LME-MCO Quarterly Performance Measures:

Performance Report

First Quarter SFY 2022-2023

July 1 - September 30, 2022

(All Measures Reported)

Prepared by:
Quality Management Team
Division of Mental Health, Developmental Disabilities, and Substance Use Services

July 13, 2023

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Quality
NC DMH/DD/SUS

Introduction

The NC Department of Health and Human Services (NCDHHS), Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) has been tracking the effectiveness of community systems through statewide performance indicators since 2006[1]. These indicators provide a means for Executive Leadership, the NC public and General Assembly to monitor how the public service system is performing its responsibilities. Regular reporting of community progress also assists local and state managers in identifying areas of success and areas in need of attention. Problems caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities.

These performance indicators describe an observed level of activity (percent of persons that received a service for a MH, I/DD, or SUD condition or that received a timely follow-up service), but do not explain why the level is as it is. Results do not reveal the substantial "behind-the-scene" activities, processes and interactions involving service providers, LME-MCO and state staff, consumers, and family members, and cannot reveal which factors account for differences in measured levels of quality. Identifying and understanding these factors require additional investigation and may serve as the starting point for program management initiatives or quality improvement efforts.

The performance indicators in this report were chosen to reflect:

- accepted standards of care,
- fair and reliable measures, and
- readily available data sources.

In this report, there are 34 broad category of indicators with 144 items measured. Each performance indicator includes an overview explaining the rationale and a description of the measure. Performance data is summarized for each LME-MCO and the state as a whole for the most recent period for which data is available.

The data in this report is a compilation of LME-MCO reported performance measures data submitted to DMH/DD/SUS on 2/17/23 for the 1st Quarter SFY2023 measurement period. Please note that the performance data for the quarter is based on claims paid as of 4 months following the end of the quarter. It does not include data for claims that may have been adjudicated and paid after that point in time. Therefore, the data may be incomplete. The 4 months claims cutoff following the end of the measurement period is a compromise intended to provide more timely data that should be mostly complete vs. waiting longer for all claims to be processed and paid for the data to be fully complete.

On 6/16/23 LME-MCOs were provided a DRAFT report annotating data anomalies and/or missing data identified by DMH/DD/SUS. They were given the opportunity to review the DRAFT report to resolve identified anomalies, provide any missing data, and compare their data to other LME-MCOs and statewide data to ensure their reported numbers are accurate and complete.

LME-MCOs were asked to submit any needed corrections to the DMH/DD/SUS Quality Management Section by 6/30/23 so the report can be finalized. The data in this revised report includes all corrections received as of 7/13/23.

Please direct any questions about the performance indicators in this report to the DMH/DD/SUS Quality Management Team at contactdmhquality@dhhs.nc.gov or (984) 236-5200.

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1. This report fulfills the requirements of S.L. 2006-142 (HB 2077) and 122C - 112.1 that directs the Department of Health and Human Services to develop and monitor critical indicators of LME-MCO performance.

North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

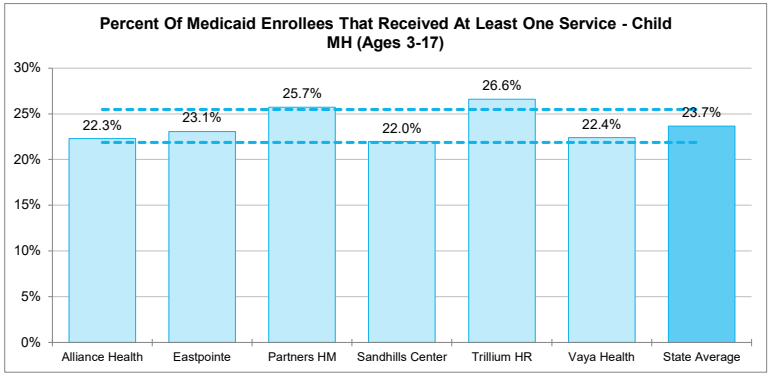
PENETRATION

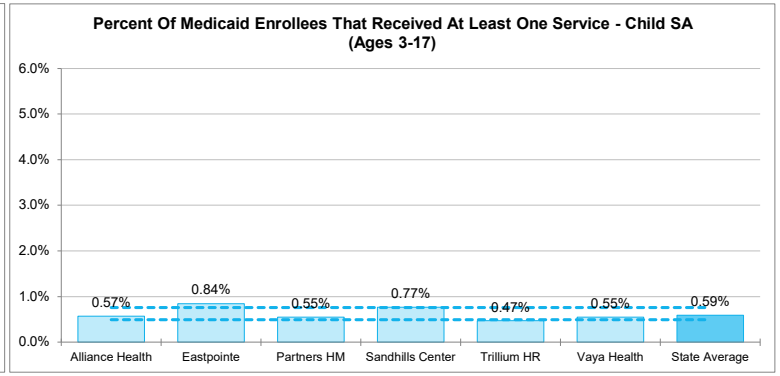
3.1 Persons Served: Medicaid Enrollees

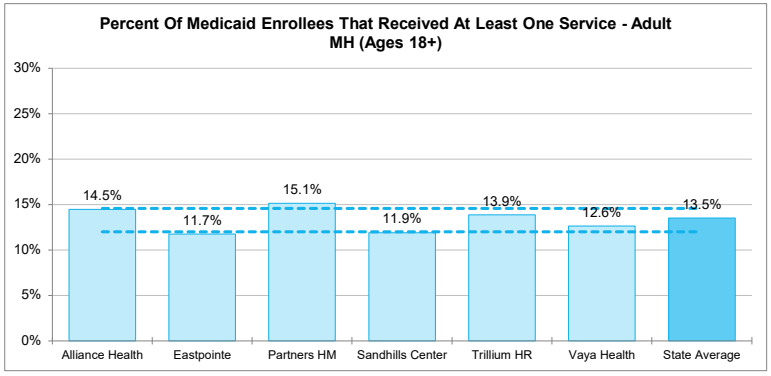
Rationale: NC has designed its public system to serve those persons who have the highest need for specialized mental health, intellectual or developmental disabilitites,and substance use services and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. Service penetration is an indicator of system access that has been used to characterize how accessible a particular service or group of services is for persons eligible to receive those services.

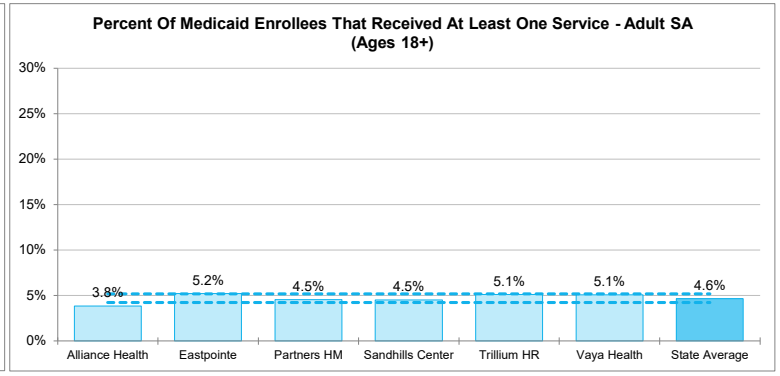
Description: Service penetration is the percentage of individuals eligible to receive services for a covered condition who actually receive a service for that condition witihin a specified time frame. For persons enrolled in the Medicaid 1915 b/c waiver, it is the unduplicated number of persons who received a service for a covered condition (e.g. MH, I/DD, or SUD diagnosis) during the measurement period divided by the number of persons enrolled in the Medicaid 1915 b/c waiver during the measurement period. This rate is computed for 6 age-disability groups - Children and Adults with a MH condition, Children and Adults with a Substance Use Disorder, and Children and Adults with an Intellectual or Developmental Disability - and for All Ages and Disabilities combined.

	Child MH (Ages 3-17)			Adult MH (Ages 18+)			Child SA (Ages 3-17)			Adult SA (Ages 18+)		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate
LME-MCO	**Number That Received At Least One Service**	**Number Of Medicaid Enrollees**	**Percent That Received At Least One Service**	**Number That Received At Least One Service**	**Number Of Medicaid Enrollees**	**Percent That Received At Least One Service**	**Number That Received At Least One Service**	**Number Of Medicaid Enrollees**	**Percent That Received At Least One Service**	**Number That Received At Least One Service**	**Number Of Medicaid Enrollees**	**Percent That Received At Least One Service**
Alliance Health	6,023	27,024	22.3%	13,920	96,221	14.5%	154	27,024	0.57%	3,679	96,221	3.8%
Eastpointe	1,994	8,640	23.1%	5,220	44,480	11.7%	73	8,640	0.84%	2,317	44,480	5.2%
Partners Health Management	5,150	20,022	25.7%	11,911	78,645	15.1%	110	20,022	0.55%	3,574	78,645	4.5%
Sandhills Center	3,158	14,371	22.0%	7,271	61,091	11.9%	110	14,371	0.77%	2,761	61,091	4.5%
Trillium Health Resources	4,858	18,269	26.6%	10,292	74,241	13.9%	86	18,269	0.47%	3,788	74,241	5.1%
Vaya Health	4,894	21,849	22.4%	10,230	81,014	12.6%	120	21,849	0.55%	4,100	81,014	5.1%
Statewide	26,077	110,175	23.7%	58,844	435,692	13.5%	653	110,175	0.59%	20,219	435,692	4.6%
Standard Deviation			1.8%			1.3%			0.13%			0.5%
LME-MCO Average			23.7%			13.3%			0.62%			4.7%









North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

PENETRATION

3.1 Persons Served: Medicaid Enrollees

Rationale: NC has designed its public system to serve those persons who have the highest need for specialized mental health, intellectual or developmental disabilitites,and substance use services and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. Service penetration is an indicator of system access that has been used to characterize how accessible a particular service or group of services is for persons eligible to receive those services.

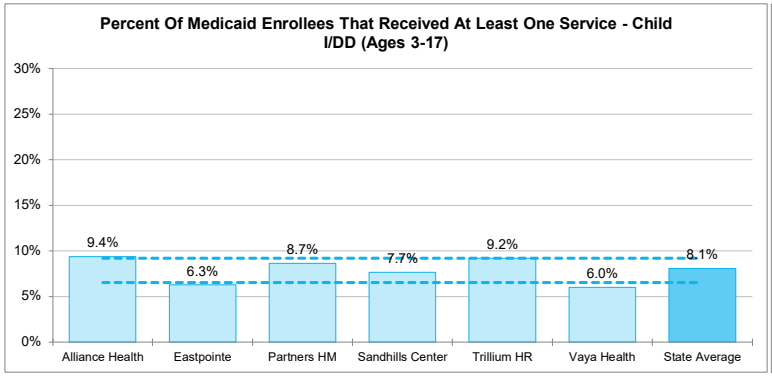
Description: Service penetration is the percentage of individuals eligible to receive services for a covered condition who actually receive a service for that condition witihin a specified time frame. For persons enrolled in the Medicaid 1915 b/c waiver, it is the unduplicated number of persons who received a service for a covered condition (e.g. MH, I/DD, or SUD diagnosis) during the measurement period divided by the number of persons enrolled in the Medicaid 1915 b/c waiver during the measurement period. This rate is computed for 6 age-disability groups - Children and Adults with a MH condition, Children and Adults with a Substance Use Disorder, and Children and Adults with an Intellectual or Developmental Disability - and for All Ages and Disabilities combined.

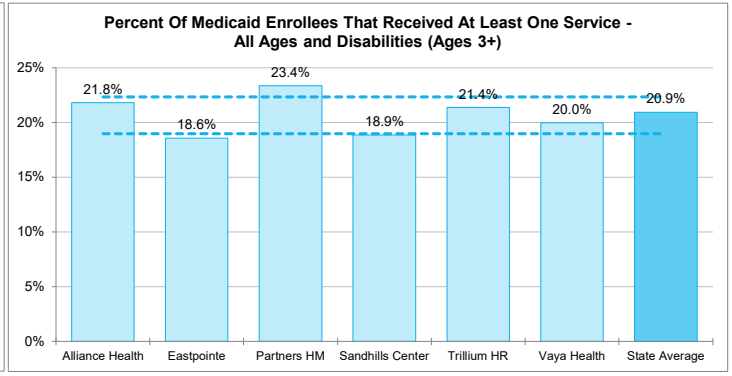
	Child I/DD (Ages 3-17)			Adult I/DD (Ages 18+)			All Ages and Disabilities (Ages 3+)		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate
LME-MCO	**Number That Received At Least One Service**	**Number Of Medicaid Enrollees**	**Percent That Received At Least One Service**	**Number That Received At Least One Service**	**Number Of Medicaid Enrollees**	**Percent That Received At Least One Service**	**Number That Received At Least One Service**	**Number Of Medicaid Enrollees**	**Percent That Received At Least One Service**
Alliance Health	2,538	27,024	9.4%	5,411	96,221	5.6%	26,883	123,245	21.8%
Eastpointe	543	8,640	6.3%	1,623	44,480	3.6%	9,860	53,120	18.6%
Partners Health Management	1,732	20,022	8.7%	4,426	78,645	5.6%	23,039	98,667	23.4%
Sandhills Center	1,103	14,371	7.7%	2,690	61,091	4.4%	14,244	75,462	18.9%
Trillium Health Resources	1,681	18,269	9.2%	3,815	74,241	5.1%	19,772	92,510	21.4%
Vaya Health	1,318	21,849	6.0%	3,913	81,014	4.8%	20,543	102,863	20.0%
Statewide	8,915	110,175	8.1%	21,878	435,692	5.0%	114,341	545,867	20.9%
Standard Deviation			1.3%			0.7%			1.7%
LME-MCO Average			7.9%			4.9%			20.7%

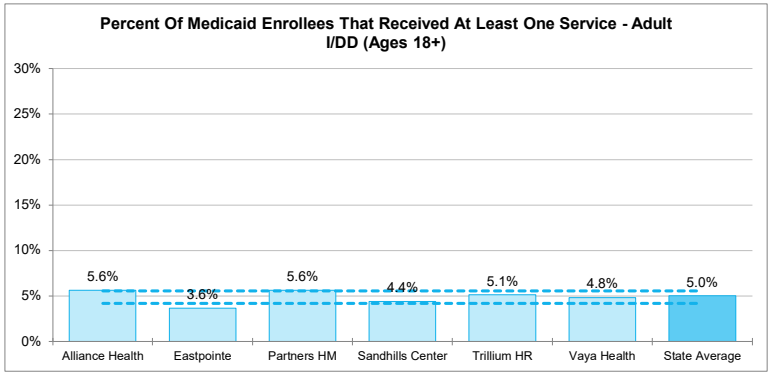
Red font: Number that received a service for All Ages and Disabilities ≥ sum of the numbers in each age disability.*

Sum of # in each age disability that rec'd a service	Medicaid Enrollees Sum of Children + Adults
31,725	123,245
11,770	53,120
26,903	98,667
17,093	75,462
24,520	92,510
24,575	102,863

* The number for All Ages and Disabilities should be < than the sum as persons with dual diagnoses can be included in > one







North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

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PENETRATION

3.1 Persons Served: Medicaid Enrollees (SFYTD)

Rationale: NC has designed its public system to serve those persons who have the highest need for specialized mental health, intellectual or developmental disabilitites,and substance use services and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. Service penetration is an indicator of system access that has been used to characterize how accessible a particular service or group of services is for persons eligible to receive those services.

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	Child MH (Ages 3-17)			Adult MH (Ages 18+)			Child SA (Ages 3-17)			Adult SA (Ages 18+)		
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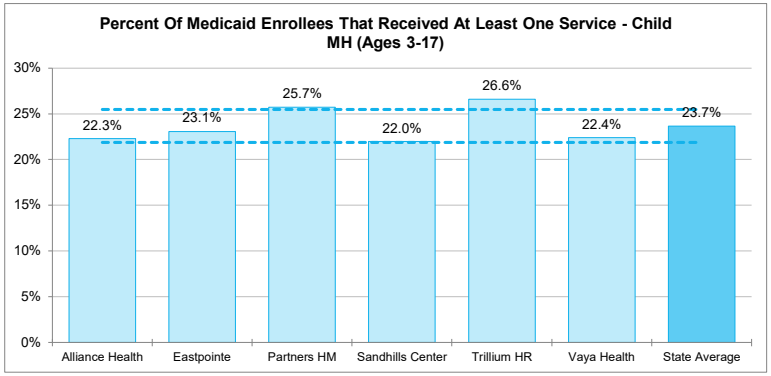

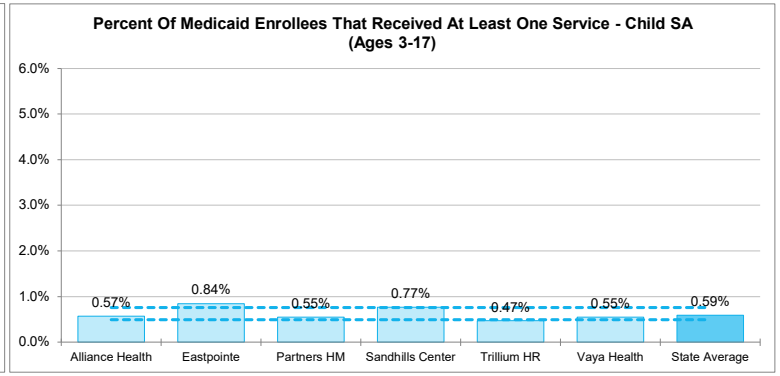

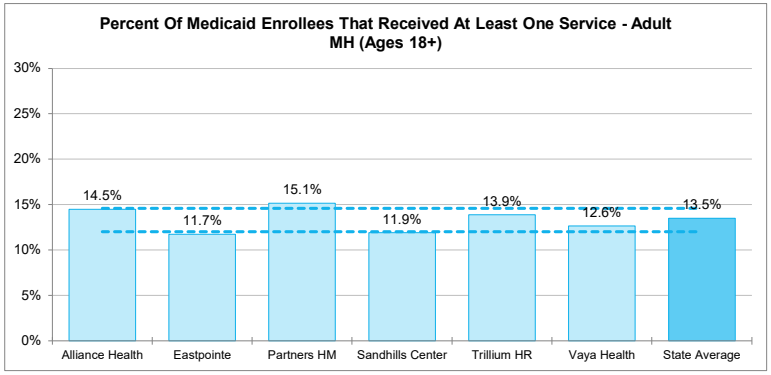

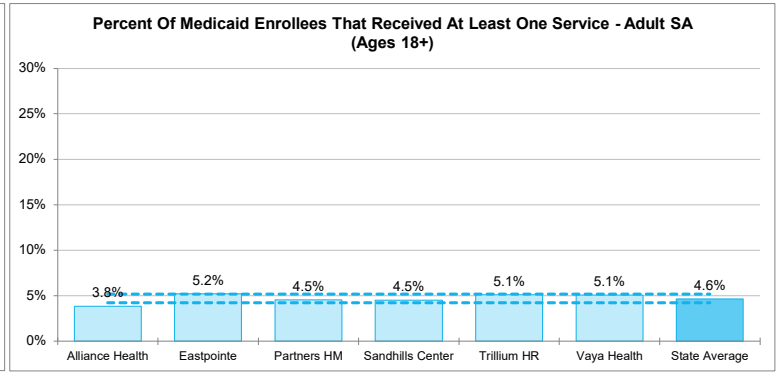

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PENETRATION

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	Child I/DD (Ages 3-17)			Adult I/DD (Ages 18+)			All Ages and Disabilities (Ages 3+)		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate
LME-MCO	**Number That Received At Least One Service**	**Number Of Medicaid Enrollees**	**Percent That Received At Least One Service**	**Number That Received At Least One Service**	**Number Of Medicaid Enrollees**	**Percent That Received At Least One Service**	**Number That Received At Least One Service**	**Number Of Medicaid Enrollees**	**Percent That Received At Least One Service**
Alliance Health	2,538	27,024	9.4%	5,411	96,221	5.6%	26,883	123,245	21.8%
Eastpointe	543	8,640	6.3%	1,623	44,480	3.6%	9,860	53,120	18.6%
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Statewide	8,915	110,175	8.1%	21,878	435,692	5.0%	114,341	545,867	20.9%
Standard Deviation			1.3%			0.7%			1.7%
LME-MCO Average			7.9%			4.9%			20.7%

Red font: Number that received a service for All Ages and Disabilities ≥ sum of the numbers in each age disability.*

Sum of # in each age disability that rec'd a service	Medicaid Enrollees Sum of Children + Adults
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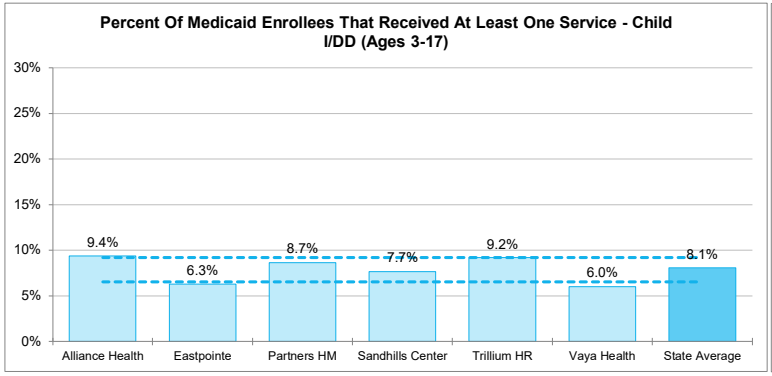

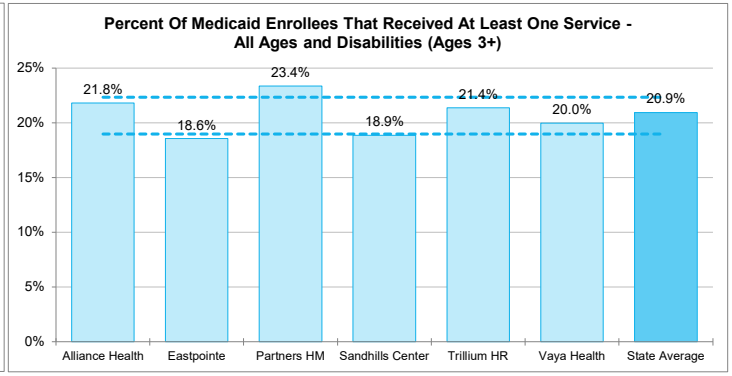

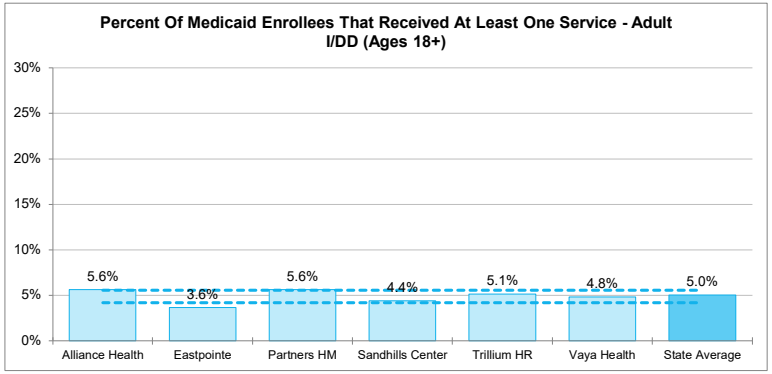

North Carolina LME-MCO Performance Measurement Reporting
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State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

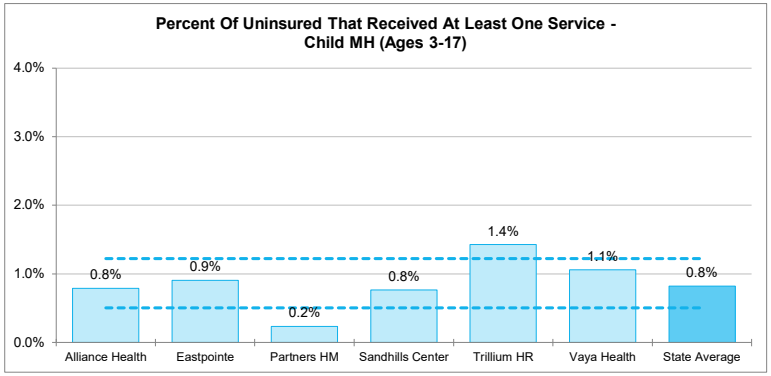
PENETRATION

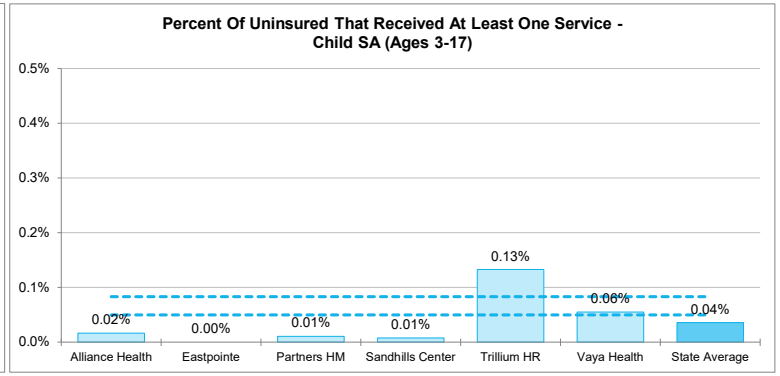
3.2 Persons Served: Non-Medicaid (State and Federal Block Grant Funded)

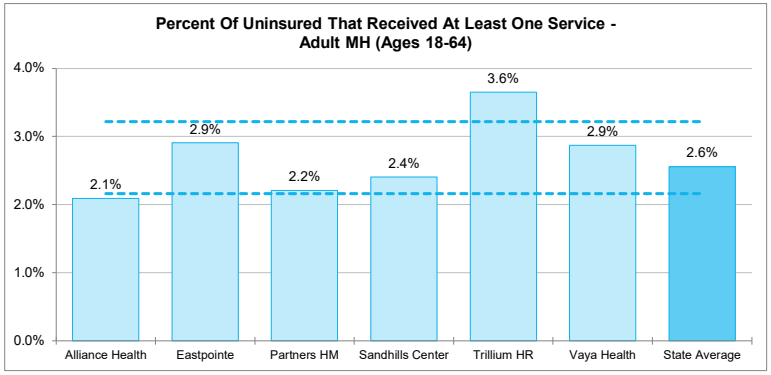
Rationale: NC has designed its public system to serve those persons who have the highest need for specialized mental health, intellectual or developmental disabilitites,and substance use services and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. Service penetration is an indicator of system access that has been used to characterize how accessible a particular service or group of services is for persons eligible to receive those services.

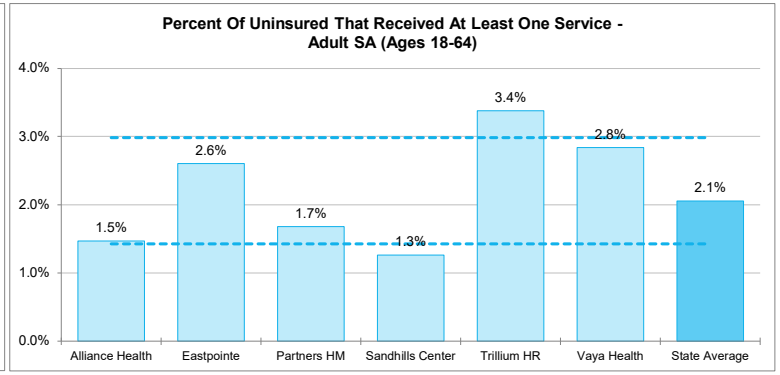
Description: Service penetration is the percentage of individuals eligible to receive services for a covered condition who actually receive a service for that condition witihin a specified time frame. For persons receiving State and Federal Block Grant funded services, it is the unduplicated number of persons who received a service for a covered condition (e.g. MH, I/DD, or SUD diagnosis) during the measurement period divided by the estimated number of uninsured non-elderly persons for 6 age-disability groups - Children and Adults under age 65 with a MH condition, Children and Adults under age 65 with a Substance Use Disorder, and Children and Adults under age 65 with an Intellectual or Developmental Disability - and for All Ages under age 65 and Disabilities combined.

	Child MH (Ages 3-17)			Adult MH (Ages 18-64)			Child SA (Ages 3-17)			Adult SA (Ages 18-64)		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate
LME-MCO	**Number That Received At Least One Service**	**Number Of Uninsured Population**	**Percent That Received At Least One Service**	**Number That Received At Least One Service**	**Number Of Uninsured Population**	**Percent That Received At Least One Service**	**Number That Received At Least One Service**	**Number Of Uninsured Population**	**Percent That Received At Least One Service**	**Number That Received At Least One Service**	**Number Of Uninsured Population**	**Percent That Received At Least One Service**
Alliance Health	241	30,659	0.8%	6,194	296,528	2.1%	5	30,659	0.02%	4,355	296,528	1.5%
Eastpointe	63	6,952	0.9%	2,039	70,173	2.9%	0	6,952	0.00%	1,826	70,173	2.6%
Partners Health Management	45	19,246	0.2%	4,209	190,537	2.2%	2	19,246	0.01%	3,201	190,537	1.7%
Sandhills Center	102	13,352	0.8%	3,320	138,192	2.4%	1	13,352	0.01%	1,745	138,192	1.3%
Trillium Health Resources	204	14,305	1.4%	4,938	135,307	3.6%	19	14,305	0.13%	4,569	135,307	3.4%
Vaya Health	173	16,307	1.1%	4,970	173,141	2.9%	9	16,307	0.06%	4,915	173,141	2.8%
Statewide	828	100,822	0.8%	25,670	1,003,878	2.6%	36	100,822	0.04%	20,611	1,003,878	2.1%
Standard Deviation			0.4%			0.5%			0.05%			0.8%
LME-MCO Average			0.9%			2.7%			0.04%			2.2%









North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

PENETRATION

3.2 Persons Served: Non-Medicaid (State and Federal Block Grant Funded)

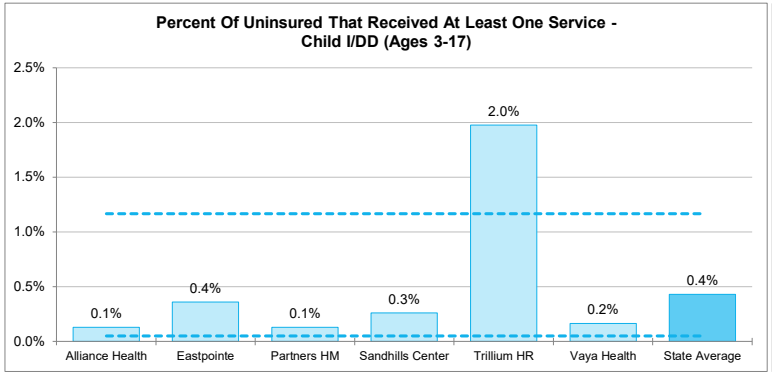
Rationale: NC has designed its public system to serve those persons who have the highest need for specialized mental health, intellectual or developmental disabilitites,and substance use services and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. Service penetration is an indicator of system access that has been used to characterize how accessible a particular service or group of services is for persons eligible to receive those services.

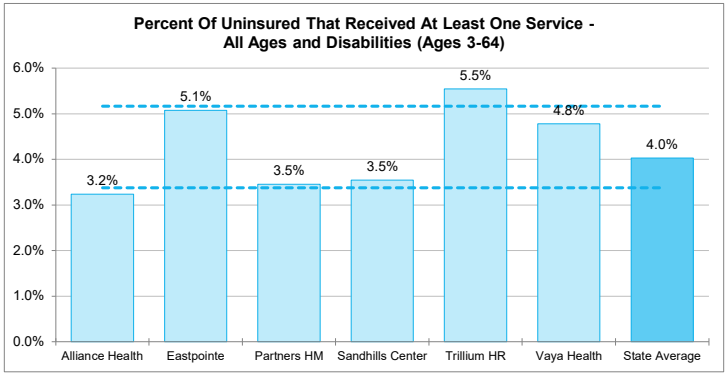
Description: Service penetration is the percentage of individuals eligible to receive services for a covered condition who actually receive a service for that condition witihin a specified time frame. For persons receiving State and Federal Block Grant funded services, it is the unduplicated number of persons who received a service for a covered condition (e.g. MH, I/DD, or SUD diagnosis) during the measurement period divided by the estimated number of uninsured non-elderly persons for 6 age-disability groups - Children and Adults under age 65 with a MH condition, Children and Adults under age 65 with a Substance Use Disorder, and Children and Adults under age 65 with an Intellectual or Developmental Disability - and for All Ages under age 65 and Disabilities combined.

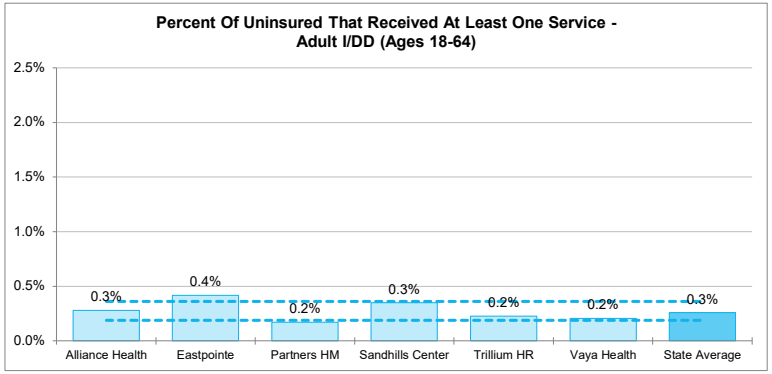
	Child I/DD (Ages 3-17)			Adult I/DD (Ages 18-64)			All Ages and Disabilities (Ages 3-64)			
	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate	
LME-MCO	**Number That Received At Least One Service**	**Number Of Uninsured Population**	**Percent That Received At Least One Service**	**Number That Received At Least One Service**	**Number Of Uninsured Population**	**Percent That Received At Least One Service**	**Number That Received At Least One Service**	**Number Of Uninsured Population**	**Percent That Received At Least One Service**	Sum of # in each age disability that rec'd a service
Alliance Health	40	30,659	0.1%	831	296,528	0.3%	10,236	316,226	3.2%	11,666
Eastpointe	25	6,952	0.4%	293	70,173	0.4%	3,774	74,419	5.1%	4,246
Partners Health Management	25	19,246	0.1%	324	190,537	0.2%	6,959	201,301	3.5%	7,806
Sandhills Center	35	13,352	0.3%	481	138,192	0.3%	5,167	145,789	3.5%	5,684
Trillium Health Resources	283	14,305	2.0%	307	135,307	0.2%	8,100	146,187	5.5%	10,320
Vaya Health	27	16,307	0.2%	355	173,141	0.2%	8,777	183,642	4.8%	10,449
Statewide	435	100,822	0.4%	2,591	1,003,878	0.3%	43,013	1,067,565	4.0%	
Standard Deviation			0.7%			0.1%			0.9%	
LME-MCO Average			0.5%			0.3%			4.3%	

Red font: Number that received a service for All Ages and Disabilities ≥ sum of the numbers in each age disability.*

* The number for All Ages and Disabilities should be < than the sum as persons with dual diagnoses can be included in > one







North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

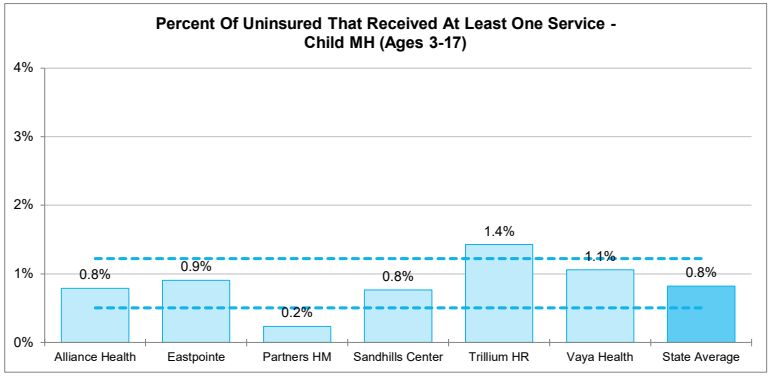
PENETRATION

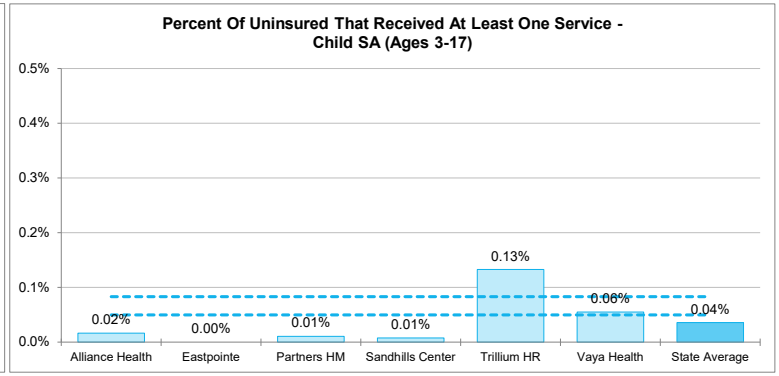
3.2 Persons Served: Non-Medicaid (State and Federal Block Grant Funded) (SFYTD)

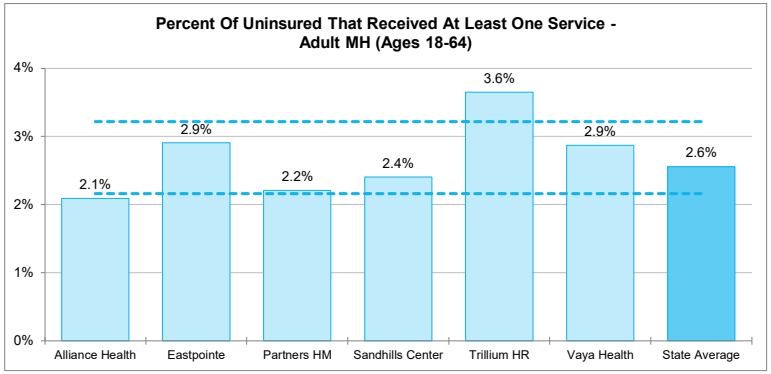
Rationale: NC has designed its public system to serve those persons who have the highest need for specialized mental health, intellectual or developmental disabilitites,and substance use services and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. Service penetration is an indicator of system access that has been used to characterize how accessible a particular service or group of services is for persons eligible to receive those services.

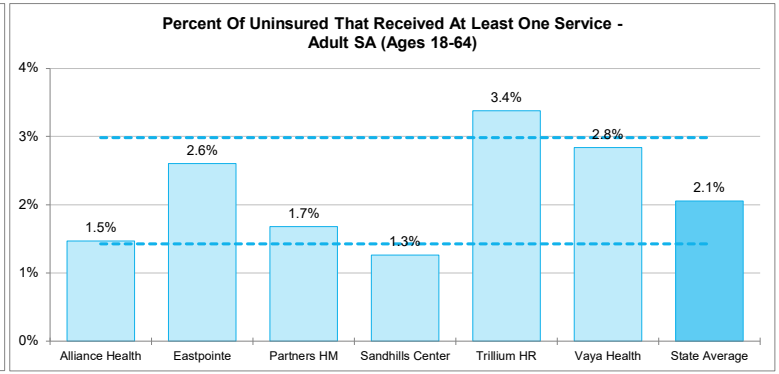
Description: Service penetration is the percentage of individuals eligible to receive services for a covered condition who actually receive a service for that condition withiin a specified time frame. For persons receiving State and Federal Block Grant funded services, it is the undupllicated number of persons who received a service for a covered condition (e.g. MH, I/DD, or SUD diagnosis) during the measurement period divided by the estimated number of uninsured non-elderly persons for 6 age-disability groups - Children and Adults under age 65 with a MH condition, Children and Adults under age 65 with a Substance Use Disorder, and Children and Adults under age 65 with an Intellectual or Developmental Disability - and for All Ages under age 65 and Disabilities combined.

	Child MH (Ages 3-17)			Adult MH (Ages 18-64)			Child SA (Ages 3-17)			Adult SA (Ages 18-64)		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate
LME-MCO	**Number That Received At Least One Service**	**Number Of Uninsured Population**	**Percent That Received At Least One Service**	**Number That Received At Least One Service**	**Number Of Uninsured Population**	**Percent That Received At Least One Service**	**Number That Received At Least One Service**	**Number Of Uninsured Population**	**Percent That Received At Least One Service**	**Number That Received At Least One Service**	**Number Of Uninsured Population**	**Percent That Received At Least One Service**
Alliance Health	241	30,659	0.8%	6,194	296,528	2.1%	5	30,659	0.02%	4,355	296,528	1.5%
Eastpointe	63	6,952	0.9%	2,039	70,173	2.9%	0	6,952	0.00%	1,826	70,173	2.6%
Partners Health Management	45	19,246	0.2%	4,209	190,537	2.2%	2	19,246	0.01%	3,201	190,537	1.7%
Sandhills Center	102	13,352	0.8%	3,320	138,192	2.4%	1	13,352	0.01%	1,745	138,192	1.3%
Trillium Health Resources	204	14,305	1.4%	4,938	135,307	3.6%	19	14,305	0.13%	4,569	135,307	3.4%
Vaya Health	173	16,307	1.1%	4,970	173,141	2.9%	9	16,307	0.06%	4,915	173,141	2.8%
Statewide	828	100,822	0.8%	25,670	1,003,878	2.6%	36	100,822	0.04%	20,611	1,003,878	2.1%
Standard Deviation			0.4%			0.5%			0.05%			0.8%
LME-MCO Average			0.9%			2.7%			0.04%			2.2%









North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

PENETRATION

3.2 Persons Served: Non-Medicaid (State and Federal Block Grant Funded) (SFYTD)

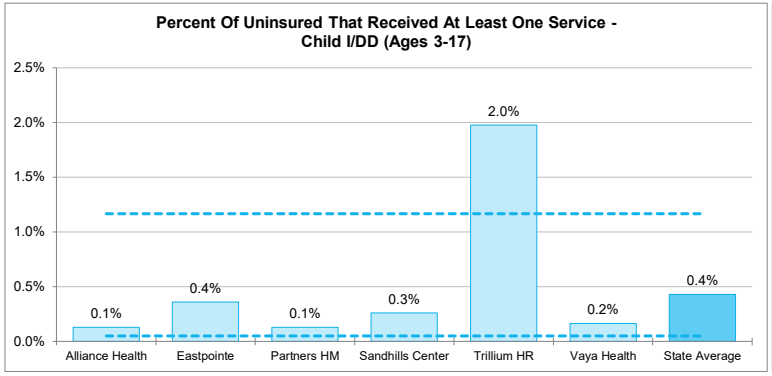
Rationale: NC has designed its public system to serve those persons who have the highest need for specialized mental health, intellectual or developmental disabilitites,and substance use services and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. Service penetration is an indicator of system access that has been used to characterize how accessible a particular service or group of services is for persons eligible to receive those services.

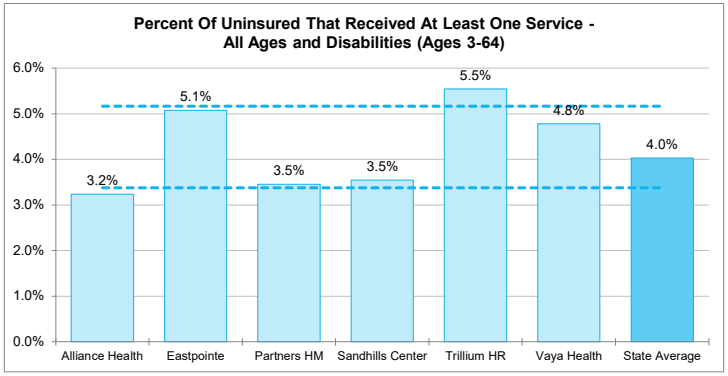
Description: Service penetration is the percentage of individuals eligible to receive services for a covered condition who actually receive a service for that condition withihn a specified time frame. For persons receiving State and Federal Block Grant funded services, it is the undupllicated number of persons who received a service for a covered condition (e.g. MH, I/DD, or SUD diagnosis) during the measurement period divided by the estimated number of uninsured non-elderly persons for 6 age-disability groups - Children and Adults under age 65 with a MH condition, Children and Adults under age 65 with a Substance Use Disorder, and Children and Adults under age 65 with an Intellectual or Developmental Disability - and for All Ages under age 65 and Disabilities combined.

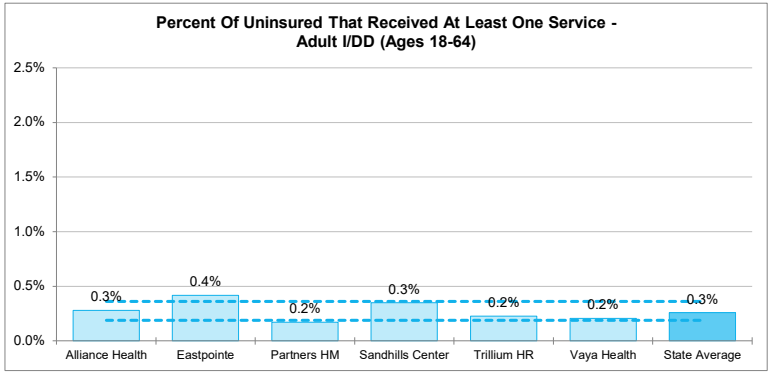
	Child I/DD (Ages 3-17)			Adult I/DD (Ages 18-64)			All Ages and Disabilities (Ages 3-64)			
	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate	
LME-MCO	**Number That Received At Least One Service**	**Number Of Uninsured Population**	**Percent That Received At Least One Service**	**Number That Received At Least One Service**	**Number Of Uninsured Population**	**Percent That Received At Least One Service**	**Number That Received At Least One Service**	**Number Of Uninsured Population**	**Percent That Received At Least One Service**	Sum of # in each age disability that rec'd a service
Alliance Health	40	30,659	0.1%	831	296,528	0.3%	10,236	316,226	3.2%	11,666
Eastpointe	25	6,952	0.4%	293	70,173	0.4%	3,774	74,419	5.1%	4,246
Partners Health Management	25	19,246	0.1%	324	190,537	0.2%	6,959	201,301	3.5%	7,806
Sandhills Center	35	13,352	0.3%	481	138,192	0.3%	5,167	145,789	3.5%	5,684
Trillium Health Resources	283	14,305	2.0%	307	135,307	0.2%	8,100	146,187	5.5%	10,320
Vaya Health	27	16,307	0.2%	355	173,141	0.2%	8,777	183,642	4.8%	10,449
Statewide	435	100,822	0.4%	2,591	1,003,878	0.3%	43,013	1,067,565	4.0%	
Standard Deviation			0.7%			0.1%			0.9%	
LME-MCO Average			0.5%			0.3%			4.3%	

Red font: Number that received a service for All Ages and Disabilities ≥ sum of the numbers in each age disability.

* The number for All Ages and Disabilities should be < than the sum as persons with dual diagnoses can be included in > one disability group.







INITIATION AND ENGAGEMENT

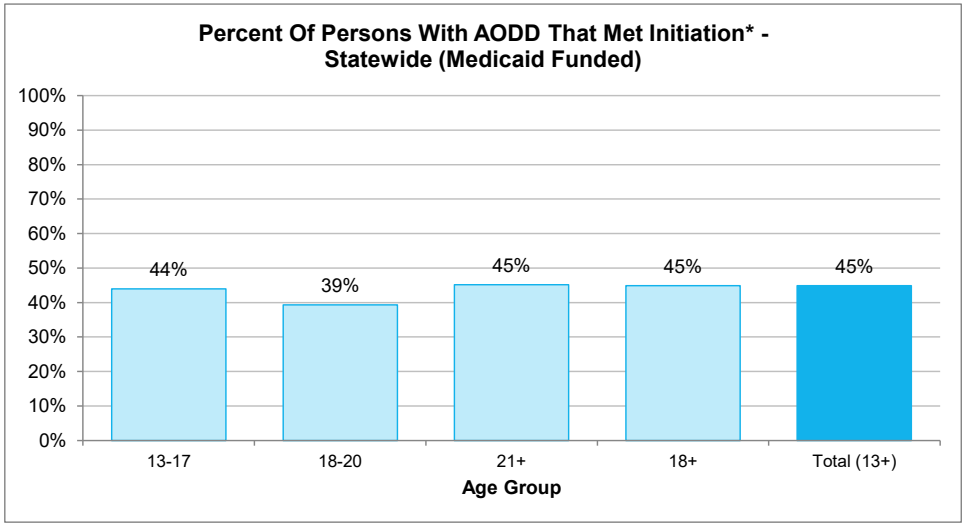
4.1. Initiation and Engagement of Substance Abuse Treatment (By Age Group)

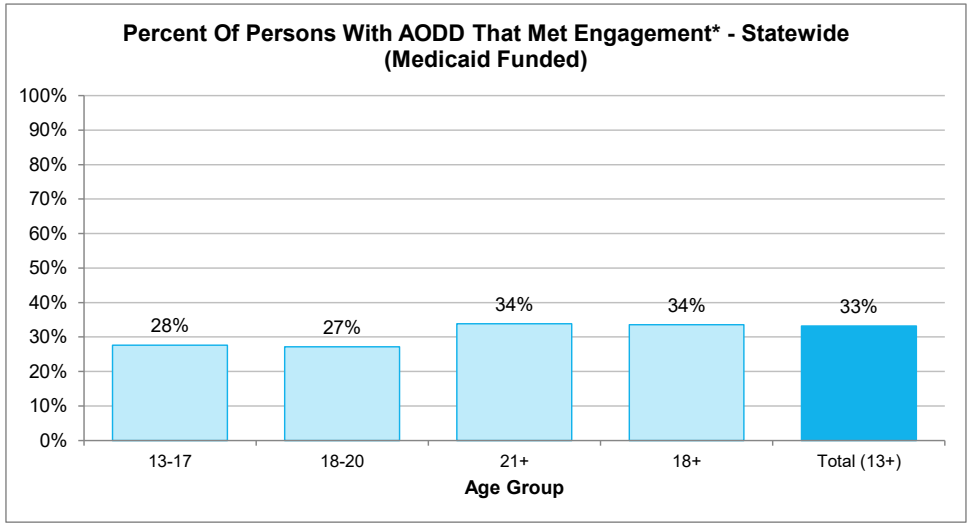
Rationale: For persons with substance use disorders to recover control over their lives and maintain stability, they need to fully initiate and become engaged in treatment services and supports. Treatment for alcohol and other drug (AOD) dependence can improve health, productivity, and social outcomes. It can also save millions of dollars on health care and related costs. Initiation and engagement are nationally accepted measures of access. The initiation and engagement measures were originally developed by the Washington Circle, an organization supported by the federal Center for Substance Abuse Treatment, and then adapted for use as Healthcare Enterprise Data Information System (HEDIS ©) measures.

Description: ***Initiation*** is measured as the percent of persons starting a new episode of alcohol or other drug dependence (defined as having no prior Medicaid or state-funded mh/dd/su service for an AOD diagnosis for at least 60 days) who receive a 2nd service for an AOD diagnosis within 14 days of the first service. ***Engagement*** is measured as the percent of persons who after meeting the initiation criteria receive an additional 2 visits for an AOD diagnosis within the next 30 days (a total of 4 visits within the first 44 days of service). This indicator looks at initiation and engagement for five age groups (13-17, 18-20, 21+, 18+, and 13+).

Medicaid Funded

	Numerator1			Numerator2	Denominator	Rate1			Rate2
Age Groups	**Number With 2nd Service Or Visit Within 14 Days (Initiation)**	**Number With 2nd Service Or Visit More Than 14 Days**	**Number With No 2nd Visit**	**Number With 2 Or More Services/ Visits Within 30 Days After Initiation (Engagement)**	**Total Number with an Initial Visit (New Episode of Care)**	**Percent With 2nd Service Or Visit Within 14 Days (Initiation)**	**Percent With 2nd Service Or Visit More Than 14 Days**	**Percent With No 2nd Service**	**Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)**
13-17	172	52	167	108	391	44%	13%	43%	28%
18-20	123	40	150	85	313	39%	13%	48%	27%
21+	3,044	860	2,837	2,279	6,741	45%	13%	42%	34%
18+	3,167	900	2,987	2,364	7,054	45%	13%	42%	34%
Total (13+)	3,339	952	3,154	2,472	7,445	45%	13%	42%	33%





* Received a 2nd service or visit within 14 days of the 1st service.

* Received 2 or more services or visits within 30 days after meeting initiation requirements.

North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

Report Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

INITIATION AND ENGAGEMENT

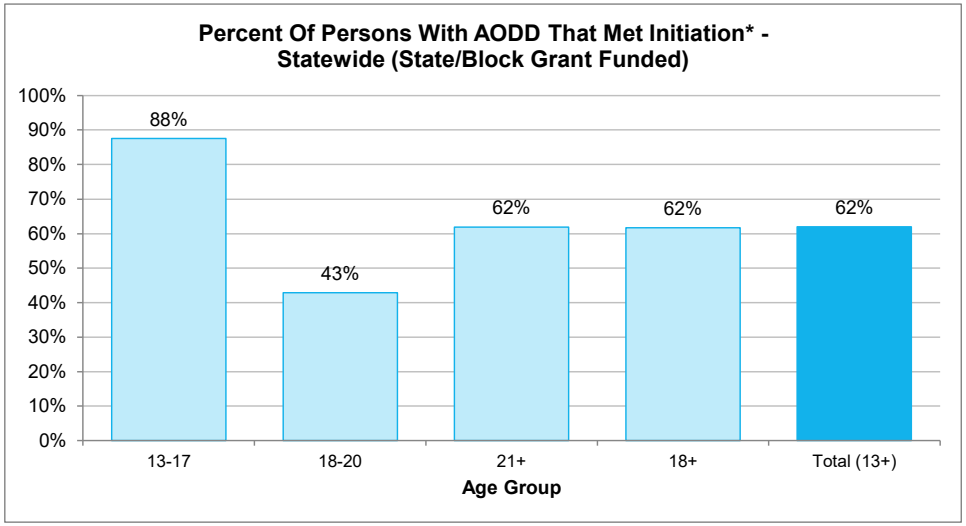
4.1. Initiation and Engagement of Substance Abuse Treatment (By Age Group)

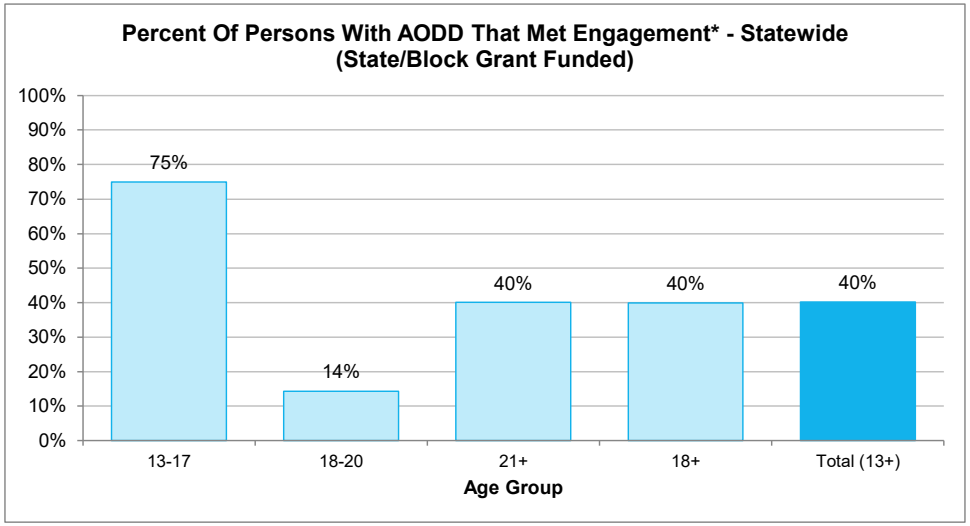
Rationale: For persons with substance use disorders to recover control over their lives and maintain stability, they need to fully initiate and become engaged in treatment services and supports. Treatment for alcohol and other drug (AOD) dependence can improve health, productivity, and social outcomes. It can also save millions of dollars on health care and related costs. Initiation and engagement are nationally accepted measures of access. The initiation and engagement measures were originally developed by the Washington Circle, an organization supported by the federal Center for Substance Abuse Treatment, and then adapted for use as Healthcare Enterprise Data Information System (HEDIS ©) measures.

Description: ***Initiation*** is measured as the percent of persons starting a new episode of alcohol or other drug dependence (defined as having no prior Medicaid or state-funded mh/dd/su service for an AOD diagnosis for at least 60 days) who receive a 2nd service for an AOD diagnosis within 14 days of the first service. ***Engagement*** is measured as the percent of persons who after meeting the initiation criteria receive an additional 2 visits for an AOD diagnosis within the next 30 days (a total of 4 visits within the first 44 days of service). This indicator looks at initiation and engagement for five age groups (13-17, 18-20, 21+, 18+, and 13+).

State/Block Grant Funded

	Numerator1			Numerator2	Denominator	Rate1			Rate2
Age Groups	**Number With 2nd Service Or Visit Within 14 Days (Initiation)**	**Number With 2nd Service Or Visit More Than 14 Days**	**Number With No 2nd Visit**	**Number With 2 Or More Services/ Visits Within 30 Days After Initiation (Engagement)**	**Total Number with an Initial Visit (New Episode of Care)**	**Percent With 2nd Service Or Visit Within 14 Days (Initiation)**	**Percent With 2nd Service Or Visit More Than 14 Days**	**Percent With No 2nd Service**	**Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)**
13-17	14	2	0	12	16	88%	13%	0%	75%
18-20	6	1	7	2	14	43%	7%	50%	14%
21+	1,217	262	487	788	1,966	62%	13%	25%	40%
18+	1,223	263	494	790	1,980	62%	13%	25%	40%
Total (13+)	1,237	265	494	802	1,996	62%	13%	25%	40%





* Received a 2nd service or visit within 14 days of the 1st service.

* Received 2 or more services or visits within 30 days after meeting initiation requirements.

INITIATION AND ENGAGEMENT

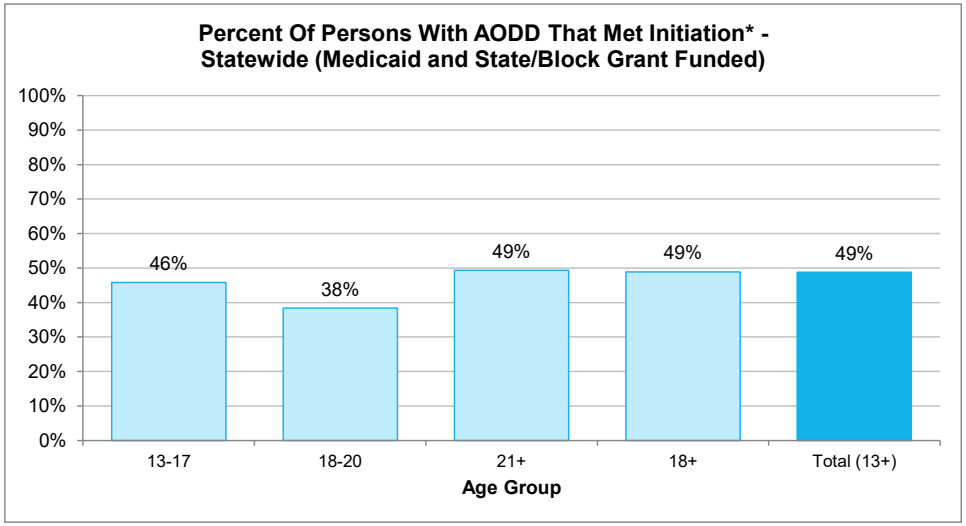
4.1. Initiation and Engagement of Substance Abuse Treatment (By Age Group)

Rationale: For persons with substance use disorders to recover control over their lives and maintain stability, they need to fully initiate and become engaged in treatment services and supports. Treatment for alcohol and other drug (AOD) dependence can improve health, productivity, and social outcomes. It can also save millions of dollars on health care and related costs. Initiation and engagement are nationally accepted measures of access. The initiation and engagement measures were originally developed by the Washington Circle, an organization supported by the federal Center for Substance Abuse Treatment, and then adapted for use as Healthcare Enterprise Data Information System (HEDIS ©) measures.

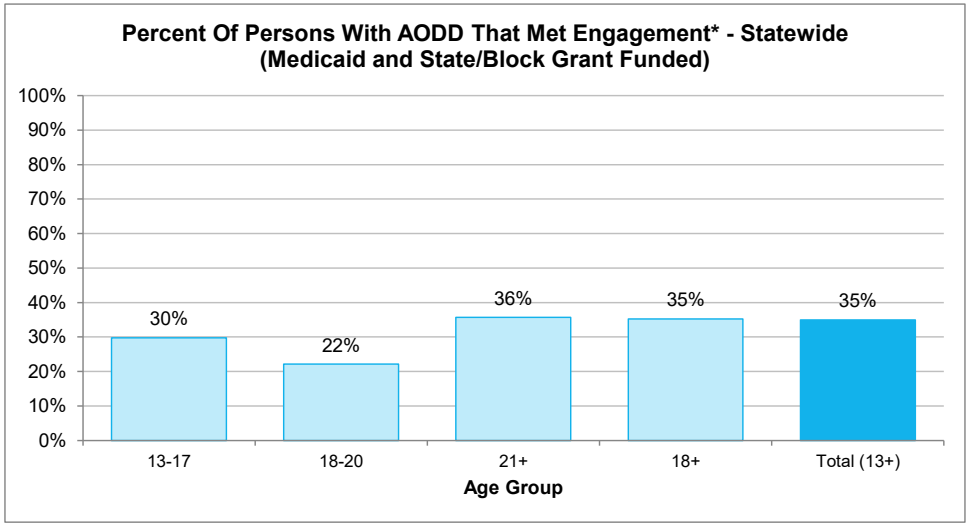
Description: ***Initiation*** is measured as the percent of persons starting a new episode of alcohol or other drug dependence (defined as having no prior Medicaid or state-funded mh/dd/su service for an AOD diagnosis for at least 60 days) who receive a 2nd service for an AOD diagnosis within 14 days of the first service. ***Engagement*** is measured as the percent of persons who after meeting the initiation criteria receive an additional 2 visits for an AOD diagnosis within the next 30 days (a total of 4 visits within the first 44 days of service). This indicator looks at initiation and engagement for five age groups (13-17, 18-20, 21+, 18+, and 13+).

Medicaid and State/Block Grant Funded

	Numerator1			Numerator2	Denominator	Rate1			Rate2
Age Groups	**Number With 2nd Service Or Visit Within 14 Days (Initiation)**	**Number With 2nd Service Or Visit More Than 14 Days**	**Number With No 2nd Visit**	**Number With 2 Or More Services/ Visits Within 30 Days After Initiation (Engagement)**	**Total Number with an Initial Visit (New Episode of Care)**	**Percent With 2nd Service Or Visit Within 14 Days (Initiation)**	**Percent With 2nd Service Or Visit More Than 14 Days**	**Percent With No 2nd Service**	**Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)**
13-17	189	55	169	123	413	46%	13%	41%	30%
18-20	132	42	170	76	344	38%	12%	49%	22%
21+	4,409	1,149	3,385	3,192	8,943	49%	13%	38%	36%
18+	4,541	1,191	3,555	3,268	9,287	49%	13%	38%	35%
Total (13+)	4,730	1,246	3,724	3,391	9,700	49%	13%	38%	35%



* Received a 2nd service or visit within 14 days of the 1st service.



* Received 2 or more services or visits within 30 days after meeting initiation requirements.

North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

Report Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

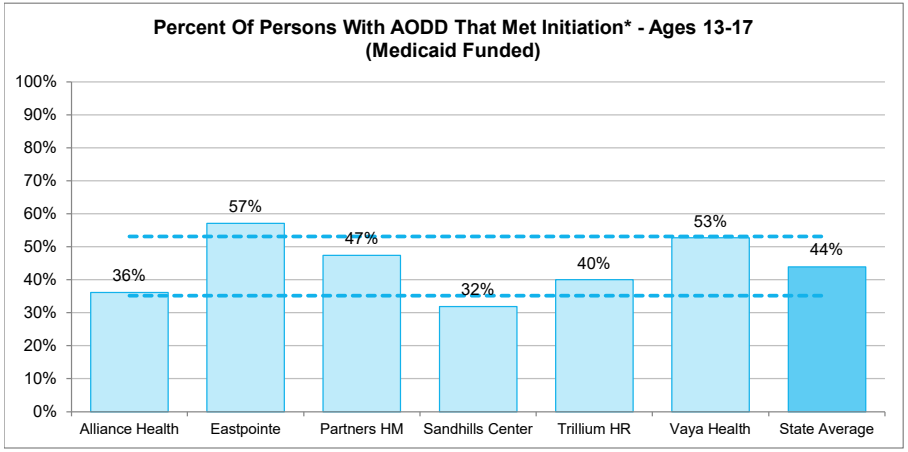
INITIATION AND ENGAGEMENT

4.1. Initiation and Engagement of Substance Abuse Treatment (By Age Group)

Rationale: For persons with substance use disorders to recover control over their lives and maintain stability, they need to fully initiate and become engaged in treatment services and supports. Treatment for alcohol and other drug (AOD) dependence can improve health, productivity, and social outcomes. It can also save millions of dollars on health care and related costs. Initiation and engagement are nationally accepted measures of access. The initiation and engagement measures were originally developed by the Washington Circle, an organization supported by the federal Center for Substance Abuse Treatment, and then adapted for use as Healthcare Enterprise Data Information System (HEDIS ©) measures.

Description: ***Initiation*** is measured as the percent of persons starting a new episode of alcohol or other drug dependence (defined as having no prior Medicaid or state-funded mh/dd/su service for an AOD diagnosis for at least 60 days) who receive a 2nd service for an AOD diagnosis within 14 days of the first service. ***Engagement*** is measured as the percent of persons who after meeting the initiation criteria receive an additional 2 visits for an AOD diagnosis within the next 30 days (a total of 4 visits within the first 44 days of service). This indicator looks at initiation and engagement for five age groups (13-17, 18-20, 21+, 18+, and 13+).

	Numerator1			Numerator2	Denominator	Rate1			Rate2
LME-MCO	**Number With 2nd Service Or Visit Within 14 Days (Initiation)**	**Number With 2nd Service Or Visit More Than 14 Days**	**Number With No 2nd Visit**	**Number With 2 Or More Services/ Visits Within 30 Days After Initiation (Engagement)**	**Total Number with an Initial Visit (New Episode of Care)**	**Percent With 2nd Service Or Visit Within 14 Days (Initiation)**	**Percent With 2nd Service Or Visit More Than 14 Days**	**Percent With No 2nd Service**	**Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)**
Persons Ages 13-17 (Medicaid Funded)									
Alliance Health	30	12	41	20	83	36%	14%	49%	24%
Eastpointe	24	4	14	17	42	57%	10%	33%	40%
Partners Health Management	54	12	48	34	114	47%	11%	42%	30%
Sandhills Center	15	9	23	9	47	32%	19%	49%	19%
Trillium Health Resources	20	11	19	7	50	40%	22%	38%	14%
Vaya Health	29	4	22	21	55	53%	7%	40%	38%
State Average	172	52	167	108	391	44%	13%	43%	28%
Standard Deviation						9.0%	5.3%	5.7%	9.6%
LME-MCO Average						44%	14%	42%	28%



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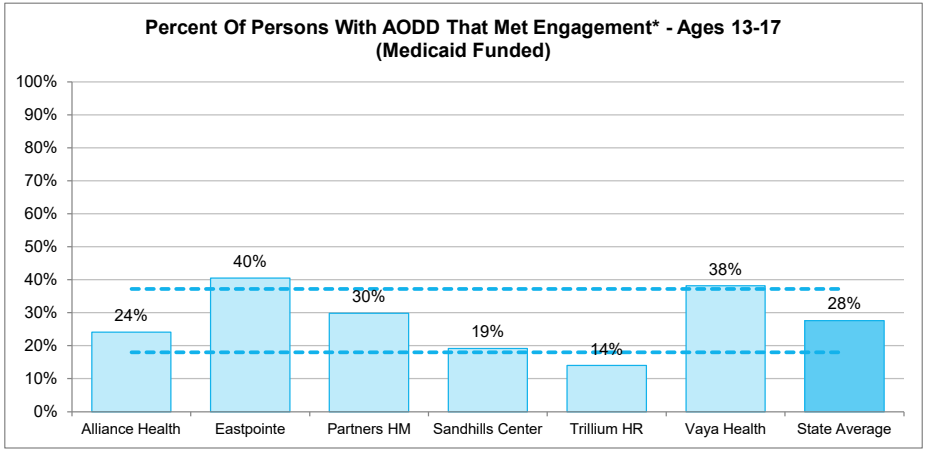

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North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

Report Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

INITIATION AND ENGAGEMENT

4.1. Initiation and Engagement of Substance Abuse Treatment (By Age Group)

Rationale: For persons with substance use disorders to recover control over their lives and maintain stability, they need to fully initiate and become engaged in treatment services and supports. Treatment for alcohol and other drug (AOD) dependence can improve health, productivity, and social outcomes. It can also save millions of dollars on health care and related costs. Initiation and engagement are nationally accepted measures of access. The initiation and engagement measures were originally developed by the Washington Circle, an organization supported by the federal Center for Substance Abuse Treatment, and then adapted for use as Healthcare Enterprise Data Information System (HEDIS ©) measures.

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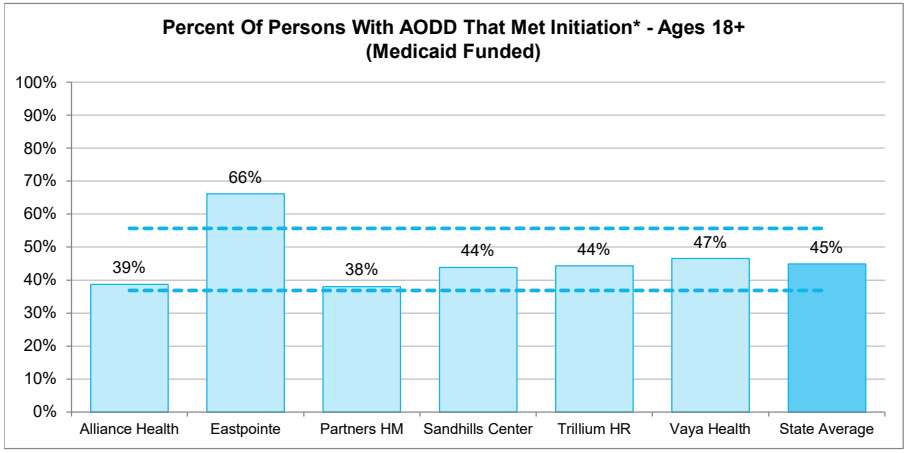
Persons Ages 18+ (Medicaid Funded)									
Alliance Health	467	157	582	327	1,206	39%	13%	48%	27%
Eastpointe	673	80	264	576	1,017	66%	8%	26%	57%
Partners Health Management	784	282	996	576	2,062	38%	14%	48%	28%
Sandhills Center	373	96	382	292	851	44%	11%	45%	34%
Trillium Health Resources	443	172	385	282	1,000	44%	17%	39%	28%
Vaya Health	427	113	378	311	918	47%	12%	41%	34%
State Average	3,167	900	2,987	2,364	7,054	45%	13%	42%	34%
Standard Deviation						9.4%	2.8%	7.7%	10.2%
LME-MCO Average						46%	13%	41%	35%



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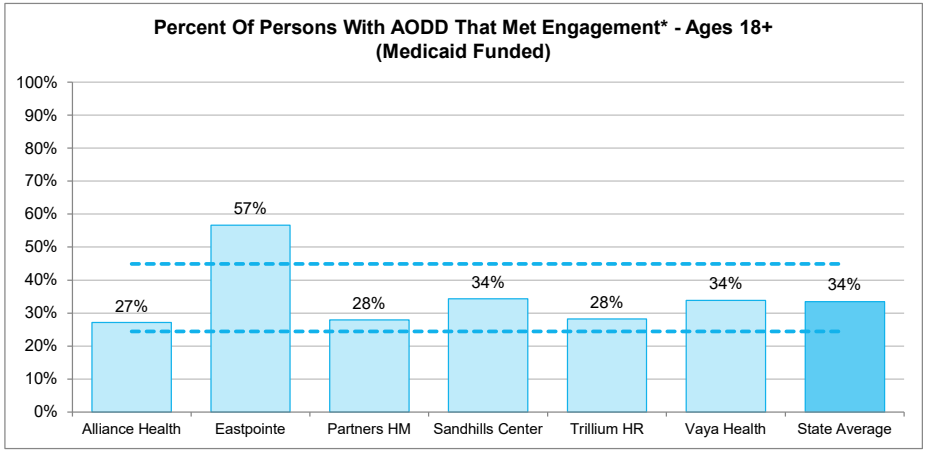

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North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

Report Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

INITIATION AND ENGAGEMENT

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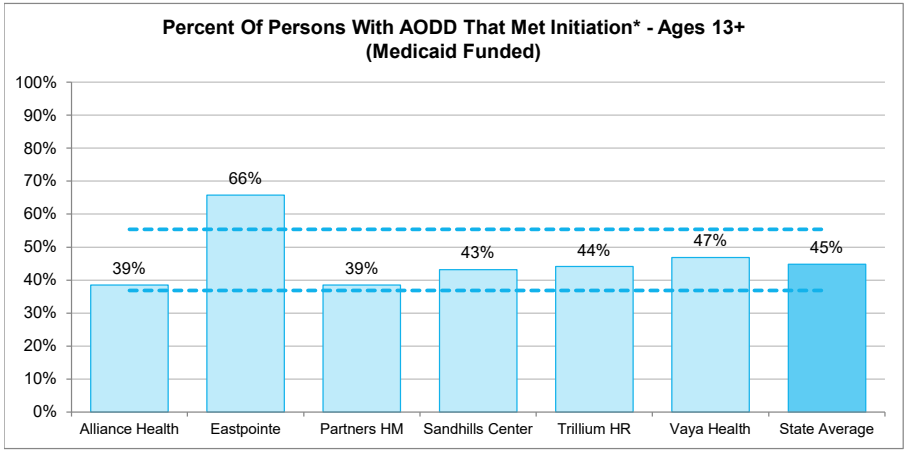
Persons Ages 13+ (Medicaid Funded)									
Alliance Health	497	169	623	347	1,289	39%	13%	48%	27%
Eastpointe	697	84	278	593	1,059	66%	8%	26%	56%
Partners Health Management	838	294	1,044	610	2,176	39%	14%	48%	28%
Sandhills Center	388	105	405	301	898	43%	12%	45%	34%
Trillium Health Resources	463	183	404	289	1,050	44%	17%	38%	28%
Vaya Health	456	117	400	332	973	47%	12%	41%	34%
State Average	3,339	952	3,154	2,472	7,445	45%	13%	42%	33%
Standard Deviation						9.3%	2.8%	7.6%	10.1%
LME-MCO Average						46%	13%	41%	34%



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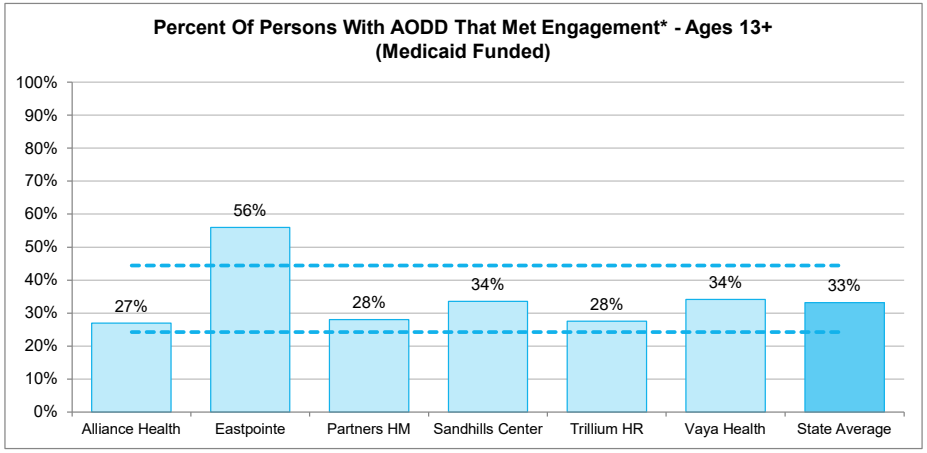

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North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

Report Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

INITIATION AND ENGAGEMENT

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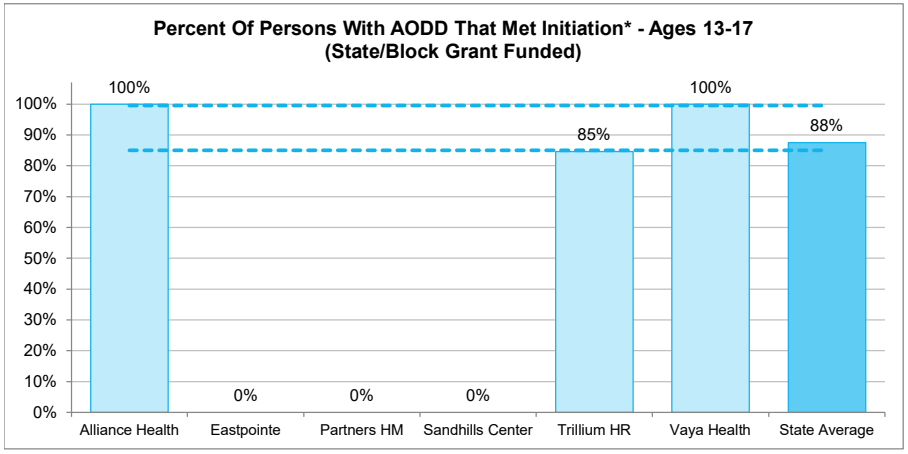
Persons Ages 13-17 (State/Block Grant Funded)									
Alliance Health	1	0	0	1	1	100%	0%	0%	100%
Eastpointe	0	0	0	0	0				
Partners Health Management	0	0	0	0	0				
Sandhills Center	0	0	0	0	0				
Trillium Health Resources	11	2	0	9	13	85%	15%	0%	69%
Vaya Health	2	0	0	2	2	100%	0%	0%	100%
State Average	14	2	0	12	16	88%	13%	0%	75%
Standard Deviation						7.3%	7.3%	0.0%	14.5%
LME-MCO Average		[Eastpointe, Partners, and Sandhills reported no individuals in this age group beginning a new episode of care this quarter.]				95%	5%	0%	90%



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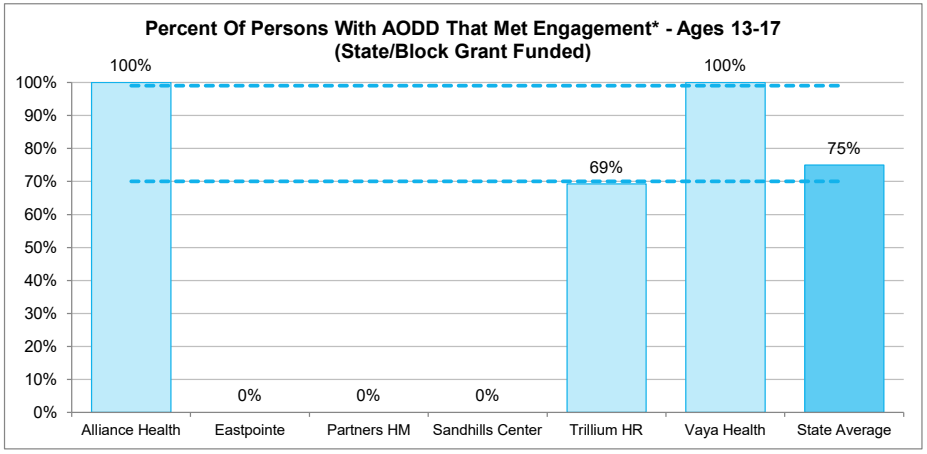

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North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

Report Year:	2023	**Measurement Period:**	Jul - Sep 2022
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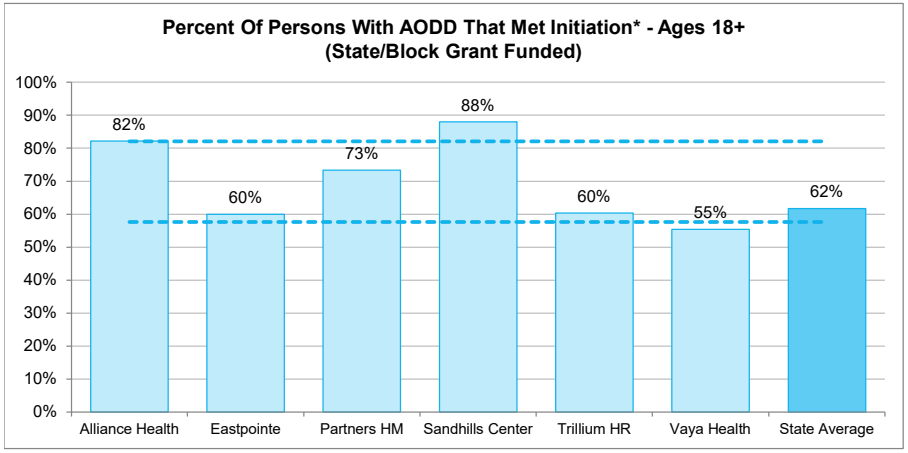
Persons Ages 18+ (State/Block Grant Funded)									
Alliance Health	37	1	7	31	45	82%	2%	16%	69%
Eastpointe	6	0	4	4	10	60%	0%	40%	40%
Partners Health Management	44	2	14	40	60	73%	3%	23%	67%
Sandhills Center	44	1	5	43	50	88%	2%	10%	86%
Trillium Health Resources	1,061	258	440	649	1,759	60%	15%	25%	37%
Vaya Health	31	1	24	23	56	55%	2%	43%	41%
State Average	1,223	263	494	790	1,980	62%	13%	25%	40%
Standard Deviation						12.2%	4.9%	11.9%	18.4%
LME-MCO Average						70%	4%	26%	57%



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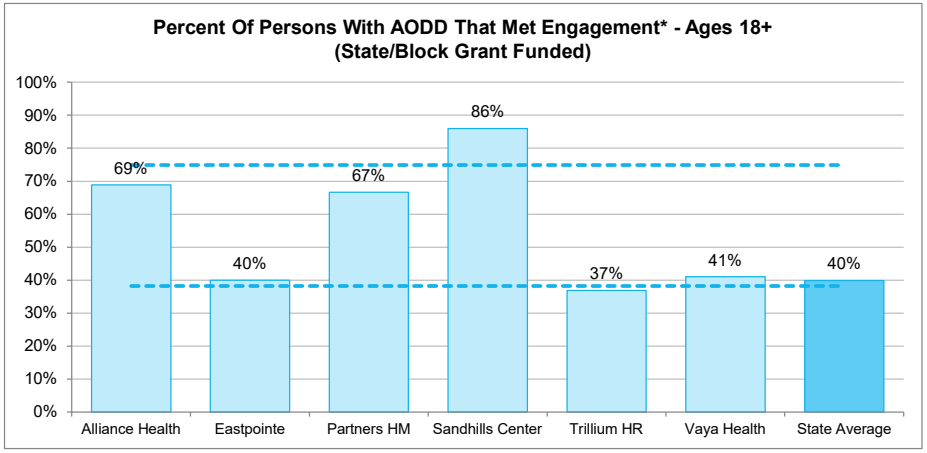

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North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

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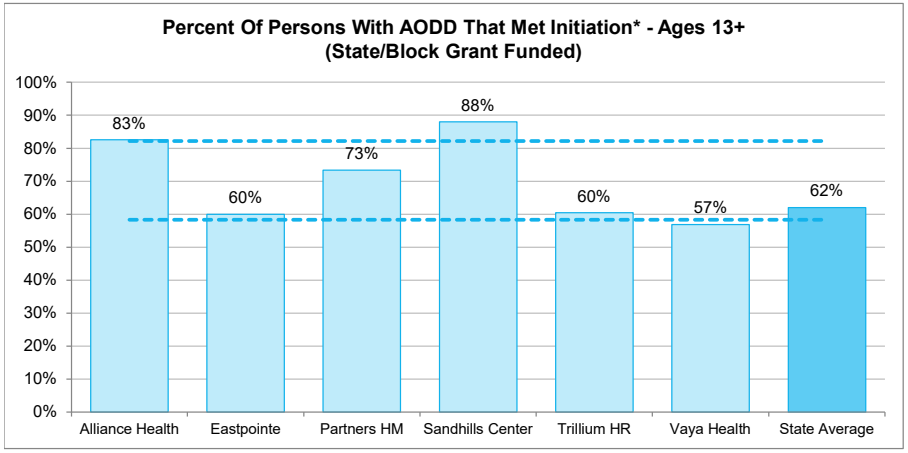
Persons Ages 13+ (State/Block Grant Funded)									
Alliance Health	38	1	7	32	46	83%	2%	15%	70%
Eastpointe	6	0	4	4	10	60%	0%	40%	40%
Partners Health Management	44	2	14	40	60	73%	3%	23%	67%
Sandhills Center	44	1	5	43	50	88%	2%	10%	86%
Trillium Health Resources	1,072	260	440	658	1,772	60%	15%	25%	37%
Vaya Health	33	1	24	25	58	57%	2%	41%	43%
State Average	1,237	265	494	802	1,996	62%	13%	25%	40%
Standard Deviation						11.9%	4.9%	11.6%	18.1%
LME-MCO Average						70%	4%	26%	57%



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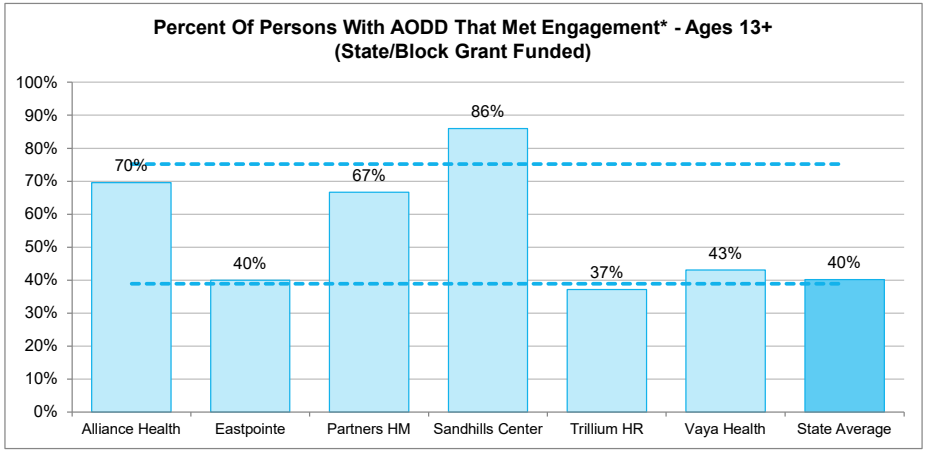

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North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

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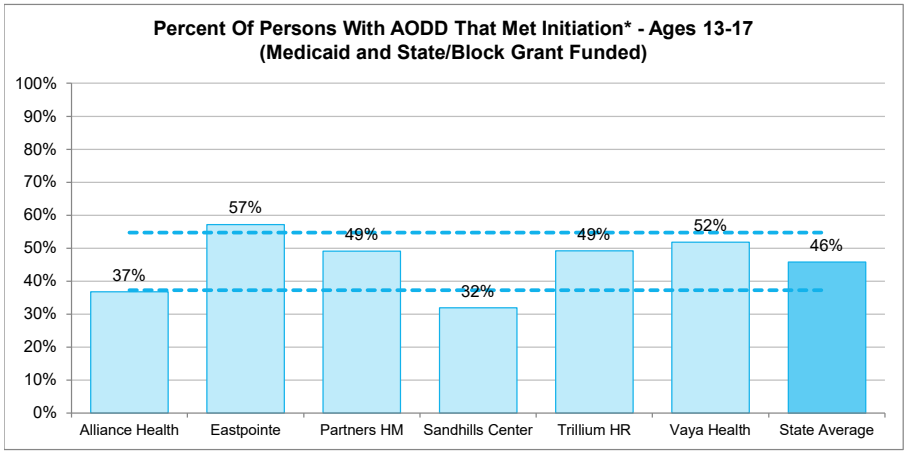
Persons Ages 13-17 (Medicaid and State/Block Grant Funded)									
Alliance Health	32	12	43	22	87	37%	14%	49%	25%
Eastpointe	24	4	14	17	42	57%	10%	33%	40%
Partners Health Management	58	12	48	38	118	49%	10%	41%	32%
Sandhills Center	15	9	23	9	47	32%	19%	49%	19%
Trillium Health Resources	31	13	19	16	63	49%	21%	30%	25%
Vaya Health	29	5	22	21	56	52%	9%	39%	38%
State Average	189	55	169	123	413	46%	13%	41%	30%
Standard Deviation						8.8%	4.7%	7.2%	7.4%
LME-MCO Average						46%	14%	40%	30%



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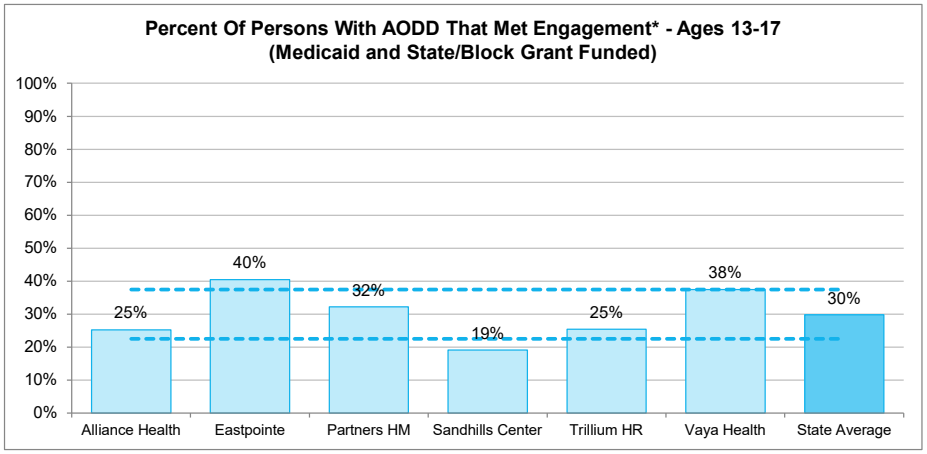

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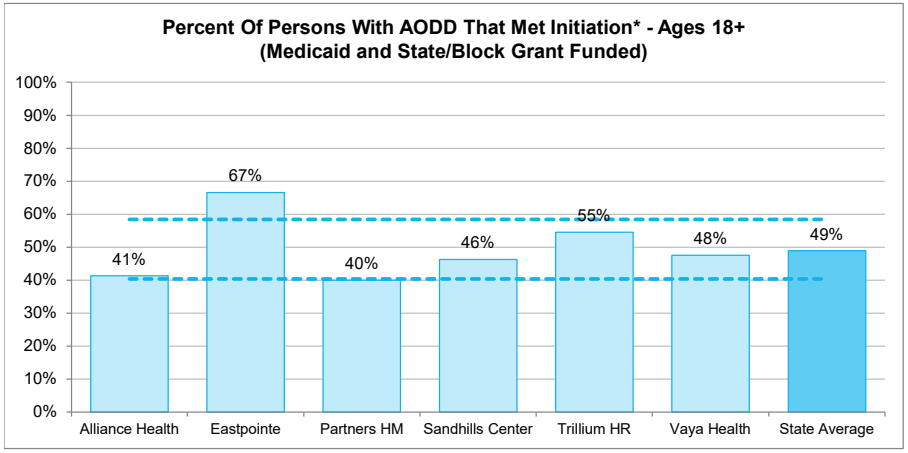
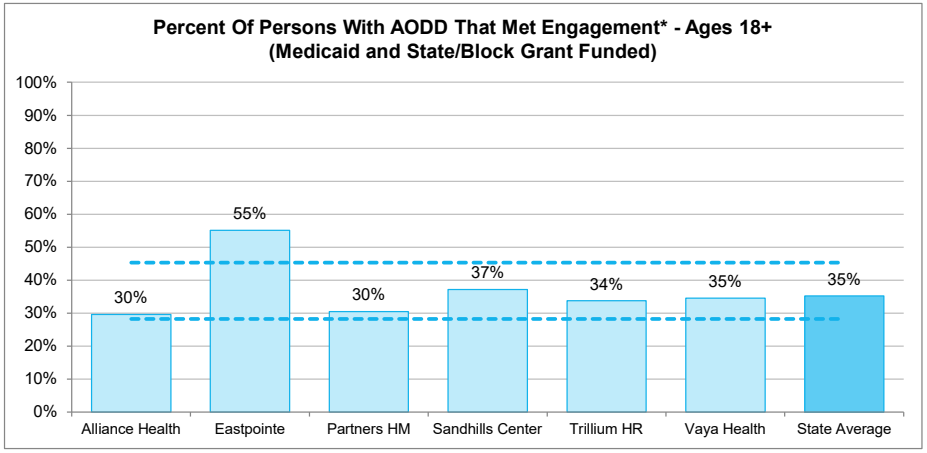
Persons Ages 18+ (Medicaid and State/Block Grant Funded)									
Alliance Health	526	157	590	377	1,273	41%	12%	46%	30%
Eastpointe	694	81	268	575	1,043	67%	8%	26%	55%
Partners Health Management	924	304	1,082	704	2,310	40%	13%	47%	30%
Sandhills Center	417	97	387	335	901	46%	11%	43%	37%
Trillium Health Resources	1,504	432	823	931	2,759	55%	16%	30%	34%
Vaya Health	476	120	405	346	1,001	48%	12%	40%	35%
State Average	4,541	1,191	3,555	3,268	9,287	49%	13%	38%	35%
Standard Deviation						9.0%	2.4%	8.1%	8.6%
LME-MCO Average						49%	12%	39%	37%



* Received a 2nd service or visit within 14 days of the 1st service.



* Received 2 or more services or visits within 30 days after meeting initiation requirements.

North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

Report Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

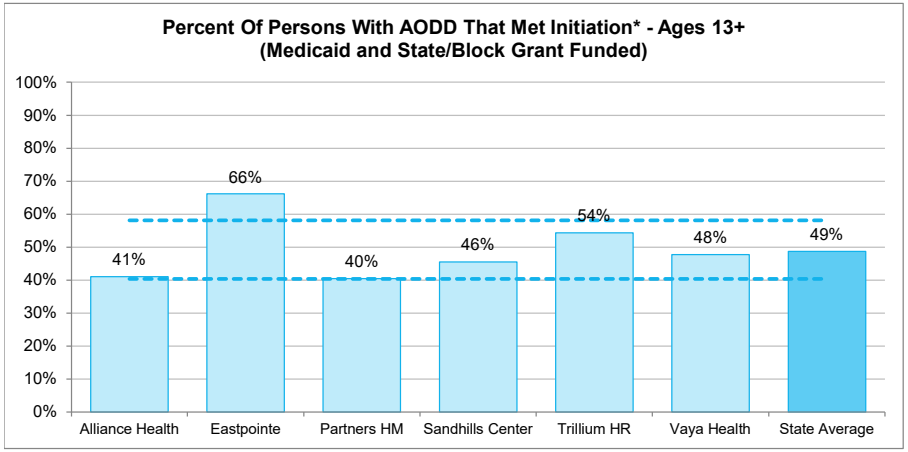
INITIATION AND ENGAGEMENT

4.1. Initiation and Engagement of Substance Abuse Treatment (By Age Group)

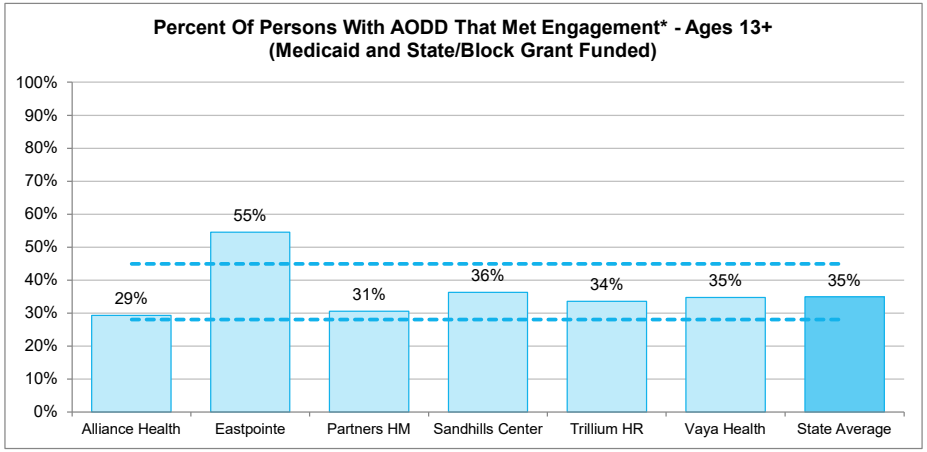
Rationale: For persons with substance use disorders to recover control over their lives and maintain stability, they need to fully initiate and become engaged in treatment services and supports. Treatment for alcohol and other drug (AOD) dependence can improve health, productivity, and social outcomes. It can also save millions of dollars on health care and related costs. Initiation and engagement are nationally accepted measures of access. The initiation and engagement measures were originally developed by the Washington Circle, an organization supported by the federal Center for Substance Abuse Treatment, and then adapted for use as Healthcare Enterprise Data Information System (HEDIS ©) measures.

Description: ***Initiation*** is measured as the percent of persons starting a new episode of alcohol or other drug dependence (defined as having no prior Medicaid or state-funded mh/dd/su service for an AOD diagnosis for at least 60 days) who receive a 2nd service for an AOD diagnosis within 14 days of the first service. ***Engagement*** is measured as the percent of persons who after meeting the initiation criteria receive an additional 2 visits for an AOD diagnosis within the next 30 days (a total of 4 visits within the first 44 days of service). This indicator looks at initiation and engagement for five age groups (13-17, 18-20, 21+, 18+, and 13+).

	Numerator1			Numerator2	Denominator	Rate1			Rate2
LME-MCO	**Number With 2nd Service Or Visit Within 14 Days (Initiation)**	**Number With 2nd Service Or Visit More Than 14 Days**	**Number With No 2nd Visit**	**Number With 2 Or More Services/ Visits Within 30 Days After Initiation (Engagement)**	**Total Number with an Initial Visit (New Episode of Care)**	**Percent With 2nd Service Or Visit Within 14 Days (Initiation)**	**Percent With 2nd Service Or Visit More Than 14 Days**	**Percent With No 2nd Service**	**Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)**
Persons Ages 13+ (Medicaid and State/Block Grant Funded)									
Alliance Health	558	169	633	399	1,360	41%	12%	47%	29%
Eastpointe	718	85	282	592	1,085	66%	8%	26%	55%
Partners Health Management	982	316	1,130	742	2,428	40%	13%	47%	31%
Sandhills Center	432	106	410	344	948	46%	11%	43%	36%
Trillium Health Resources	1,535	445	842	947	2,822	54%	16%	30%	34%
Vaya Health	505	125	427	367	1,057	48%	12%	40%	35%
State Average	4,730	1,246	3,724	3,391	9,700	49%	13%	38%	35%
Standard Deviation						8.9%	2.4%	8.0%	8.4%
LME-MCO Average						49%	12%	39%	37%



* Received a 2nd service or visit within 14 days of the 1st service.



* Received 2 or more services or visits within 30 days after meeting initiation requirements.

INITIATION AND ENGAGEMENT

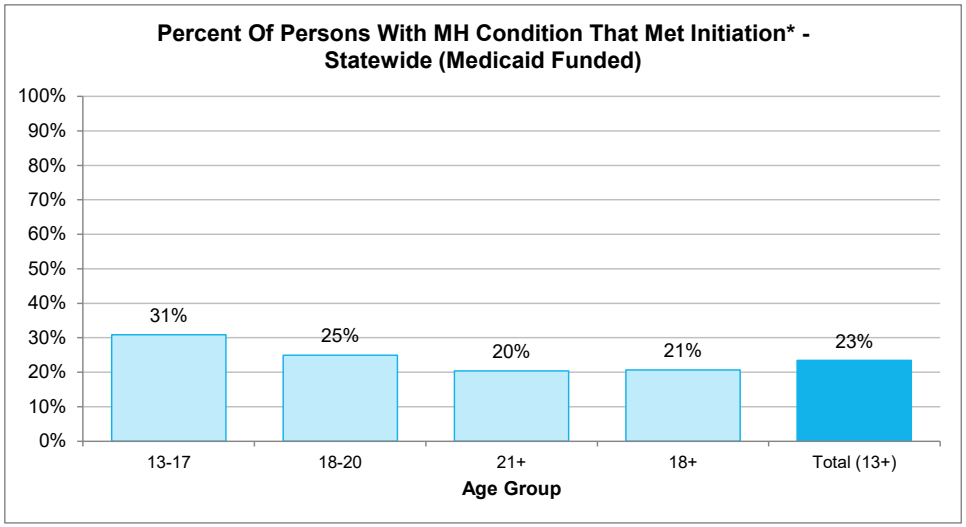
4.2. Initiation and Engagement of Mental Health Treatment (By Age Group)

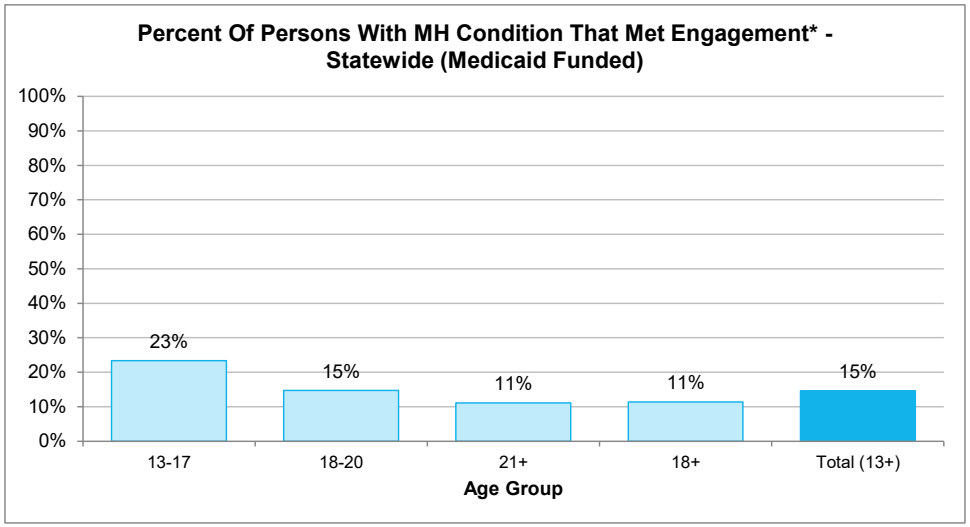
Rationale: For persons with mental illness to recover control over their lives and maintain stability, they need to fully initiate and become engaged in treatment services and supports. Treatment for mental illness can improve health, productivity, and social outcomes. It can also save millions of dollars on health care and related costs. Initiation and engagement are nationally accepted measures of access. The initiation and engagement measures were originally developed as a measure for persons with SUD by the Washington Circle, an organization supported by the federal Center for Substance Abuse Treatment, and then adapted for use as Healthcare Enterprise Data Information System (HEDIS ©) measures. The measure was further adapted by DMH/DD/SUS for use with persons with mental illness.

Description: ***Initiation*** is measured as the percent of persons starting a new episode of care for a mental illness (defined as having no prior Medicaid or state-funded mh/dd/su service for an MH diagnosis for at least 180 days) who receive a 2nd service for an MH diagnosis within 14 days of the first service. ***Engagement*** is measured as the percent of persons who after meeting the initiation criteria receive an additional 2 visits for a MH diagnosis within the next 30 days (a total of 4 visits within the first 44 days of service). This indicator looks at initiation and engagement for five age groups (13-17, 18-20, 21+, 18+, and 13+).

Medicaid Funded

	Numerator1			Numerator2	Denominator	Rate1			Rate2
Age Groups	**Number With 2nd Service Or Visit Within 14 Days (Initiation)**	**Number With 2nd Service Or Visit More Than 14 Days**	**Number With No 2nd Visit**	**Number With 2 Or More Services/ Visits Within 30 Days After Initiation (Engagement)**	**Total Number with an Initial Visit (New Episode of Care)**	**Percent With 2nd Service Or Visit Within 14 Days (Initiation)**	**Percent With 2nd Service Or Visit More Than 14 Days**	**Percent With No 2nd Service**	**Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)**
13-17	2,580	1,848	3,938	1,956	8,366	31%	22%	47%	23%
18-20	428	349	939	252	1,716	25%	20%	55%	15%
21+	4,149	3,518	12,728	2,256	20,395	20%	17%	62%	11%
18+	4,577	3,867	13,667	2,508	22,111	21%	17%	62%	11%
Total (13+)	7,157	5,715	17,605	4,464	30,477	23%	19%	58%	15%





* Received a 2nd service or visit within 14 days of the 1st service.

* Received 2 or more services or visits within 30 days after meeting initiation requirements.

INITIATION AND ENGAGEMENT

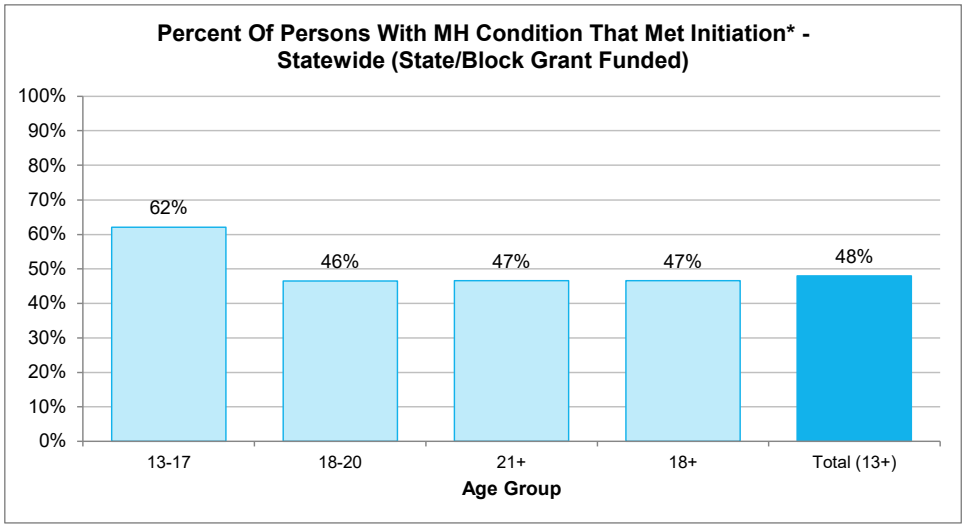
4.2. Initiation and Engagement of Mental Health Treatment (By Age Group)

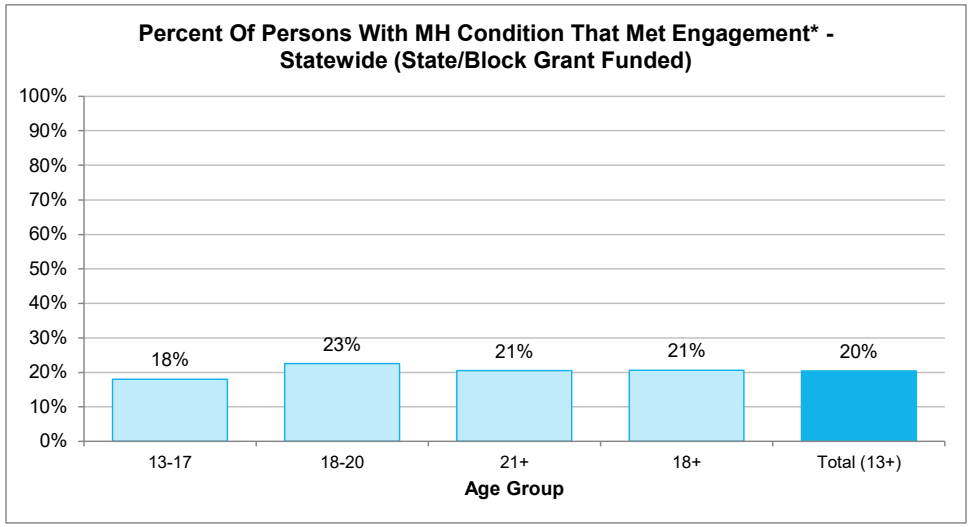
Rationale: For persons with mental illness to recover control over their lives and maintain stability, they need to fully initiate and become engaged in treatment services and supports. Treatment for mental illness can improve health, productivity, and social outcomes. It can also save millions of dollars on health care and related costs. Initiation and engagement are nationally accepted measures of access. The initiation and engagement measures were originally developed as a measure for persons with SUD by the Washington Circle, an organization supported by the federal Center for Substance Abuse Treatment, and then adapted for use as Healthcare Enterprise Data Information System (HEDIS ©) measures. The measure was further adapted by DMH/DD/SUS for use with persons with mental illness.

Description: ***Initiation*** is measured as the percent of persons starting a new episode of care for a mental illness (defined as having no prior Medicaid or state-funded mh/dd/su service for an MH diagnosis for at least 180 days) who receive a 2nd service for an MH diagnosis within 14 days of the first service. ***Engagement*** is measured as the percent of persons who after meeting the initiation criteria receive an additional 2 visits for a MH diagnosis within the next 30 days (a total of 4 visits within the first 44 days of service). This indicator looks at initiation and engagement for five age groups (13-17, 18-20, 21+, 18+, and 13+).

State/Block Grant Funded

	Numerator1			Numerator2	Denominator	Rate1			Rate2
Age Groups	**Number With 2nd Service Or Visit Within 14 Days (Initiation)**	**Number With 2nd Service Or Visit More Than 14 Days**	**Number With No 2nd Visit**	**Number With 2 Or More Services/ Visits Within 30 Days After Initiation (Engagement)**	**Total Number with an Initial Visit (New Episode of Care)**	**Percent With 2nd Service Or Visit Within 14 Days (Initiation)**	**Percent With 2nd Service Or Visit More Than 14 Days**	**Percent With No 2nd Service**	**Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)**
13-17	100	16	45	29	161	62%	10%	28%	18%
18-20	33	9	29	16	71	46%	13%	41%	23%
21+	791	309	597	348	1,697	47%	18%	35%	21%
18+	824	318	626	364	1,768	47%	18%	35%	21%
Total (13+)	924	334	671	393	1,929	48%	17%	35%	20%





* Received a 2nd service or visit within 14 days of the 1st service.

* Received 2 or more services or visits within 30 days after meeting initiation requirements.

INITIATION AND ENGAGEMENT

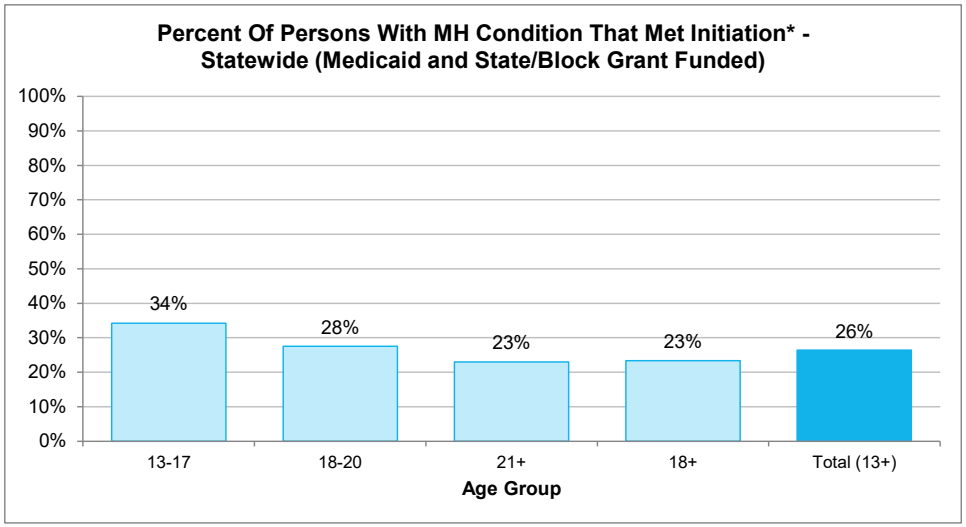
4.2. Initiation and Engagement of Mental Health Treatment (By Age Group)

Rationale: For persons with mental illness to recover control over their lives and maintain stability, they need to fully initiate and become engaged in treatment services and supports. Treatment for mental illness can improve health, productivity, and social outcomes. It can also save millions of dollars on health care and related costs. Initiation and engagement are nationally accepted measures of access. The initiation and engagement measures were originally developed as a measure for persons with SUD by the Washington Circle, an organization supported by the federal Center for Substance Abuse Treatment, and then adapted for use as Healthcare Enterprise Data Information System (HEDIS ©) measures. The measure was further adapted by DMH/DD/SUS for use with persons with mental illness.

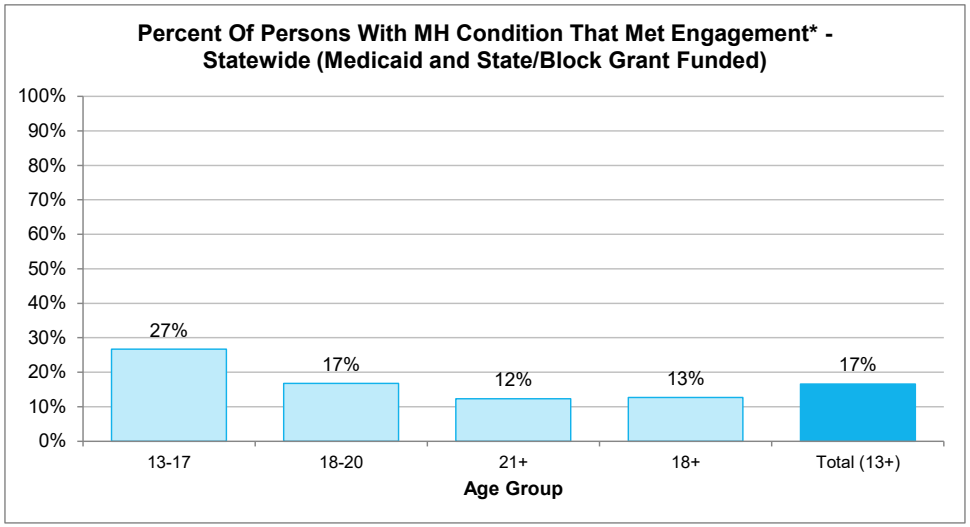
Description: ***Initiation*** is measured as the percent of persons starting a new episode of care for a mental illness (defined as having no prior Medicaid or state-funded mh/dd/su service for an MH diagnosis for at least 180 days) who receive a 2nd service for an MH diagnosis within 14 days of the first service. ***Engagement*** is measured as the percent of persons who after meeting the initiation criteria receive an additional 2 visits for a MH diagnosis within the next 30 days (a total of 4 visits within the first 44 days of service). This indicator looks at initiation and engagement for five age groups (13-17, 18-20, 21+, 18+, and 13+).

Medicaid and State/Block Grant Funded

	Numerator1			Numerator2	Denominator	Rate1			Rate2
Age Groups	**Number With 2nd Service Or Visit Within 14 Days (Initiation)**	**Number With 2nd Service Or Visit More Than 14 Days**	**Number With No 2nd Visit**	**Number With 2 Or More Services/ Visits Within 30 Days After Initiation (Engagement)**	**Total Number with an Initial Visit (New Episode of Care)**	**Percent With 2nd Service Or Visit Within 14 Days (Initiation)**	**Percent With 2nd Service Or Visit More Than 14 Days**	**Percent With No 2nd Service**	**Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)**
13-17	3,378	2,129	4,368	2,633	9,875	34%	22%	44%	27%
18-20	536	393	1,020	327	1,949	28%	20%	52%	17%
21+	5,320	4,078	13,762	2,850	23,160	23%	18%	59%	12%
18+	5,856	4,471	14,782	3,177	25,109	23%	18%	59%	13%
Total (13+)	9,234	6,600	19,150	5,810	34,984	26%	19%	55%	17%



* Received a 2nd service or visit within 14 days of the 1st service.



* Received 2 or more services or visits within 30 days after meeting initiation requirements.

North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

Report Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

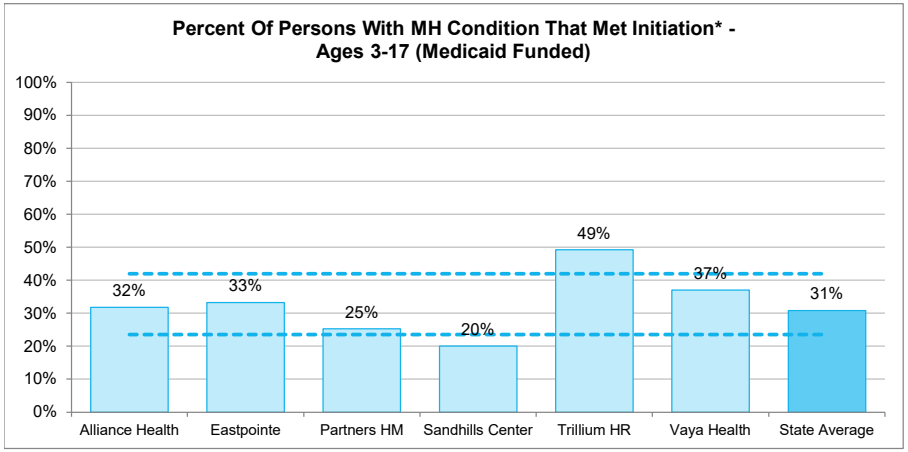
INITIATION AND ENGAGEMENT

4.2. Initiation and Engagement of Mental Health Treatment (By Age Group)

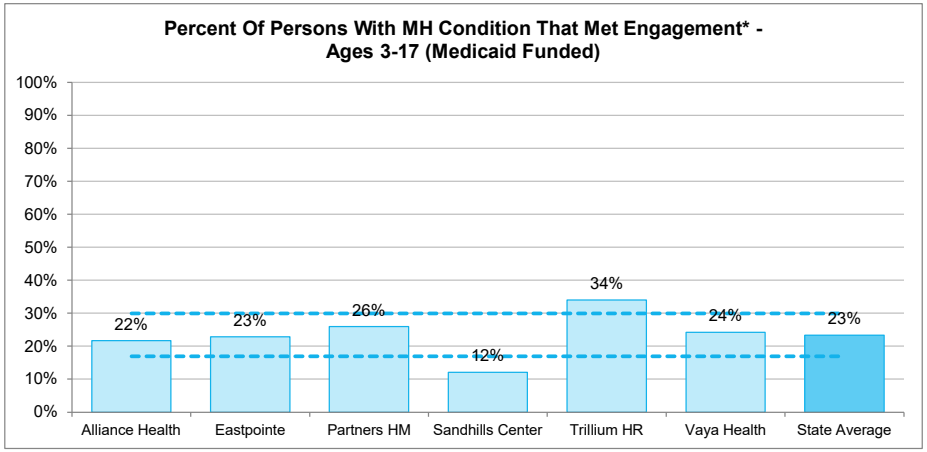
Rationale: For persons with mental illness to recover control over their lives and maintain stability, they need to fully initiate and become engaged in treatment services and supports. Treatment for mental illness can improve health, productivity, and social outcomes. It can also save millions of dollars on health care and related costs. Initiation and engagement are nationally accepted measures of access. The initiation and engagement measures were originally developed as a measure for persons with SUD by the Washington Circle, an organization supported by the federal Center for Substance Abuse Treatment, and then adapted for use as Healthcare Enterprise Data Information System (HEDIS ©) measures. The measure was further adapted by DMH/DD/SUS for use with persons with mental illness.

Description: ***Initiation*** is measured as the percent of persons starting a new episode of care for a mental illness (defined as having no prior Medicaid or state-funded mh/dd/sa service for an MH diagnosis for at least 180 days) who receive a 2nd service for an MH diagnosis within 14 days of the first service. ***Engagement*** is measured as the percent of persons who after meeting the initiation criteria receive an additional 2 visits for a MH diagnosis within the next 30 days (a total of 4 visits within the first 44 days of service). This indicator looks at initiation and engagement for five age groups (3-17, 18-20, 21+, 18+, and 13+).

	Numerator1			Numerator2	Denominator	Rate1			Rate2
LME-MCO	**Number With 2nd Service Or Visit Within 14 Days (Initiation)**	**Number With 2nd Service Or Visit More Than 14 Days**	**Number With No 2nd Visit**	**Number With 2 Or More Services/ Visits Within 30 Days After Initiation (Engagement)**	**Total Number with an Initial Visit (New Episode of Care)**	**Percent With 2nd Service Or Visit Within 14 Days (Initiation)**	**Percent With 2nd Service Or Visit More Than 14 Days**	**Percent With No 2nd Service**	**Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)**
Persons Ages 3-17 (Medicaid Funded)									
Alliance Health	620	398	935	423	1,953	32%	20%	48%	22%
Eastpointe	237	143	333	163	713	33%	20%	47%	23%
Partners Health Management	650	626	1,294	666	2,570	25%	24%	50%	26%
Sandhills Center	195	234	543	117	972	20%	24%	56%	12%
Trillium Health Resources	321	143	188	222	652	49%	22%	29%	34%
Vaya Health	557	304	645	365	1,506	37%	20%	43%	24%
State Average	2,580	1,848	3,938	1,956	8,366	31%	22%	47%	23%
Standard Deviation						9.2%	1.8%	8.4%	6.5%
LME-MCO Average						33%	22%	45%	23%



* Received a 2nd service or visit within 14 days of the 1st service.



* Received 2 or more services or visits within 30 days after meeting initiation requirements.

North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

Report Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

INITIATION AND ENGAGEMENT

4.2. Initiation and Engagement of Mental Health Treatment (By Age Group)

Rationale: For persons with mental illness to recover control over their lives and maintain stability, they need to fully initiate and become engaged in treatment services and supports. Treatment for mental illness can improve health, productivity, and social outcomes. It can also save millions of dollars on health care and related costs. Initiation and engagement are nationally accepted measures of access. The initiation and engagement measures were originally developed as a measure for persons with SUD by the Washington Circle, an organization supported by the federal Center for Substance Abuse Treatment, and then adapted for use as Healthcare Enterprise Data Information System (HEDIS ©) measures. The measure was further adapted by DMH/DD/SUS for use with persons with mental illness.

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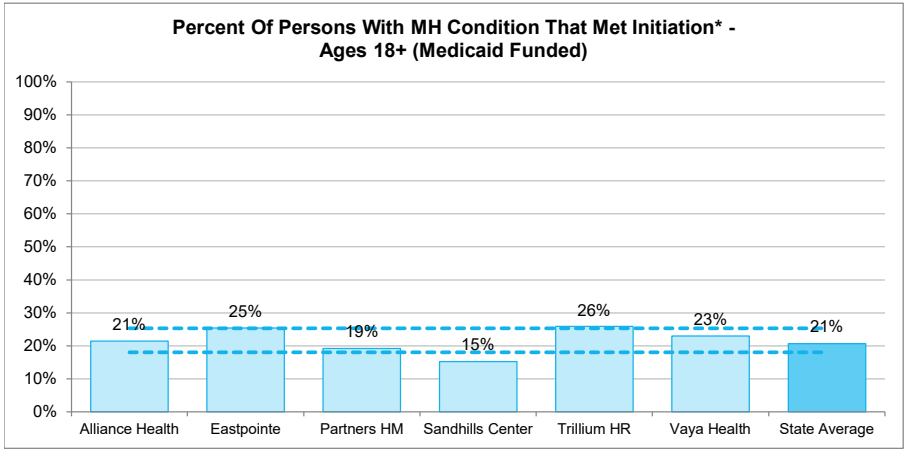
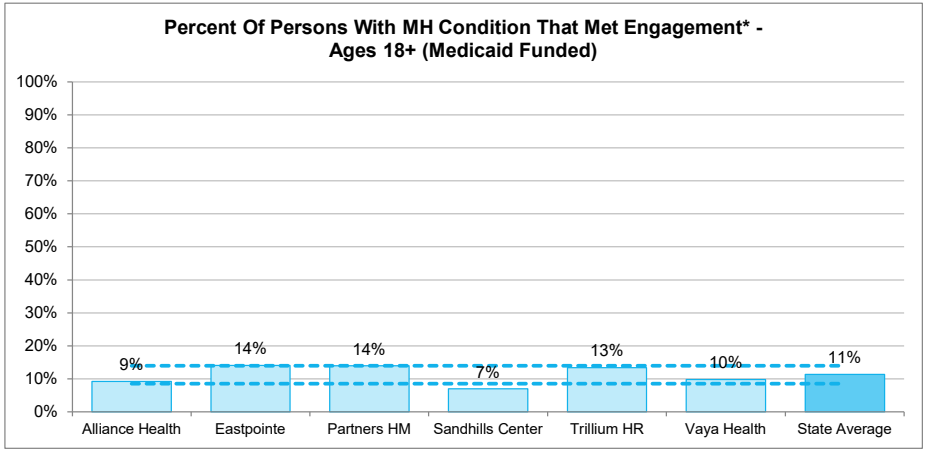
	Numerator1			Numerator2	Denominator	Rate1			Rate2
LME-MCO	**Number With 2nd Service Or Visit Within 14 Days (Initiation)**	**Number With 2nd Service Or Visit More Than 14 Days**	**Number With No 2nd Visit**	**Number With 2 Or More Services/ Visits Within 30 Days After Initiation (Engagement)**	**Total Number with an Initial Visit (New Episode of Care)**	**Percent With 2nd Service Or Visit Within 14 Days (Initiation)**	**Percent With 2nd Service Or Visit More Than 14 Days**	**Percent With No 2nd Service**	**Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)**
Persons Ages 18+ (Medicaid Funded)									
Alliance Health	1,097	876	3,144	473	5,117	21%	17%	61%	9%
Eastpointe	524	355	1,185	291	2,064	25%	17%	57%	14%
Partners Health Management	1,478	1,368	4,844	1,070	7,690	19%	18%	63%	14%
Sandhills Center	437	441	1,993	201	2,871	15%	15%	69%	7%
Trillium Health Resources	330	304	643	171	1,277	26%	24%	50%	13%
Vaya Health	711	523	1,858	302	3,092	23%	17%	60%	10%
State Average	4,577	3,867	13,667	2,508	22,111	21%	17%	62%	11%
Standard Deviation						3.7%	2.7%	5.8%	2.7%
LME-MCO Average						22%	18%	60%	11%



* Received a 2nd service or visit within 14 days of the 1st service.



* Received 2 or more services or visits within 30 days after meeting initiation requirements.

North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

Report Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

INITIATION AND ENGAGEMENT

4.2. Initiation and Engagement of Mental Health Treatment (By Age Group)

Rationale: For persons with mental illness to recover control over their lives and maintain stability, they need to fully initiate and become engaged in treatment services and supports. Treatment for mental illness can improve health, productivity, and social outcomes. It can also save millions of dollars on health care and related costs. Initiation and engagement are nationally accepted measures of access. The initiation and engagement measures were originally developed as a measure for persons with SUD by the Washington Circle, an organization supported by the federal Center for Substance Abuse Treatment, and then adapted for use as Healthcare Enterprise Data Information System (HEDIS ©) measures. The measure was further adapted by DMH/DD/SUS for use with persons with mental illness.

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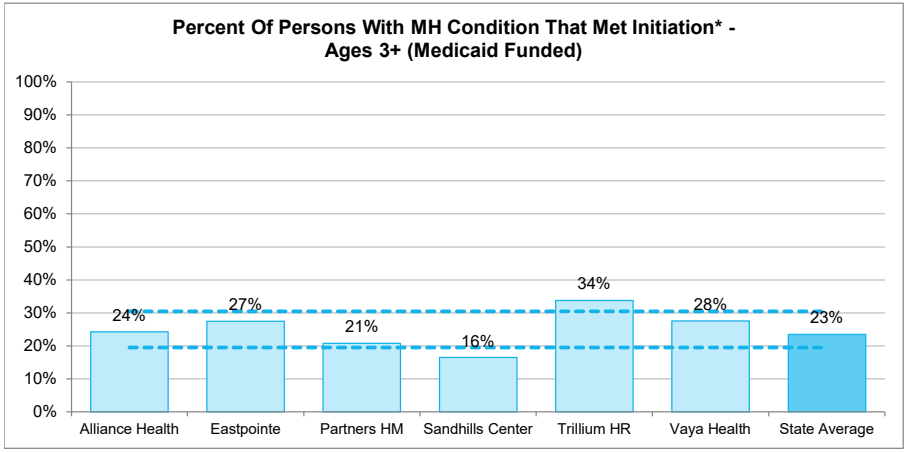
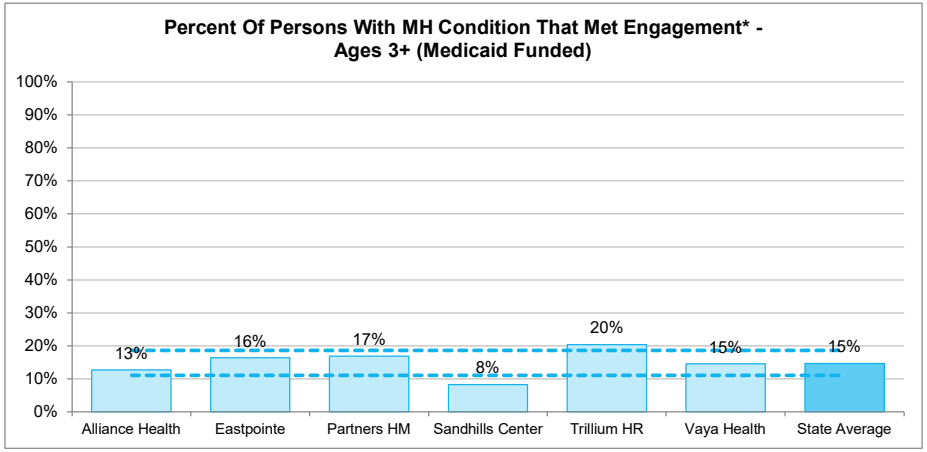
	Numerator1			Numerator2	Denominator	Rate1			Rate2
LME-MCO	**Number With 2nd Service Or Visit Within 14 Days (Initiation)**	**Number With 2nd Service Or Visit More Than 14 Days**	**Number With No 2nd Visit**	**Number With 2 Or More Services/ Visits Within 30 Days After Initiation (Engagement)**	**Total Number with an Initial Visit (New Episode of Care)**	**Percent With 2nd Service Or Visit Within 14 Days (Initiation)**	**Percent With 2nd Service Or Visit More Than 14 Days**	**Percent With No 2nd Service**	**Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)**
Persons Ages 3+ (Medicaid Funded)									
Alliance Health	1,717	1,274	4,079	896	7,070	24%	18%	58%	13%
Eastpointe	761	498	1,518	454	2,777	27%	18%	55%	16%
Partners Health Management	2,128	1,994	6,138	1,736	10,260	21%	19%	60%	17%
Sandhills Center	632	675	2,536	318	3,843	16%	18%	66%	8%
Trillium Health Resources	651	447	831	393	1,929	34%	23%	43%	20%
Vaya Health	1,268	827	2,503	667	4,598	28%	18%	54%	15%
State Average	7,157	5,715	17,605	4,464	30,477	23%	19%	58%	15%
Standard Deviation						5.5%			3.8%
LME-MCO Average						25%	19%	56%	15%



* Received a 2nd service or visit within 14 days of the 1st service.



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North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

Report Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

INITIATION AND ENGAGEMENT

4.2. Initiation and Engagement of Mental Health Treatment (By Age Group)

Rationale: For persons with mental illness to recover control over their lives and maintain stability, they need to fully initiate and become engaged in treatment services and supports. Treatment for mental illness can improve health, productivity, and social outcomes. It can also save millions of dollars on health care and related costs. Initiation and engagement are nationally accepted measures of access. The initiation and engagement measures were originally developed as a measure for persons with SUD by the Washington Circle, an organization supported by the federal Center for Substance Abuse Treatment, and then adapted for use as Healthcare Enterprise Data Information System (HEDIS ©) measures. The measure was further adapted by DMH/DD/SUS for use with persons with mental illness.

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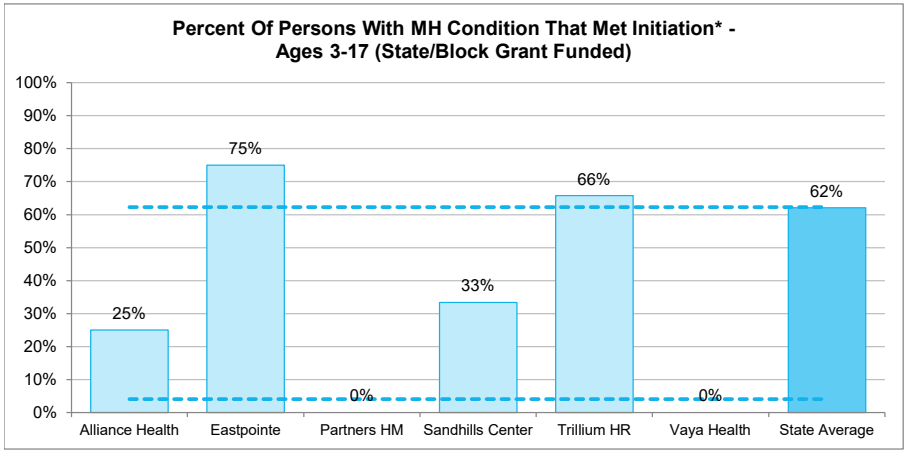
	Numerator1			Numerator2	Denominator	Rate1			Rate2
LME-MCO	**Number With 2nd Service Or Visit Within 14 Days (Initiation)**	**Number With 2nd Service Or Visit More Than 14 Days**	**Number With No 2nd Visit**	**Number With 2 Or More Services/ Visits Within 30 Days After Initiation (Engagement)**	**Total Number with an Initial Visit (New Episode of Care)**	**Percent With 2nd Service Or Visit Within 14 Days (Initiation)**	**Percent With 2nd Service Or Visit More Than 14 Days**	**Percent With No 2nd Service**	**Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)**
Persons Ages 3-17 (State/Block Grant Funded)									
Alliance Health	2	0	6	1	8	25%	0%	75%	13%
Eastpointe	3	0	1	1	4	75%	0%	25%	25%
Partners Health Management	0	2	0	0	2	0%	100%	0%	0%
Sandhills Center	1	1	1	1	3	33%	33%	33%	33%
Trillium Health Resources	94	13	36	26	143	66%	9%	25%	18%
Vaya Health	0	0	1	0	1	0%	0%	100%	0%
State Average	100	16	45	29	161	62%	10%	28%	18%
Standard Deviation						29.1%	36.1%	33.8%	12.3%
LME-MCO Average						33%	24%	43%	15%



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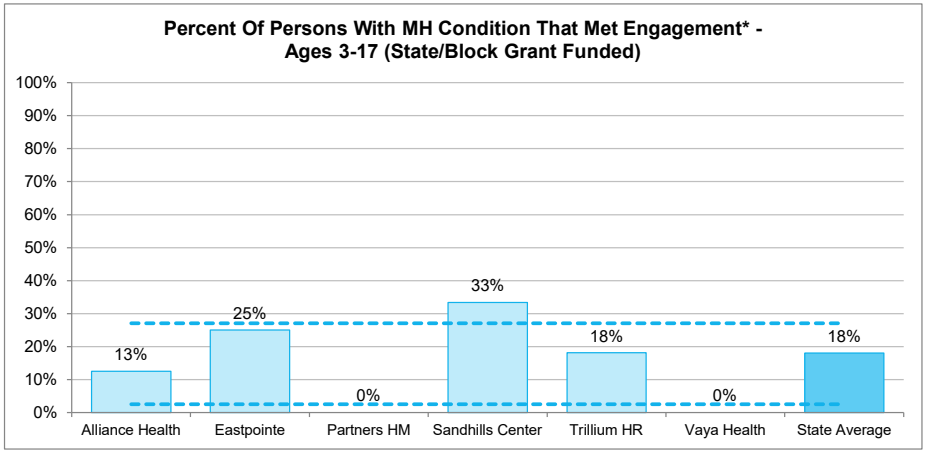

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North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

Report Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

INITIATION AND ENGAGEMENT

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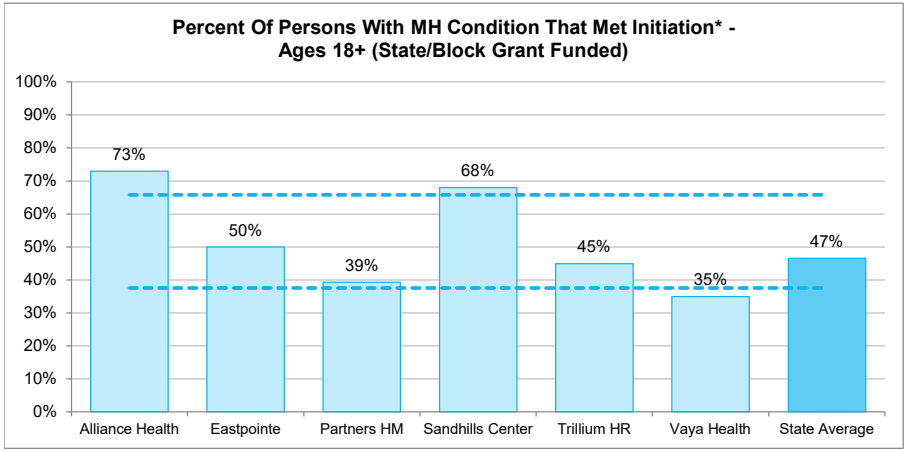
Persons Ages 18+ (State/Block Grant Funded)									
Alliance Health	89	3	30	65	122	73%	2%	25%	53%
Eastpointe	5	0	5	4	10	50%	0%	50%	40%
Partners Health Management	42	3	62	30	107	39%	3%	58%	28%
Sandhills Center	34	5	11	24	50	68%	10%	22%	48%
Trillium Health Resources	618	295	463	215	1,376	45%	21%	34%	16%
Vaya Health	36	12	55	26	103	35%	12%	53%	25%
State Average	824	318	626	364	1,768	47%	18%	35%	21%
Standard Deviation						14.2%	7.3%	14.2%	13.2%
LME-MCO Average						52%	8%	40%	35%



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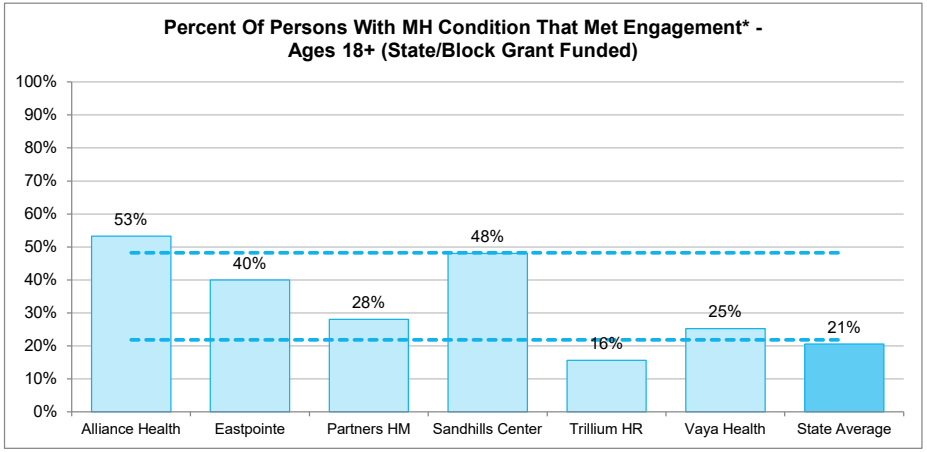

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North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

Report Year:	2023	**Measurement Period:**	Jul - Sep 2022
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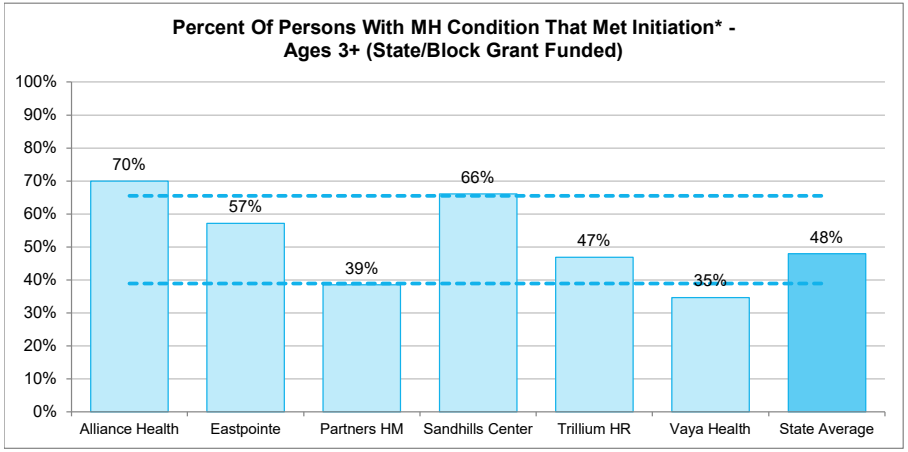
Persons Ages 3+ (State/Block Grant Funded)									
Alliance Health	91	3	36	66	130	70%	2%	28%	51%
Eastpointe	8	0	6	5	14	57%	0%	43%	36%
Partners Health Management	42	5	62	30	109	39%	5%	57%	28%
Sandhills Center	35	6	12	25	53	66%	11%	23%	47%
Trillium Health Resources	712	308	499	241	1,519	47%	20%	33%	16%
Vaya Health	36	12	56	26	104	35%	12%	54%	25%
State Average	924	334	671	393	1,929	48%	17%	35%	20%
Standard Deviation						13.3%	6.9%	12.8%	12.3%
LME-MCO Average						52%	8%	39%	34%



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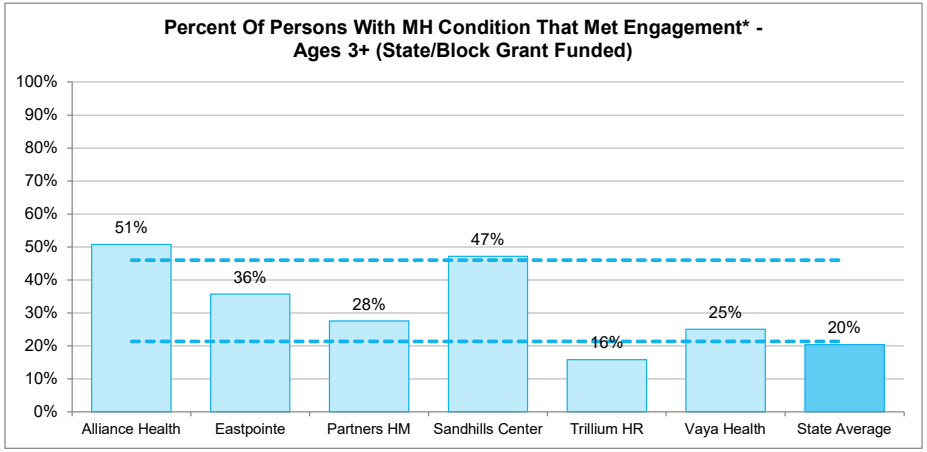

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North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

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INITIATION AND ENGAGEMENT

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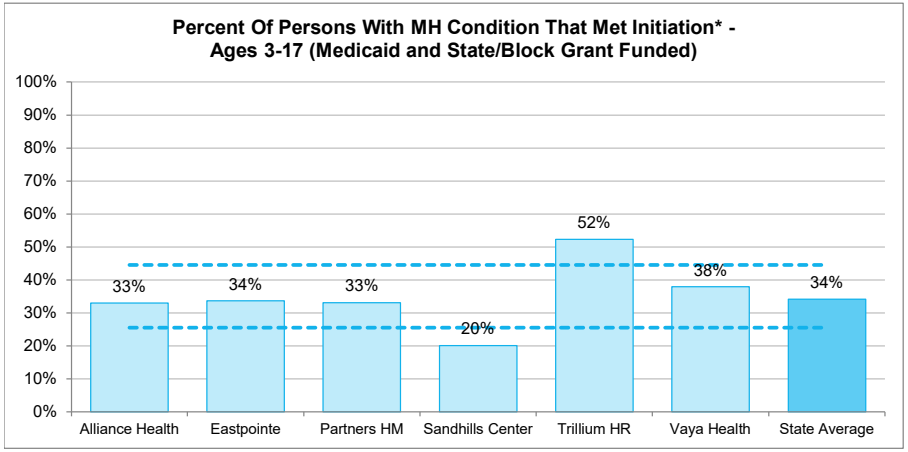
Persons Ages 3-17 (Medicaid and State/Block Grant Funded)									
Alliance Health	700	435	986	487	2,121	33%	21%	46%	23%
Eastpointe	259	157	353	176	769	34%	20%	46%	23%
Partners Health Management	1,192	824	1,580	1,192	3,596	33%	23%	44%	33%
Sandhills Center	196	235	544	118	975	20%	24%	56%	12%
Trillium Health Resources	416	156	223	250	795	52%	20%	28%	31%
Vaya Health	615	322	682	410	1,619	38%	20%	42%	25%
State Average	3,378	2,129	4,368	2,633	9,875	34%	22%	44%	27%
Standard Deviation						9.5%	1.7%	8.2%	6.9%
LME-MCO Average						35%	21%	44%	25%



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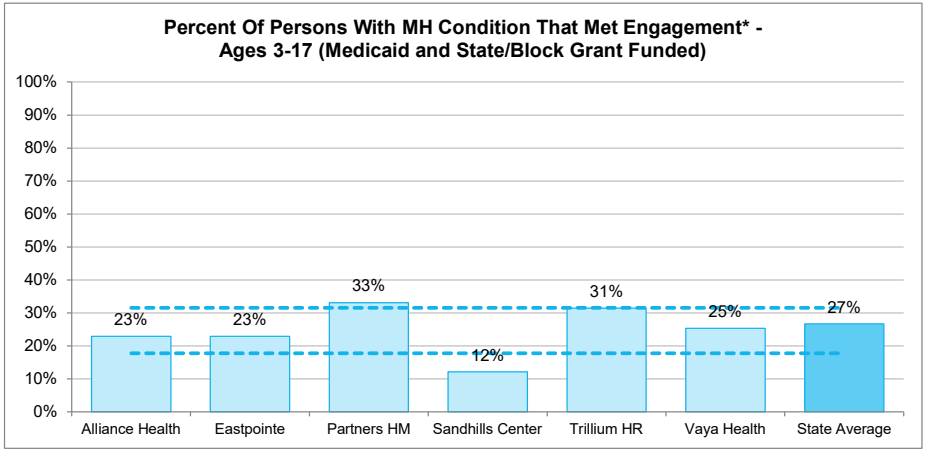

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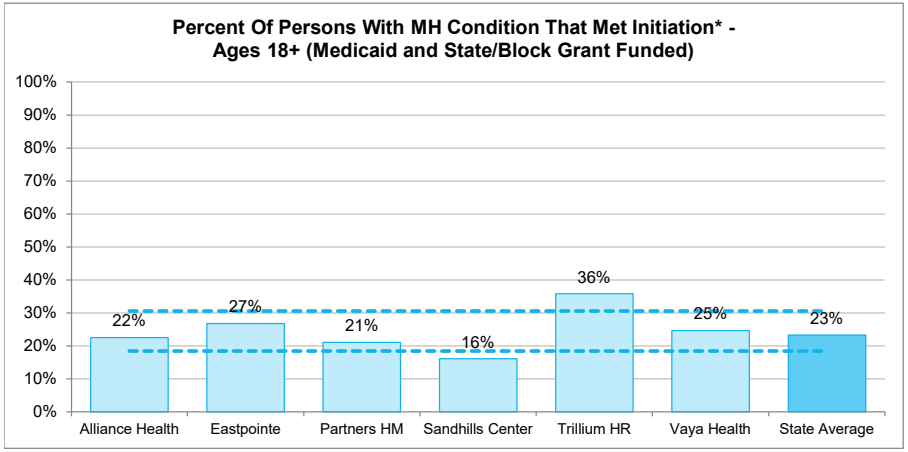
Persons Ages 18+ (Medicaid and State/Block Grant Funded)									
Alliance Health	1,219	939	3,262	550	5,420	22%	17%	60%	10%
Eastpointe	581	373	1,216	322	2,170	27%	17%	56%	15%
Partners Health Management	1,806	1,547	5,231	1,326	8,584	21%	18%	61%	15%
Sandhills Center	471	446	2,004	225	2,921	16%	15%	69%	8%
Trillium Health Resources	950	599	1,103	386	2,652	36%	23%	42%	15%
Vaya Health	829	567	1,966	368	3,362	25%	17%	58%	11%
State Average	5,856	4,471	14,782	3,177	25,109	23%	18%	59%	13%
Standard Deviation						6.0%	2.3%	8.1%	2.9%
LME-MCO Average						24%	18%	58%	12%



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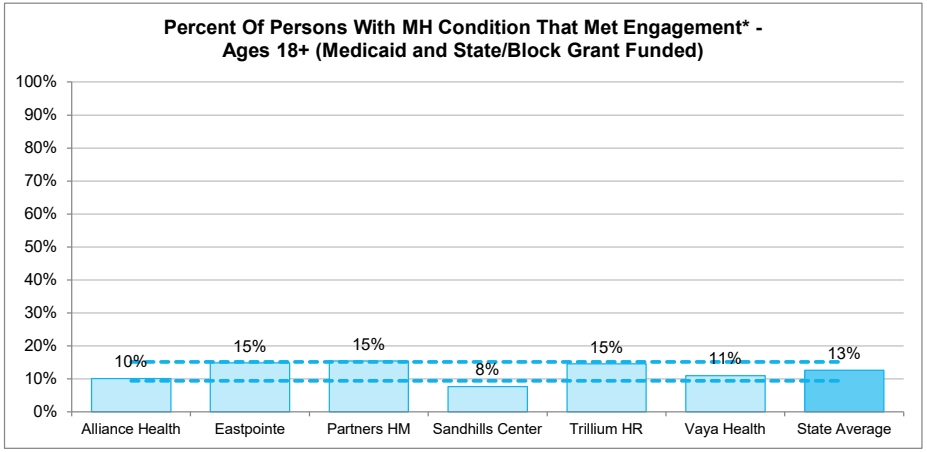

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North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

Report Year:	2023	**Measurement Period:**	Jul - Sep 2022
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INITIATION AND ENGAGEMENT

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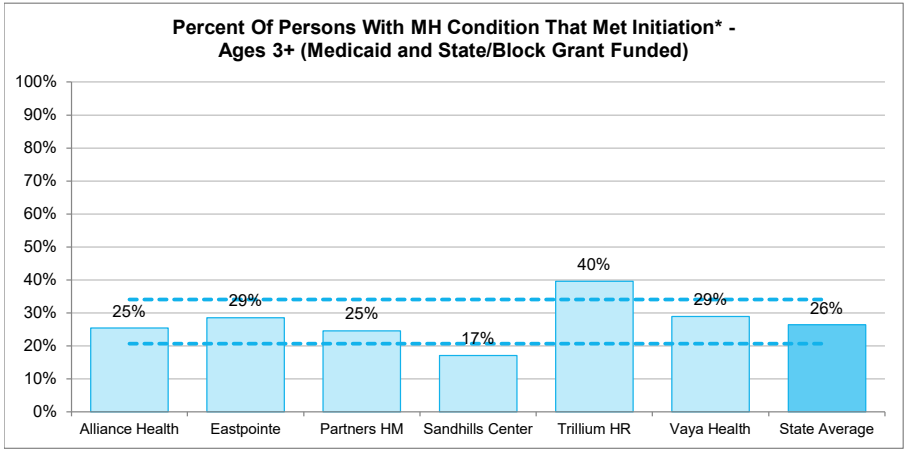
Persons Ages 3+ (Medicaid and State/Block Grant Funded)									
Alliance Health	1,919	1,374	4,248	1,037	7,541	25%	18%	56%	14%
Eastpointe	840	530	1,569	498	2,939	29%	18%	53%	17%
Partners Health Management	2,998	2,371	6,811	2,518	12,180	25%	19%	56%	21%
Sandhills Center	667	681	2,548	343	3,896	17%	17%	65%	9%
Trillium Health Resources	1,366	755	1,326	636	3,447	40%	22%	38%	18%
Vaya Health	1,444	889	2,648	778	4,981	29%	18%	53%	16%
State Average	9,234	6,600	19,150	5,810	34,984	26%	19%	55%	17%
Standard Deviation						6.7%	1.5%	8.0%	3.8%
LME-MCO Average						27%	19%	54%	16%



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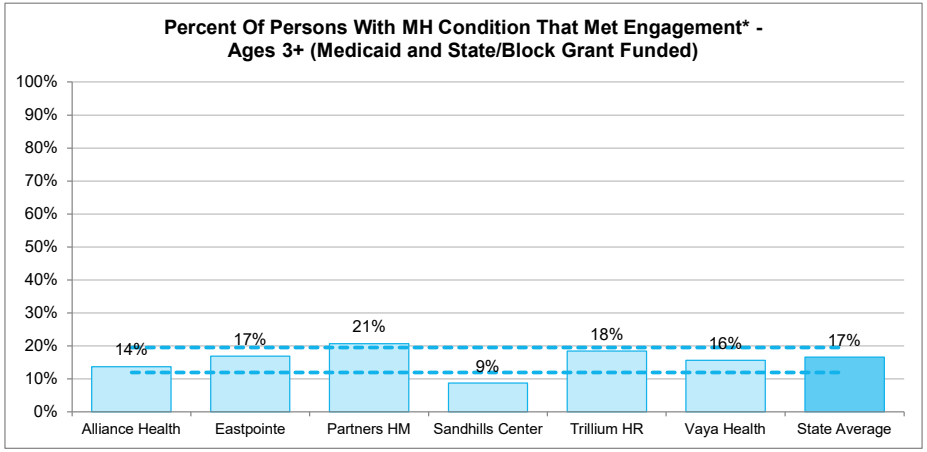

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North Carolina LME-MCO Performance Measurement Reporting
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State Fiscal Year: 2023 **Measurement Period:** Jul - Sep 2022
Report Quarter: 2nd Quarter

CRISIS AND INPATIENT SERVICES

5.1 Short-Term Care In State Psychiatric Hospitals

Rationale: Serving individuals in crisis in the least restrictive setting as appropriate and as close to home as possible helps families stay in touch and participate in the individual's recovery.

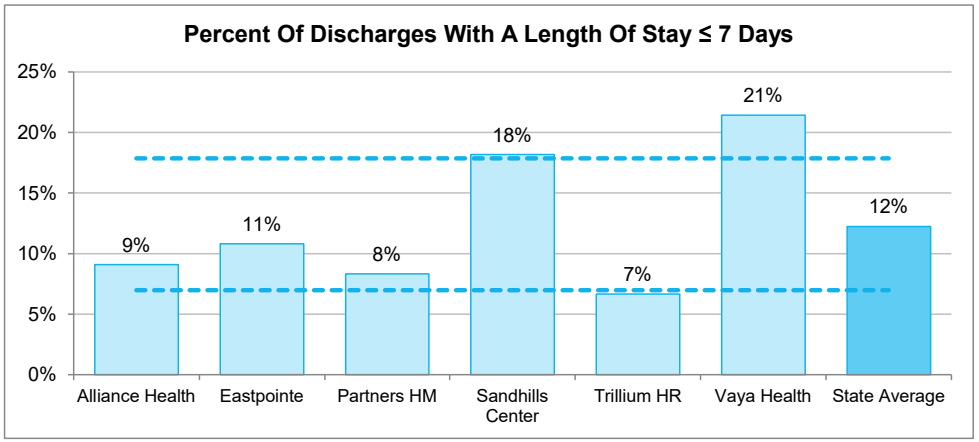
State psychiatric hospitals provide a safety net for the community service system. An adequate community system should provide short-term inpatient care in a local hospital in the community. This reserves high-cost state facility beds for consumers with more intensive, long-term care needs.

Reducing the short-term use of state psychiatric hospitals allows persons to receive acute services closer to home and provides more effective and efficient use of funds for community services. This is a Mental Health Block Grant measure required by the Center for Mental Health Services (CMHS).

Description: This indicator measures the percent of persons discharged from state psychiatric hospitals each quarter, that fall within the responsibility of an LME-MCO to coordinate services (as described in the footnote below), with a length of stay of 7 days or less.

Consumers Discharged With A Length Of Stay Of 7 Days Or Less

	Numerator	Denominator	Rate
LME-MCO	**Number of Discharges with a LOS ≤ 7 Days**	**Total Discharges**	**Percent with a Length Of Stay ≤ 7 Days**
Alliance Health	4	44	9%
Eastpointe	4	37	11%
Partners Health Management	1	12	8%
Sandhills Center	2	11	18%
Trillium Health Resources	1	15	7%
Vaya Health	6	28	21%
State Average	18	147	12%
Standard Deviation			5.4%
LME-MCO Average			12%



Data Source: State Psychiatric Hospital data in CDW as of 10/17/22. Discharges have been filtered to include only "direct" discharges to sources that fall within the responsibility of an LME-MCO to coordinate services (e.g. to other outpatient and residential non state facility, self/no referral, unknown, community agency, private physician, other health care, family friends, nonresidential treatment/habilitation program, acute care hospital, outpatient services, residential care, other). Discharges for other reasons (e.g. transfers to other facilities, to medical visits, out-of-state, to correctional facilities, deaths, etc.) are not included as LME-MCOs would not be expected to coordinate services for these individuals nor to have any impact on readmission rates.

CRISIS AND INPATIENT SERVICES

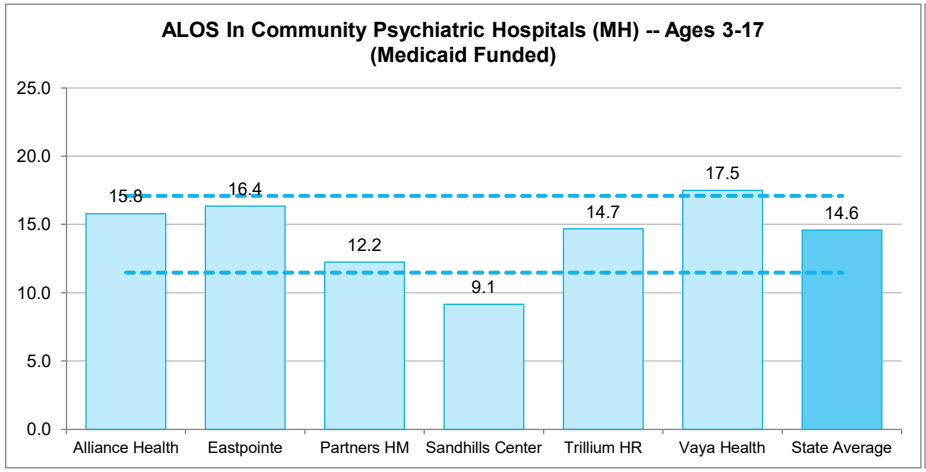
5.3 Length of Stay in Community Psychiatric Hospitals (Principal MH Diagnosis)

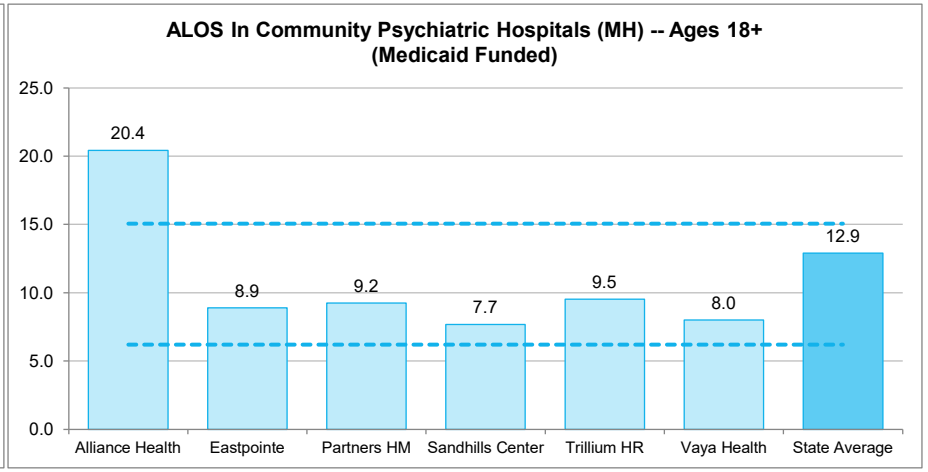
Rationale: Length of stay is commonly used as a quality metric. The average length of stay (ALOS) refers to the average number of days that patients stay in the hospital. ALOS is often used as an indicator of efficiency. All other things being equal, a shorter stay will reduce the cost per discharge and shift care from inpatient to less expensive post-acute settings. Longer stays can be indicative of poor-value care: inefficient hospital processes may cause delays in providing treatment; errors and poor-quality care may mean patients need further treatment or recovery time; poor care co-ordination may leave people stuck in the hospital waiting for ongoing care to be arranged. Stays that are too short can be indicative of poor-value care as well: some people may be discharged too early, when staying in the hospital longer could have improved their outcomes or reduced chances of readmission.

Description: The measure provides the average length of stay for persons with a principal mental health diagnosis who were discharged during the measurement period from a community inpatient facility for acute mental health care.

Length of Stay in Community Psychiatric Hospitals -- Principal MH Diagnosis (Medicaid Funded)

LME-MCO	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate
	Ages 3-17			Ages 18+			Total (Ages 3+)		
	Total Number Inpatient Days	Total Number Discharges	Average LOS	Total Number Inpatient Days	Total Number Discharges	Average LOS	Total Number Inpatient Days	Total Number Discharges	Average LOS
Alliance Health	1,516	96	15.8	18,868	924	20.4	20,384	1,020	20.0
Eastpointe	605	37	16.4	1,716	193	8.9	2,321	230	10.1
Partners Health Management	1,298	106	12.2	4,866	527	9.2	6,164	633	9.7
Sandhills Center	375	41	9.1	1,318	172	7.7	1,693	213	7.9
Trillium Health Resources	1,806	123	14.7	5,034	528	9.5	6,840	651	10.5
Vaya Health	1,732	99	17.5	2,551	319	8.0	4,283	418	10.2
State Average	7,332	502	14.6	34,353	2,663	12.9	41,685	3,165	13.2
Standard Deviation			2.8			4.4			3.9
LME-MCO Average			14.3			10.6			11.4





North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

CRISIS AND INPATIENT SERVICES

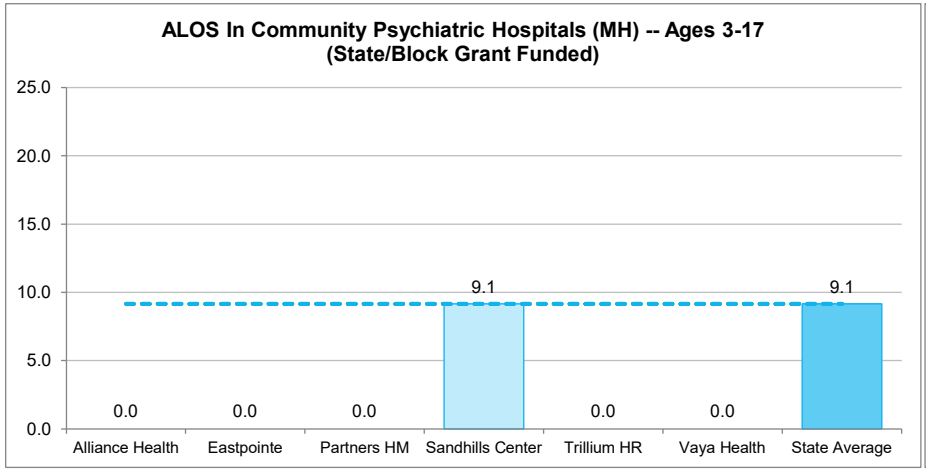
5.3 Length of Stay in Community Psychiatric Hospitals (Principal MH Diagnosis)

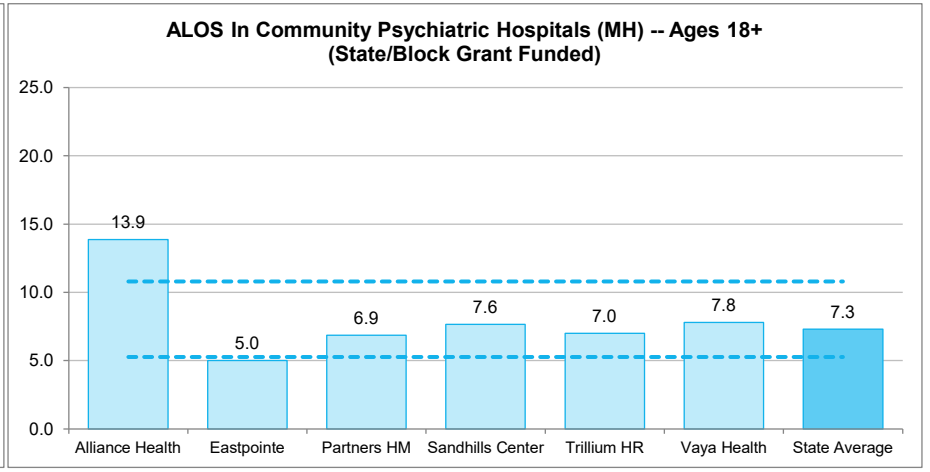
Rationale: Length of stay is commonly used as a quality metric. The average length of stay (ALOS) refers to the average number of days that patients stay in the hospital. ALOS is often used as an indicator of efficiency. All other things being equal, a shorter stay will reduce the cost per discharge and shift care from inpatient to less expensive post-acute settings. Longer stays can be indicative of poor-value care: inefficient hospital processes may cause delays in providing treatment; errors and poor-quality care may mean patients need further treatment or recovery time; poor care co-ordination may leave people stuck in the hospital waiting for ongoing care to be arranged. Stays that are too short can be indicative of poor-value care as well: some people may be discharged too early, when staying in the hospital longer could have improved their outcomes or reduced chances of readmission.

Description: The measure provides the average length of stay for persons with a principal mental health diagnosis who were discharged during the measurement period from a community inpatient facility for acute mental health care.

Length of Stay in Community Psychiatric Hospitals -- Principal MH Diagnosis (State/Block Grant Funded)

LME-MCO	Ages 3-17 Numerator: Total Number Inpatient Days	Ages 3-17 Denominator: Total Number Discharges	Ages 3-17 Rate: Average LOS	Ages 18+ Numerator: Total Number Inpatient Days	Ages 18+ Denominator: Total Number Discharges	Ages 18+ Rate: Average LOS	Total (Ages 3+) Numerator: Total Number Inpatient Days	Total (Ages 3+) Denominator: Total Number Discharges	Total (Ages 3+) Rate: Average LOS
Alliance Health	0	0		97	7	13.9	97	7	13.9
Eastpointe	0	0		5	1	5.0	5	1	5.0
Partners Health Management	0	0		48	7	6.9	48	7	6.9
Sandhills Center	375	41	9.1	1,322	173	7.6	1,697	214	7.9
Trillium Health Resources	0	0		2,204	315	7.0	2,204	315	7.0
Vaya Health	0	0		39	5	7.8	39	5	7.8
State Average	375	41	9.1	3,715	508	7.3	4,090	549	7.4
Standard Deviation			0.0			2.8			2.8
LME-MCO Average			9.1			8.0			8.1





North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

CRISIS AND INPATIENT SERVICES

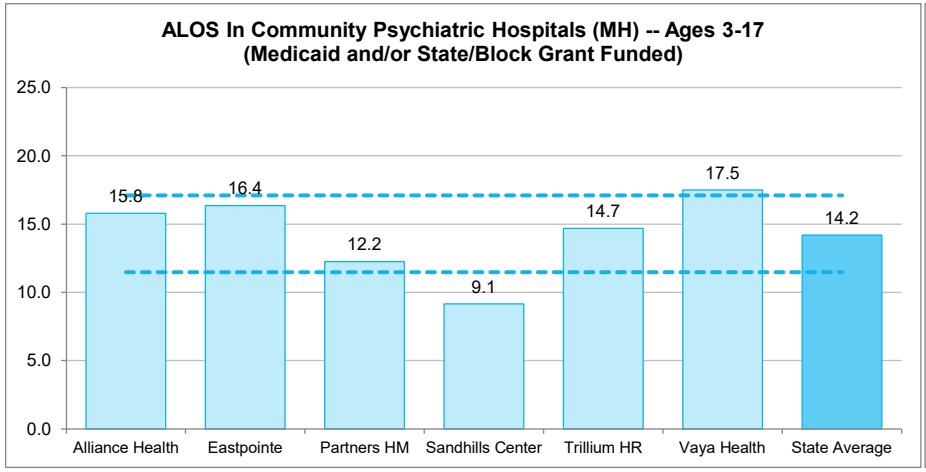
5.3 Length of Stay in Community Psychiatric Hospitals (Principal MH Diagnosis)

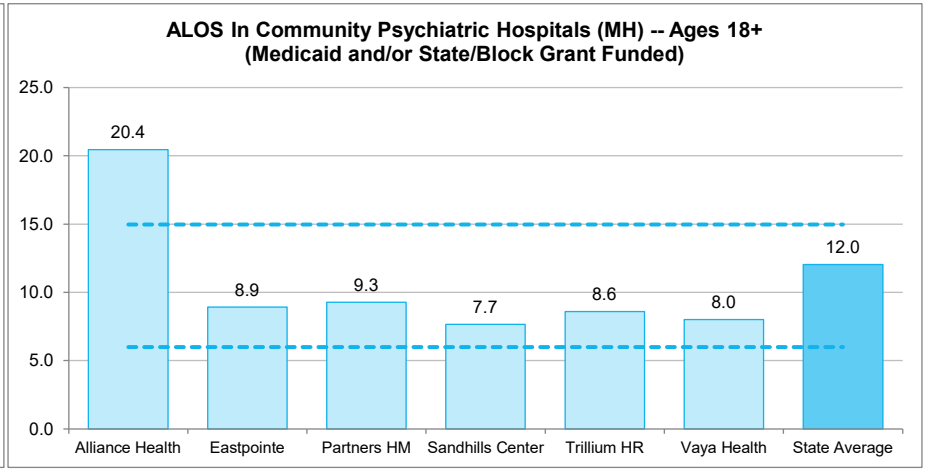
Rationale: Length of stay is commonly used as a quality metric. The average length of stay (ALOS) refers to the average number of days that patients stay in the hospital. ALOS is often used as an indicator of efficiency. All other things being equal, a shorter stay will reduce the cost per discharge and shift care from inpatient to less expensive post-acute settings. Longer stays can be indicative of poor-value care: inefficient hospital processes may cause delays in providing treatment; errors and poor-quality care may mean patients need further treatment or recovery time; poor care co-ordination may leave people stuck in the hospital waiting for ongoing care to be arranged. Stays that are too short can be indicative of poor-value care as well: some people may be discharged too early, when staying in the hospital longer could have improved their outcomes or reduced chances of readmission.

Description: The measure provides the average length of stay for persons with a principal mental health diagnosis who were discharged during the measurement period from a community inpatient facility for acute mental health care.

Length of Stay in Community Psychiatric Hospitals -- Principal MH Diagnosis (Medicaid and/or State/Block Grant Funded)

LME-MCO	Ages 3-17 Numerator: Total Number Inpatient Days	Ages 3-17 Denominator: Total Number Discharges	Ages 3-17 Rate: Average LOS	Ages 18+ Numerator: Total Number Inpatient Days	Ages 18+ Denominator: Total Number Discharges	Ages 18+ Rate: Average LOS	Total (Ages 3+) Numerator: Total Number Inpatient Days	Total (Ages 3+) Denominator: Total Number Discharges	Total (Ages 3+) Rate: Average LOS
Alliance Health	1,516	96	15.8	18,787	919	20.4	20,303	1,015	20.0
Eastpointe	605	37	16.4	1,711	192	8.9	2,316	229	10.1
Partners Health Management	1,298	106	12.2	4,818	520	9.3	6,116	626	9.8
Sandhills Center	750	82	9.1	2,640	345	7.7	3,390	427	7.9
Trillium Health Resources	1,806	123	14.7	7,238	843	8.6	9,044	966	9.4
Vaya Health	1,732	99	17.5	2,512	314	8.0	4,244	413	10.3
State Average	7,707	543	14.2	37,706	3,133	12.0	45,413	3,676	12.4
Standard Deviation			2.8			4.5			4.0
LME-MCO Average			14.3			10.5			11.2





North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

CRISIS AND INPATIENT SERVICES

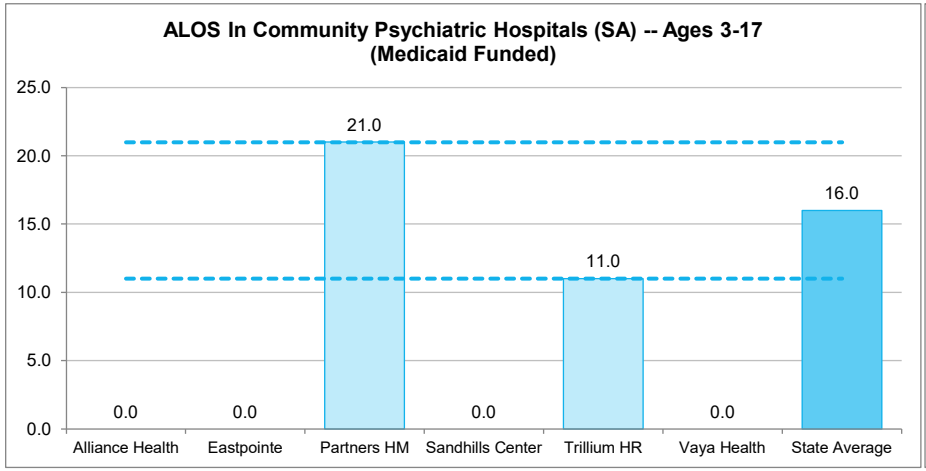
5.4 Length of Stay in Community Psychiatric Hospitals (Principal SA Diagnosis)

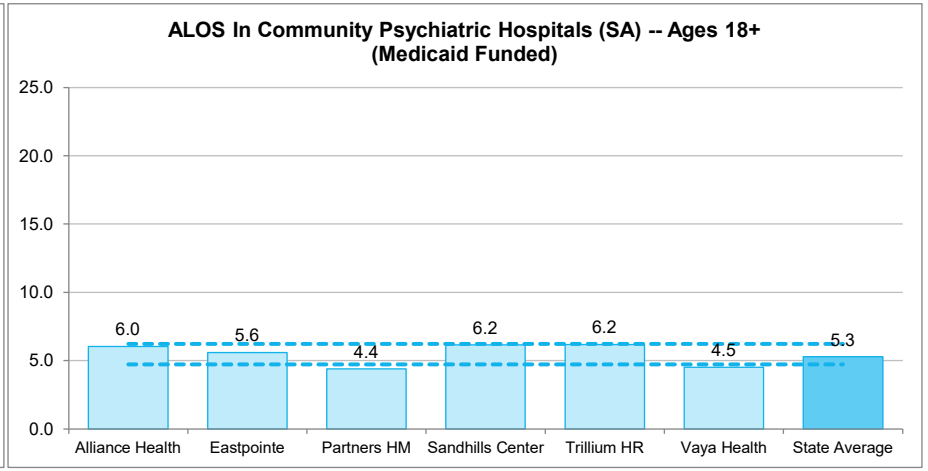
Rationale: Length of stay is commonly used as a quality metric. The average length of stay (ALOS) refers to the average number of days that patients stay in the hospital. ALOS is often used as an indicator of efficiency. All other things being equal, a shorter stay will reduce the cost per discharge and shift care from inpatient to less expensive post-acute settings. Longer stays can be indicative of poor-value care: inefficient hospital processes may cause delays in providing treatment; errors and poor-quality care may mean patients need further treatment or recovery time; poor care co-ordination may leave people stuck in the hospital waiting for ongoing care to be arranged. Stays that are too short can be indicative of poor-value care as well: some people may be discharged too early, when staying in the hospital longer could have improved their outcomes or reduced chances of readmission.

Description: The measure provides the average length of stay for persons with a principal substance use disorder diagnosis who were discharged during the measurement period from a community inpatient facility for acute substance use care.

Length of Stay in Community Psychiatric Hospitals -- Principal SA Diagnosis (Medicaid Funded)

LME-MCO	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate
	Ages 3-17			Ages 18+			Total (Ages 3+)		
	Total Number Inpatient Days	Total Number Discharges	Average LOS	Total Number Inpatient Days	Total Number Discharges	Average LOS	Total Number Inpatient Days	Total Number Discharges	Average LOS
Alliance Health	0	0		193	32	6.0	193	32	6.0
Eastpointe	0	0		285	51	5.6	285	51	5.6
Partners Health Management	21	1	21.0	289	66	4.4	310	67	4.6
Sandhills Center	0	0		123	20	6.2	123	20	6.2
Trillium Health Resources	11	1	11.0	191	31	6.2	202	32	6.3
Vaya Health	0	0		149	33	4.5	149	33	4.5
State Average	32	2	16.0	1,230	233	5.3	1,262	235	5.4
Standard Deviation			5.0			0.7			0.7
LME-MCO Average			16.0			5.5			5.5





CRISIS AND INPATIENT SERVICES

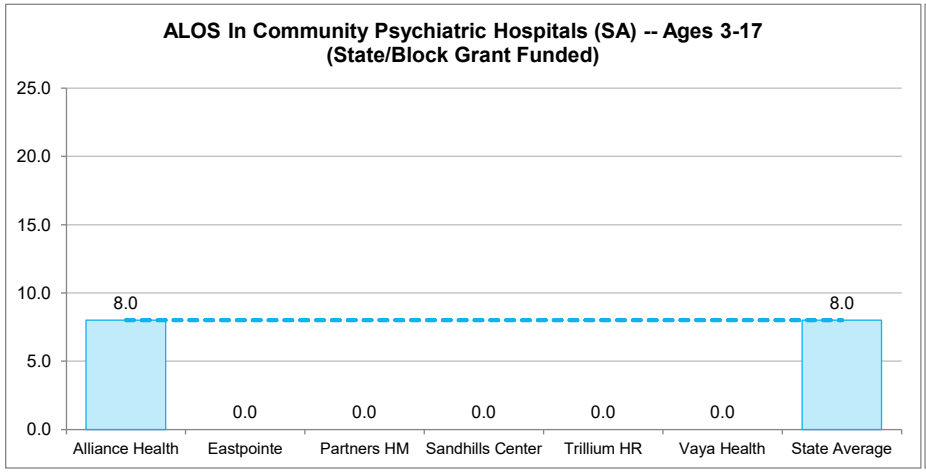
5.4 Length of Stay in Community Psychiatric Hospitals (Principal SA Diagnosis)

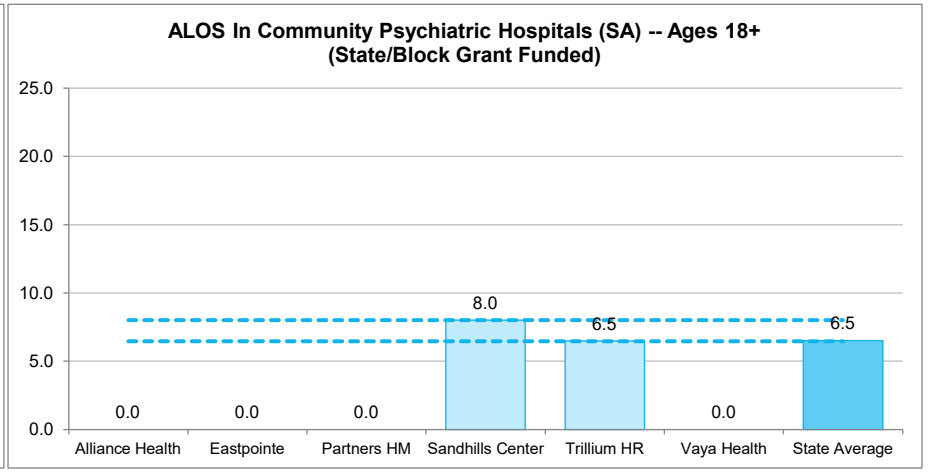
Rationale: Length of stay is commonly used as a quality metric. The average length of stay (ALOS) refers to the average number of days that patients stay in the hospital. ALOS is often used as an indicator of efficiency. All other things being equal, a shorter stay will reduce the cost per discharge and shift care from inpatient to less expensive post-acute settings. Longer stays can be indicative of poor-value care: inefficient hospital processes may cause delays in providing treatment; errors and poor-quality care may mean patients need further treatment or recovery time; poor care co-ordination may leave people stuck in the hospital waiting for ongoing care to be arranged. Stays that are too short can be indicative of poor-value care as well: some people may be discharged too early, when staying in the hospital longer could have improved their outcomes or reduced chances of readmission.

Description: The measure provides the average length of stay for persons with a principal substance use disorder diagnosis who were discharged during the measurement period from a community inpatient facility for acute substance use care.

Length of Stay in Community Psychiatric Hospitals -- Principal SA Diagnosis (State/Block Grant Funded)

LME-MCO	Ages 3-17 Numerator: Total Number Inpatient Days	Ages 3-17 Denominator: Total Number Discharges	Ages 3-17 Rate: Average LOS	Ages 18+ Numerator: Total Number Inpatient Days	Ages 18+ Denominator: Total Number Discharges	Ages 18+ Rate: Average LOS	Total (Ages 3+) Numerator: Total Number Inpatient Days	Total (Ages 3+) Denominator: Total Number Discharges	Total (Ages 3+) Rate: Average LOS
Alliance Health	40	5	8.0	0	0		40	5	8.0
Eastpointe	0	0		0	0				
Partners Health Management	0	0		0	0				
Sandhills Center	0	0		8	1	8.0	8	1	8.0
Trillium Health Resources	0	0		317	49	6.5	317	49	6.5
Vaya Health	0	0		0	0				
State Average	40	5	8.0	325	50	6.5	365	55	6.6
Standard Deviation			0.0			0.8			0.7
LME-MCO Average			8.0			7.2			7.5





North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

CRISIS AND INPATIENT SERVICES

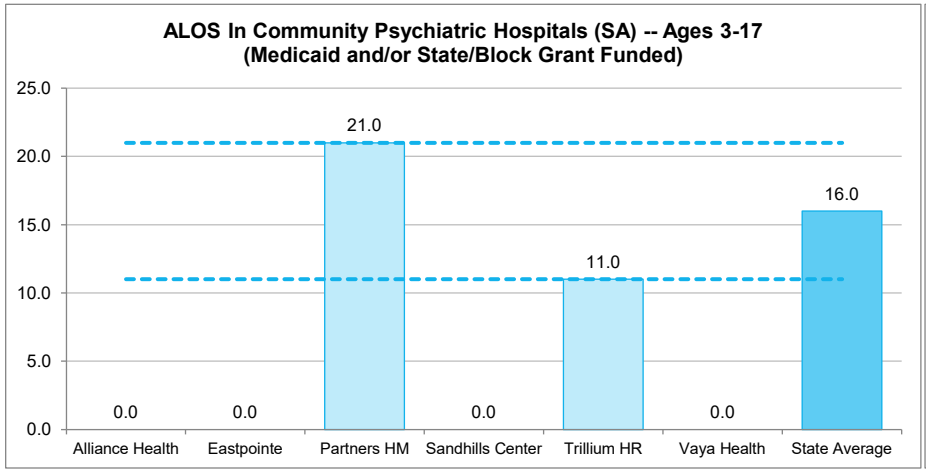
5.4 Length of Stay in Community Psychiatric Hospitals (Principal SA Diagnosis)

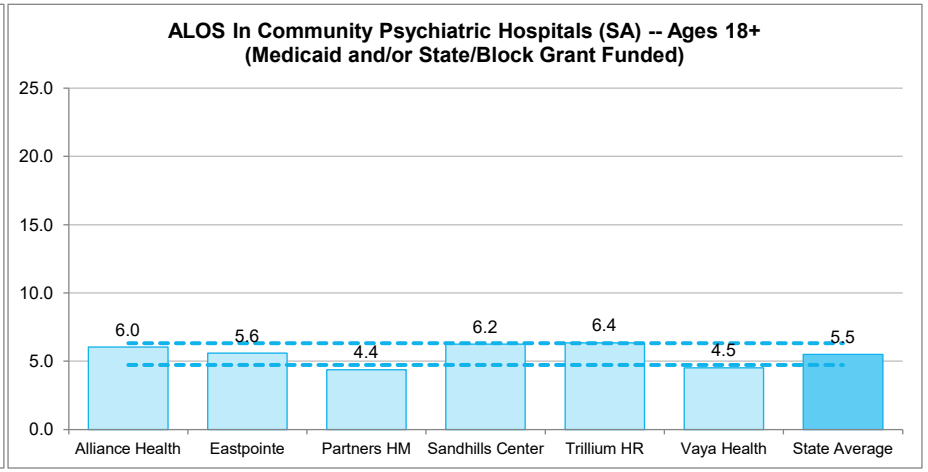
Rationale: Length of stay is commonly used as a quality metric. The average length of stay (ALOS) refers to the average number of days that patients stay in the hospital. ALOS is often used as an indicator of efficiency. All other things being equal, a shorter stay will reduce the cost per discharge and shift care from inpatient to less expensive post-acute settings. Longer stays can be indicative of poor-value care: inefficient hospital processes may cause delays in providing treatment; errors and poor-quality care may mean patients need further treatment or recovery time; poor care co-ordination may leave people stuck in the hospital waiting for ongoing care to be arranged. Stays that are too short can be indicative of poor-value care as well: some people may be discharged too early, when staying in the hospital longer could have improved their outcomes or reduced chances of readmission.

Description: The measure provides the average length of stay for persons with a principal substance use disorder diagnosis who were discharged during the measurement period from a community inpatient facility for acute substance use care.

Length of Stay in Community Psychiatric Hospitals -- Principal SA Diagnosis (Medicaid and/or State/Block Grant Funded)

LME-MCO	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate
	Ages 3-17			Ages 18+			Total (Ages 3+)		
	Total Number Inpatient Days	Total Number Discharges	Average LOS	Total Number Inpatient Days	Total Number Discharges	Average LOS	Total Number Inpatient Days	Total Number Discharges	Average LOS
Alliance Health	0	0		193	32	6.0	193	32	6.0
Eastpointe	0	0		285	51	5.6	285	51	5.6
Partners Health Management	21	1	21.0	289	66	4.4	310	67	4.6
Sandhills Center	0	0		131	21	6.2	131	21	6.2
Trillium Health Resources	11	1	11.0	508	80	6.4	519	81	6.4
Vaya Health	0	0		149	33	4.5	149	33	4.5
State Average	32	2	16.0	1,555	283	5.5	1,587	285	5.6
Standard Deviation			5.0			0.8			0.7
LME-MCO Average			16.0			5.5			5.6





North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

Vaya noted their ED data indicates a decline. Their Provider Network staff are working with providers to resolve an NCTracks issue that has impacted claims processing. They will need to update the data once the claims processing issue is resolved.

CRISIS AND INPATIENT

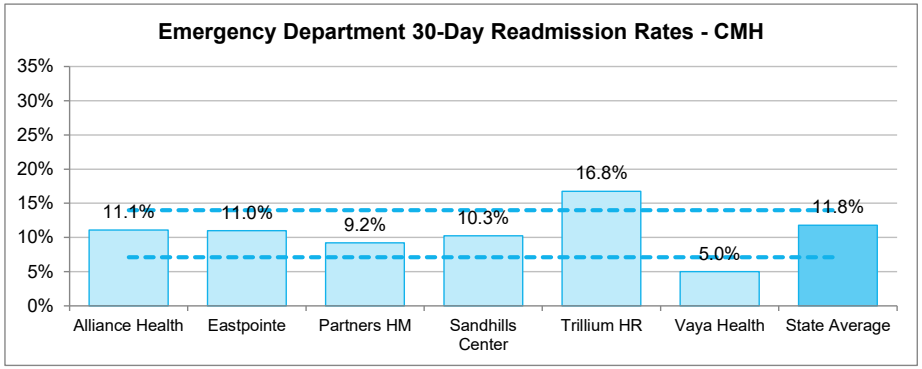
5.5 Emergency Department Readmissions (Medicaid Only)

Rationale: Successful community living following discharge from a emergency department (ED) for a principal MH, I/DD, or SUD diagnosis, without repeated admissions to ED care, requires effective treatment planning, coordination, and ongoing appropriate levels of community care and supports. Timely follow-up care and engagement in community care and supports will reduce avoidable utilization of the ED for MH, I/DD, and SUD diagnoses and enable greater recovery. A low ED readmission rate is a nationally accepted indicator of how well a community is assisting individuals at risk for repeated ED admissions.

Description: This indicator measures the percent of persons admitted to an emergency department each quarter that are readmissions to an emergency department for a MH, I/DD, or SUD principal diagnosis within 30 days of a prior discharge. This rate is computed for 6 age-disability groups - Children and Adults with a MH condition, Children and Adults with a Substance Use Disorder, and Children and Adults with an Intellectual or Developmental Disability - and for All Ages and Disabilities combined.

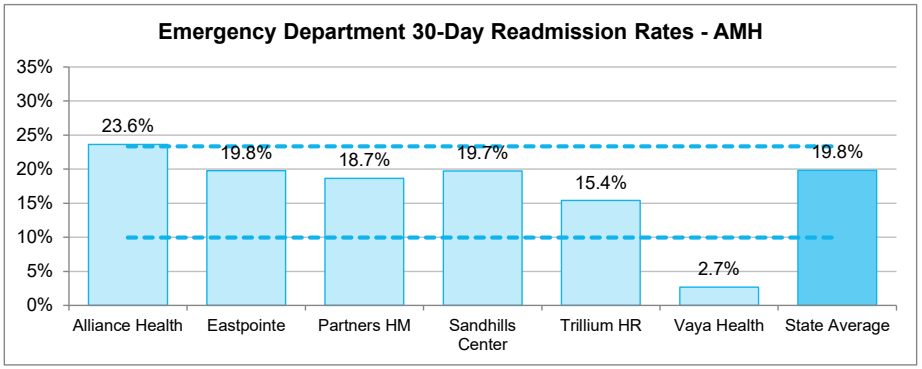
Child Mental Health (Ages 3-17)

LME-MCO	Numerator: Number that are Readmissions within 30 days	Denominator: Number of ED Admissions	Rate: Percent that are Readmissions within 30 Days
Alliance Health	32	289	11.1%
Eastpointe	10	91	11.0%
Partners Health Management	14	152	9.2%
Sandhills Center	12	117	10.3%
Trillium Health Resources	33	197	16.8%
Vaya Health	1	20	5.0%
State Average	102	866	11.8%
Standard Deviation			3.5%
LME-MCO Average			10.5%



Adult Mental Health (Ages 18+)

LME-MCO	Numerator: Number that are Readmissions within 30 days	Denominator: Number of ED Admissions	Rate: Percent that are Readmissions within 30 Days
Alliance Health	261	1,104	23.6%
Eastpointe	74	374	19.8%
Partners Health Management	106	568	18.7%
Sandhills Center	94	476	19.7%
Trillium Health Resources	76	494	15.4%
Vaya Health	2	74	2.7%
State Average	613	3,090	19.8%
Standard Deviation			6.7%
LME-MCO Average			16.7%



North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

Vaya noted their ED data indicates a decline. Their Provider Network staff are working with providers to resolve an NCTracks issue that has impacted claims processing. They will need to update the data once the claims processing issue is resolved.

CRISIS AND INPATIENT

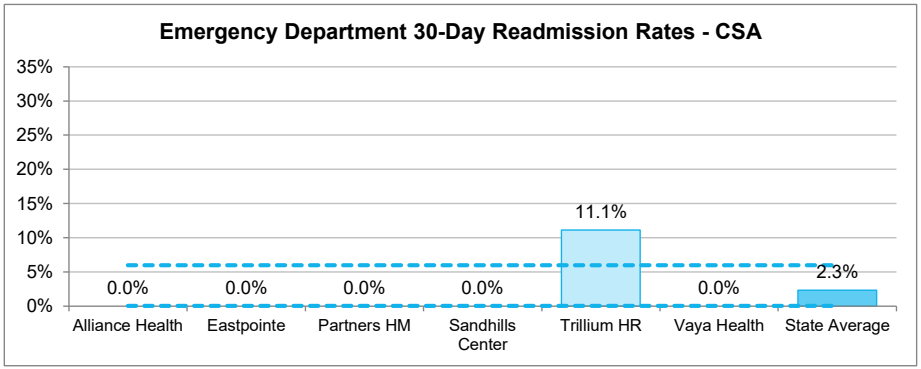
5.5 Emergency Department Readmissions (Medicaid Only)

Rationale: Successful community living following discharge from a emergency department (ED) for a principal MH, I/DD, or SUD diagnosis, without repeated admissions to ED care, requires effective treatment planning, coordination, and ongoing appropriate levels of community care and supports. Timely follow-up care and engagement in community care and supports will reduce avoidable utilization of the ED for MH, I/DD, and SUD diagnoses and enable greater recovery. A low ED readmission rate is a nationally accepted indicator of how well a community is assisting individuals at risk for repeated ED admissions.

Description: This indicator measures the percent of persons admitted to an emergency department each quarter that are readmissions to an emergency department for a MH, I/DD, or SUD principal diagnosis within 30 days of a prior discharge. This rate is computed for 6 age-disability groups - Children and Adults with a MH condition, Children and Adults with a Substance Use Disorder, and Children and Adults with an Intellectual or Developmental Disability - and for All Ages and Disabilities combined.

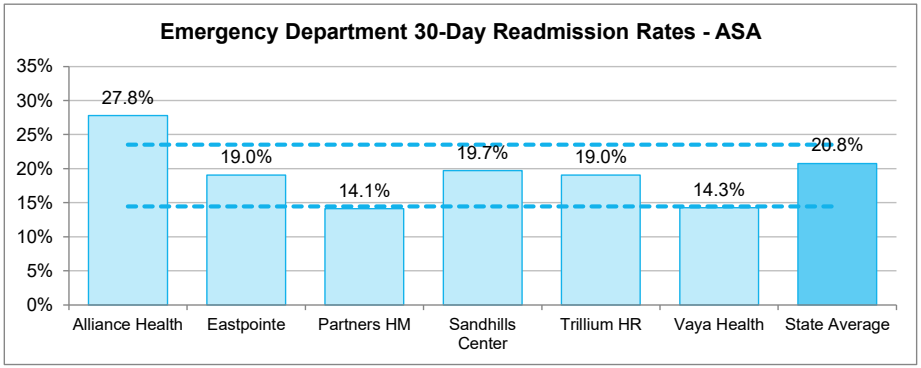
Child Substance Abuse (Ages 3-17)

	Numerator	Denominator	Rate
LME-MCO	**Number that are Readmissions within 30 days**	**Number of ED Admissions**	**Percent that are Readmissions within 30 Days**
Alliance Health	0	14	0.0%
Eastpointe	0	4	0.0%
Partners Health Management	0	6	0.0%
Sandhills Center	0	8	0.0%
Trillium Health Resources	1	9	11.1%
Vaya Health	0	2	0.0%
State Average	1	43	2.3%
Standard Deviation			4.1%
LME-MCO Average			1.9%



Adult Substance Abuse (Ages 18+)

Alliance Health	102	367	27.8%
Eastpointe	28	147	19.0%
Partners Health Management	34	241	14.1%
Sandhills Center	39	198	19.7%
Trillium Health Resources	36	189	19.0%
Vaya Health	4	28	14.3%
State Average	243	1,170	20.8%
Standard Deviation			4.5%
LME-MCO Average			19.0%



State Fiscal Year: 2023
Report Quarter: 2nd Quarter
Measurement Period: Jul - Sep 2022
Based On Claims Paid As Of: Jan 31, 2023

Vaya noted their ED data indicates a decline. Their Provider Network staff are working with providers to resolve an NCTracks issue that has impacted claims processing. They will need to update the data once the claims processing issue is resolved.

CRISIS AND INPATIENT

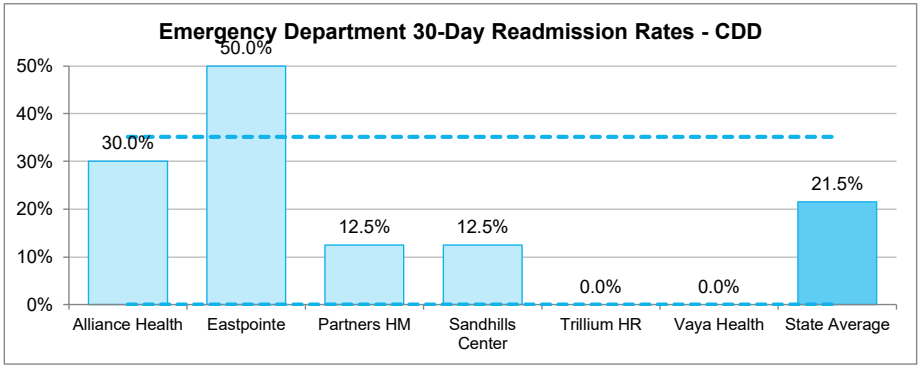
5.5 Emergency Department Readmissions (Medicaid Only)

Rationale: Successful community living following discharge from a emergency department (ED) for a principal MH, I/DD, or SUD diagnosis, without repeated admissions to ED care, requires effective treatment planning, coordination, and ongoing appropriate levels of community care and supports. Timely follow-up care and engagement in community care and supports will reduce avoidable utilization of the ED for MH, I/DD, and SUD diagnoses and enable greater recovery. A low ED readmission rate is a nationally accepted indicator of how well a community is assisting individuals at risk for repeated ED admissions.

Description: This indicator measures the percent of persons admitted to an emergency department each quarter that are readmissions to an emergency department for a MH, I/DD, or SUD principal diagnosis within 30 days of a prior discharge. This rate is computed for 6 age-disability groups - Children and Adults with a MH condition, Children and Adults with a Substance Use Disorder, and Children and Adults with an Intellectual or Developmental Disability - and for All Ages and Disabilities combined.

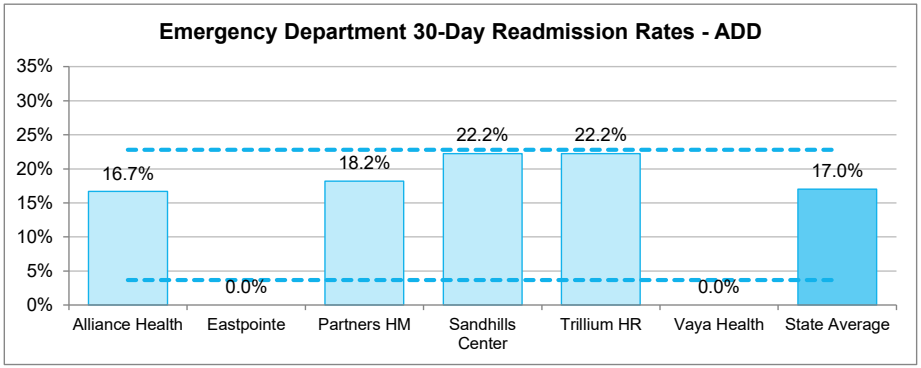
Child Intellectual or Developmental Disabilities (Ages 3-17)

LME-MCO	Numerator: Number that are Readmissions within 30 days	Denominator: Number of ED Admissions	Rate: Percent that are Readmissions within 30 Days
Alliance Health	9	30	30.0%
Eastpointe	2	4	50.0%
Partners Health Management	2	16	12.5%
Sandhills Center	1	8	12.5%
Trillium Health Resources	0	5	0.0%
Vaya Health	0	2	0.0%
State Average	14	65	21.5%
Standard Deviation			17.7%
LME-MCO Average			17.5%



Adult Intellectual or Developmental Disabilities (Ages 18+)

LME-MCO	Numerator: Number that are Readmissions within 30 days	Denominator: Number of ED Admissions	Rate: Percent that are Readmissions within 30 Days
Alliance Health	3	18	16.7%
Eastpointe	0	5	0.0%
Partners Health Management	2	11	18.2%
Sandhills Center	2	9	22.2%
Trillium Health Resources	2	9	22.2%
Vaya Health	0	1	0.0%
State Average	9	53	17.0%
Standard Deviation			9.6%
LME-MCO Average			13.2%



State Fiscal Year: 2023
Report Quarter: 2nd Quarter
Measurement Period: Jul - Sep 2022
Based On Claims Paid As Of: Jan 31, 2023

Vaya noted their ED data indicates a decline. Their Provider Network staff are working with providers to resolve an NCTracks issue that has impacted claims processing. They will need to update the data once the claims processing issue is resolved.

CRISIS AND INPATIENT

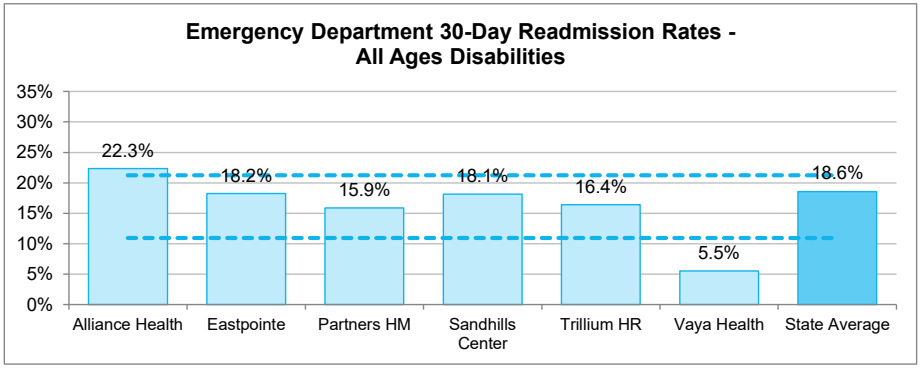
5.5 Emergency Department Readmissions (Medicaid Only)

Rationale: Successful community living following discharge from a emergency department (ED) for a principal MH, I/DD, or SUD diagnosis, without repeated admissions to ED care, requires effective treatment planning, coordination, and ongoing appropriate levels of community care and supports. Timely follow-up care and engagement in community care and supports will reduce avoidable utilization of the ED for MH, I/DD, and SUD diagnoses and enable greater recovery. A low ED readmission rate is a nationally accepted indicator of how well a community is assisting individuals at risk for repeated ED admissions.

Description: This indicator measures the percent of persons admitted to an emergency department each quarter that are readmissions to an emergency department for a MH, I/DD, or SUD principal diagnosis within 30 days of a prior discharge. This rate is computed for 6 age-disability groups - Children and Adults with a MH condition, Children and Adults with a Substance Use Disorder, and Children and Adults with an Intellectual or Developmental Disability - and for All Ages and Disabilities combined.

All Ages and Disabilities (Ages 3+)

LME-MCO	Numerator: Number that are Readmissions within 30 days	Denominator: Number of ED Admissions	Rate: Percent that are Readmissions within 30 Days
Alliance Health	407	1,822	22.3%
Eastpointe	114	625	18.2%
Partners Health Management	158	994	15.9%
Sandhills Center	148	816	18.1%
Trillium Health Resources	148	903	16.4%
Vaya Health	7	127	5.5%
State Average	982	5,287	18.6%
Standard Deviation			5.2%
LME-MCO Average			16.1%



North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**30-Day Readmission Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**180-Day Readmission Measurement Period:**	Apr - Jun 2022

CRISIS AND INPATIENT SERVICES

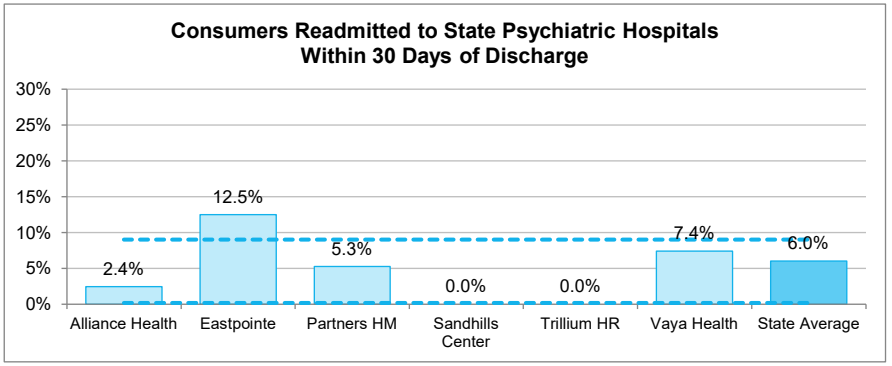
5.6 State Psychiatric Hospital Readmissions within 30 Days and 180 Days

Rationale: Successful community living following hospitalization, without repeated admissions to inpatient care, requires effective treatment planning, coordination, and ongoing appropriate levels of community care and supports. A low psychiatric hospital readmission rate is a nationally accepted indicator of how well a community is assisting individuals at risk for repeated hospitalizations. This is a MH Block Grant measure required by the Center for Mental Health Services (CMHS).

Description: This indicator measures the percent of persons discharged from a state psychiatric hospital each quarter, that fall within the responsibility of an LME-MCO to coordinate services (as described in the footnote below) that are readmitted to any state psychiatric hospital within 30 days and within 180 days following discharge.

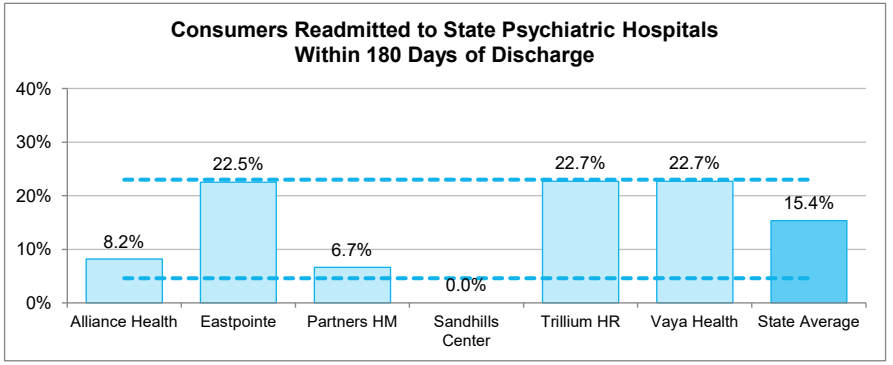
Readmitted within 30 Days (Discharges Jul - Sep 2022)

LME-MCO	Numerator: Number Readmissions	Denominator: Total Discharges	Rate: Percent Readmitted
Alliance Health	1	41	2.4%
Eastpointe	5	40	12.5%
Partners Health Management	1	19	5.3%
Sandhills Center	0	13	0.0%
Trillium Health Resources	0	9	0.0%
Vaya Health	2	27	7.4%
State Average	9	149	6.0%
Standard Deviation			4.4%
LME-MCO Average			4.6%



Readmitted within 180 Days (Discharges Apr - Jun 2022)

LME-MCO	Numerator: Number Readmissions	Denominator: Total Discharges	Rate: Percent Readmitted
Alliance Health	4	49	8.2%
Eastpointe	9	40	22.5%
Partners Health Management	1	15	6.7%
Sandhills Center	0	8	0.0%
Trillium Health Resources	5	22	22.7%
Vaya Health	5	22	22.7%
State Average	24	156	15.4%
Standard Deviation			9.2%
LME-MCO Average			13.8%



Data Source: State Hospital data in CDW as of 1/13/23. Discharges have been filtered to include only "direct" and program completion discharges to sources that fall within the responsibility of an LME-MCO to coordinate services (e.g. to other outpatient and residential non state facility, self/no referral, unknown, community agency, private physician, other health care, family friends, nonresidential treatment/habilitation program, other). Discharges for other reasons (e.g. transfers to other facilities, deaths, discharges to medical visits, etc.); to other referral sources (e.g. court, correctional facilities, nursing homes, state facilities, VA); and out-of-state are not included as LMEs would not be expected to coordinate services for these individuals nor to have any impact on readmission rates.

CRISIS AND INPATIENT SERVICES

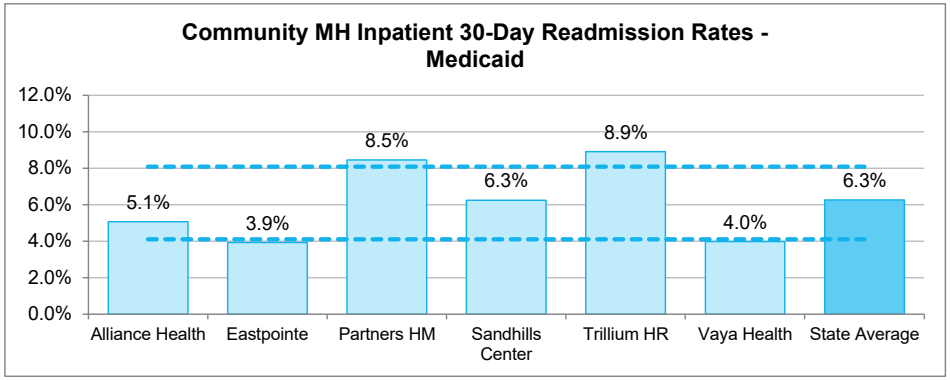
5.7. Community Mental Health Inpatient Readmissions Within 30 Days (Ages 6+)

Rationale: Successful community living following hospitalization, without repeated admissions to inpatient care, requires effective treatment planning, coordination, and ongoing appropriate levels of community care and supports. A low hospital readmission rate is a nationally accepted indicator of how well a community is assisting individuals at risk for repeated hospitalizations.

Description: This indicator measures the percent of persons discharged from a community-based hospital for a principal MH diagnosis each quarter that are readmitted to any community-based hospital for any MH, I/DD, SUD principal diagnosis within 30 days following discharge.

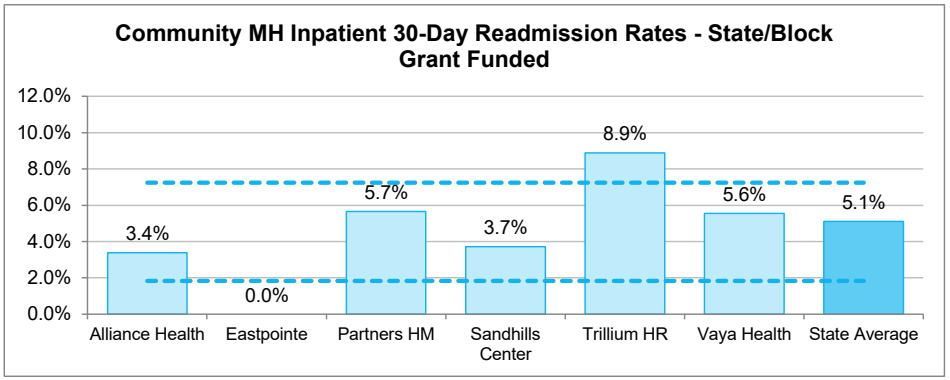
Medicaid Funded

LME-MCO	Numerator: Total Number of Readmissions within 30 days	Denominator: Total Number of Discharges	Rate: Percent Readmitted Within 30 Days
Alliance Health	52	1,025	5.1%
Eastpointe	9	229	3.9%
Partners Health Management	53	627	8.5%
Sandhills Center	13	208	6.3%
Trillium Health Resources	58	651	8.9%
Vaya Health	23	578	4.0%
State Average	208	3,318	6.3%
Standard Deviation			2.0%
LME-MCO Average			6.1%



State/Block Grant Funded

LME-MCO	Numerator: Total Number of Readmissions within 30 days	Denominator: Total Number of Discharges	Rate: Percent Readmitted Within 30 Days
Alliance Health	23	681	3.4%
Eastpointe	0	52	0.0%
Partners Health Management	35	618	5.7%
Sandhills Center	7	188	3.7%
Trillium Health Resources	28	315	8.9%
Vaya Health	22	396	5.6%
State Average	115	2,250	5.1%
Standard Deviation			2.7%
LME-MCO Average			4.5%



North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

CRISIS AND INPATIENT SERVICES

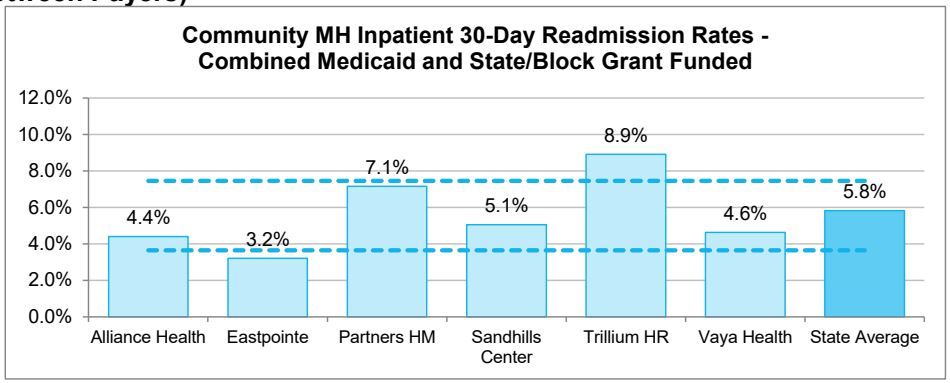
5.7. Community Mental Health Inpatient Readmissions Within 30 Days (Ages 6+)

Rationale: Successful community living following hospitalization, without repeated admissions to inpatient care, requires effective treatment planning, coordination, and ongoing appropriate levels of community care and supports. A low hospital readmission rate is a nationally accepted indicator of how well a community is assisting individuals at risk for repeated hospitalizations.

Description: This indicator measures the percent of persons discharged from a community-based hospital for a principal MH diagnosis each quarter that are readmitted to any community-based hospital for any MH, I/DD, SUD principal diagnosis within 30 days following discharge.

Combined Medicaid and State/Block Grant Funded (Includes Cross-Overs Between Payers)

LME-MCO	Numerator: Total Number of Readmissions within 30 days	Denominator: Total Number of Discharges	Rate: Percent Readmitted Within 30 Days
Alliance Health	75	1,708	4.4%
Eastpointe	9	281	3.2%
Partners Health Management	89	1,245	7.1%
Sandhills Center	20	396	5.1%
Trillium Health Resources	86	966	8.9%
Vaya Health	45	974	4.6%
State Average	324	5,570	5.8%
Standard Deviation			1.9%
LME-MCO Average			5.6%



North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

CRISIS AND INPATIENT SERVICES

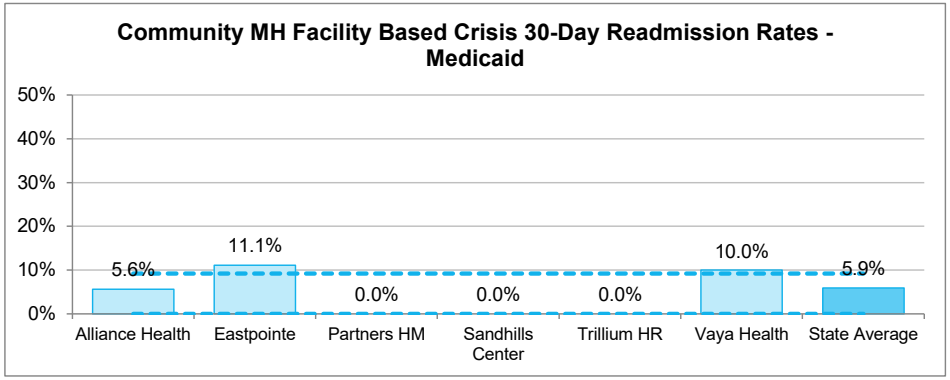
5.7. Community Mental Health Facility Based Crisis Readmissions Within 30 Days (Ages 6+)

Rationale: Successful community living following discharge from a facility based crisis service, without repeated admissions to facility based crisis care, requires effective treatment planning, coordination, and ongoing appropriate levels of community care and supports. A low readmission rate is a nationally accepted indicator of how well a community is assisting individuals at risk for repeated crisis care.

Description: This indicator measures the percent of persons discharged from a facility based crisis service for a principal MH diagnosis each quarter that are readmitted to a facility based crisis service for any MH, I/DD, SUD principal diagnosis within 30 days following discharge.

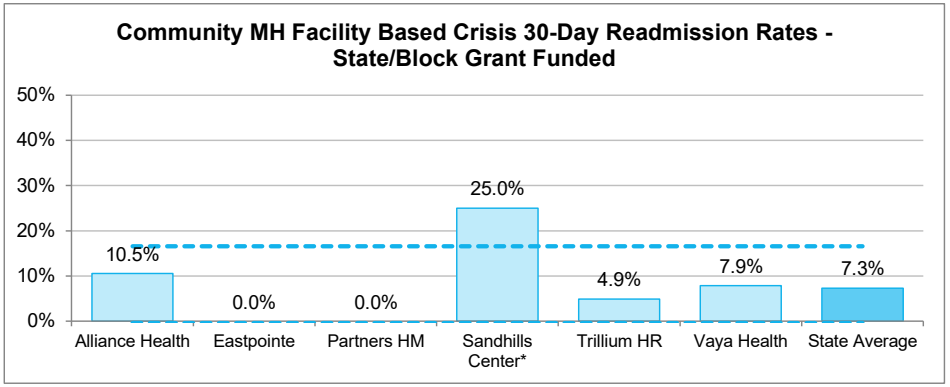
Medicaid Funded

LME-MCO	Numerator: Total Number of Readmissions within 30 days	Denominator: Total Number of Discharges	Rate: Percent Readmitted Within 30 Days
Alliance Health	4	71	5.6%
Eastpointe	1	9	11.1%
Partners Health Management	0	25	0.0%
Sandhills Center	0	8	0.0%
Trillium Health Resources	0	19	0.0%
Vaya Health	7	70	10.0%
State Average	12	202	5.9%
Standard Deviation			4.8%
LME-MCO Average			4.5%



State/Block Grant Funded

LME-MCO	Numerator: Total Number of Readmissions within 30 days	Denominator: Total Number of Discharges	Rate: Percent Readmitted Within 30 Days
Alliance Health	10	95	10.5%
Eastpointe	0	10	0.0%
Partners Health Management	0	24	0.0%
Sandhills Center	1	4	25.0%
Trillium Health Resources	3	61	4.9%
Vaya Health	3	38	7.9%
State Average	17	232	7.3%
Standard Deviation			8.5%
LME-MCO Average			8.1%



North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

CRISIS AND INPATIENT SERVICES

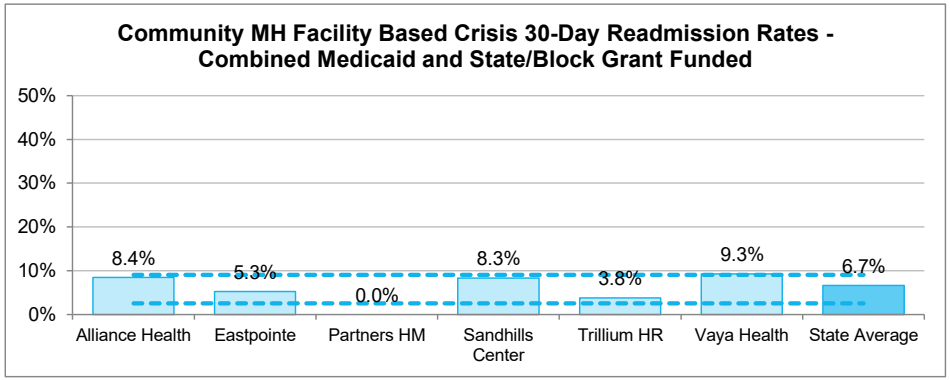
5.7. Community Mental Health Facility Based Crisis Readmissions Within 30 Days (Ages 6+)

Rationale: Successful community living following discharge from a facility based crisis service, without repeated admissions to facility based crisis care, requires effective treatment planning, coordination, and ongoing appropriate levels of community care and supports. A low readmission rate is a nationally accepted indicator of how well a community is assisting individuals at risk for repeated crisis care.

Description: This indicator measures the percent of persons discharged from a facility based crisis service for a principal MH diagnosis each quarter that are readmitted to a facility based crisis service for any MH, I/DD, SUD principal diagnosis within 30 days following discharge.

Combined Medicaid and State/Block Grant Funded (Includes Cross-Overs Between Payers)

LME-MCO	Numerator: Total Number of Readmissions within 30 days	Denominator: Total Number of Discharges	Rate: Percent Readmitted Within 30 Days
Alliance Health	14	166	8.4%
Eastpointe	1	19	5.3%
Partners Health Management	0	49	0.0%
Sandhills Center	1	12	8.3%
Trillium Health Resources	3	80	3.8%
Vaya Health	10	108	9.3%
State Average	29	434	6.7%
Standard Deviation			3.3%
LME-MCO Average			5.8%



North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

CRISIS AND INPATIENT SERVICES

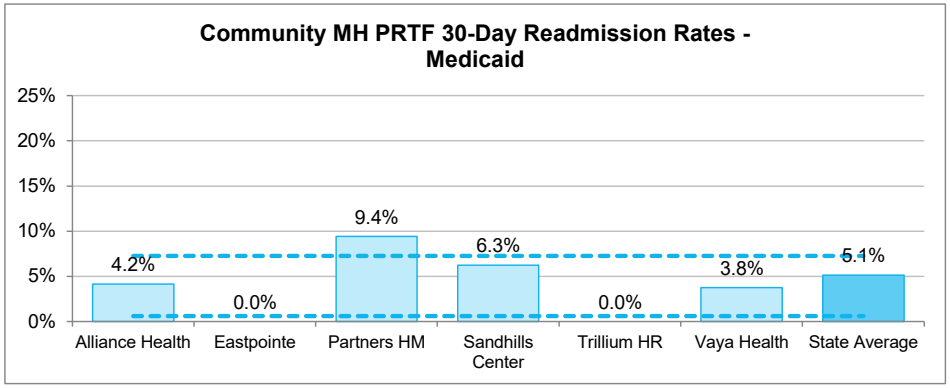
5.7. Community Mental Health PRTF Readmissions Within 30 Days (Ages 6+)

Rationale: Successful community living following care in a Psychiatric Residential Treatment Facility (PRTF), without repeated admissions, requires effective treatment planning, coordination, and ongoing appropriate levels of community care and supports. A low readmission rate is a nationally accepted indicator of how well a community is assisting individuals at risk for repeated stays in a PRTF.

Description: This indicator measures the percent of persons discharged from a PRTF for a principal MH diagnosis each quarter that are readmitted to any PRTF within 30 days following discharge.

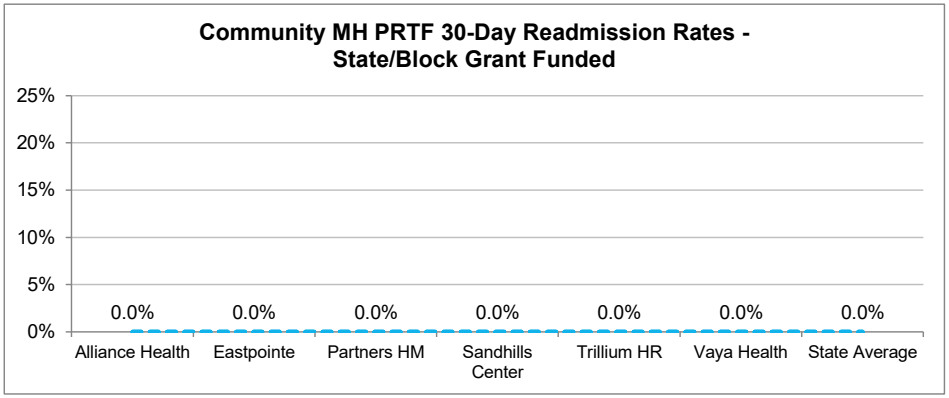
Medicaid Funded

LME-MCO	Numerator: Total Number of Readmissions within 30 days	Denominator: Total Number of Discharges	Rate: Percent Readmitted Within 30 Days
Alliance Health	2	48	4.2%
Eastpointe	0	22	0.0%
Partners Health Management	5	53	9.4%
Sandhills Center	5	80	6.3%
Trillium Health Resources	0	16	0.0%
Vaya Health	2	53	3.8%
State Average	14	272	5.1%
Standard Deviation			3.3%
LME-MCO Average			3.9%



State/Block Grant Funded

LME-MCO	Numerator: Total Number of Readmissions within 30 days	Denominator: Total Number of Discharges	Rate: Percent Readmitted Within 30 Days
Alliance Health	0	0	
Eastpointe	0	0	
Partners Health Management	0	0	
Sandhills Center	0	0	
Trillium Health Resources	0	0	
Vaya Health	0	0	
State Average	0	0	
Standard Deviation			0.0%
LME-MCO Average			0.0%



North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

CRISIS AND INPATIENT SERVICES

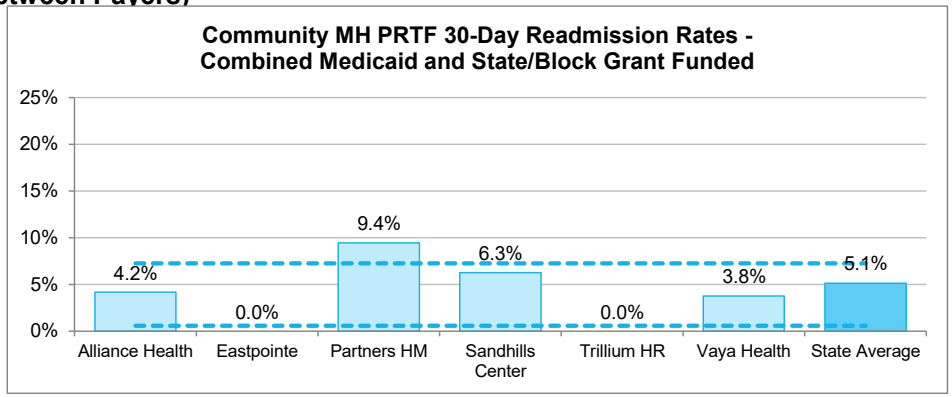
5.7. Community Mental Health PRTF Readmissions Within 30 Days (Ages 6+)

Rationale: Successful community living following care in a Psychiatric Residential Treatment Facility (PRTF), without repeated admissions, requires effective treatment planning, coordination, and ongoing appropriate levels of community care and supports. A low readmission rate is a nationally accepted indicator of how well a community is assisting individuals at risk for repeated stays in a PRTF.

Description: This indicator measures the percent of persons discharged from a PRTF for a principal MH diagnosis each quarter that are readmitted to any PRTF within 30 days following discharge.

Combined Medicaid and State/Block Grant Funded (Includes Cross-Overs Between Payers)

LME-MCO	Numerator: Total Number of Readmissions within 30 days	Denominator: Total Number of Discharges	Rate: Percent Readmitted Within 30 Days
Alliance Health	2	48	4.2%
Eastpointe	0	22	0.0%
Partners Health Management	5	53	9.4%
Sandhills Center	5	80	6.3%
Trillium Health Resources	0	16	0.0%
Vaya Health	2	53	3.8%
State Average	14	272	5.1%
Standard Deviation			3.3%
LME-MCO Average			3.9%



North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**30-Day Readmission Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**180-Day Readmission Measurement Period:**	Apr - Jun 2022

CRISIS AND INPATIENT SERVICES

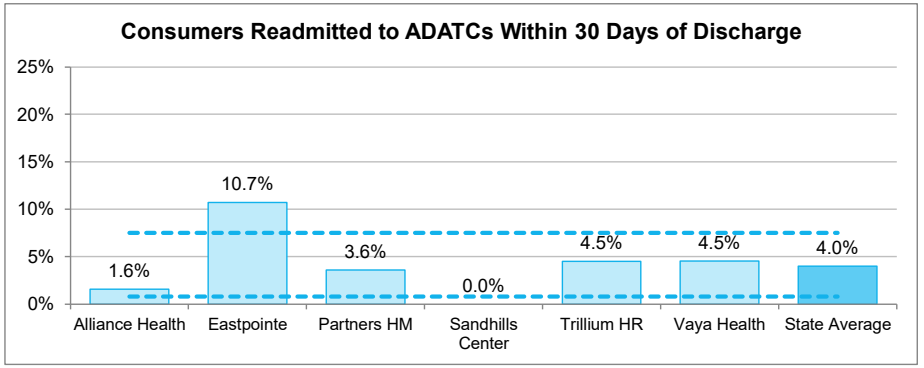
5.8 State ADATC Readmissions within 30 Days and 180 Days

Rationale: Successful community living following care in a State Alcohol and Drug Abuse Treatment Center (ADATC), without repeated admissions, requires effective treatment planning, coordination, and ongoing appropriate levels of community care and supports. A low readmission rate is a nationally accepted indicator of how well a community is assisting individuals at risk for repeated stays in an ADATC.

Description: This indicator measures the percent of persons discharged from a State ADATC for a principal SUD diagnosis each quarter that are readmitted to any ADATC within 30 days and within 180 days following discharge.

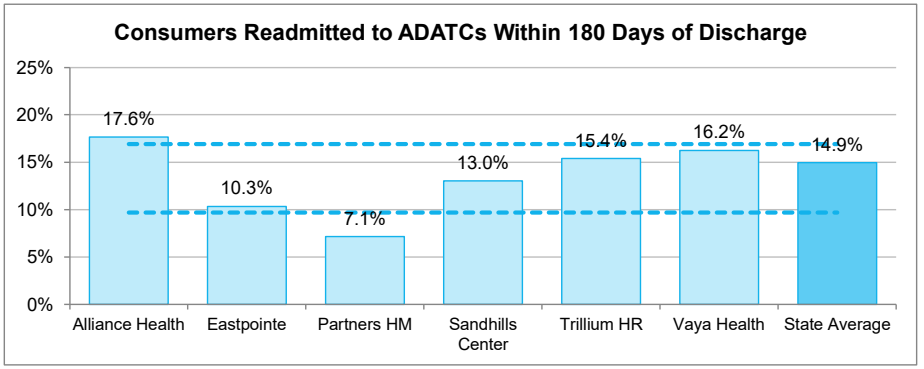
Readmitted within 30 Days (Discharges Jul - Sep 2022)

	Numerator	Denominator	Rate
LME-MCO	**Number Readmissions**	**Total Discharges**	**Percent Readmitted**
Alliance Health	1	64	1.6%
Eastpointe	3	28	10.7%
Partners Health Management	1	28	3.6%
Sandhills Center	0	39	0.0%
Trillium Health Resources	5	111	4.5%
Vaya Health	7	154	4.5%
State Average	17	424	4.0%
Standard Deviation			3.4%
LME-MCO Average			4.1%



Readmitted within 180 Days (Discharges Apr - Jun 2022)

Alliance Health	12	68	17.6%
Eastpointe	3	29	10.3%
Partners Health Management	2	28	7.1%
Sandhills Center	6	46	13.0%
Trillium Health Resources	20	130	15.4%
Vaya Health	25	154	16.2%
State Average	68	455	14.9%
Standard Deviation			3.6%
LME-MCO Average			13.3%



Data Source: State ADATC data in CDW as of 1/13/23. Discharges have been filtered to include only "direct" and program completion discharges to sources that fall within the responsibility of an LME-MCO to coordinate services (e.g. to other outpatient and residential non state facility, self/no referral, unknown, community agency, private physician, other health care, family friends, nonresidential treatment/habilitation program, other). Discharges for other reasons (e.g. transfers to other facilities, deaths, discharges to medical visits, etc.); to other referral sources (e.g. court, correctional facilities, nursing homes, state facilities, VA); and out-of-state are not included as LMEs would not be expected to coordinate services for these individuals nor to have any impact on readmission rates.

North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

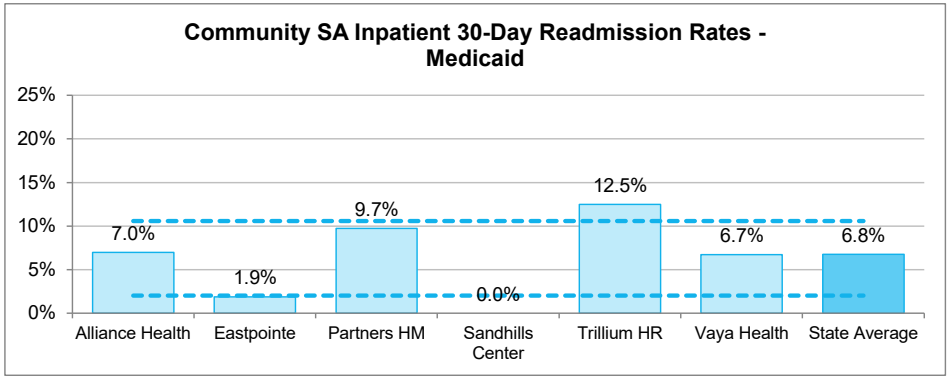
CRISIS AND INPATIENT SERVICES

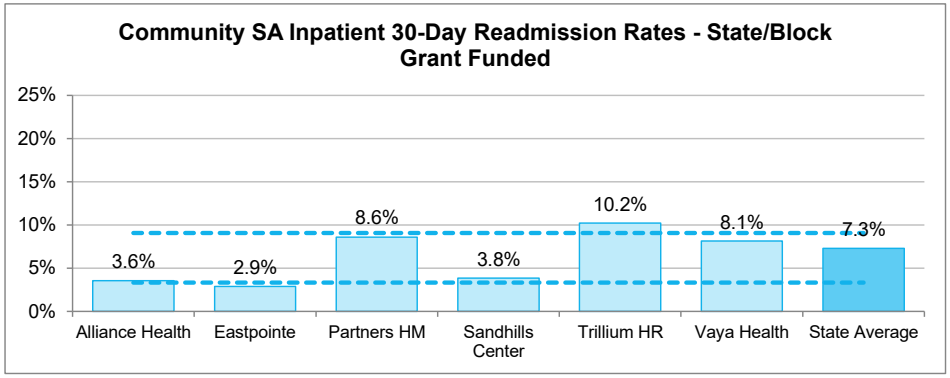
5.9. Community Substance Abuse Inpatient Readmissions Within 30 Days (Ages 6+)

Rationale: Successful community living following hospitalization, without repeated admissions to inpatient care, requires effective treatment planning, coordination, and ongoing appropriate levels of community care and supports. A low hospital readmission rate is a nationally accepted indicator of how well a community is assisting individuals at risk for repeated hospitalizations.

Description: This indicator measures the percent of persons discharged from a community-based hospital for a principal SUD diagnosis each quarter that are readmitted to any community-based hospital for any MH, I/DD, SUD principal diagnosis within 30 days following discharge.

	Numerator	Denominator	Rate
LME-MCO	**Total Number of Readmissions within 30 days**	**Total Number of Discharges**	**Percent Readmitted Within 30 Days**
Medicaid Funded			
Alliance Health	6	86	7.0%
Eastpointe	1	53	1.9%
Partners Health Management	7	72	9.7%
Sandhills Center	0	22	0.0%
Trillium Health Resources	4	32	12.5%
Vaya Health	14	208	6.7%
State Average	32	473	6.8%
Standard Deviation			4.3%
LME-MCO Average			6.3%
State/Block Grant Funded			
Alliance Health	2	56	3.6%
Eastpointe	2	69	2.9%
Partners Health Management	13	151	8.6%
Sandhills Center	3	78	3.8%
Trillium Health Resources	5	49	10.2%
Vaya Health	42	516	8.1%
State Average	67	919	7.3%
Standard Deviation			2.9%
LME-MCO Average			6.2%





North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
Report Quarter:	2nd Quarter	**Based On Claims Paid As Of:**	Jan 31, 2023

CRISIS AND INPATIENT SERVICES

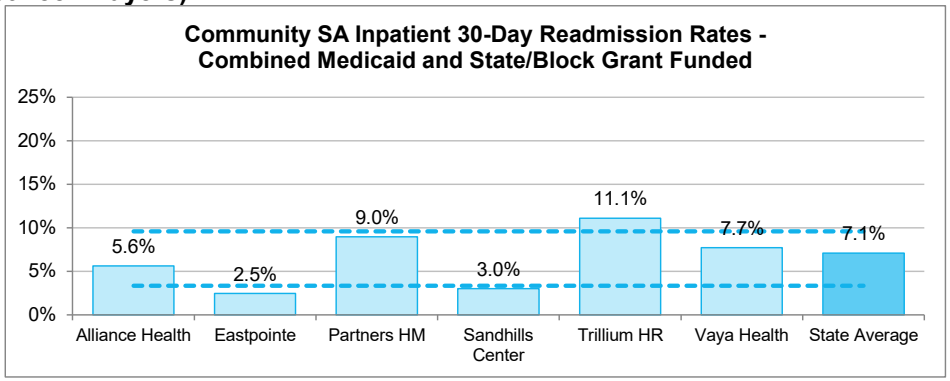
5.9. Community Substance Abuse Inpatient Readmissions Within 30 Days (Ages 6+)

Rationale: Successful community living following hospitalization, without repeated admissions to inpatient care, requires effective treatment planning, coordination, and ongoing appropriate levels of community care and supports. A low hospital readmission rate is a nationally accepted indicator of how well a community is assisting individuals at risk for repeated hospitalizations.

Description: This indicator measures the percent of persons discharged from a community-based hospital for a principal SUD diagnosis each quarter that are readmitted to any community-based hospital for any MH, I/DD, SUD principal diagnosis within 30 days following discharge.

Combined Medicaid and State/Block Grant Funded (Includes Cross-Overs Between Payers)

	Numerator	Denominator	Rate
LME-MCO	**Total Number of Readmissions within 30 days**	**Total Number of Discharges**	**Percent Readmitted Within 30 Days**
Alliance Health	8	142	5.6%
Eastpointe	3	122	2.5%
Partners Health Management	20	223	9.0%
Sandhills Center	3	100	3.0%
Trillium Health Resources	9	81	11.1%
Vaya Health	56	724	7.7%
State Average	99	1,392	7.1%
Standard Deviation			3.1%
LME-MCO Average			6.5%



North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures

State Fiscal Year:	2023	**Measurement Period:**	Jul - Sep 2022
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CRISIS AND INPATIENT SERVICES

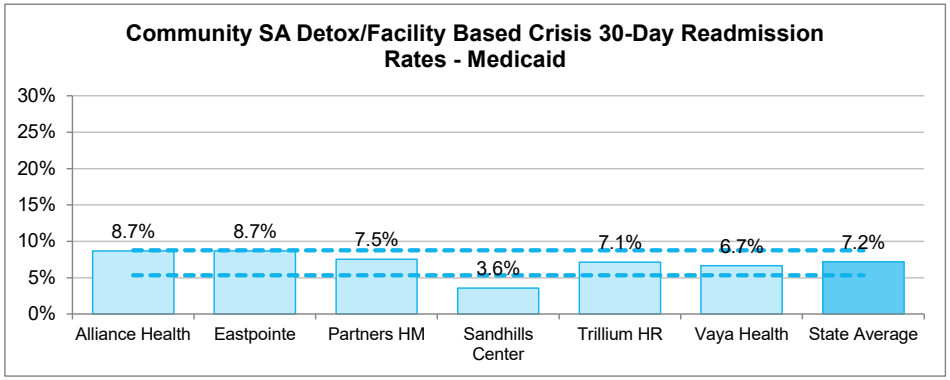
5.9. Community Substance Abuse Detox/Facility Based Crisis Readmissions Within 30 Days (Ages 6+)

Rationale: Successful community living following discharge from a Detox/Facility Based Crisis facility, without repeated admissions to Detox/Facility Based Crisis facility care, requires effective treatment planning, coordination, and ongoing appropriate levels of community care and supports. A low readmission rate is a nationally accepted indicator of how well a community is assisting individuals at risk for repeated Detox/Facility Based Crisis facility stays.

Description: This indicator measures the percent of persons discharged from a Detox/Facility Based Crisis facility for a principal SUD diagnosis each quarter that are readmitted to any Detox/Facility Based Crisis facility within 30 days following discharge.

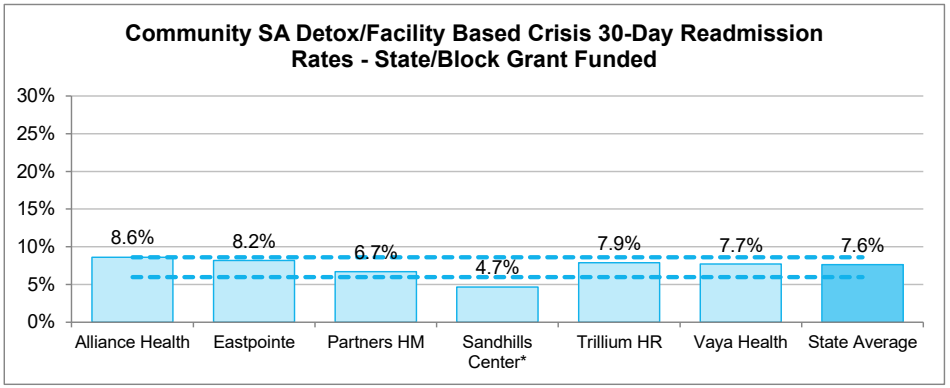
Medicaid Funded

	Numerator	Denominator	Rate
LME-MCO	**Total Number of Readmissions within 30 days**	**Total Number of Discharges**	**Percent Readmitted Within 30 Days**
Alliance Health	11	127	8.7%
Eastpointe	4	46	8.7%
Partners Health Management	8	106	7.5%
Sandhills Center	2	56	3.6%
Trillium Health Resources	8	112	7.1%
Vaya Health	11	165	6.7%
State Average	44	612	7.2%
Standard Deviation			1.7%
LME-MCO Average			7.0%



State/Block Grant Funded

Alliance Health	43	499	8.6%
Eastpointe	9	110	8.2%
Partners Health Management	31	464	6.7%
Sandhills Center	5	107	4.7%
Trillium Health Resources	40	506	7.9%
Vaya Health	34	441	7.7%
State Average	162	2,127	7.6%
Standard Deviation			1.3%
LME-MCO Average			7.3%



North Carolina LME-MCO Performance Measurement Reporting
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CRISIS AND INPATIENT SERVICES

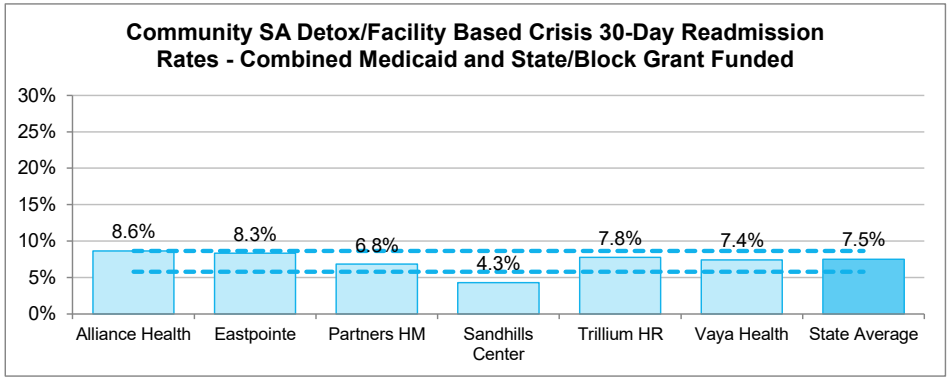
5.9. Community Substance Abuse Detox/Facility Based Crisis Readmissions Within 30 Days (Ages 6+)

Rationale: Successful community living following discharge from a Detox/Facility Based Crisis facility, without repeated admissions to Detox/Facility Based Crisis facility care, requires effective treatment planning, coordination, and ongoing appropriate levels of community care and supports. A low readmission rate is a nationally accepted indicator of how well a community is assisting individuals at risk for repeated Detox/Facility Based Crisis facility stays.

Description: This indicator measures the percent of persons discharged from a Detox/Facility Based Crisis facility for a principal SUD diagnosis each quarter that are readmitted to any Detox/Facility Based Crisis facility within 30 days following discharge.

Combined Medicaid and State/Block Grant Funded (Includes Cross-Overs Between Payers)

	Numerator	Denominator	Rate
LME-MCO	**Total Number of Readmissions within 30 days**	**Total Number of Discharges**	**Percent Readmitted Within 30 Days**
Alliance Health	54	626	8.6%
Eastpointe	13	156	8.3%
Partners Health Management	39	570	6.8%
Sandhills Center	7	163	4.3%
Trillium Health Resources	48	618	7.8%
Vaya Health	45	606	7.4%
State Average	206	2,739	7.5%
Standard Deviation			1.4%
LME-MCO Average			7.2%



North Carolina LME-MCO Performance Measurement Reporting
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CONTINUITY OF CARE

6.1 Follow-Up After Discharge: State Psychiatric Hospitals

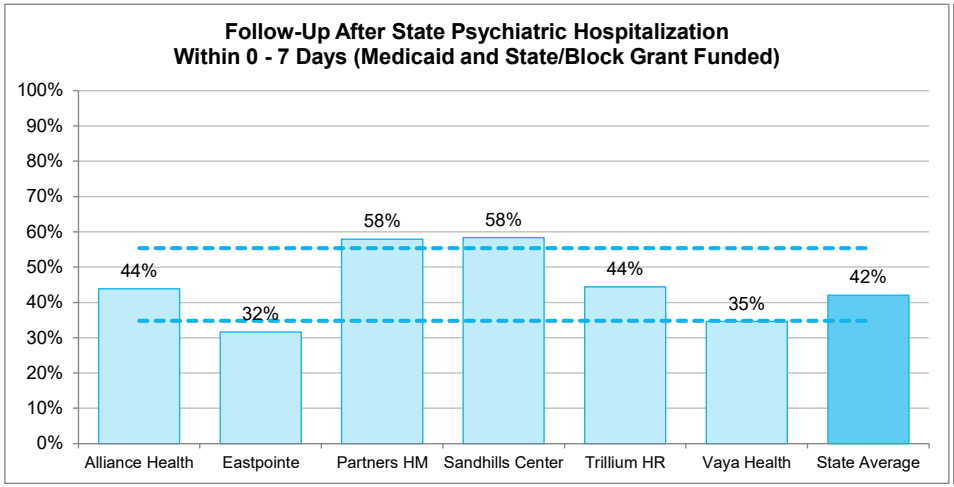
Rationale: Timely follow-up care after discharge from an inpatient facility is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary re-hospitalization. Receiving a community-based service within 7 days and within 30 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and extent of coordination across levels of care.

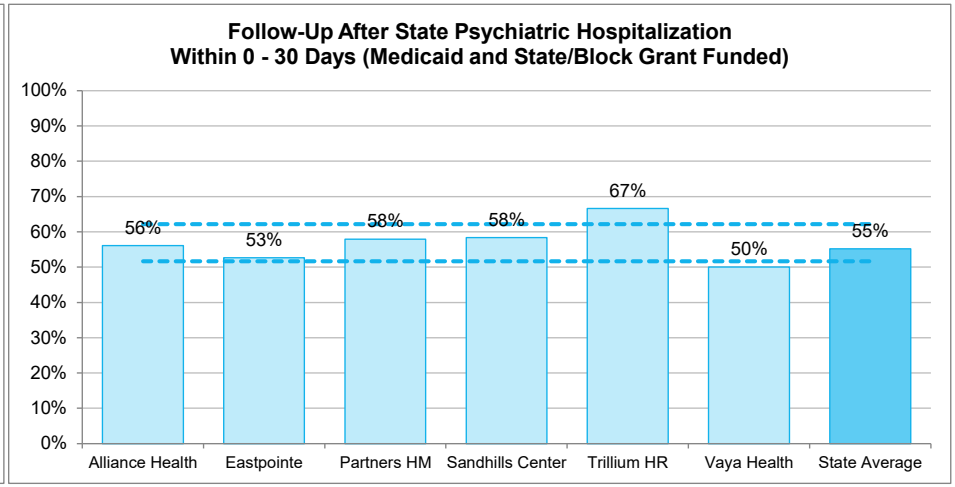
Description: This indicator measures the percent of persons discharged from a state psychiatric hospital each quarter, that fall within the responsibility of an LME-MCO to coordinate services, that receive a follow-up visit with a behavioral health practitioner within 7 days and within 30 days after discharge .

Follow-Up After State Psychiatric Hospitalization (Medicaid and/or State/Block Grant Funded)

LME-MCO	Numerator: Total Number Received Behavioral Health Follow-Up Care (Other Than ED Or Mobile Crisis) 0 - 7 Days	Numerator: 8 - 30 Days	Numerator: >30 Days	Numerator: Not Seen*	Denominator: Total Number of Discharges	Rate: Percent Received Behavioral Health Follow-Up Care (Other Than ED Or Mobile Crisis) 0 - 7 Days	Rate: 8 - 30 Days	Rate: >30 Days	Rate: Not Seen*
Alliance Health	18	5	3	15	41	44%	12%	7%	37%
Eastpointe	12	8	6	12	38	32%	21%	16%	32%
Partners Health Management	11	0	2	6	19	58%	0%	11%	32%
Sandhills Center	7	0	0	5	12	58%	0%	0%	42%
Trillium Health Resources	4	2	1	2	9	44%	22%	11%	22%
Vaya Health	9	4	1	12	26	35%	15%	4%	46%
State Average	61	19	13	52	145	42%	13%	9%	36%
Standard Deviation						10.3%			
LME-MCO Average						45%			

* Not Seen by the claims paid cutoff date for the measure.





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CONTINUITY OF CARE

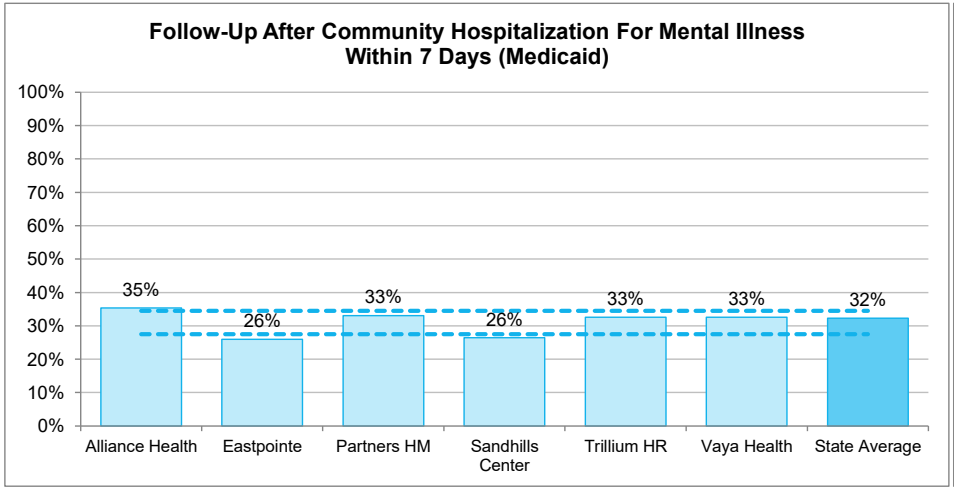
6.2. Follow-Up After Discharge: Community Mental Health Inpatient Treatment (Hospital, Ages 6+)

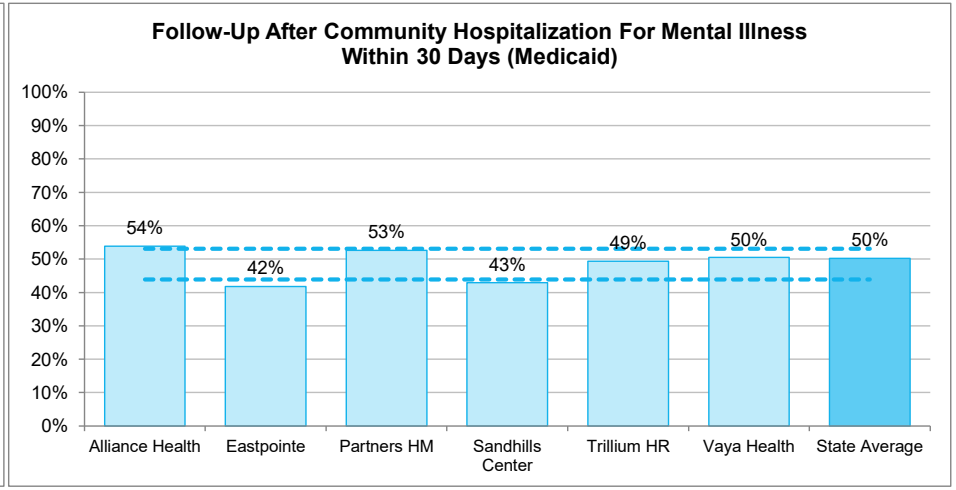
Rationale: Timely follow-up care after discharge from an inpatient facility is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary re-hospitalization. Receiving a community-based service within 7 days and within 30 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and extent of coordination across levels of care.

Description: This indicator measures the percent of discharges from a community hospital each quarter for persons with a principal mental health diagnosis that receive a follow-up visit with a behavioral health practitioner within 7 days and within 30 days after discharge .

	Numerator	Numerator	Numerator	Numerator	Denominator	Rate	Rate	Rate	Rate
LME-MCO	**Total Number Received Outpatient Visit**				**Total Number of Discharges**	**Percent Received Outpatient Visit**			
	0 - 7 Days	**0 - 30 Days**	**> 30 Days**	**Not Seen***		**0 - 7 Days**	**0 - 30 Days**	**> 30 Days**	**Not Seen***
Follow-Up After Community Hospitalization (Medicaid Funded)									
Alliance Health	323	492	153	268	913	35%	54%	17%	29%
Eastpointe	79	127	43	134	304	26%	42%	14%	44%
Partners Health Management	218	347	114	198	659	33%	53%	17%	30%
Sandhills Center	75	122	60	102	284	26%	43%	21%	36%
Trillium Health Resources	181	274	77	204	555	33%	49%	14%	37%
Vaya Health	202	313	95	212	620	33%	50%	15%	34%
State Average	1,078	1,675	542	1,118	3,335	32%	50%	16%	34%
Standard Deviation						3.5%	4.6%		
LME-MCO Average						31%	49%	16%	35%

* Not Seen by the claims paid cutoff date for the measure.





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CONTINUITY OF CARE

6.2. Follow-Up After Discharge: Community Mental Health Inpatient Treatment (Hospital, Ages 6+)

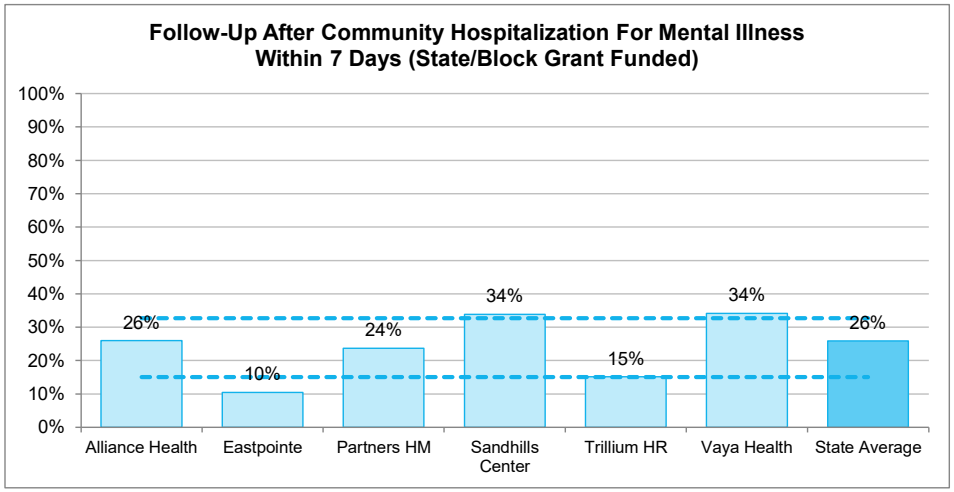
Rationale: Timely follow-up care after discharge from an inpatient facility is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary re-hospitalization. Receiving a community-based service within 7 days and within 30 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and extent of coordination across levels of care.

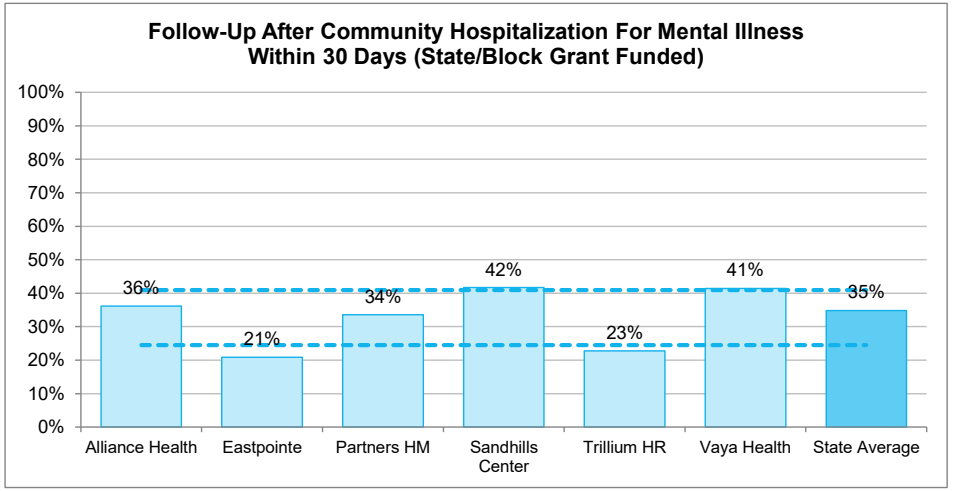
Description: This indicator measures the percent of discharges from a community hospital each quarter for persons with a principal mental health diagnosis that receive a follow-up visit with a behavioral health practitioner within 7 days and within 30 days after discharge .

Follow-Up After Community Hospitalization (State/Federal Block Grant Funded)

	Numerator	Numerator	Numerator	Numerator	Denominator	Rate	Rate	Rate	Rate
LME-MCO	**Total Number Received Outpatient Visit**				**Total Number of Discharges**	**Percent Received Outpatient Visit**			
	0 - 7 Days	**0 - 30 Days**	**> 30 Days**	**Not Seen***		**0 - 7 Days**	**0 - 30 Days**	**> 30 Days**	**Not Seen***
Alliance Health	158	220	60	329	609	26%	36%	10%	54%
Eastpointe	7	14	5	48	67	10%	21%	7%	72%
Partners Health Management	134	190	37	339	566	24%	34%	7%	60%
Sandhills Center	65	80	13	99	192	34%	42%	7%	52%
Trillium Health Resources	44	66	19	205	290	15%	23%	7%	71%
Vaya Health	161	195	34	242	471	34%	41%	7%	51%
State Average	569	765	168	1,262	2,195	26%	35%	8%	57%
Standard Deviation						8.8%	8.2%		
LME-MCO Average						24%	33%	7%	60%

* Not Seen by the claims paid cutoff date for the measure.





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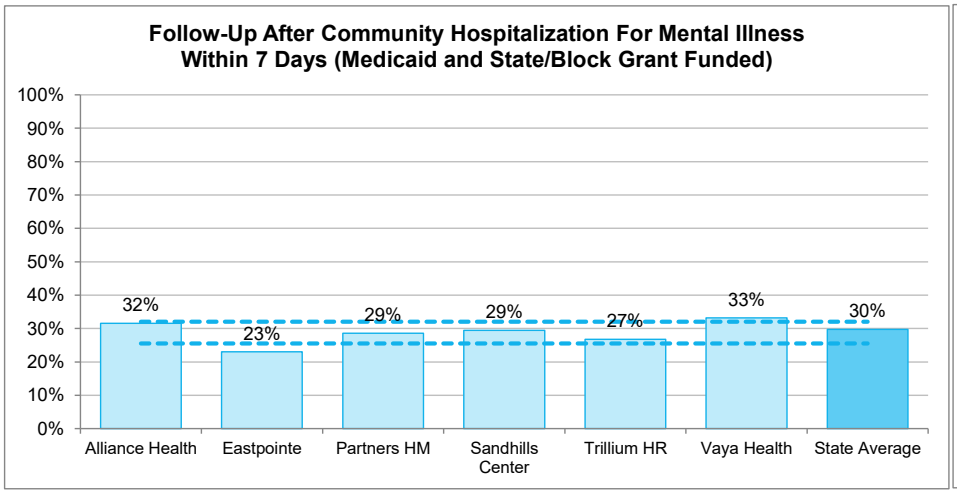
CONTINUITY OF CARE

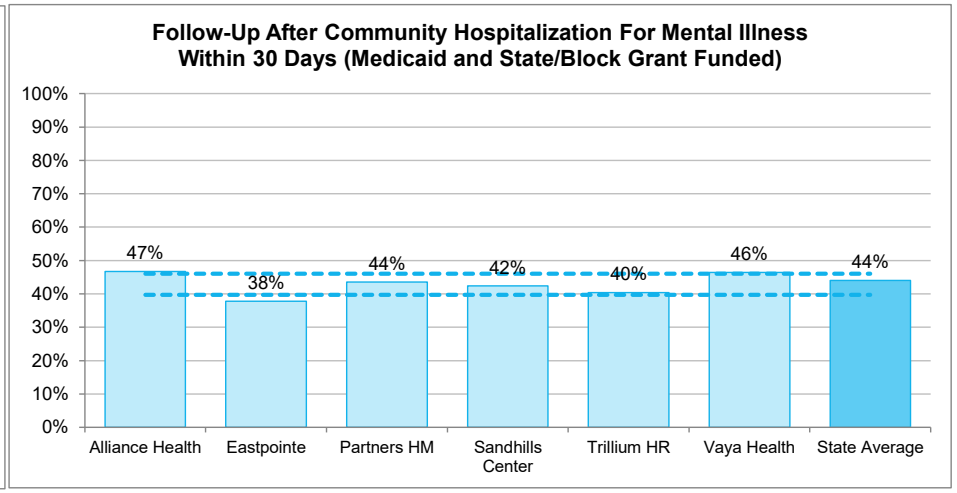
6.2. Follow-Up After Discharge: Community Mental Health Inpatient Treatment (Hospital, Ages 6+)

Rationale: Timely follow-up care after discharge from an inpatient facility is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary re-hospitalization. Receiving a community-based service within 7 days and within 30 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and extent of coordination across levels of care.

Description: This indicator measures the percent of discharges from a community hospital each quarter for persons with a principal mental health diagnosis that receive a follow-up visit with a behavioral health practitioner within 7 days and within 30 days after discharge .

	Numerator	Numerator	Numerator	Numerator	Denominator	Rate	Rate	Rate	Rate
LME-MCO	**Total Number Received Outpatient Visit**				**Total Number of Discharges**	**Percent Received Outpatient Visit**			
	0 - 7 Days	**0 - 30 Days**	**> 30 Days**	**Not Seen***		**0 - 7 Days**	**0 - 30 Days**	**> 30 Days**	**Not Seen***
Follow-Up After Community Hospitalization (Combined Medicaid and State/Block Grant Funded -- Includes Cross-Overs Between Payers)									
Alliance Health	484	715	216	601	1,532	32%	47%	14%	39%
Eastpointe	86	141	48	184	373	23%	38%	13%	49%
Partners Health Management	354	540	151	549	1,240	29%	44%	12%	44%
Sandhills Center	140	202	73	201	476	29%	42%	15%	42%
Trillium Health Resources	226	341	97	407	845	27%	40%	11%	48%
Vaya Health	365	510	131	458	1,099	33%	46%	12%	42%
State Average	1,655	2,449	716	2,400	5,565	30%	44%	13%	43%
Standard Deviation	* Not Seen by the claims paid cutoff date for the measure.					3.3%	3.2%		
LME-MCO Average						29%	43%	13%	44%





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6.3 Follow-Up After Discharge: State Alcohol and Drug Abuse Treatment Centers (ADATCs)

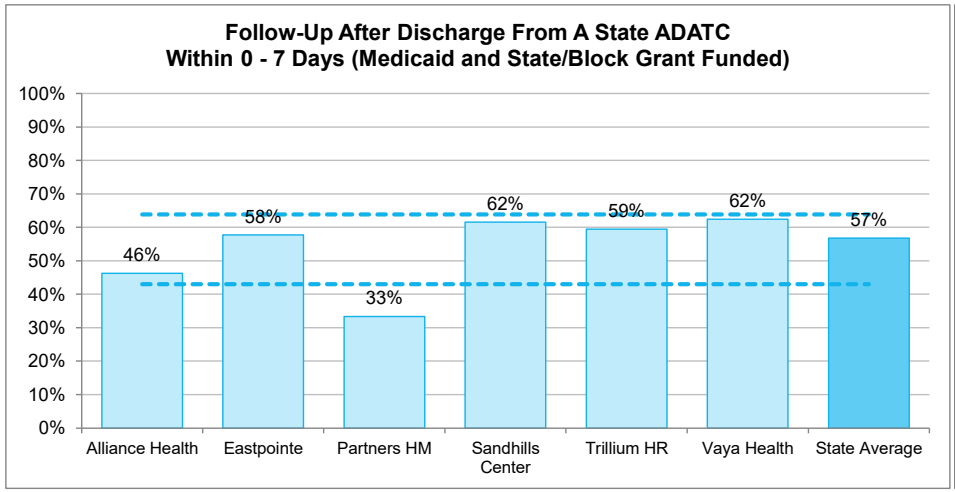
Rationale: Timely follow-up care after discharge from an inpatient facility is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary re-admission. Receiving a community-based service within 7 days and within 30 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and extent of coordination across levels of care.

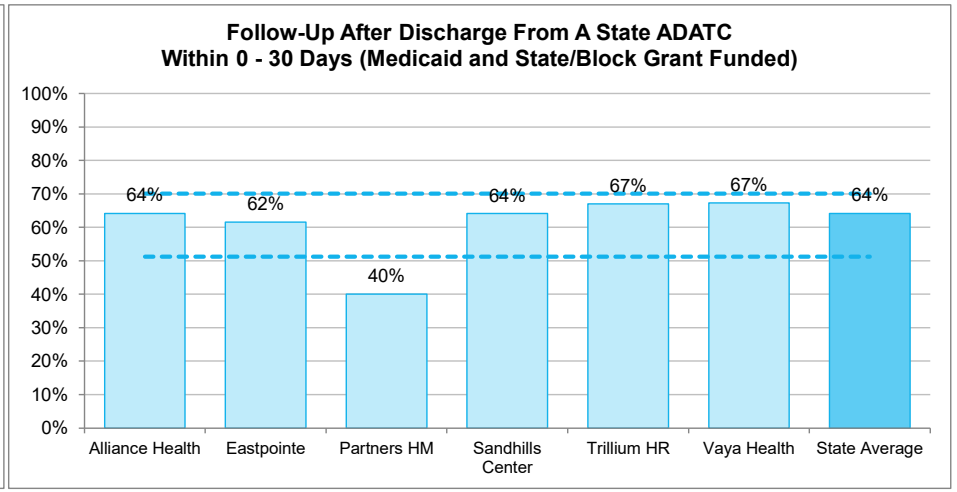
Description: This indicator measures the percent of discharges from an ADATC each quarter, that fall within the responsibility of an LME-MCO to coordinate services, that receive a follow-up visit with a behavioral health practitioner within 7 days and within 30 days after discharge.

Follow-Up After Discharge From A State ADATC (Medicaid and/or State/Block Grant Funded)

	Numerator	Numerator	Numerator	Numerator	Denominator	Rate	Rate	Rate	Rate
LME-MCO	**Total Number Received Behavioral Health Follow-Up Care (Other Than ED Or Mobile Crisis)**				**Total Number of Discharges**	**Percent Received Behavioral Health Follow-Up Care (Other Than ED Or Mobile Crisis)**			
	0 - 7 Days	**8 - 30 Days**	**>30 Days**	**Not Seen***		**0 - 7 Days**	**8 - 30 Days**	**>30 Days**	**Not Seen***
Alliance Health	31	12	6	18	67	46%	18%	9%	27%
Eastpointe	15	1	5	5	26	58%	4%	19%	19%
Partners Health Management	10	2	5	13	30	33%	7%	17%	43%
Sandhills Center	24	1	1	13	39	62%	3%	3%	33%
Trillium Health Resources	63	8	4	31	106	59%	8%	4%	29%
Vaya Health	103	8	14	40	165	62%	5%	8%	24%
State Average	246	32	35	120	433	57%	7%	8%	28%
Standard Deviation						10.5%			
LME-MCO Average						53%			

* Not Seen by the claims paid cutoff date for the measure.





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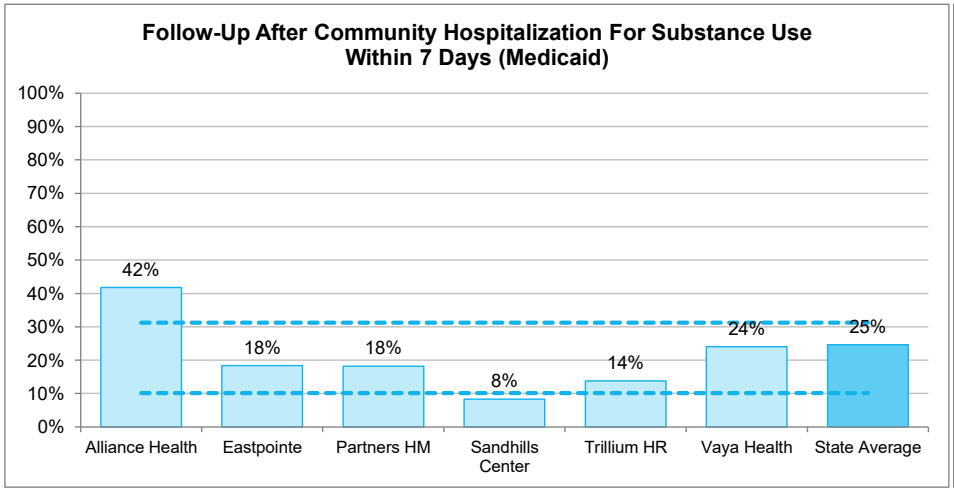
6.4. Follow-Up After Discharge: Community Substance Abuse Inpatient Treatment (Ages 6+)

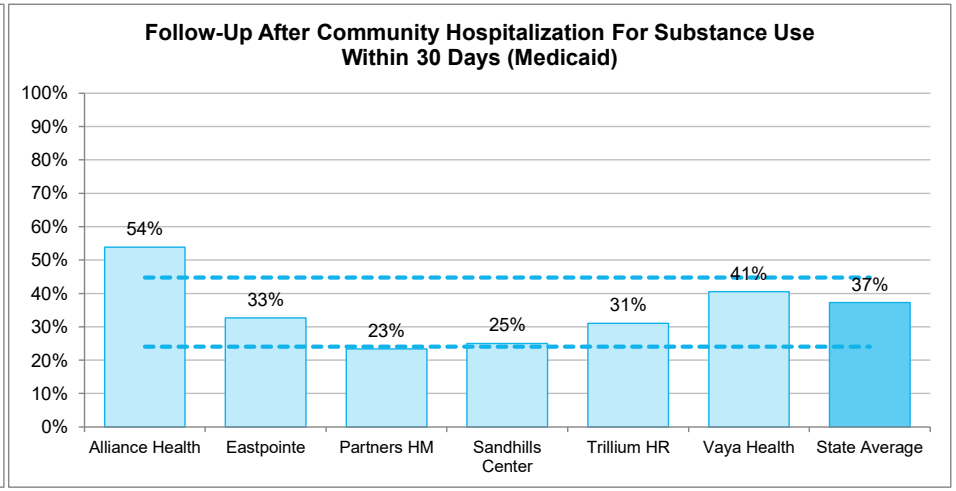
Rationale: Timely follow-up care after discharge from an inpatient facility or crisis service is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary re-hospitalization and reuse of crisis services. Receiving a community-based service within 7 days and within 30 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and extent of coordination across levels of care.

Description: This indicator measures the percent of discharges for persons who received treatment for a substance use disorder in a community hospital or detox/facility based crisis service each quarter that receive a follow-up visit with a behavioral health practitioner within 7 days and within 30 days after discharge .

	Numerator	Numerator	Numerator	Numerator	Denominator	Rate	Rate	Rate	Rate
LME-MCO	**Total Number Received Outpatient Visit**				**Total Number of Discharges**	**Percent Received Outpatient Visit**			
	0 - 7 Days	**0 - 30 Days**	**> 30 Days**	**Not Seen***		**0 - 7 Days**	**0 - 30 Days**	**> 30 Days**	**Not Seen***
Follow-Up After Community Hospitalization (Medicaid Funded)									
Alliance Health	38	49	10	32	91	42%	54%	11%	35%
Eastpointe	9	16	8	25	49	18%	33%	16%	51%
Partners Health Management	14	18	13	46	77	18%	23%	17%	60%
Sandhills Center	2	6	6	12	24	8%	25%	25%	50%
Trillium Health Resources	4	9	3	17	29	14%	31%	10%	59%
Vaya Health	19	32	9	38	79	24%	41%	11%	48%
State Average	86	130	49	170	349	25%	37%	14%	49%
Standard Deviation						10.5%	10.3%		
LME-MCO Average						21%	34%		

* Not Seen by the claims paid cutoff date for the measure.





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6.4. Follow-Up After Discharge: Community Substance Abuse Inpatient Treatment (Ages 6+)

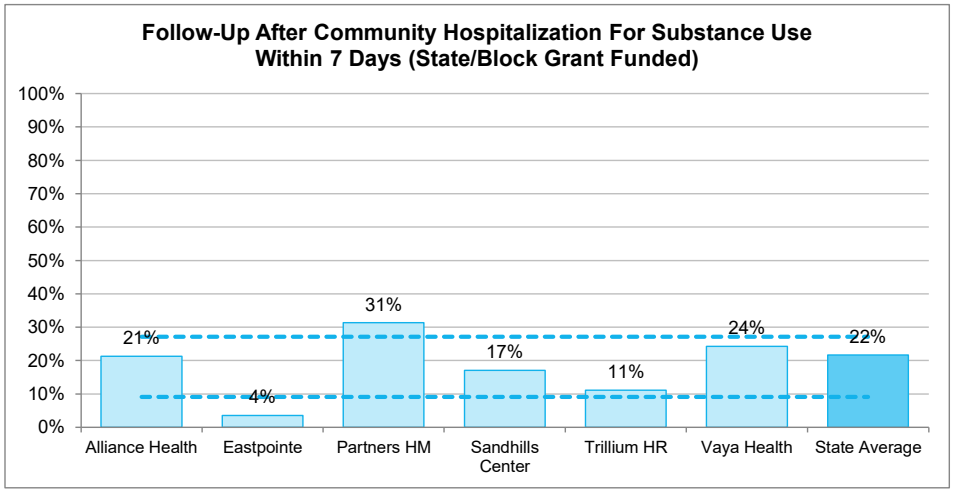
Rationale: Timely follow-up care after discharge from an inpatient facility or crisis service is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary re-hospitalization and reuse of crisis services. Receiving a community-based service within 7 days and within 30 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and extent of coordination across levels of care.

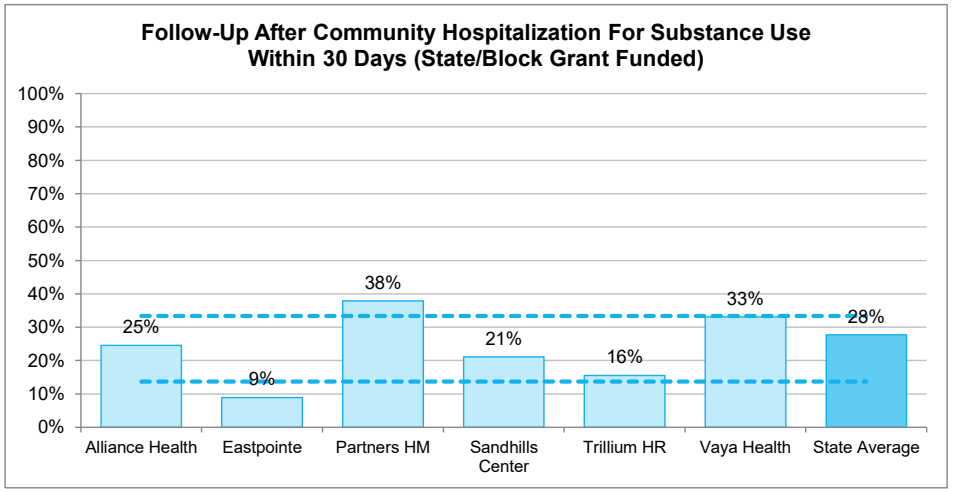
Description: This indicator measures the percent of discharges for persons who received treatment for a substance use disorder in a community hospital or detox/facility based crisis service each quarter that receive a follow-up visit with a behavioral health practitioner within 7 days and within 30 days after discharge .

Follow-Up After Community Hospitalization (State/Federal Block Grant Funded)

LME-MCO	Numerator: Total Number Received Outpatient Visit 0 - 7 Days	Numerator: Total Number Received Outpatient Visit 0 - 30 Days	Numerator: Total Number Received Outpatient Visit > 30 Days	Numerator: Total Number Received Outpatient Visit Not Seen*	Denominator: Total Number of Discharges	Rate: Percent Received Outpatient Visit 0 - 7 Days	Rate: Percent Received Outpatient Visit 0 - 30 Days	Rate: Percent Received Outpatient Visit > 30 Days	Rate: Percent Received Outpatient Visit Not Seen*
Alliance Health	13	15	7	39	61	21%	25%	11%	64%
Eastpointe	2	5	4	47	56	4%	9%	7%	84%
Partners Health Management	48	58	15	80	153	31%	38%	10%	52%
Sandhills Center	13	16	6	54	76	17%	21%	8%	71%
Trillium Health Resources	5	7	2	36	45	11%	16%	4%	80%
Vaya Health	33	45	12	79	136	24%	33%	9%	58%
State Average	114	146	46	335	527	22%	28%	9%	64%
Standard Deviation						9.0%	9.9%		
LME-MCO Average						18%	24%		

* Not Seen by the claims paid cutoff date for the measure.





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6.4. Follow-Up After Discharge: Community Substance Abuse Inpatient Treatment (Ages 6+)

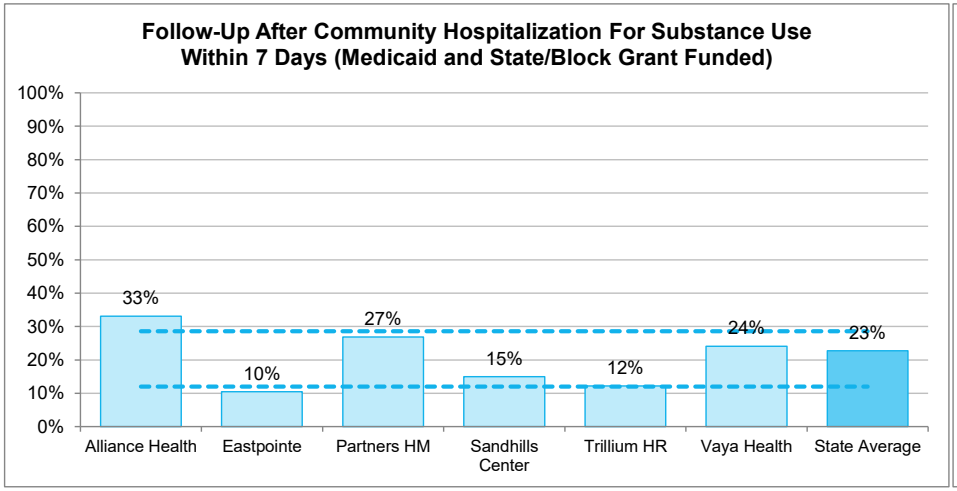
Rationale: Timely follow-up care after discharge from an inpatient facility or crisis service is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary re-hospitalization and reuse of crisis services. Receiving a community-based service within 7 days and within 30 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and extent of coordination across levels of care.

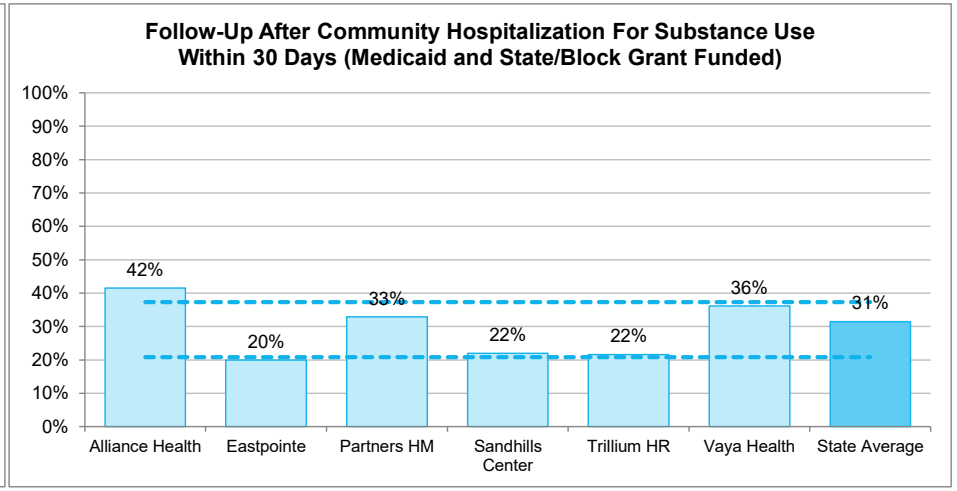
Description: This indicator measures the percent of discharges for persons who received treatment for a substance use disorder in a community hospital or detox/facility based crisis service each quarter that receive a follow-up visit with a behavioral health practitioner within 7 days and within 30 days after discharge .

Follow-Up After Community Hospitalization (Combined Medicaid and State/Block Grant Funded -- Includes Cross-Overs Between Payers)

	Numerator	Numerator	Numerator	Numerator	Denominator	Rate	Rate	Rate	Rate
LME-MCO	**Total Number Received Outpatient Visit**				**Total Number of Discharges**	**Percent Received Outpatient Visit**			
	0 - 7 Days	**0 - 30 Days**	**> 30 Days**	**Not Seen***		**0 - 7 Days**	**0 - 30 Days**	**> 30 Days**	**Not Seen***
Alliance Health	51	64	17	73	154	33%	42%	11%	47%
Eastpointe	11	21	12	72	105	10%	20%	11%	69%
Partners Health Management	62	76	28	127	231	27%	33%	12%	55%
Sandhills Center	15	22	12	66	100	15%	22%	12%	66%
Trillium Health Resources	9	16	5	53	74	12%	22%	7%	72%
Vaya Health	52	78	21	117	216	24%	36%	10%	54%
State Average	200	277	95	508	880	23%	31%	11%	58%
Standard Deviation						8.3%	8.2%		
LME-MCO Average						20%	29%		

* Not Seen by the claims paid cutoff date for the measure.





North Carolina LME-MCO Performance Measurement Reporting
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CONTINUITY OF CARE

6.4. Follow-Up After Discharge: Community Substance Abuse Inpatient Treatment (Ages 6+)

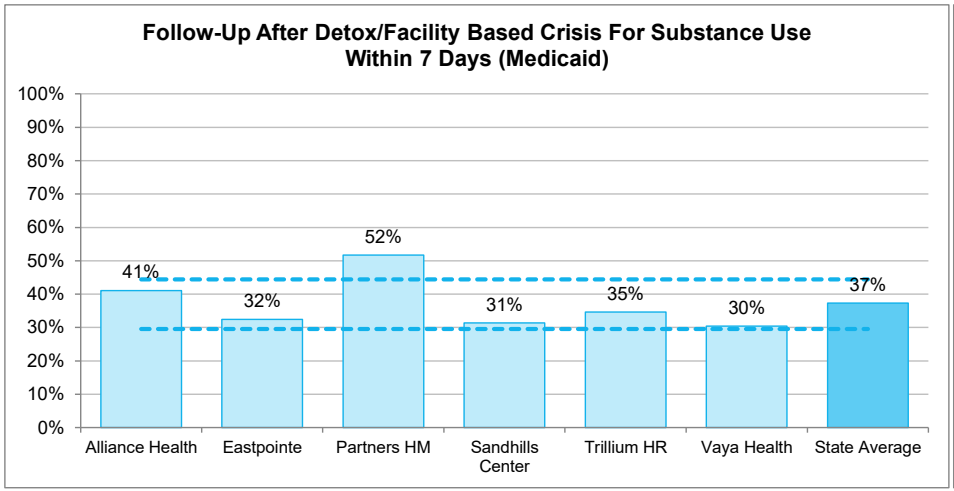
Rationale: Timely follow-up care after discharge from an inpatient facility or crisis service is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary re-hospitalization and reuse of crisis services. Receiving a community-based service within 7 days and within 30 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and extent of coordination across levels of care.

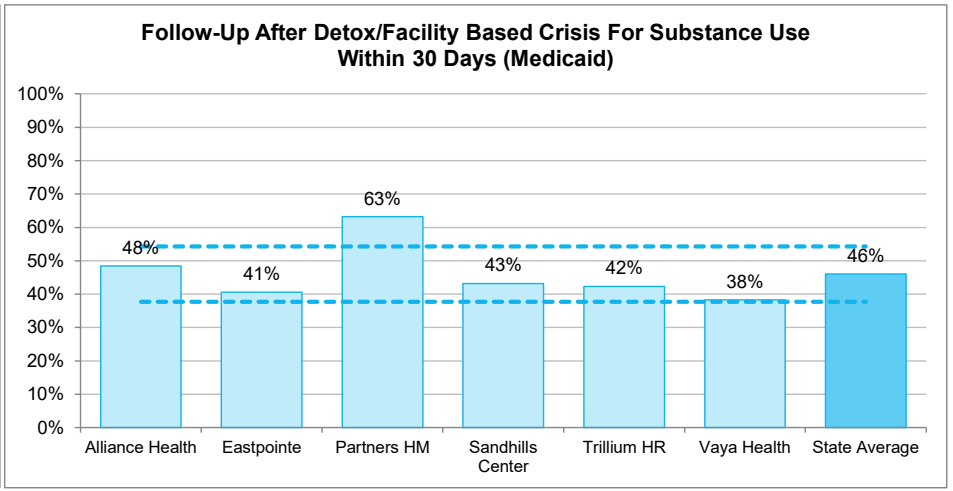
Description: This indicator measures the percent of discharges for persons who received treatment for a substance use disorder in a community hospital or detox/facility based crisis service each quarter that receive a follow-up visit with a behavioral health practitioner within 7 days and within 30 days after discharge .

Follow-Up After Detox/Facility Based Crisis Services (Medicaid Funded)

LME-MCO	Numerator: Total Number Received Outpatient Visit 0 - 7 Days	Numerator: Total Number Received Outpatient Visit 0 - 30 Days	Numerator: Total Number Received Outpatient Visit > 30 Days	Numerator: Total Number Received Outpatient Visit Not Seen*	Denominator: Total Number of Discharges	Rate: Percent Received Outpatient Visit 0 - 7 Days	Rate: Percent Received Outpatient Visit 0 - 30 Days	Rate: Percent Received Outpatient Visit > 30 Days	Rate: Percent Received Outpatient Visit Not Seen*
Alliance Health	39	46	15	34	95	41%	48%	16%	36%
Eastpointe	12	15	6	16	37	32%	41%	16%	43%
Partners Health Management	45	55	10	22	87	52%	63%	11%	25%
Sandhills Center	16	22	8	21	51	31%	43%	16%	41%
Trillium Health Resources	36	44	11	49	104	35%	42%	11%	47%
Vaya Health	39	49	19	60	128	30%	38%	15%	47%
State Average	187	231	69	202	502	37%	46%	14%	40%
Standard Deviation						7.5%	8.3%		
LME-MCO Average						37%	46%		

* Not Seen by the claims paid cutoff date for the measure.





North Carolina LME-MCO Performance Measurement Reporting
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6.4. Follow-Up After Discharge: Community Substance Abuse Inpatient Treatment (Ages 6+)

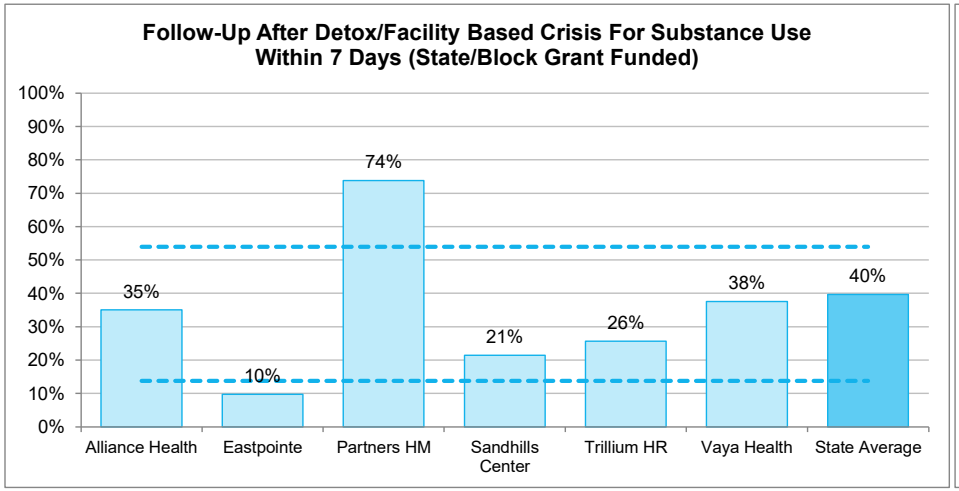
Rationale: Timely follow-up care after discharge from an inpatient facility or crisis service is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary re-hospitalization and reuse of crisis services. Receiving a community-based service within 7 days and within 30 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and extent of coordination across levels of care.

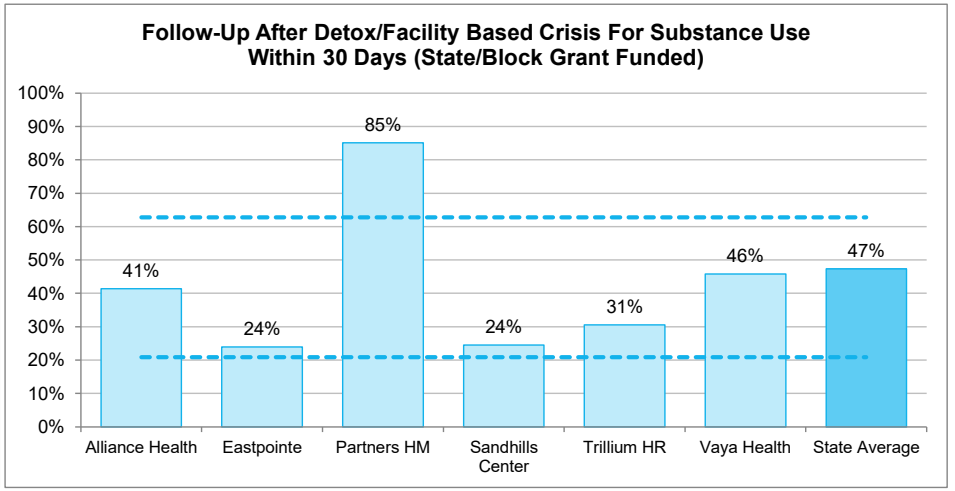
Description: This indicator measures the percent of discharges for persons who received treatment for a substance use disorder in a community hospital or detox/facility based crisis service each quarter that receive a follow-up visit with a behavioral health practitioner within 7 days and within 30 days after discharge .

Follow-Up After Detox/Facility Based Crisis Services (State/Federal Block Grant Funded)

LME-MCO	Numerator: Total Number Received Outpatient Visit 0 - 7 Days	Numerator: Total Number Received Outpatient Visit 0 - 30 Days	Numerator: Total Number Received Outpatient Visit > 30 Days	Numerator: Total Number Received Outpatient Visit Not Seen*	Denominator: Total Number of Discharges	Rate: Percent Received Outpatient Visit 0 - 7 Days	Rate: Percent Received Outpatient Visit 0 - 30 Days	Rate: Percent Received Outpatient Visit > 30 Days	Rate: Percent Received Outpatient Visit Not Seen*
Alliance Health	149	176	57	192	425	35%	41%	13%	45%
Eastpointe	9	22	5	65	92	10%	24%	5%	71%
Partners Health Management	302	348	10	51	409	74%	85%	2%	12%
Sandhills Center	21	24	9	65	98	21%	24%	9%	66%
Trillium Health Resources	120	143	30	295	468	26%	31%	6%	63%
Vaya Health	147	179	40	172	391	38%	46%	10%	44%
State Average	748	892	151	840	1,883	40%	47%	8%	45%
Standard Deviation						20.1%	21.0%		
LME-MCO Average						34%	42%		

* Not Seen by the claims paid cutoff date for the measure.





North Carolina LME-MCO Performance Measurement Reporting
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CONTINUITY OF CARE

6.4. Follow-Up After Discharge: Community Substance Abuse Inpatient Treatment (Ages 6+)

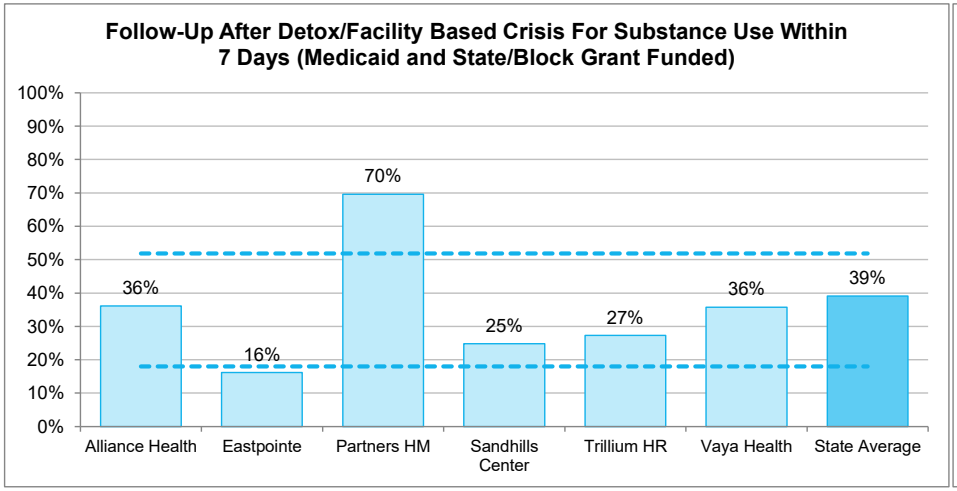
Rationale: Timely follow-up care after discharge from an inpatient facility or crisis service is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary re-hospitalization and reuse of crisis services. Receiving a community-based service within 7 days and within 30 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and extent of coordination across levels of care.

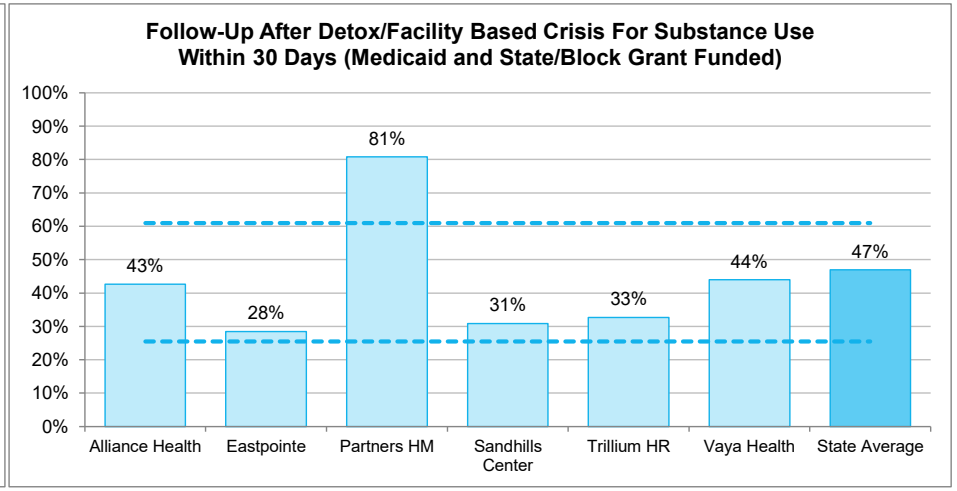
Description: This indicator measures the percent of discharges for persons who received treatment for a substance use disorder in a community hospital or detox/facility based crisis service each quarter that receive a follow-up visit with a behavioral health practitioner within 7 days and within 30 days after discharge .

Follow-Up After Detox/Facility Based Crisis Services (Combined Medicaid and State/Block Grant Funded -- Includes Cross-Overs Between Payers)

	Numerator	Numerator	Numerator	Numerator	Denominator	Rate	Rate	Rate	Rate
LME-MCO	**Total Number Received Outpatient Visit**				**Total Number of Discharges**	**Percent Received Outpatient Visit**			
	0 - 7 Days	**0 - 30 Days**	**> 30 Days**	**Not Seen***		**0 - 7 Days**	**0 - 30 Days**	**> 30 Days**	**Not Seen***
Alliance Health	188	222	72	227	521	36%	43%	14%	44%
Eastpointe	21	37	11	82	130	16%	28%	8%	63%
Partners Health Management	347	403	21	75	499	70%	81%	4%	15%
Sandhills Center	37	46	17	86	149	25%	31%	11%	58%
Trillium Health Resources	156	187	41	344	572	27%	33%	7%	60%
Vaya Health	187	230	59	234	523	36%	44%	11%	45%
State Average	936	1,125	221	1,048	2,394	39%	47%	9%	44%
Standard Deviation						16.9%	17.8%		
LME-MCO Average						35%	43%		

* Not Seen by the claims paid cutoff date for the measure.





North Carolina LME-MCO Performance Measurement Reporting
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6.4. Follow-Up After Discharge: Community Substance Abuse Inpatient Treatment (Ages 6+)

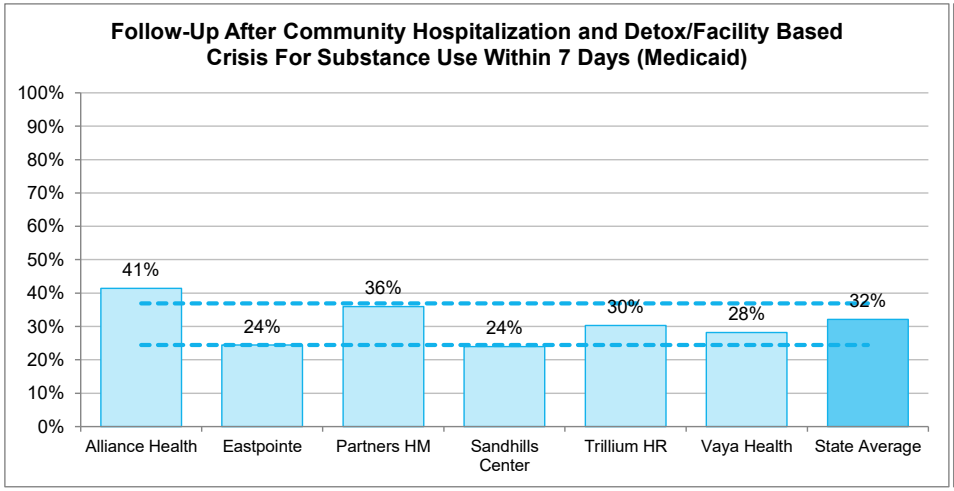
Rationale: Timely follow-up care after discharge from an inpatient facility or crisis service is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary re-hospitalization and reuse of crisis services. Receiving a community-based service within 7 days and within 30 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and extent of coordination across levels of care.

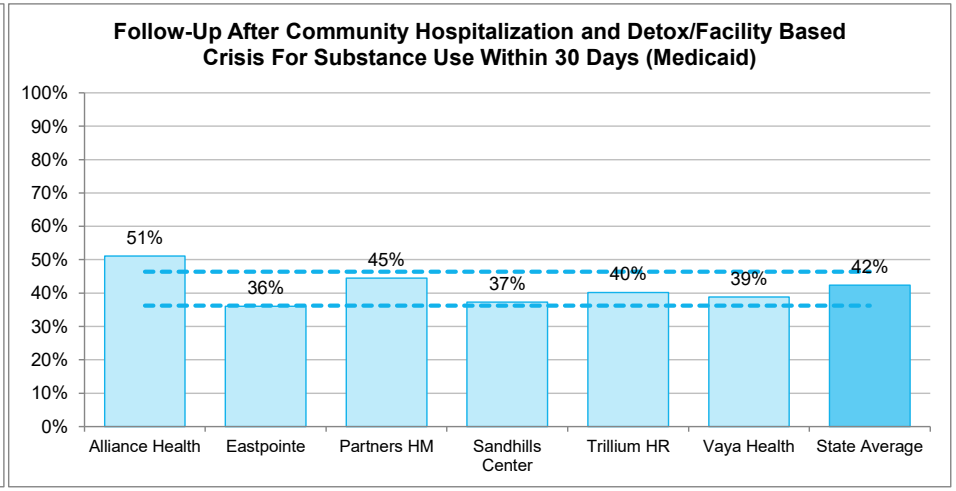
Description: This indicator measures the percent of discharges for persons who received treatment for a substance use disorder in a community hospital or detox/facility based crisis service each quarter that receive a follow-up visit with a behavioral health practitioner within 7 days and within 30 days after discharge .

Follow-Up After Community Hospitalization and Detox/Facility Based Crisis Services Combined (Medicaid Funded)

	Numerator	Numerator	Numerator	Numerator	Denominator	Rate	Rate	Rate	Rate
LME-MCO	**Total Number Received Outpatient Visit**				**Total Number of Discharges**	**Percent Received Outpatient Visit**			
	0 - 7 Days	**0 - 30 Days**	**> 30 Days**	**Not Seen***		**0 - 7 Days**	**0 - 30 Days**	**> 30 Days**	**Not Seen***
Alliance Health	77	95	25	66	186	41%	51%	13%	35%
Eastpointe	21	31	14	41	86	24%	36%	16%	48%
Partners Health Management	59	73	23	68	164	36%	45%	14%	41%
Sandhills Center	18	28	14	33	75	24%	37%	19%	44%
Trillium Health Resources	40	53	14	65	132	30%	40%	11%	49%
Vaya Health	58	80	28	98	206	28%	39%	14%	48%
State Average	273	360	118	371	849	32%	42%	14%	44%
Standard Deviation						6.2%	5.1%		
LME-MCO Average						31%	41%		

* Not Seen by the claims paid cutoff date for the measure.





North Carolina LME-MCO Performance Measurement Reporting
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6.4. Follow-Up After Discharge: Community Substance Abuse Inpatient Treatment (Ages 6+)

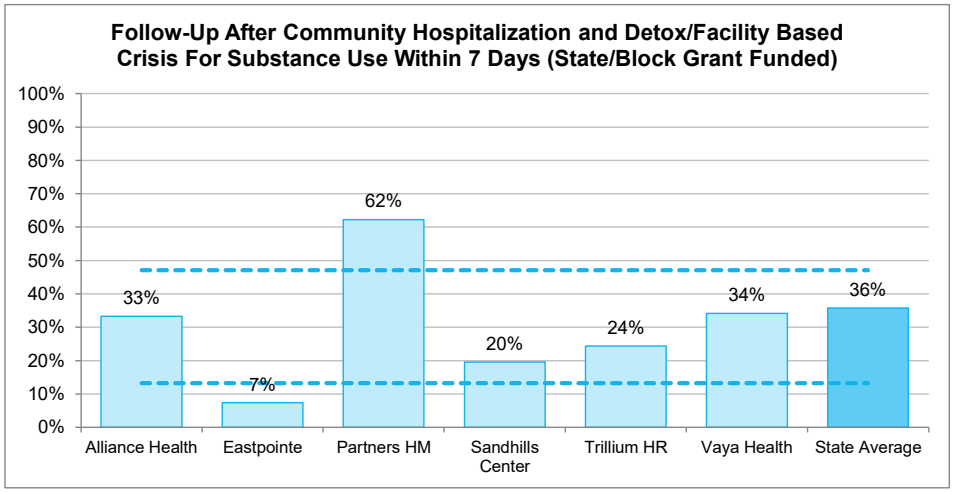
Rationale: Timely follow-up care after discharge from an inpatient facility or crisis service is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary re-hospitalization and reuse of crisis services. Receiving a community-based service within 7 days and within 30 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and extent of coordination across levels of care.

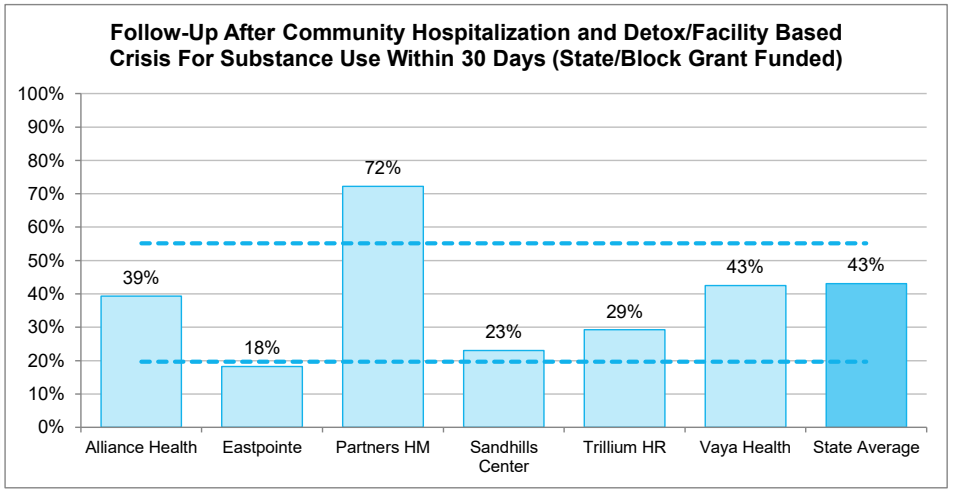
Description: This indicator measures the percent of discharges for persons who received treatment for a substance use disorder in a community hospital or detox/facility based crisis service each quarter that receive a follow-up visit with a behavioral health practitioner within 7 days and within 30 days after discharge .

Follow-Up After Community Hospitalization and Detox/Facility Based Crisis Services Combined (State/Federal Block Grant Funded)

LME-MCO	Numerator: Total Number Received Outpatient Visit 0 - 7 Days	Numerator: Total Number Received Outpatient Visit 0 - 30 Days	Numerator: Total Number Received Outpatient Visit > 30 Days	Numerator: Total Number Received Outpatient Visit Not Seen*	Denominator: Total Number of Discharges	Rate: Percent Received Outpatient Visit 0 - 7 Days	Rate: Percent Received Outpatient Visit 0 - 30 Days	Rate: Percent Received Outpatient Visit > 30 Days	Rate: Percent Received Outpatient Visit Not Seen*
Alliance Health	162	191	64	231	486	33%	39%	13%	48%
Eastpointe	11	27	9	112	148	7%	18%	6%	76%
Partners Health Management	350	406	25	131	562	62%	72%	4%	23%
Sandhills Center	34	40	15	119	174	20%	23%	9%	68%
Trillium Health Resources	125	150	32	331	513	24%	29%	6%	65%
Vaya Health	180	224	52	251	527	34%	43%	10%	48%
State Average	862	1,038	197	1,175	2,410	36%	43%	8%	49%
Standard Deviation						16.9%	17.7%		
LME-MCO Average						30%	37%		

* Not Seen by the claims paid cutoff date for the measure.





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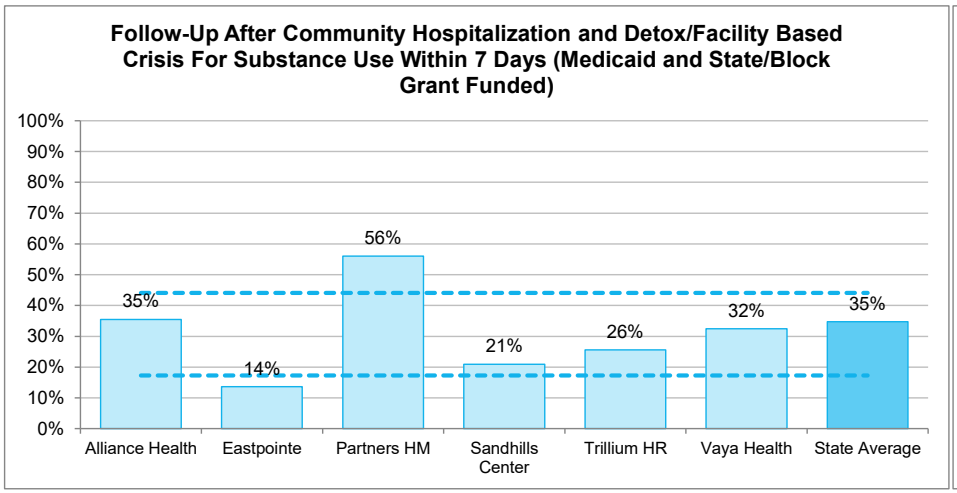
6.4. Follow-Up After Discharge: Community Substance Abuse Inpatient Treatment (Ages 6+)

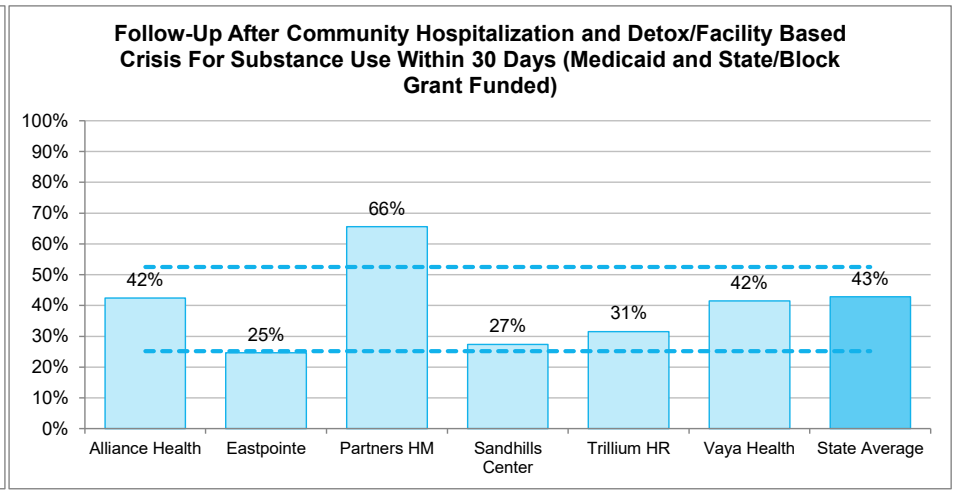
Rationale: Timely follow-up care after discharge from an inpatient facility or crisis service is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary re-hospitalization and reuse of crisis services. Receiving a community-based service within 7 days and within 30 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and extent of coordination across levels of care.

Description: This indicator measures the percent of discharges for persons who received treatment for a substance use disorder in a community hospital or detox/facility based crisis service each quarter that receive a follow-up visit with a behavioral health practitioner within 7 days and within 30 days after discharge .

	Numerator	Numerator	Numerator	Numerator	Denominator	Rate	Rate	Rate	Rate
LME-MCO	**Total Number Received Outpatient Visit**				**Total Number of Discharges**	**Percent Received Outpatient Visit**			
	0 - 7 Days	**0 - 30 Days**	**> 30 Days**	**Not Seen***		**0 - 7 Days**	**0 - 30 Days**	**> 30 Days**	**Not Seen***
Follow-Up After Community Hospitalization and Detox/Facility Based Crisis Services Combined (Combined Medicaid and State/Block Grant Funded)									
Alliance Health	239	286	89	300	675	35%	42%	13.2%	44.4%
Eastpointe	32	58	23	154	235	14%	25%	10%	66%
Partners Health Management	409	479	49	202	730	56%	66%	7%	28%
Sandhills Center	52	68	29	152	249	21%	27%	12%	61%
Trillium Health Resources	165	203	46	396	645	26%	31%	7%	61%
Vaya Health	239	306	80	351	737	32%	42%	11%	48%
State Average	1,136	1,400	316	1,555	3,271	35%	43%	10%	48%
Standard Deviation						13.4%	13.7%		
LME-MCO Average						31%	39%		

* Not Seen by the claims paid cutoff date for the measure.





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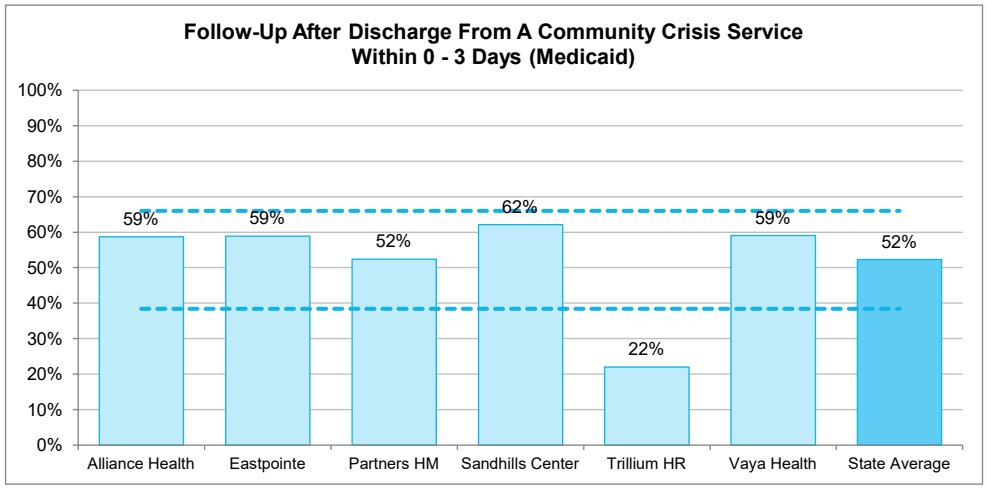
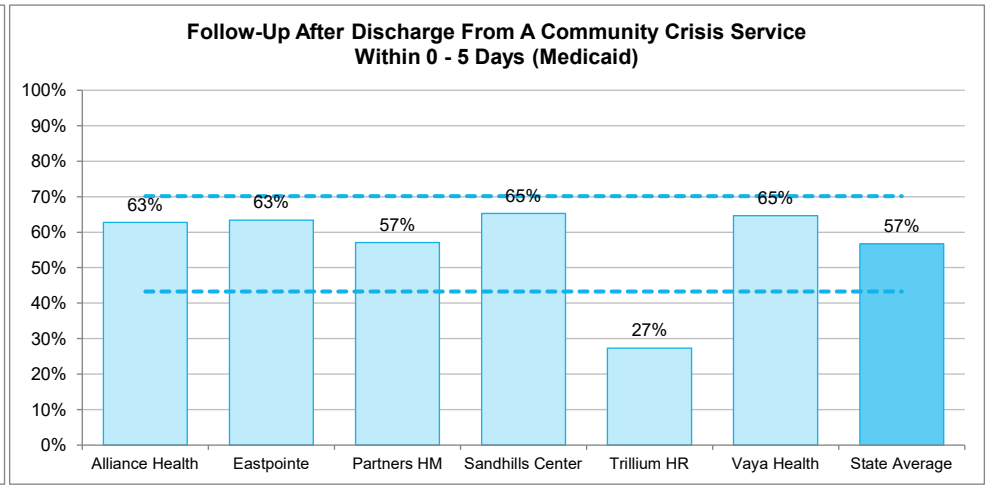
6.5. Follow-Up After Discharge From A Community Crisis Service (Ages 6+)

Rationale: Timely follow-up care after discharge from a crisis service is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary reuse of crisis services or hospitalization. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and extent of coordination across levels of care.

Description: This indicator measures the percent of discharges for persons who received treatment in a community-based crisis service each quarter that receive a follow-up visit with a behavioral health practitioner or a state facility service within 3 days and within 5 days after discharge .

	Numerator	Numerator	Numerator	Numerator	Numerator	Denominator	Rate	Rate	Rate	Rate	Rate
LME-MCO	**Total Number Received Non-Crisis Follow-Up Care**					**Total Number of Discharges**	**Percent Received Non-Crisis Follow-Up Care**				
	0 - 3 Days	**4 - 5 Days**	**6 - 14 Days**	**> 14 Days**	**Not Seen***		**0 - 3 Days**	**4 - 5 Days**	**6 - 14 Days**	**> 14 Days**	**Not Seen***
Medicaid Funded											
Alliance Health	1,814	125	272	502	376	3,089	59%	4%	9%	16%	12%
Eastpointe	619	47	72	136	177	1,051	59%	4%	7%	13%	17%
Partners Health Management	210	19	46	68	58	401	52%	5%	11%	17%	14%
Sandhills Center	740	38	86	162	166	1,192	62%	3%	7%	14%	14%
Trillium Health Resources	349	84	170	269	715	1,587	22%	5%	11%	17%	45%
Vaya Health	808	77	108	184	191	1,368	59%	6%	8%	13%	14%
State Average	4,540	390	754	1,321	1,683	8,688	52%	4%	9%	15%	19%
Standard Deviation	* Not Seen by the claims paid cutoff date for the measure.						13.8%	0.8%			
LME-MCO Average							52%	5%			





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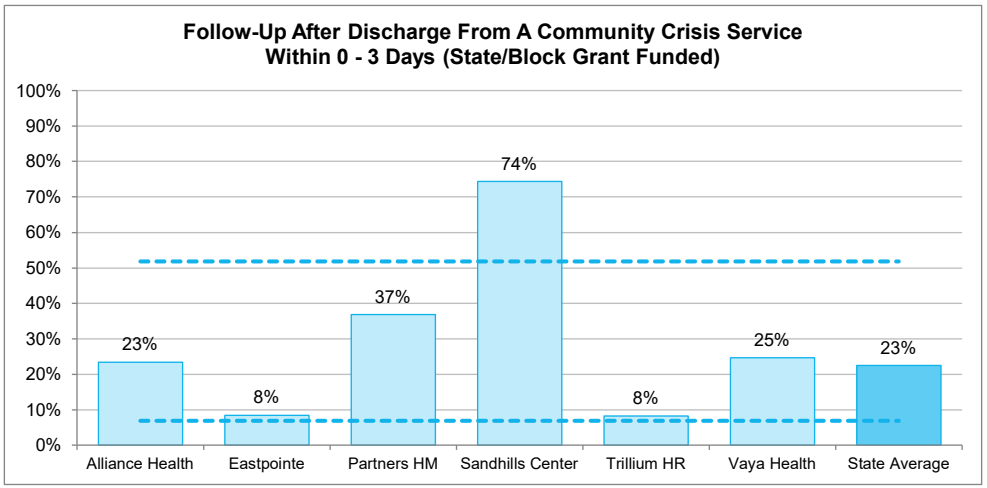
6.5. Follow-Up After Discharge From A Community Crisis Service (Ages 6+)

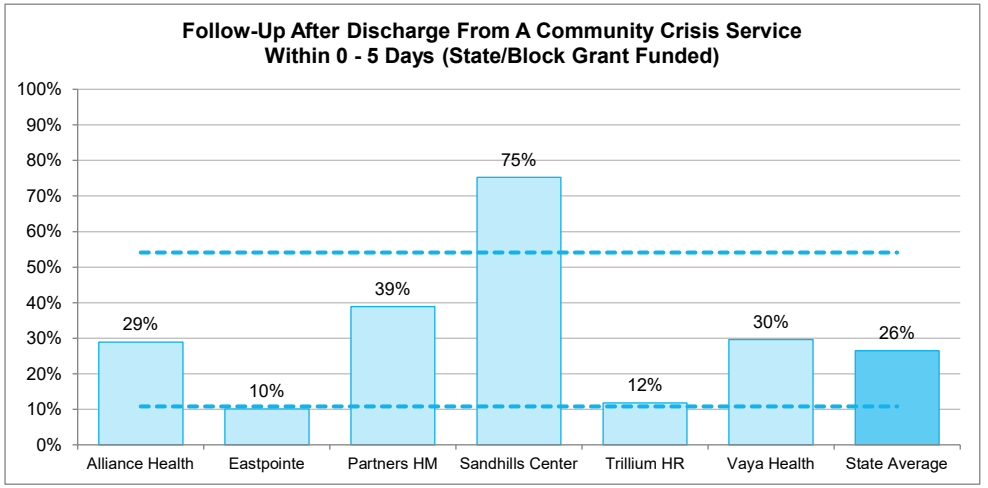
Rationale: Timely follow-up care after discharge from a crisis service is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary reuse of crisis services or hospitalization. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and extent of coordination across levels of care.

Description: This indicator measures the percent of discharges for persons who received treatment in a community-based crisis service each quarter that receive a follow-up visit with a behavioral health practitioner or a state facility service within 3 days and within 5 days after discharge .

	Numerator	Numerator	Numerator	Numerator	Numerator	Denominator	Rate	Rate	Rate	Rate	Rate
LME-MCO	**Total Number Received Non-Crisis Follow-Up Care**					**Total Number of Discharges**	**Percent Received Non-Crisis Follow-Up Care**				
	0 - 3 Days	**4 - 5 Days**	**6 - 14 Days**	**> 14 Days**	**Not Seen***		**0 - 3 Days**	**4 - 5 Days**	**6 - 14 Days**	**> 14 Days**	**Not Seen***
State/Federal Block Grant Funded											
Alliance Health	224	53	82	121	478	958	23%	6%	9%	13%	50%
Eastpointe	21	4	23	37	163	248	8%	2%	9%	15%	66%
Partners Health Management	201	11	35	85	213	545	37%	2%	6%	16%	39%
Sandhills Center	180	2	7	7	46	242	74%	1%	3%	3%	19%
Trillium Health Resources	119	52	77	159	1,038	1,445	8%	4%	5%	11%	72%
Vaya Health	329	66	151	196	590	1,332	25%	5%	11%	15%	44%
State Average	1,074	188	375	605	2,528	4,770	23%	4%	8%	13%	53%
Standard Deviation							22.4%	1.7%			
LME-MCO Average							29%	3%			

* Not Seen by the claims paid cutoff date for the measure.





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CONTINUITY OF CARE

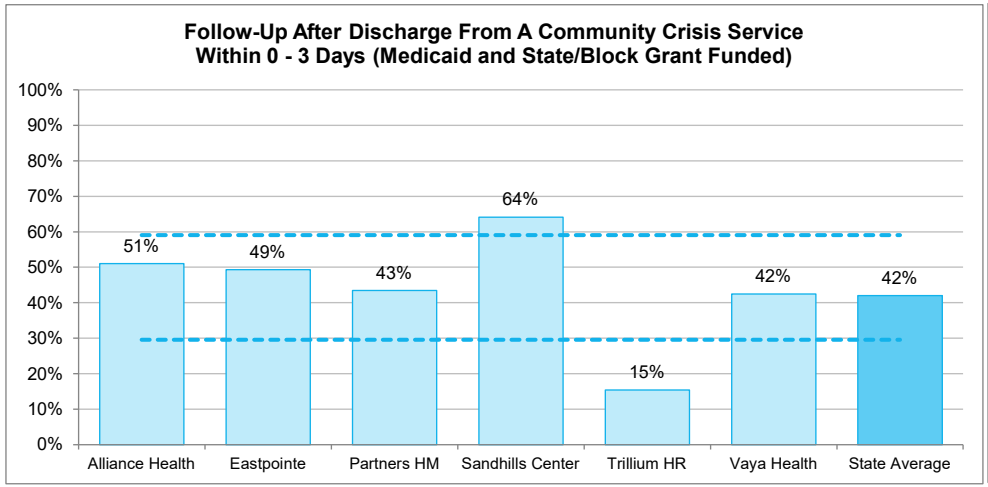
6.5. Follow-Up After Discharge From A Community Crisis Service (Ages 6+)

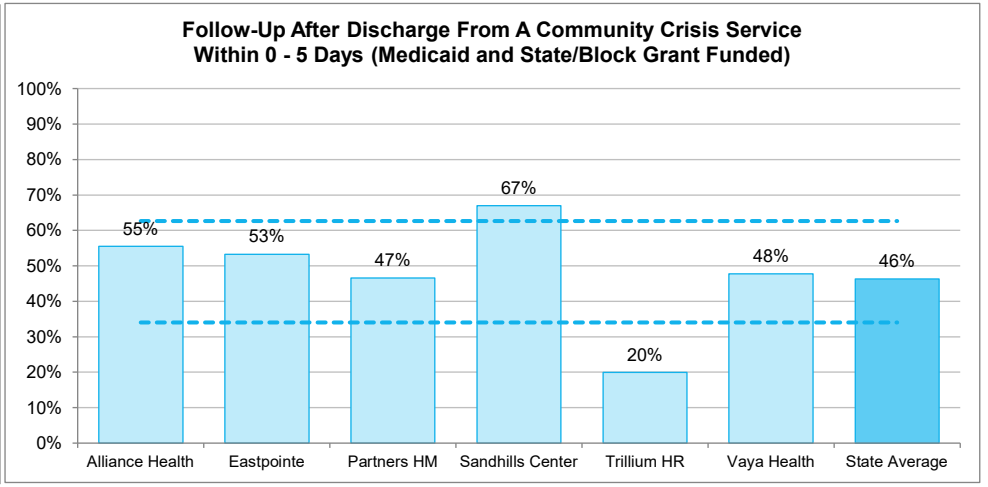
Rationale: Timely follow-up care after discharge from a crisis service is critical to promoting recovery and successful living in one's community, minimizing adverse outcomes, and preventing unnecessary reuse of crisis services or hospitalization. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and extent of coordination across levels of care.

Description: This indicator measures the percent of discharges for persons who received treatment in a community-based crisis service each quarter that receive a follow-up visit with a behavioral health practitioner or a state facility service within 3 days and within 5 days after discharge .

	Numerator	Numerator	Numerator	Numerator	Numerator	Denominator	Rate	Rate	Rate	Rate	Rate
LME-MCO	**Total Number Received Non-Crisis Follow-Up Care**					**Total Number of Discharges**	**Percent Received Non-Crisis Follow-Up Care**				
	0 - 3 Days	**4 - 5 Days**	**6 - 14 Days**	**> 14 Days**	**Not Seen***		**0 - 3 Days**	**4 - 5 Days**	**6 - 14 Days**	**> 14 Days**	**Not Seen***
Combined Medicaid and State/Block Grant Funded -- Includes Cross-Overs Between Payers											
Alliance Health	2,066	179	350	609	843	4,047	51%	4%	9%	15%	21%
Eastpointe	641	51	95	174	338	1,299	49%	4%	7%	13%	26%
Partners Health Management	411	30	81	153	271	946	43%	3%	9%	16%	29%
Sandhills Center	920	40	93	169	212	1,434	64%	3%	6%	12%	15%
Trillium Health Resources	468	136	247	428	1,753	3,032	15%	4%	8%	14%	58%
Vaya Health	1,147	143	261	375	774	2,700	42%	5%	10%	14%	29%
State Average	5,653	579	1,127	1,908	4,191	13,458	42%	4%	8%	14%	31%
Standard Deviation							14.7%				
LME-MCO Average							44%	4%			

* Not Seen by the claims paid cutoff date for the measure.





State Fiscal Year: 2023
Report Quarter: 2nd Quarter
Measurement Period: Oct 2021 - Sep 2022

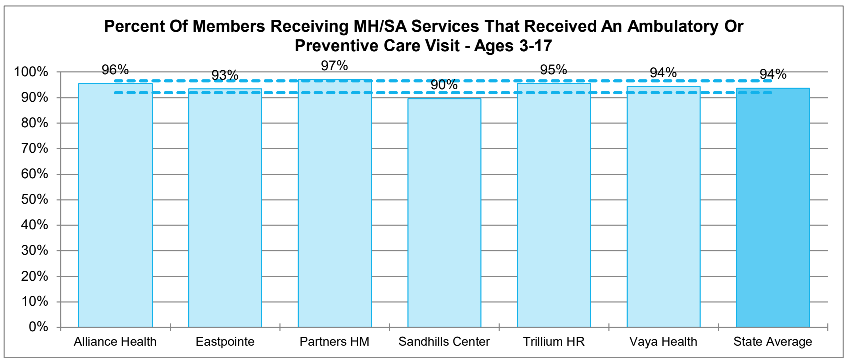
CONTINUITY OF CARE

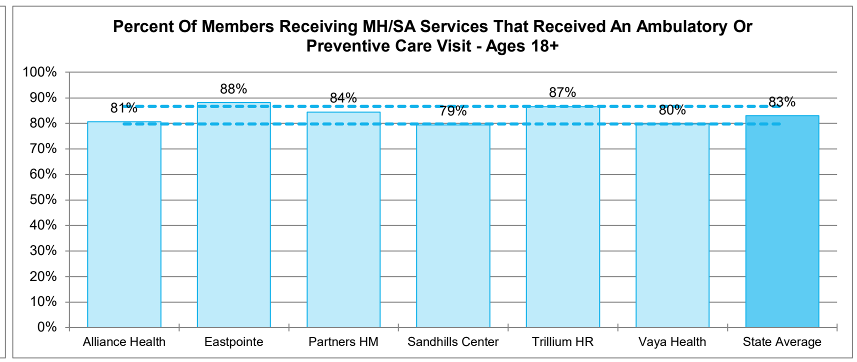
6.6 Medical Care Coordination (Medicaid Only)

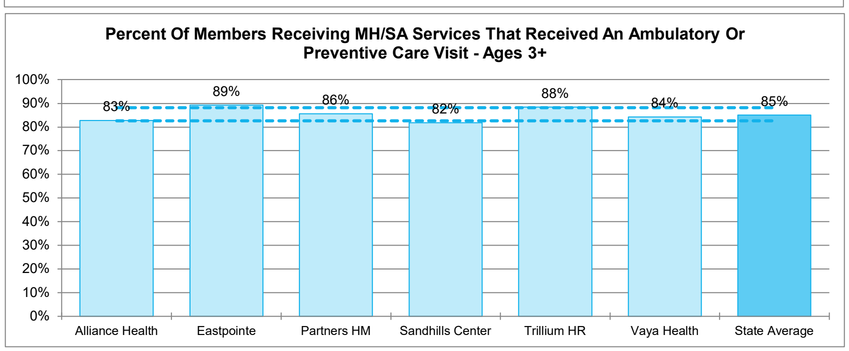
Rationale: Designing programs to integrate the delivery and management of behavioral health and physical health services provides a critical opportunity to achieve better health outcomes as well as control spending. This measure was adapted from two Healthcare Enterprise Data Information System (HEDIS ©) measures -- Adults' Access to Preventive/Ambulatory Health Services and Children and Adolescents' Access to Primary Care Practitioners.

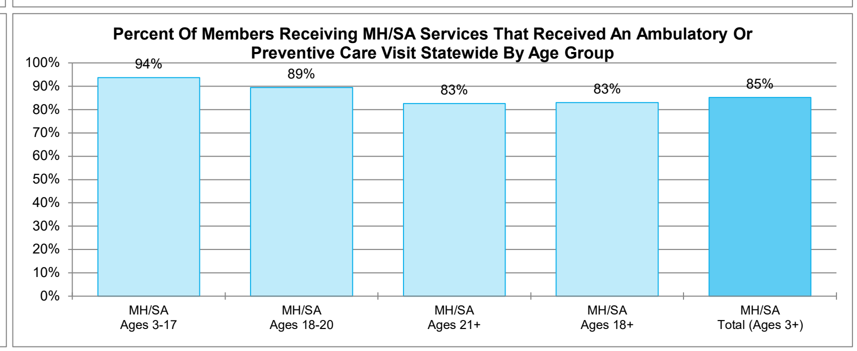
Description: This indicator measures the percentage of continuously enrolled Medicaid recipients under the 1915 b/c waiver who received a behavioral health (MH, I/DD, SUD) service during a rolling one-year period that also had at least one primary care or preventive health visit during that period. For persons ages 7-20, the measure looks for a primary care or preventive health service over the last two years.

	MH/SA Ages 3-17			MH/SA Ages 18+			MH/SA Total (Ages 3+)		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate
LME-MCO	Number In The Denominator With ≥1 Ambulatory Or Preventive Care Visits	Number Continuously Enrolled Persons That Received ≥1 MH/SA Service During The Measurement Period	Percent Of Members Receiving MH/SA Services That Received An Ambulatory Or Preventive Care Visit	Number In The Denominator With ≥1 Ambulatory Or Preventive Care Visits	Number Continuously Enrolled Persons That Received ≥1 MH/SA Service During The Measurement Period	Percent Of Members Receiving MH/SA Services That Received An Ambulatory Or Preventive Care Visit	Number In The Denominator With ≥1 Ambulatory Or Preventive Care Visits	Number Continuously Enrolled Persons That Received ≥1 MH/SA Service During The Measurement Period	Percent Of Members Receiving MH/SA Services That Received An Ambulatory Or Preventive Care Visit
Alliance Health	2,041	2,137	96%	10,459	12,976	81%	12,500	15,113	83%
Eastpointe	2,297	2,459	93%	8,426	9,552	88%	10,723	12,011	89%
Partners Health Management	1,639	1,688	97%	14,028	16,605	84%	15,667	18,293	86%
Sandhills Center	4,344	4,848	90%	12,441	15,674	79%	16,785	20,522	82%
Trillium Health Resources	3,500	3,667	95%	12,006	13,861	87%	15,506	17,528	88%
Vaya Health	5,383	5,707	94%	10,194	12,772	80%	15,577	18,479	84%
Statewide	19,204	20,506	94%	67,554	81,440	83%	86,758	101,946	85%
Standard Deviation			2.4%			3.4%			2.8%
LME-MCO Average			94%			83%			85%









North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures
State Fiscal Year: 2023
Report Quarter: 2nd Quarter
Measurement Period: Oct 2021 - Sep 2022

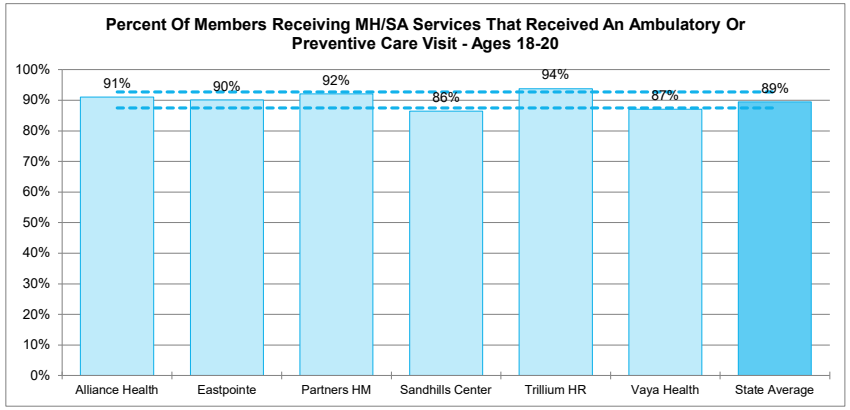
CONTINUITY OF CARE

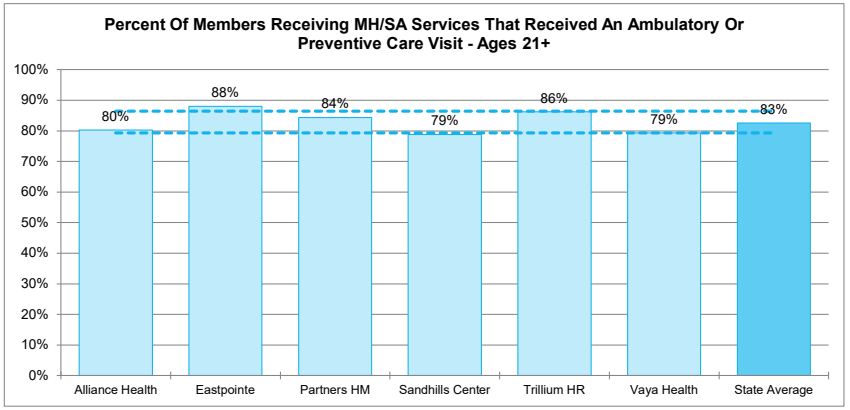
6.6 Medical Care Coordination (Medicaid Only)

Rationale: Designing programs to integrate the delivery and management of behavioral health and physical health services provides a critical opportunity to achieve better health outcomes as well as control spending. This measure was adapted from two Healthcare Enterprise Data Information System (HEDIS ©) measures -- Adults' Access to Preventive/Ambulatory Health Services and Children and Adolescents' Access to Primary Care Practitioners.

Description: This indicator measures the percentage of continuously enrolled Medicaid recipients under the 1915 b/c waiver who received a behavioral health (MH, I/DD, SUD) service during a rolling one-year period that also had at least one primary care or preventive health visit during that period. For persons ages 7-20, the measure looks for a primary care or preventive health service over the last two years.

	MH/SA Ages 18-20			MH/SA Ages 21+		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
LME-MCO	**Number In The Denominator With ≥1 Ambulatory Or Preventive Care Visits**	**Number Continuously Enrolled Persons That Received ≥1 MH/SA Service During The Measurement Period**	**Percent Of Members Receiving MH/SA Services That Received An Ambulatory Or Preventive Care Visit**	**Number In The Denominator With ≥1 Ambulatory Or Preventive Care Visits**	**Number Continuously Enrolled Persons That Received ≥1 MH/SA Service During The Measurement Period**	**Percent Of Members Receiving MH/SA Services That Received An Ambulatory Or Preventive Care Visit**
Alliance Health	379	416	91%	10,080	12,560	80%
Eastpointe	641	711	90%	7,785	8,841	88%
Partners Health Management	234	254	92%	13,794	16,351	84%
Sandhills Center	922	1,067	86%	11,519	14,607	79%
Trillium Health Resources	669	713	94%	11,337	13,148	86%
Vaya Health	639	734	87%	9,555	12,038	79%
Statewide	3,484	3,895	89%	64,070	77,545	83%
Standard Deviation			2.6%			3.5%
LME-MCO Average			90%			83%





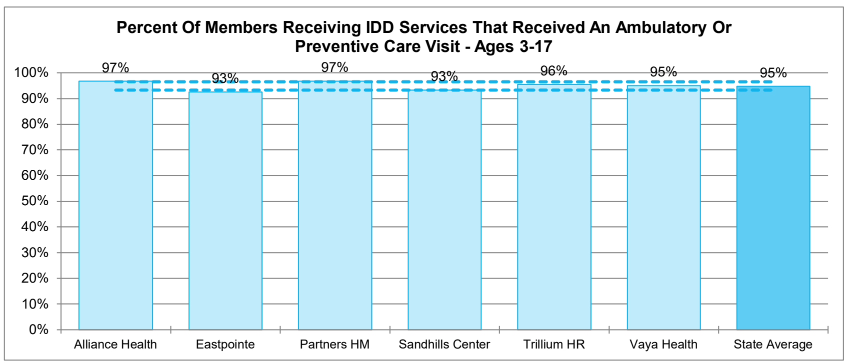
CONTINUITY OF CARE

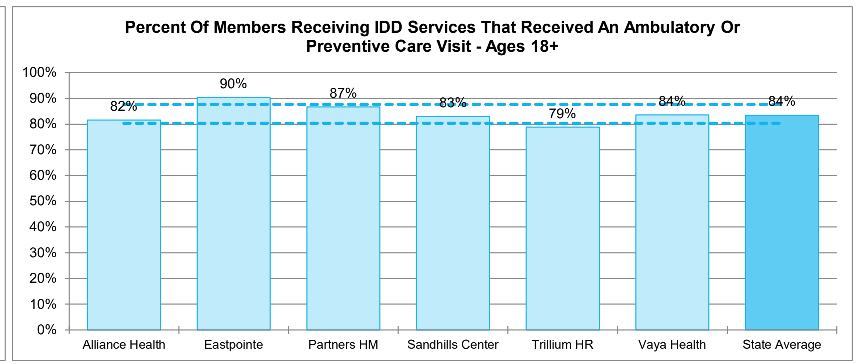
6.6 Medical Care Coordination (Medicaid Only)

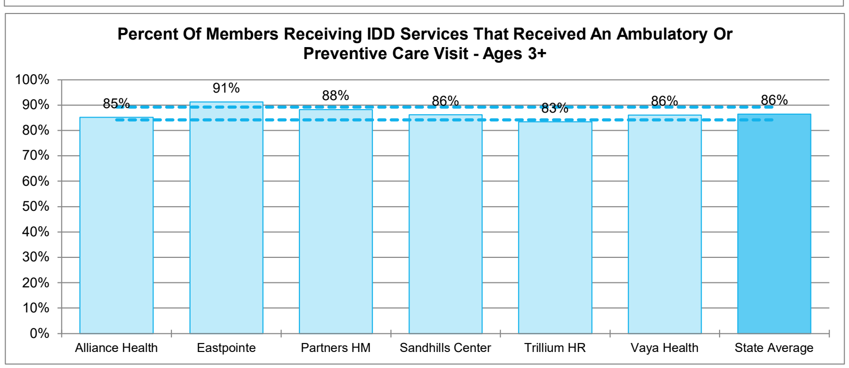
Rationale: Designing programs to integrate the delivery and management of behavioral health and physical health services provides a critical opportunity to achieve better health outcomes as well as control spending. This measure was adapted from two Healthcare Enterprise Data Information System (HEDIS ©) measures -- Adults' Access to Preventive/Ambulatory Health Services and Children and Adolescents' Access to Primary Care Practitioners.

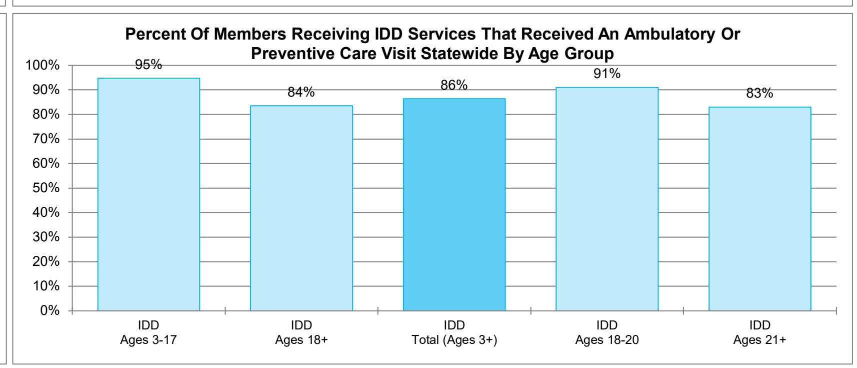
Description: This indicator measures the percentage of continuously enrolled Medicaid recipients under the 1915 b/c waiver who received a behavioral health (MH, I/DD, SUD) service during a rolling one-year period that also had at least one primary care or preventive health visit during that period. For persons ages 7-20, the measure looks for a primary care or preventive health service over the last two years.

	IDD Ages 3-17			IDD Ages 18+			IDD Total (Ages 3+)		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate
LME-MCO	Number In The Denominator With ≥1 Ambulatory Or Preventive Care Visits	Number Continuously Enrolled Persons That Received ≥1 IDD Service During The Measurement Period	Percent Of Members Receiving IDD Services That Received An Ambulatory Or Preventive Care Visit	Number In The Denominator With ≥1 Ambulatory Or Preventive Care Visits	Number Continuously Enrolled Persons That Received ≥1 IDD Service During The Measurement Period	Percent Of Members Receiving IDD Services That Received An Ambulatory Or Preventive Care Visit	Number In The Denominator With ≥1 Ambulatory Or Preventive Care Visits	Number Continuously Enrolled Persons That Received ≥1 IDD Service During The Measurement Period	Percent Of Members Receiving IDD Services That Received An Ambulatory Or Preventive Care Visit
Alliance Health	893	923	97%	2,454	3,005	82%	3,347	3,928	85%
Eastpointe	1,248	1,349	93%	1,678	1,858	90%	2,926	3,207	91%
Partners Health Management	771	796	97%	3,865	4,458	87%	4,636	5,254	88%
Sandhills Center	1,175	1,259	93%	2,324	2,799	83%	3,499	4,058	86%
Trillium Health Resources	1,487	1,557	96%	3,279	4,159	79%	4,766	5,716	83%
Vaya Health	673	708	95%	2,161	2,585	84%	2,834	3,293	86%
Statewide	6,247	6,592	95%	15,761	18,864	84%	22,008	25,456	86%
Standard Deviation			1.6%			3.7%			2.5%
LME-MCO Average			95%			84%			87%









North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures
State Fiscal Year: 2023
Report Quarter: 2nd Quarter
Measurement Period: Oct 2021 - Sep 2022

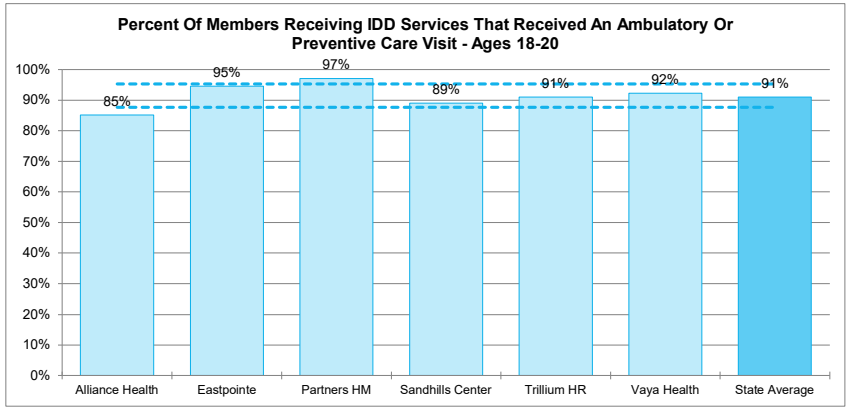
CONTINUITY OF CARE

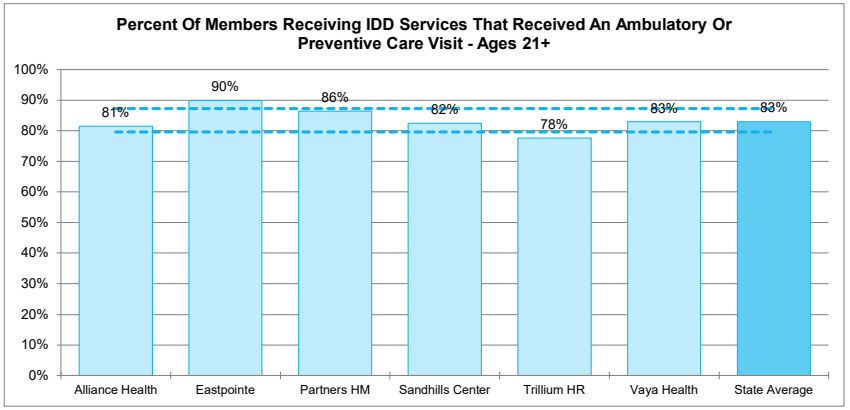
6.6 Medical Care Coordination (Medicaid Only)

Rationale: Designing programs to integrate the delivery and management of behavioral health and physical health services provides a critical opportunity to achieve better health outcomes as well as control spending. This measure was adapted from two Healthcare Enterprise Data Information System (HEDIS ©) measures -- Adults' Access to Preventive/Ambulatory Health Services and Children and Adolescents' Access to Primary Care Practitioners.

Description: This indicator measures the percentage of continuously enrolled Medicaid recipients under the 1915 b/c waiver who received a behavioral health (MH, I/DD, SUD) service during a rolling one-year period that also had at least one primary care or preventive health visit during that period. For persons ages 7-20, the measure looks for a primary care or preventive health service over the last two years.

	IDD Ages 18-20			IDD Ages 21+		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
LME-MCO	**Number In The Denominator With ≥1 Ambulatory Or Preventive Care Visits**	**Number Continuously Enrolled Persons That Received ≥1 IDD Service During The Measurement Period**	**Percent Of Members Receiving IDD Services That Received An Ambulatory Or Preventive Care Visit**	**Number In The Denominator With ≥1 Ambulatory Or Preventive Care Visits**	**Number Continuously Enrolled Persons That Received ≥1 IDD Service During The Measurement Period**	**Percent Of Members Receiving IDD Services That Received An Ambulatory Or Preventive Care Visit**
Alliance Health	138	162	85%	2,316	2,843	81%
Eastpointe	158	167	95%	1,520	1,691	90%
Partners Health Management	101	104	97%	3,764	4,354	86%
Sandhills Center	227	255	89%	2,097	2,544	82%
Trillium Health Resources	335	368	91%	2,944	3,791	78%
Vaya Health	166	180	92%	1,995	2,405	83%
Statewide	1,125	1,236	91%	14,636	17,628	83%
Standard Deviation			3.8%			3.9%
LME-MCO Average			92%			83%





North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures
State Fiscal Year: 2023
Report Quarter: 2nd Quarter
Measurement Period: Oct 2021 - Sep 2022

CONTINUITY OF CARE

6.6 Medical Care Coordination (Medicaid Only)

Rationale: Designing programs to integrate the delivery and management of behavioral health and physical health services provides a critical opportunity to achieve better health outcomes as well as control spending. This measure was adapted from two Healthcare Enterprise Data Information System (HEDIS ©) measures -- Adults' Access to Preventive/Ambulatory Health Services and Children and Adolescents' Access to Primary Care Practitioners.

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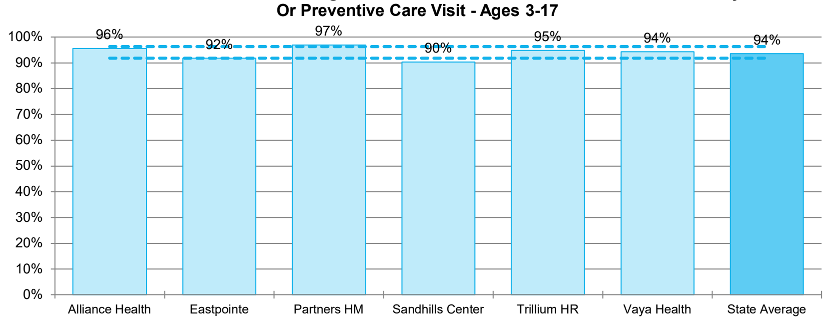
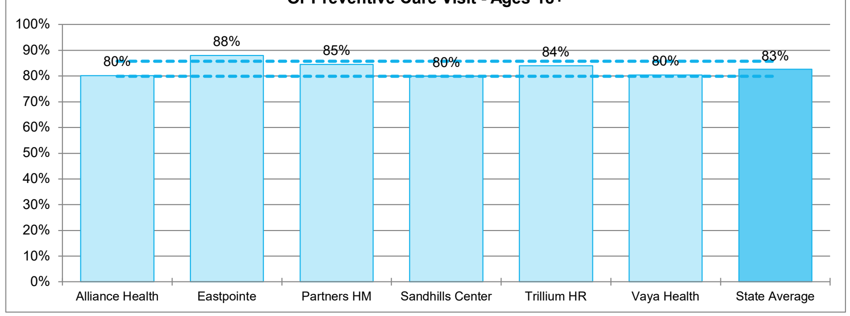
	MH/IDD/SA Ages 3-17			MH/IDD/SA Ages 18+			MH/IDD/SA Total (Ages 3+)		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate
LME-MCO	**Number In The Denominator With ≥1 Ambulatory Or Preventive Care Visits**	**Number Continuously Enrolled Persons That Received ≥1 MH/IDD/SA Service During The Measurement Period**	**Percent Of Members Receiving MH/IDD/SA Services That Received An Ambulatory Or Preventive Care Visit**	**Number In The Denominator With ≥1 Ambulatory Or Preventive Care Visits**	**Number Continuously Enrolled Persons That Received ≥1 MH/IDD/SA Service During The Measurement Period**	**Percent Of Members Receiving MH/IDD/SA Services That Received An Ambulatory Or Preventive Care Visit**	**Number In The Denominator With ≥1 Ambulatory Or Preventive Care Visits**	**Number Continuously Enrolled Persons That Received ≥1 MH/IDD/SA Service During The Measurement Period**	**Percent Of Members Receiving MH/IDD/SA Services That Received An Ambulatory Or Preventive Care Visit**
Alliance Health	2,637	2,757	96%	12,147	15,138	80%	14,784	17,895	83%
Eastpointe	2,761	3,004	92%	8,974	10,201	88%	11,735	13,205	89%
Partners Health Management	2,088	2,152	97%	16,448	19,444	85%	18,536	21,596	86%
Sandhills Center	5,519	6,107	90%	14,765	18,473	80%	20,284	24,580	83%
Trillium Health Resources	4,050	4,271	95%	13,534	16,116	84%	17,584	20,387	86%
Vaya Health	6,056	6,415	94%	12,355	15,357	80%	18,411	21,772	85%
Statewide	23,111	24,706	94%	78,223	94,729	83%	101,334	119,435	85%
Standard Deviation			2.2%			2.9%			2.2%
LME-MCO Average			94%			83%			85%

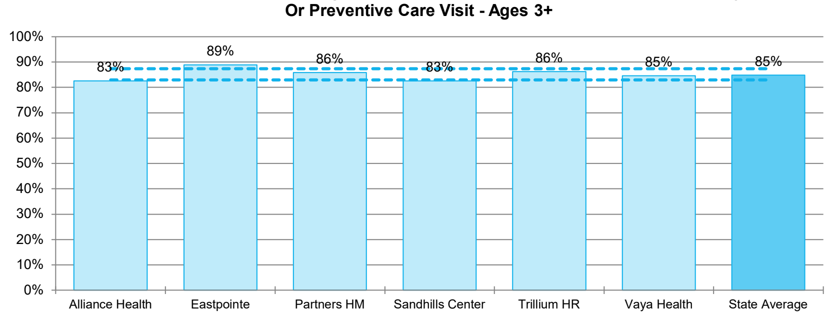
Percent Of Members Receiving MH/IDD/SA Services That Received An Ambulatory Or Preventive Care Visit - Ages 3-17



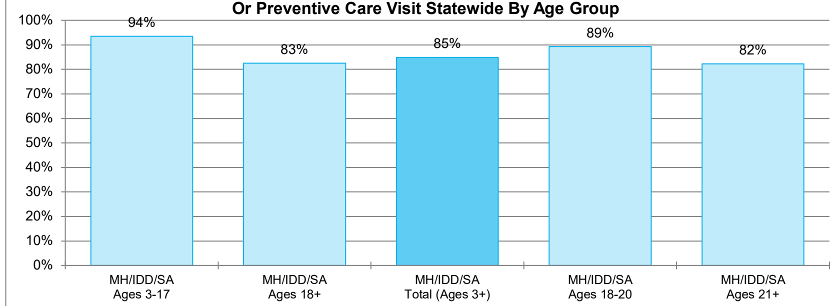
Percent Of Members Receiving MH/IDD/SA Services That Received An Ambulatory Or Preventive Care Visit - Ages 18+



Percent Of Members Receiving MH/IDD/SA Services That Received An Ambulatory Or Preventive Care Visit - Ages 3+



Percent Of Members Receiving MH/IDD/SA Services That Received An Ambulatory Or Preventive Care Visit Statewide By Age Group



North Carolina LME-MCO Performance Measurement Reporting
Part II. DMH/DD/SUS LME-MCO Quarterly Performance Measures
State Fiscal Year: 2023
Report Quarter: 2nd Quarter
Measurement Period: Oct 2021 - Sep 2022

CONTINUITY OF CARE

6.6 Medical Care Coordination (Medicaid Only)

Rationale: Designing programs to integrate the delivery and management of behavioral health and physical health services provides a critical opportunity to achieve better health outcomes as well as control spending. This measure was adapted from two Healthcare Enterprise Data Information System (HEDIS ©) measures -- Adults' Access to Preventive/Ambulatory Health Services and Children and Adolescents' Access to Primary Care Practitioners.

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	MH/IDD/SA Ages 18-20			MH/IDD/SA Ages 21+		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
LME-MCO	**Number In The Denominator With ≥1 Ambulatory Or Preventive Care Visits**	**Number Continuously Enrolled Persons That Received ≥1 MH/IDD/SA Service During The Measurement Period**	**Percent Of Members Receiving MH/IDD/SA Services That Received An Ambulatory Or Preventive Care Visit**	**Number In The Denominator With ≥1 Ambulatory Or Preventive Care Visits**	**Number Continuously Enrolled Persons That Received ≥1 MH/IDD/SA Service During The Measurement Period**	**Percent Of Members Receiving MH/IDD/SA Services That Received An Ambulatory Or Preventive Care Visit**
Alliance Health	470	524	90%	11,677	14,614	80%
Eastpointe	685	759	90%	8,289	9,442	88%
Partners Health Management	279	300	93%	16,169	19,144	84%
Sandhills Center	1,149	1,322	87%	13,616	17,151	79%
Trillium Health Resources	792	863	92%	12,742	15,253	84%
Vaya Health	805	914	88%	11,550	14,443	80%
Statewide	4,180	4,682	89%	74,043	90,047	82%
Standard Deviation			2.1%			3.0%
LME-MCO Average			90%			83%