	Sample was unbiased.	NA	No sampling used.
S2. Sampling	Sample treated all measures independently.	NA	No sampling used.
S3. Sampling	Sample size and replacement methodologies met specifications.	NA	No sampling used.

REPORTING ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
R1. Reporting	Was the measure reported accurately?	PARTIALY MET	Because of the error in the inclusion criteria, the report could be inaccurate. <u>RECOMMENDATION:</u> <i>Correct the reference date used to calculate age. Submit the corrected report to the State.</i>
R2. Reporting	Was the measure reported according to State specifications?	MET	Measure was reported according to all State specifications.



VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	PARTIALLY MET	3
N1	10	MET	10
N2	5	MET	5
N3	0	NA	NA
N4	0	NA	NA
N5	0	NA	NA
S1	0	NA	NA
S2	0	NA	NA
S3	0	NA	NA
R1	10	PARTIALLY MET	5
R2	5	MET	5

Elements with higher weights have been selected because problems with those elements could result in larger problems in data validity or accuracy.

Plan's Measure Score	48
Measure Weight Score	55
Validation Findings	87%

AUDIT DESIGNATION

FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES

Fully Compliant	Measure was fully compliant with State specifications. <i>Validation findings must be 86%–100%.</i>
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. <i>Validation findings must be 70%–85%.</i>
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. <i>Validation findings below 70% receive this mark.</i>
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.



CCME EQR HEDIS® PM VALIDATION WORKSHEET

Plan Name	Piedmont Behavior Healthcare
Name of PM	PM #33 INITIATION AND ENGAGEMENT OF AOD
Validation Period	2009
Review Performed	8/10

METHODOLOGY FOR CALCULATING MEASURE		
Administrative	Medical Record Review	Hybrid

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS® 2010 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	Documentation is appropriate and complete.



DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Data sources, based on ISCA review, are complete and 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).	PARTIALY MET	It appears that most of the performance measure specifications for the denominator are being followed. However, the calculation of age appears to be using the date the report is ran as a reference date instead of the end of the measurement year as required in the specifications. <u>RECOMMENDATION:</u> <i>Correct the reference date used to calculate age. The date should be the end of the measurement year.</i>

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	MET	Data sources, based on ISCA review, are complete and accurate.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years calculation, and adherence to specified time parameters).	MET	Based on current 2010 HEDIS® specifications, the numerator adhered to all specifications.



NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	NA	Medical record abstraction not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	NA	Hybrid method not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	NA	Medical record abstraction or hybrid method not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	Audit Specifications	Validation	Comments
S1. Sampling	Sample was unbiased.	NA	No sampling used.
S2. Sampling	Sample treated all measures independently.	NA	No sampling used.
S3. Sampling	Sample size and replacement methodologies met specifications.	NA	No sampling used.

REPORTING ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
R1. Reporting	Was the measure reported accurately?	PARTIALLY MET	Because of the error in age calculation, minor differences may be present in the reported data strata. <i>RECOMMENDATION:</i> <i>Correct the age calculation so that strata reported are correct and resubmit to the State.</i>
R2. Reporting	Was the measure reported according to State specifications?	MET	Measure was reported according to all State specifications.



VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	PARTIALY MET	3
N1	10	MET	10
N2	5	MET	5
N3	0	NA	NA
N4	0	NA	NA
N5	0	NA	NA
S1	0	NA	NA
S2	0	NA	NA
S3	0	NA	NA
R1	10	PARTIALY MET	5
R2	5	MET	5

Elements with higher weights have been selected because problems with those elements could result in larger problems in data validity or accuracy.

Plan's Measure Score	48
Measure Weight Score	55
Validation Findings	87%

AUDIT DESIGNATION

FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES

Fully Compliant	Measure was fully compliant with State specifications. <i>Validation findings must be 86%–100%.</i>
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. <i>Validation findings must be 70%–85%.</i>
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. <i>Validation findings below 70% receive this mark.</i>
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

