CCME

2018 External Quality Review

ALLIANCE BEHAVIORAL HEALTHCARE

Submitted: April 5, 2019

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

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 requires State Medicaid Agencies that contract with Prepaid Inpatient Health Plans (PIHPs) to evaluate their compliance with the state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358 (42 CFR § 438.358). This review determines the level of performance demonstrated by the Alliance Behavioral Healthcare (Alliance). This report contains a description of the process and the results of the 2018 External Quality Review (EQR) The Carolinas Center for Medical Excellence (CCME) conducted on behalf of the North Carolina Department of Health and Human Services (NC DHHS) and NC Medicaid (formerly the Division of Medical Assistance, or DMA).

Goals of the review include the following:

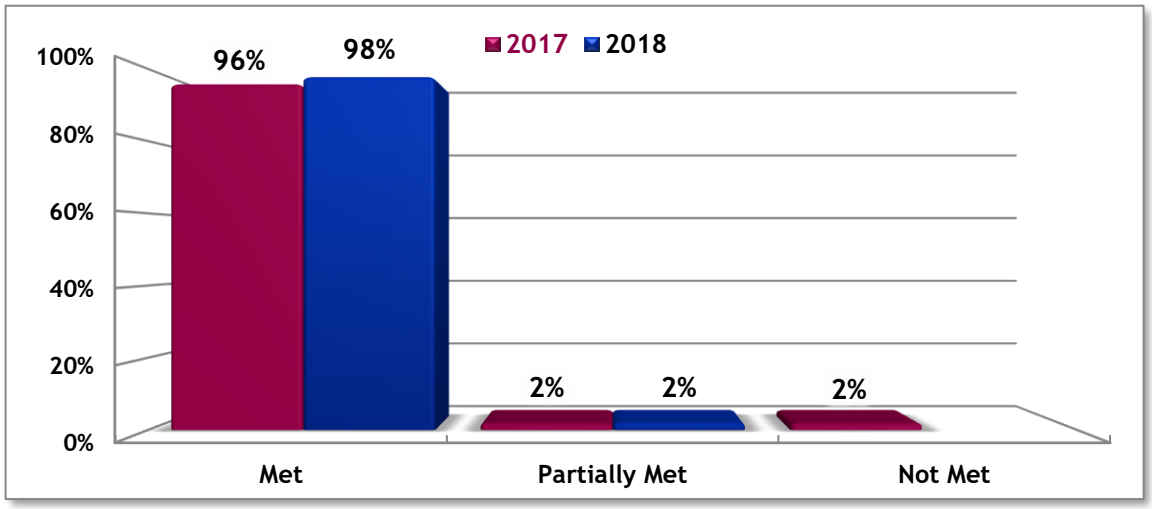
- Determine if Alliance complies with service delivery as mandated by their *DMA Contract*
- Provide feedback for potential areas of further improvement
- Verify the delivery and determine the quality of contracted health care services

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

A. Overall Findings

The 2018 Annual EQR reflects that Alliance achieved a “Met” score for 98% of the standards reviewed. As *Figure 1* indicates, 2% of the standards were scored as “Partially Met”. None of the standards were scored as “Not Met”. *Figure 1* provides a comparison of Alliance’s 2017 review results to 2018 results.

Figure 1: 2018 Annual EQR Review Results



B. Overall Recommendations

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

Administration

The Administration functions review included an examination of Alliance's policies, procedures, staffing levels, information systems, and how the health plan handles confidential health information. CCME provided two recommendations aimed at improving the information within Alliance's set of procedures and their Organizational Chart.

During the Onsite discussion about systems capability, Alliance demonstrated its AlphaMCS enrollment and claim screens, and provider web portal. Alliance uses comprehensive processes and reporting systems for enrollment, claims reporting, encounter data submission and reporting, and claim functions.

Alliance corrected most issues related to the taxonomy codes while working with NC Medicaid and its providers to address the encounter data denials related to the missing and invalid provider taxonomy codes. Since the last EQR, Alliance reduced its denial rate for encounters submitted to NCTracks to approximately 1%. Recent changes to AlphaMCS allow Alliance to process up to 12 ICD-10 diagnosis codes for Professional claims and up to 29 ICD-10 diagnosis codes for Institutional claims. Alliance was not submitting secondary

diagnosis codes to NCTracks during the review period. Per Alliance, a system correction was issued in December 2018 and now all secondary diagnosis codes are reported.

Provider Services

The Provider Services review includes Network Adequacy, Credentialing, and Recredentialing. Alliance resolved all Corrective Action items and Recommendations from the last EQR. The credentialing and recredentialing files are well organized and contain appropriate information. All standards in the Provider Services section are "Met". CCME provided "Recommendations" for a few items.

Enrollee Services

The Enrollee Services review focuses on member rights and responsibilities, member program education, behavioral health and chronic disease management education, and the Call Center. Alliance resolved each Corrective Action and Recommendation from the last EQR. Alliance rewrote the *Individual and Family Handbook* since last EQR for easier readability, targeting an eight-grade reading level. The Access and Information Center continues to meet all NC Medicaid call statistics.

Quality Improvement

This section reviews the Quality Improvement (QI) Program, QI Committee, performance measures (PMs), performance improvement projects (PIPs), provider participation in QI, and the Annual Evaluation of the QI Program. All Corrective Actions and Recommendations from the last EQR have been resolved. All standards for this EQR are "Met." Two PIPs have one recommendation each. Documentation quality within the QM Department is commendable, especially the *FY 2018 Quality Management Program Evaluation* and the *FY19-20 QM Adherence Reviews- ADHD (Adolescents) & Schizophrenia (Adults)*.

Utilization Management

This section reviews Utilization Management (UM) functions including UM, Care Coordination and Transition to Community Living Initiative (TCLI) programs. Alliance "Met" each UM review standard. CCME provided seven recommendations aimed at improving Care Coordination procedures, Jiva record availability, monitoring of Care Coordination documentation and TCLI services, and availability of TCLI materials for members with limited English proficiency.

Grievances and Appeals

Review of Alliance's Grievance files showed all Grievances were resolved within the required timeframes. Grievance policies and procedures also provided adequate guidance to staff regarding the steps for receiving, processing and resolving Grievances. One clarification is needed in *Procedures 6503, Management and Investigations of Grievances*. CCME recommended the language describing Grievance extension notifications align with the DMA Contract and federal regulations language.

The Appeal file review showed all Appeals, expedited and standard, were decided and notification to appellants sent within the required resolution timeframes. However, some internal notifications requirements were not followed. Approximately one third of the reviewed files had acknowledgment letters sent to appellants outside of the "one business day" required in Alliance's Procedure 3502, Due Process/Appeals of Medical Necessity Determinations. Likewise, the Communication Logs Appeal Staff use to capture internal Appeal steps, such as oral notifications of expedited Appeal resolution or consultation with Alliance's Chief Medical Officer (CMO), were frequently incomplete or incorrect. Based on these findings, Corrective Action is needed to ensure there is adequate staffing to consistently process Appeals within Alliance's procedural, NC Medicaid Contract, and federal regulation requirements. CCME also provides six recommendations aimed at refining or correcting language within Alliance's Appeals procedure and other documents discussing Appeals, such as the *Provider Operations Manual* and *Care Coordination Desk Reference*.

Delegation

Alliance reported five current delegated entities. Two additional delegations ended June 30, 2018. Delegation Agreements are in place with all delegated entities, with Business Associate Agreements for delegates with access to Protected Health Information (PHI). Alliance monitors its delegates. At the last EQR, there were no Recommendations and no items requiring Corrective Action. There are no Recommendations or items requiring Corrective Action for the current EQR.

Program Integrity

Alliance's case files were fully compliant and, overall, policies and procedures adequately describe Alliance's PI processes. Corrective Actions are required to improve language within Alliance procedures that explain contract requirements for payment suspension practices. CCME also recommends adding an executive summary to the file sections to capture all the key data points in one place.

Financial Services

Alliance received "Met" scores for the 2018 Financial Services EQR. CCME identified one procedure enhancement. CCME recommends adding language to *Procedure 3016, Records*

Retention and Destruction to reflect the requirement to retain all Medicaid records for ten years as noted in Section 8.3.2 of the *DMA Contract*.

Encounter Data Validation

Based on the analysis of Alliance's encounter data, we have concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues still exist with their submission of Institutional encounters and need to be addressed in order to be compliant. Alliance should take corrective action to resolve the issues identified with procedure code and diagnosis codes, as well as continue to work on improving all up front denials. They have implemented several key practices to ensure that their front end denials continue to go down as well as their total outstanding encounter denials. It is HMS's expectation that Alliance will be able to demonstrate accurate and complete data for encounters submitted in 2018 and moving forward.

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

METHODOLOGY

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

On January 16, 2019, CCME sent notification to Alliance that the annual EQR was being initiated (see *Attachment 1*). This notification included:

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

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

The review consisted of two segments. The first was a Desk Review of materials and documents received from Alliance on February 6, 2019 and reviewed in CCME's offices (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. Also included in the Desk Review was a review of Credentialing, Grievance, Utilization, Care Coordination, Transition to Community Living Initiative, and Appeal files.

The second segment was a two-day, Onsite review conducted on March 6, 2019 and March 7, 2019, at Alliance's corporate office in Morrisville, NC. CCME's Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's Onsite activities included

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

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

FINDINGS

CCME's EQR findings are summarized in the following pages of this report and are based on the regulations set forth in *42 CFR § 438.358* and the contract requirements between Alliance and NC Medicaid. Strengths, weaknesses, Corrective Action items, and recommendations are identified where applicable. Areas of review were identified as meeting a standard "Met," acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (*Attachment 4*).

A. Administration

The Administration functions review examined Alliance's policies, procedures, staffing levels, information systems, and how the PIHP handles confidential health information.

Policies & Procedures

CCME's review of the Alliance's policies and procedures showed that Alliance has 84 policies and 219 procedures. There was evidence that each policy and procedure was reviewed within the past year and that there is an active revision process. Compliance 360 houses the policies and procedures and facilitates availability to staff.

Within the reference grid of each procedure, relevant Utilization Review Accreditation Commission (URAC) standards, codes of federal regulations, Department of Mental Health *(DMH)* and *DMA Contracts* are generally referenced. However, throughout the procedures, URAC language and requirements are often all that is referenced. For example, there is no reference to *Attachment M* of the *DMA Contract* in the Appeals procedure. Yet that attachment governs Medicaid requirements for processing Appeals.

It is understood that URAC requirements are, at times, more restrictive. Not all contracts and accreditation requirements align procedurally. For example, the *DMA Contract* requirements for Appeals differ from those of URAC. Referencing *DMA Contract*, *Attachment M, Section G.5* and *6* in the Appeal procedure would better guide staff through the required procedural steps notifications when Alliance extends the resolution timeframe for a Medicaid Appeal. CCME recommends that Alliance remove the specific references to URAC within the body of their procedures and add the specific *DMA Contract* requirements in the reference grid.

Organizational Staffing/ Management

Alliance has a dedicated and stable Executive Leadership Team and ample staff in place to ensure they can meet the needs of their members. Last year, CCME recommended that Alliance delineate the departmental oversight by the Chief Medical Officer (CMO) on the *Organizational Chart*. Don Fowls, MD joined Alliance during this past year and the details

of his oversight were added to their *Organizational Chart*. During the Onsite discussion, Dr. Fowls described additional support and oversight is provided by the two Associate Medical Directors (AMDs), Drs. Middendorf and Kaesemeyer. CCME recommends adding to the *Organizational Chart* the AMD oversight to highlight the level of physician support the Medical Department provides.

Confidentiality

Alliance's policies and procedures address confidentiality practices and requirements including:

- Access and Amendment to Protected Health Information (PHI)
- Records Retention and Destruction
- Designated Record Set
- Medicaid Funded Service Records Transfer and Storage
- Health Insurance Portability and Accountability Act (HIPAA) Privacy Compliance
- Disaster Plan for Recovery of Records
- HIPAA Oversight
- Confidentiality of Information
- Removal and Transportation of PHI
- Privacy Security Breach Notification
- Release of Information
- Uses and Disclosure-Minimum Necessary
- De-identification and Re-identification of PHI

These policies and procedures sufficiently address DMA contractual, state, and federal confidentiality requirements.

Alliance makes sure all new staff are trained on confidentiality on the first day of their employment and requires new staff to sign a confidentiality agreement prior to accessing the electronic record system. Alliance conducts annual training for existing staff that includes confidentiality.

Information Systems Capabilities Assessment

As required by its contract with CCME, IPRO reviewed Alliance's information system capabilities using the Information Systems Capabilities Assessment (ISCA), as specified in the CMS protocol.

Upon receipt of the completed ISCA tool from Alliance with supporting documentation, IPRO reviewed the responses and followed up on areas requiring clarification via interviews and a systems walk through at the Alliance office located in Morrisville, NC, on March 7, 2019.

Enrollment Systems

From 2015 to 2017 there was a small increase year to year in Alliance's enrollment. Comparative end-of-year enrollment totals were reported as follows:

Table 1: Enrollment Counts

2015	2016	2017
211,269	220,771	223,347

During the ISCA Onsite review, Alliance discussed the AlphaMCS enrollment process. This system maintains a member's enrollment history. Alliance receives daily and quarterly Global Eligibility File (GEF) from NC Medicaid. The daily and quarterly files are received from the state system, NCTracks, and compared against existing eligibility in the AlphaMCS system. The daily file is an incremental load and the quarterly file is a full replacement. After loading the GEF, the system determines which members are additions, changes, or terminations. An Enrollment Representative identifies and works on eligibility load related errors.

Alliance assigns a unique member identification number and stores the Medicaid identification number received on the GEF. Alliance's eligibility system prevents duplicate records by merging multiple member records and linking patient historical claims. The member's Medicaid ID is the primary identifier. Member eligibility records include the complete enrollment history for each member. Providers can look up and confirm a member's eligibility through the AlphaMCS Provider Portal.

WellSky (formerly Mediware) captures Alliance's enrollment data nightly, which is loaded into AlphaMCS. WellSky receives all managed care organization (MCO) data and parses out Alliance's data. The data are imported and available for reporting. A check to confirm

data validity includes counting enrollment totals. Backups are scheduled daily, incrementally, and weekly.

Claims Systems

Alliance uses the AlphaMCS for claims processing. Claims can be received via the Provider Portal, HIPAA 837, or via paper claims. Alliances receives a small number of claims via paper claims solely from out-of-network providers and from Emergency Departments (EDs).

If a required field is missing from the claim, the Provider Portal will not allow the claim to be submitted. Claims submitted electronically with missing required fields are rejected. Claim rejections automatically generate HIPAA 999 transaction file notices to providers. Claims needing rework are held until they receive additional information to process the claim. The batch adjudication process occurs nightly. Alliance auto-adjudicates 84% of the Institutional claims and almost 99% of Professional claims. Claims Processors manually process ED claims. Alliance Claim Processors do not add or change any information on the claims. Claims are processed during the nightly adjudication and assigned an AlphaMCS claim number.

Alliance accepts ICD-10 procedure codes and Diagnosis-related groups (DRG)s if providers include them on the UB-04 claim or on the 837I. DRG codes are displayed on Alliance's claim system. Alliance provided a recent report as supporting documentation. Overall, Alliance does not receive ICD-10 procedure codes on provider claims as this is not common for behavioral health billing.

Alliance noted that the AlphaMCS system was upgraded and now captures up to 12 diagnosis codes for Professional claims (via an 837P file or the provider portal) and up to 29 submitted for Institutional claims (via an 837I or the provider portal). A function was added to AlphaMCS to display all of the primary and admitting diagnosis code for both Institutional and Professional claims.

Per the ISCA response and Onsite interviews, Alliance Claim Staff conduct routine and non-routine claim audits. A random weekly sample of 2.5% of all claims adjudicated during the previous week; 50% focused audit of inpatient hospital claims over $5,000; weekly 3% focused on audit of ED claims.

CCME analyzed Alliance's processes for collecting, adjudicating and reporting claims through a review of its ISCA response and supporting documentation. A discussion of Alliance's Provider Direct claims entry portal and the AlphaMCS claims processing system was conducted during the Onsite review.

Alliance receives claims via HIPAA File, Paper Claim and the Provider Web Portal. *Table 2* highlights the percentages of claims received through these methods.

Table 2: Claim Method Percentages

Source	HIPAA File	Paper	Provider Web Portal
Institutional	60.7%	.9%	38.4 %
Professional	75.6%	.05%	24.3%

Note: Paper claims are received for out-of-state services.

Alliance adjudicates claims nightly. Any claim that is missing information will be pended and worked by a Claims Specialist.

Alliance processes eligible paper claims within 10 days of receipt. Approved claims are paid within 30 calendar days of receipt. Claims submitted through an electronic file are processed nightly.

ICD-10 procedure codes are not submitted to NCTracks. When providers use them, Alliance accepts DRGs if the provider includes the values on an 837I. DRG codes are available for reporting purposes but are not submitted to NCTracks.

Reporting

Alliance created a near real-time replication from the production AlphaMCS system to a Structured Query Language (SQL) data repository. This SQL server captures all the enrollment and claims information in AlphaMCS. Both systems can be used to create reports and data extracts. There are many reports in the AlphaMCS system that are used by all NC MCOs using AlphaMCS. Alliance specific reporting is performed through the SQL server database. The current data warehouse is also updated daily.

For reports that are in the AlphaMCS system, WellSky programmers use SQL Server to create data extracts and analytic reports. For Alliance SQL reporting, they do not outsource any of their programming needs and use internal staff for all programming. Alliance reported that they employ a Director of Data Science and Analytical Research, an additional Data Scientist, a staff of six business intelligence (BI) developers, two data architects, one Extract, Transfer, and Load (ETL) Developer and four Power Business Analysts, that support the Data Analytics program and are knowledgeable on the structure of WellSky/AlphaMCS system and databases. Alliance noted at the Onsite that they added two staff to the department who perform advanced research analytics.

Encounter Data Submissions

Alliance's submission process to NCTracks is fully automated. Weekly Alliance submits claims to NCTracks using the 837I and 837P file formats. The 835 file from NCTracks is used to review denials. A total of 106,893 Institutional and 2,357,894 Professional encounters were submitted to NCTracks for 2017 dates of service. Alliance identified 1,998 denied and not yet accepted Institutional and 37,219 Professional encounters with 2017 dates of service. Alliance's strategy to continue to reduce, correct and resubmit encounter denials includes providing continuous provider education, rebilling corrected encounter denials, using the internal Account Receivables application to monitor and track encounter claims, and dedicating claims staff to reviewing and resubmitting denied encounters.

Alliance's accounts receivable (AR) system is used to reconcile the encounter data submitted to NCTracks and to work through the encounter data denials. The system is robust and includes several volume reports and a notes section for each denial. Alliance's encounter reconciliation process tracks all historical encounter submissions, matches the claims submitted and identifies the encounters initially submitted and awaiting resubmission, or claims initially submitted and not yet resubmitted. Once the issue with the denied claim is corrected, they request from the AlphaMCS system a new file containing these rebills, which then is sent to NCTracks for processing. The process would then repeat itself should any claims be denied.

Alliance improved encounter data submissions and the reduction of denials since the last ISCA audit. Based on a report provided by NC Medicaid, Alliance is running at a greater than 99% acceptance rate.

Alliance noted that ICD-10 procedure codes and DRG codes are not submitted to NCTracks. NC Medicaid confirmed that these are not required fields, but if are available, should be submitted.

Per the ISCA response, Alliance advised that all ICD-10 diagnosis codes for Professional and Institutional claims are submitted to NCTracks. However, based on further discussions CCME determined that secondary diagnosis codes were not sent to NCTracks for Institutional services during this review period and only began to be submitted in December 2018.

Figure 2, Administrative Findings, shows that 95% of the standards in this section were scored as "Met" and provides and overview of the 2017 EQR scores as compared to the 2017 scores. See Attachment 4, Tabular Spreadsheet, for additional details.

Figure 2: Administration Comparative Findings

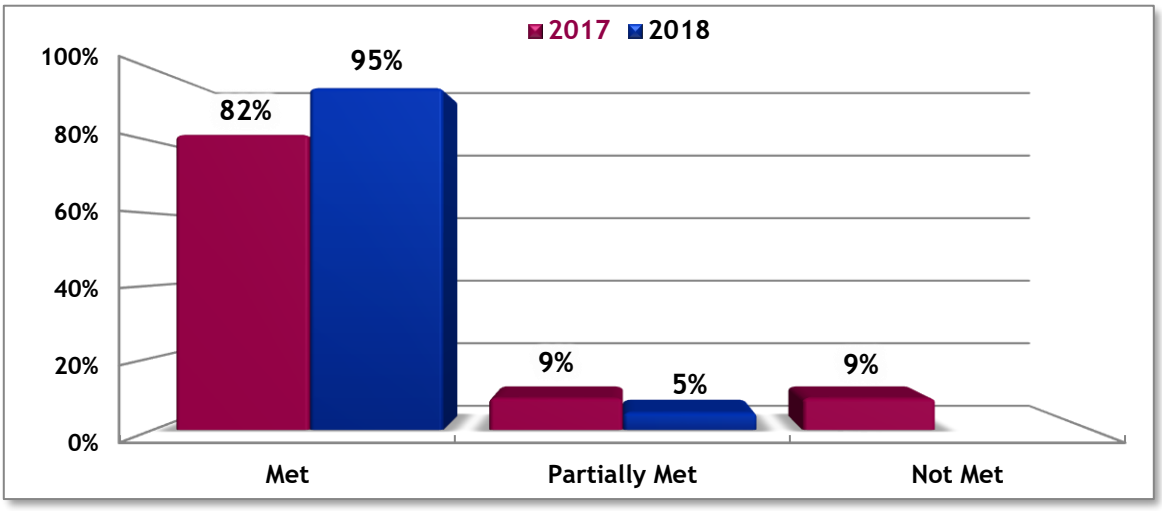


Table 3: Administration

Section	Standard	2018 Review
Management Information Systems	The MCO has the capabilities in place to submit the State required data elements to DMA on the encounter data submission	**Partially Met**

Strengths

- Alliance uses the Compliance 360 platform to maintain and manage their policies and procedures.
- Alliance uses the quarterly Global Eligibility File (GEF) from NC Medicaid to enhance their enrollment reconciliation process.
- Alliance's current NCTracks encounter acceptance rate has improved since last year's EQR. Alliance, while working with NC Medicaid, has made significant improvements in the rate of accepted encounter submissions to the state since the last EQR, averaging over 99%.
- Claims, Encounter, and IT Staff are knowledgeable about their processes, and are dedicated to improving encounter data submissions, and reducing the number of encounter data denials and the denied encounters resubmissions. Alliance added Research Analysts to their Data Team.
- Alliance trains new staff on confidentiality on their first day of employment.

Weaknesses

- The oversight and support provided by the Associate Medical Directors are not represented on the *Organizational Chart*.
- There are several opportunities within Alliance procedures to cite specific *DMA Contract* requirements.
- Alliance did not submit secondary ICD-10 diagnosis codes to NCTracks during the review period but noted that they did correct this December 2018.
- Alliance identified 1,998 denied and not yet accepted Institutional and 37,219 Professional encounters with 2017 dates of service.

Corrective Action

- Confirm secondary ICD-10 diagnosis codes are currently being sent to NCTracks.

Recommendations

- Add to the *Organizational Chart* the support and oversight by the Associate Medical Directors.
- Remove the specific references to URAC within the body of procedures and add the specific *DMA Contract* requirements in the reference grid of each procedure.
- Even though Alliance's denial rate is near 1%, they identified 1,998 denied and not yet accepted Institutional and 37,219 Professional encounters with 2017 dates of service. They should continue to work with NC Medicaid to re-submit these to NCTracks.

B. Provider Services

The Provider Services External Quality Review (EQR) is composed of Credentialing and Recredentialing, and Network Adequacy (including Provider Accessibility, Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, and Practitioner Medical Records). CCME reviewed relevant policies and procedures, the *Provider Operations Manual*, clinical practice guidelines, credentialing and recredentialing files, provider network information, the 2018 *Network Adequacy and Accessibility Analysis (Gaps Analysis)*, the *Alliance Choice and Access Exception Request FY19,* and the Alliance website.

Alliance submitted Procedure 6011, Primary Source Verification, and Procedure 6030, Credentialing Criteria and Enrollment Process for Network Participation, as the Credentialing Plan. Procedure 6030 outlines "criteria for credentialing, re-credentialing and enrollment in the Alliance Closed Network." The procedure provides information about the Credentialing Committee, including establishing what constitutes a quorum ("Quorum is reached when 33% of voting members are present plus the Chairperson"), as

well as indicating "The Provider Network Credentialing Committee is chaired by the Chief Medical Officer or an Associate Medical Director in his absence." The procedure states, "The Provider Network Credentialing Committee may meet on a bi-weekly basis or at least monthly to review credentialing files, review any identified quality of care concerns related to an applicant and take actions," and indicates the Credentialing Committee Chair is a "non-voting member except in the event of a tied vote."

Dr. Katherine Hobbs-Knutson, the former Chief Medical Officer (CMO), chaired the Credentialing Committee until the end of June 2018. Dr. Heidi Middendorf, Associate Medical Director (AMD) and a board-certified psychiatrist, chaired the committee meetings beginning July 3, 2018. Beginning August 14, 2018, Dr. Nadiya Kaesemeyer, AMD and a board-certified psychiatrist, began co-chairing the committee with Dr. Middendorf. The *Credentialing Committee Organization Chart* dated 01.28.19 lists two provider members and five Alliance employee members designated as voting members of the committee.

A review of the Credentialing Committee Minutes confirmed the committee met at least monthly, with 29 Credentialing Committee meetings from January 16, 2018, through December 18, 2018. A quorum was present at each meeting. Attendance of voting members ranged from 71% to 94% of the meetings at which they were a member.

Credentialing/recredentialing files were well-organized and contained appropriate documentation. Alliance does not delegate any credentialing functions.

As required by North Carolina (NC) Medicaid, Alliance conducts an annual *Network Adequacy and Accessibility Analysis (Gaps Analysis)*, which includes obtaining feedback from members, providers and other stakeholders, as well as Geo-Access studies. The Appendix D: Community Feedback section of the report includes charts with analysis of the feedback from member, provider, stakeholder, and staff groups.

Page 46 of the *Gaps Analysis* dated September 2018 states, "the Alliance service network meets geographic access and choice expectations for Outpatient, Community/Mobile, Crisis, Inpatient and C-Waiver service categories." Child and Adolescent Day Treatment and Opioid Treatment services are the only identified Medicaid-funded location-based services that did not meet geographic access and choice expectations. There is limited choice in Cumberland County for both services, and limited choice in parts of Johnston County for Opioid Treatment Services.

The *Gaps Analysis* "serves as the basis for the *FY19 Network Access Plan*, a section of the *Network Adequacy and Accessibility Analysis* that details specific priorities for addressing identified community needs and gaps." Alliance identified the *FY19 Network Access Plan* as their *Network Development Plan*.

During Onsite discussion, Alliance staff reported a Child and Adolescent Day Treatment provider was added in Cumberland County, and that provider is adding a second classroom. Alliance is also seeking to add a provider who is not school-based and has requested a "waiver of provider choice while we continue to work with Cumberland schools."

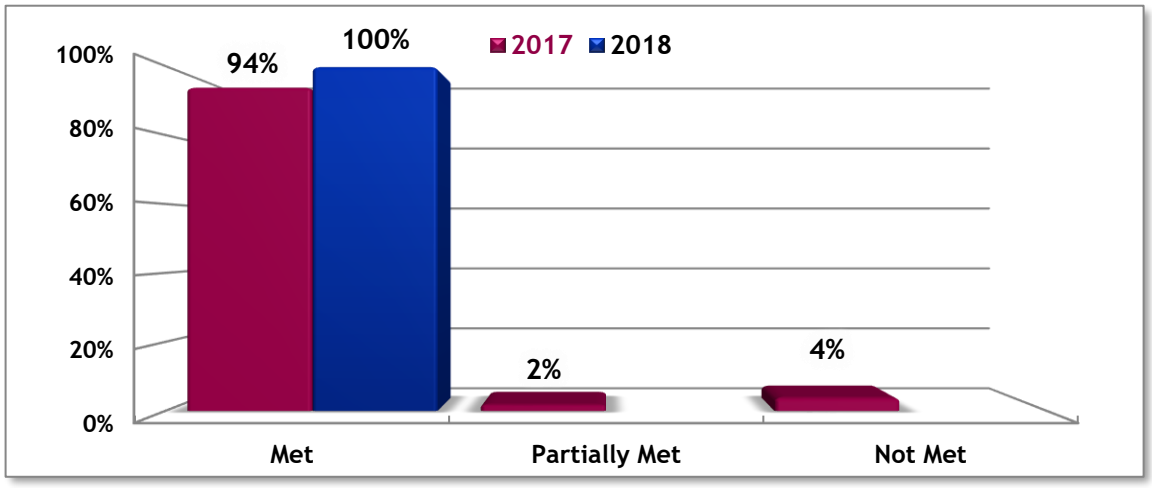
The *Gaps Analysis* states, "We will request a waiver of provider choice while we reach out to existing opioid treatment providers to pursue service expansion in Cumberland and Johnston Counties. Members have access to Office-Based Opioid Treatment (OBOT) in each county."

Procedure 6034, Provider Orientation and Education, addresses "new provider orientation and education expectations of providers." The procedure states, "New Providers receive a Welcome Letter once fully approved to join the Alliance Behavioral Healthcare Network. The Welcome Letter includes the name of the Provider's assigned Network Specialist, approved Services and Sites, and a link to the Alliance Behavioral Healthcare website that outlines additional key publications and contacts for each functional area."

During the Onsite discussion, Alliance staff reported providers are encouraged to sign up for news feeds, "which include anything Alliance posts." Providers can choose to receive these daily or weekly. Communication Bulletins convey important information to providers. Via the website, Alliance offers Recovery University, an "online training gateway that allows users to register for all Alliance trainings (online and in-person), complete evaluations, view courses attended and print certificates, plus gain access to a number of additional courses." Through this program, practitioners and provider staff can obtain training at minimal costs.

Figure 3, Provider Services Findings, shows that 100% of the standards in the Provider Services section were scored as "Met." *Figure 3* provides an overview of 2017 scores compared to 2018 scores.

Figure 3: Provider Services Findings



Strengths

- Credentialing/recredentialing files were well organized and contained appropriate documentation.
- The *Provider Operations Manual* is detailed and provides enough information to help providers navigate the health plan.
- Alliance offers Recovery University, an "online training gateway that allows users to register for all Alliance trainings (online and in-person), complete evaluations, view courses attended and print certificates, plus gain access to a number of additional courses." Through this program, practitioners and provider staff can obtain training at minimal costs.
- The Appendix D: Community Feedback section of the Alliance 2018 *Network Adequacy and Accessibility Analysis* includes charts reflecting analysis of the feedback from member, provider, stakeholder, and staff groups.

Weaknesses

- One of the two physician initial credentialing files did not contain Primary Source Verification (PSV) of education. Alliance *Procedure 6011, Primary Source Verification*, indicates one source for verifying physician education is Intellicorp.
- One credentialing file and two recredentialing files had a screenshot of the *NC DHHS State Exclusion List* that was dated prior to the date of the practitioner applications.
- Four of the nine recredentialing practitioners were recredentialed from a week to over three weeks late.

- The *Individual and Family Handbook* does not clearly communicate that, if medically necessary treatment is required but specialty services are not available in-network, the member may use an out-of-network specialist with no benefit penalty.

Recommendations

- If the physician is board certified, ensure PSV of certification is in the credentialing file. If the physician graduated from an international medical school, ensure PSV of Educational Commission for Foreign Medical Graduates (ECFMG) certification is in the file. Correct *Procedure 6011, Primary Source Verification*, and any other documents containing the list of required materials, to indicate that: a.) if the physician is board certified, Alliance will conduct PSV of board certification; b.) if the physician graduated from an international medical school, Alliance will conduct PSV of ECFMG certification; and c.) if the physician is neither board certified nor has ECFMG certification, Alliance will conduct PSV of the physician's education. See *DMA Contract, Attachment O*.
- Discuss with NC Medicaid Alliance's practice of using Intellicorp PSV of physician education. Retain evidence of the discussion with NC Medicaid.
- Per *Procedure 6030*, ensure providers are recredentialed within three years of the date of the approval of initial credentialing or the most recent recredentialing.
- Confirm all credentialing and recredentialing files include evidence of the query of the *NC DHHS State Exclusion List* conducted as part of/during the credentialing/ recredentialing process. See Alliance *Procedure 6011, Primary Source Verification*, and *DMA Contract, Attachment B, Section 7.6.4*.
- Revise the *Individual and Family Handbook* to clearly indicate that, if a network specialist is not available, the member may use an out-of-network specialist with no benefit penalty. See *42 CFR § 438.206* and *DMA Contract Attachment B, Section 6.4.5*.

C. Enrollee Services

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

CCME reviewed Alliance's Member Services, including relevant policies and procedures, the *Individual and Family Handbook*, the *Provider Directory*, Access and Information Center training, orientation materials, new member correspondence and documentation, member and community education offerings, and the website.

Within 14 days of the initial request for services, Alliance provides new members with a *Welcome Letter*. The letter directs members to the Prepaid Inpatient Health Plan (PIHP)

website for written materials including *"Alliance Consumer and Family Handbook."* The handbook name changed to "*Individual and Family Handbook"* and that needs to be updated in the *Welcome Letter*. Also provided in the mailing with the letter is the Notice of Privacy Practices (NPP) and information about the Alliance Crisis and Assessment Centers. For members without internet access, the Access and Information telephone number is provided in the *Welcome Letter* so they may call to ask questions or request copies of any documentation. The *Welcome Letter* is available in Spanish also.

The *Individual and Family Handbook* was updated since the last EQR and incorporates simple language, targeting an eighth-grade reading level. Brochures are aimed at a fifth-sixth grade reading level.

To comply with the NC Medicaid contract, Alliance needs to update written Enrollee materials. No locations are mentioned where post stabilization services are available. The *Individual and Family Handbook* has sections for out-of-area and out-of-network. In the out-of-network section, the second paragraph changes subjects to explain out-of-area. Out-of-area is not explained clearly so that the member knows the procedures for obtaining out-of-area coverage of services, if special procedures exist. Procedures for obtaining out-of-state services are not mentioned. Re-wording and adding a statement to call the Access and Information Center and the phone number would be helpful. Page four of *Procedure 3500, Individual Rights and Responsibilities* states, "Members have the right to recommend changes to Alliance policies and services. To do so, they may email their recommendations to the Director of Individual and Family Affairs, dwright@alliancebhc.org, or mail to…." This right and the procedure for members to recommend changes in the PIHP's policies and procedures are not included in member written material and should be included. All other items required to be given to members in written materials were included.

Five terminated provider files were reviewed to assess if members were notified within 15 calendar days after determination that a provider is terminated. Only one set of letters to members included the date of their provider's termination from the network. CCME recommends including the date of the provider's termination within the member communication letters, especially if the termination is requested by the provider, making an Appeal unlikely.

CCME recommends adding a reference in the *Individual and Family Handbook* about the online Alliance Recovery University and how it is a useful educational tool for members. More detail that directs members to the Alliance Recovery University website would be useful.

The Access and Information Center is staffed 24/7/365. Positions include teleworkers and onsite staff. All staff start onsite and go through a six to nine-week training program that includes competency modules and mentoring with peers.

The Access and Information Center handles most calls. Protocall, a delegated contractor handles rollover calls. Alliance samples calls that Protocall handles and will continue to randomly select calls semiannually for review. Protocall's measured call statistics are not as good as the Access and Information Center statistics. Aggregated, Alliance continues to meet NC Medicaid call standards.

Alliance "Met" 94% of the Enrollee EQR standards. *Figure 4* shows a comparison of the percentage scores for 2017 and 2018.

Figure 4: Enrollee Services Findings

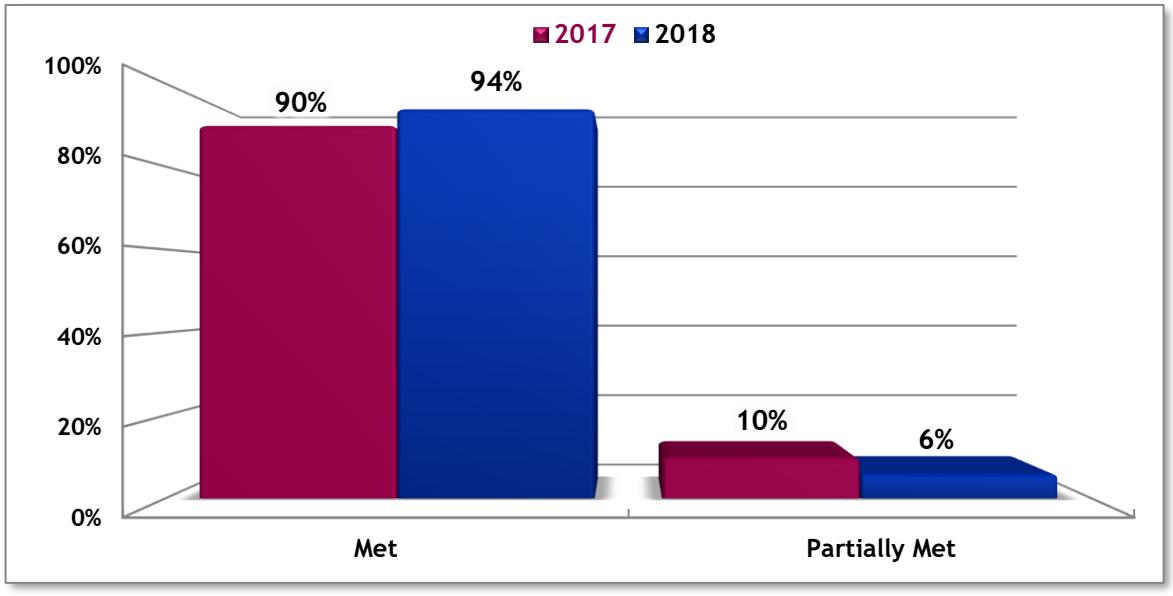


Table 4: Enrollee Services

Section	Standard	2018 Review
Enrollee PIHP Program Education	Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid waiver managed care program which they are contractually entitled, including: The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract; Procedures for obtaining out-of-area or out-of-state coverage of or services, if special procedures exist; The enrollee's right to recommend changes in the PIHP's policies and procedures; The procedure for recommending changes in the PIHP's policies and procedures;	**Partially Met**

Strengths

- The *Individual and Family Handbook* was re-written since the last EQR for easier readability, targeting an eight-grade reading level.
- The Access and Information Center continues to meet NC Medicaid call statistics.
- Alliance highlighted several projects that go beyond EQR including: the transportation pilot, Alliance Cares (food security, homeless winter clothing drive, backpack project), and drug disposal pouches.

Weaknesses

- The *Welcome Letter* directs members to the AllianceBHC.org website for written materials including the *"Alliance Consumer and Family Handbook."* That document is now called the *Individual and Family Handbook*.
- The locations at which providers and hospitals furnish post stabilization services is not stated in member written materials.
- The procedures for members to obtain out-of-area or out-of-state coverage of services, if special procedures exist, is not explained in member written materials.
- The member's right to recommend changes in the PIHP's policies and procedures is not listed in the *Individual and Family Handbook* or other member written materials.
- The procedure for recommending changes in the PIHP's policies and procedures is not included in member written materials.

- Only one set of letters to members explaining their provider's termination from the network included the date of their provider's termination. Onsite discussion revealed that Alliance does not routinely include the provider's termination date because the provider has the right to Appeal.
- The *Individual and Family Handbook* does not describe the Alliance Recovery University, which is intended for provider, member, and staff education. The handbook directs members to the website's home page for member educational materials.

Corrective Action

- Within member written materials, add examples of where post stabilization services are available.
- Re-word the out-of-area section in the *Individual and Family Handbook* so the member knows the procedures for obtaining out-of-area coverage of services, if special procedures exist. Add similar documentation that explains the procedures for obtaining out-of-state coverage or services, if special procedures exist.
- Ensure all printed materials are updated to include the member's right to recommend changes in the PIHP's policies and procedures.
- Ensure all printed materials are updated to include the procedure for members to recommend changes in the PIHP's policies and procedure.

Recommendations

- Update the *Welcome Letter's* reference to *"Alliance Consumer and Family Handbook"* to say *Individual and Family Handbook*.
- Include the date of the provider's termination from the network in the communication letter to the members when the provider requests to leave the network.
- Update the *Individual and Family Handbook* to explain the Alliance Recovery University and how it is useful to members. More detail to direct members to the Alliance Recovery University website would be useful.

D. Quality Improvement

This section reviews the Quality Improvement (QI) Program, QI Committee, performance measures (PMs), performance improvement projects (PIPs), provider participation in QI, and the Annual Evaluation of the QI Program. Alliance's *FY 2019 Quality Management*

Program Description explains the formal QI Program with clearly defined goals, structure, scope, and methodology.

As described in the *FY 2019 Quality Management Program Description*, the "QM Department has developed a process to assess provider compliance with the clinical practice guidelines adopted by Alliance. This process involves: identifying two or more milestone elements in a clinical practice guideline; determining provider compliance via data analysis or record reviews; informing providers of any compliance issues via training and other communications; and identifying outlier providers for focused training." This process starts with Provider Quality Committee. Alliance documents the monitoring of chosen Clinical Practice Guidelines in a detailed and complete, nine-page document, called *FY19-20 QM Adherence Reviews- ADHD (Adolescents) & Schizophrenia (Adults)*.

Alliance tracks and compares the survey results year to year to analyze trends. The *FY 2018 Quality Management Program Evaluation* identifies areas for improvement from all surveys combined. The "All Provider Presentation June 2018" has high level Experience of Care and Health Outcome (ECHO) Survey reports for five composite adult survey areas and four composite child survey areas. The Perception of Care and Provider Survey results were shared too.

The *QM Work Plan* Excel document is updated monthly. It is easy to see progress each month with the updates captured and saved monthly under that month's name in the Excel file name.

The QI Committee (QIC) is the main, formal quality committee. QIC representatives who attend other committees share information from those other committees at QIC. QIC met monthly, except for September and December, with a quorum at each meeting. No members attended less than 50% of the meetings. The average member attendance was 85% for the 2017/2018 Fiscal Year. Other quality committees include the Provider Quality Committee and the Global Quality Management Committee (GQMC). The Provider Quality Committee has increased provider leadership and engagement at Alliance.

Alliance notifies providers that they are measured on QI activities and gives feedback, along with the data, regarding their QI performance. Alliances gives regular updates to providers on PIPs and shares performance during provider meetings. In this venue, no provider specific information is shared. Providers are later informed of their individual performance. Alliance reports that providers gave positive feedback on this process.

FY 2018 Quality Management Program Evaluation gives a summary of the FY 2018 QI activities, analysis, and outcome data, when available. The Alliance Board of Directors and the Global Quality Management Committee reviewed the *FY 2018 Quality Management Program Evaluation* on September 6, 2018.

Performance Measure Validation

As part of the EQR, CCME conducted the independent validation of NC Medicaid-selected B and C Waiver performance measures.

Table 5: B Waiver Measures

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

Table 6: C Waiver Measures

C WAIVER MEASURES	
Proportion of Level of Care evaluations completed at least annually for enrolled participants	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals
Proportion of Level of Care evaluations completed using approved processes and instrument	Proportion of Individual Support Plans that address identified health and safety risk factors
Proportion of New Level of Care evaluations completed using approved processes and instrument	Percentage of participants reporting that their Individual Support Plan has the services that they need
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Proportion of individuals for whom an annual ISP and/or needed updates took place
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval

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

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

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

B Waiver Measures Results

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

For the 7-day and 30-day follow-up after discharge from a Facility Based Crisis Center for mental health reasons, the rate decreased more than 20%, but the combined rate increased more than 30%. During the Onsite, Alliance explained that billing issues and provider network changes may have affected the rate. Alliance is aware of the rate decline and is working to ensure follow-up appointments are attended for members discharged from a Facility Based Crisis Center for mental health reasons.

The measure rates for 2017-2018 reported by Alliance are included in the following Tables. The previous year's rate and the rate change between the two years in also included.

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

30-day Readmission Rates for Mental Health	FY 2017	FY 2018	Change
Inpatient (Community Hospital Only)	6.6%	10.1%	3.50%
Inpatient (State Hospital Only)	5.1%	3.5%	-1.60%
Inpatient (Community and State Hospital Combined)	6.6%	9.9%	3.30%
Facility Based Crisis	12.7%	5.9%	-6.80%
Psychiatric Residential Treatment Facility (PRTF)	13.0%	17.8%	4.80%
Combined (includes cross-overs between services)	10.2%	13.7%	3.50%

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

30-day Readmission Rates for Substance Abuse	FY 2017	FY 2018	Change
Inpatient (Community Hospital Only)	11.5%	13.5%	2.00%
Inpatient (State Hospital Only)	0.0%	0.0%	0.00%
Inpatient (Community and State Hospital Combined)	10.9%	13.0%	2.10%
Detox/Facility Based Crisis	6.5%	9.6%	3.10%
Combined (includes cross-overs between services)	10.0%	13.2%	3.20%

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

Follow-up after Hospitalization for Mental Illness	FY 2017	FY 2018	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	43.4%	45.5%	2.10%
Percent Received Outpatient Visit Within 30 Days	65.8%	64.7%	-1.10%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	79.4%	54.1%	-25.30%
Percent Received Outpatient Visit Within 30 Days	88.2%	65.3%	-22.90%
PRTF			
Percent Received Outpatient Visit Within 7 Days	36.3%	37.3%	1.00%
Percent Received Outpatient Visit Within 30 Days	53.8%	53.0%	-0.80%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	13.9%	45.9%	32.00%
Percent Received Outpatient Visit Within 30 Days	32.8%	64.3%	31.50%

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

Follow-up after Hospitalization for Substance Abuse	2016	FY 2018	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	17.7%	21.3%	3.60%
Percent Received Outpatient Visit Within 30 Days	25.3%	35.3%	10.00%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	64.7%	54.1%	-10.60%
Percent Received Outpatient Visit Within 7 Days	67.0%	57.9%	-9.10%
Percent Received Outpatient Visit Within 30 Days	78.3%	64.8%	-13.50%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	36.7%	48.0%	11.30%
Percent Received Outpatient Visit Within 30 Days	46.7%	56.8%	10.10%

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2017	FY 2018	Change
Ages 13-17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	33.1%	39.9%	6.80%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	22.3%	23.9%	1.60%
Ages 18-20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	40.4%	38.7%	-1.70%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	20.2%	18.5%	-1.70%
Ages 21-34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	45.3%	50.6%	5.30%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	33.8%	39.2%	5.40%

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2017	FY 2018	Change
Ages 35-64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	44.7%	45.8%	1.10%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	32.5%	34.6%	2.10%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	31.5%	44.4%	12.90%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	25.9%	29.2%	3.30%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	43.3%	46.4%	3.10%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	31.0%	34.2%	3.20%

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

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY 2017	FY 2018	Change	FY 2017	FY 2018	Change
3-12	Male	0.4	0.3	-0.1	30.0	29.5	-0.5
	Female	0.2	0.2	0	21.0	23.0	2
	Total	0.3	0.3	0	26.5	26.8	0.3
13-17	Male	1.3	1.3	0	60.1	48.3	-11.8
	Female	2.1	2.2	0.1	37.7	33.0	-4.7
	Total	1.7	1.7	0	46.5	38.8	-7.7
18-20	Male	1.7	1.7	0	19.3	19.3	0
	Female	1.6	1.5	-0.1	19.0	12.4	-6.6
	Total	1.6	1.6	0	19.1	15.9	-3.2
21-34	Male	3.9	5.1	1.2	11.3	11.5	0.2
	Female	1.0	1.2	0.2	10.2	8.6	-1.6
	Total	1.6	2.1	0.5	10.8	10.2	-0.6

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY 2017	FY 2018	Change	FY 2017	FY 2018	Change
35-64	Male	2.9	3.2	0.3	9.8	10.8	1
	Female	1.5	1.9	0.4	9.2	9.3	0.1
	Total	2.0	2.3	0.3	9.5	10.0	0.5
65+	Male	0.6	0.5	-0.1	26.0	26.3	0.3
	Female	0.4	0.4	0	42.0	21.7	-20.3
	Total	0.5	0.4	-0.1	35.9	23.4	-12.5
Unknown	Male	0.0	0.0	0	0.0	0.0	0
	Female	0.0	0.0	0	0.0	0.0	0
	Total	0.0	0.0	0	0.0	0.0	0
Total	Male	1.3	1.4	0.1	24.1	20.9	-3.2
	Female	1.0	1.1	0.1	21.1	17.5	-3.6
	Total	1.1	1.2	0.1	22.6	19.2	-3.4

Table 13: D.2. Mental Health Utilization -% of Members that Received at Least 1 Mental Health Service in the Category Indicated during the Measurement Period

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization MH Service			Outpatient/ED MH Service		
		FY 2017	FY 2018	Change	FY 2017	FY 2018	Change	FY 2017	FY 2018	Change	FY 2017	FY 2018	Change
3-12	Male	13.32%	13.58%	0.26%	0.27%	0.26%	-0.01%	0.62%	0.51%	-0.11%	13.13%	13.50%	0.37%
	Female	9.16%	9.47%	0.31%	0.19%	0.18%	-0.01%	0.32%	0.23%	-0.09%	9.06%	9.42%	0.36%
	Total	11.28%	11.56%	0.28%	0.23%	0.22%	-0.01%	0.47%	0.37%	-0.10%	11.13%	11.50%	0.37%
13-17	Male	16.43%	16.69%	0.26%	1.22%	1.30%	0.08%	0.69%	0.48%	-0.21%	16.04%	16.52%	0.48%
	Female	18.40%	18.39%	-0.01%	1.93%	1.95%	0.02%	0.65%	0.43%	-0.22%	18.01%	18.12%	0.11%
	Total	17.41%	17.53%	0.12%	1.57%	1.62%	0.05%	0.67%	0.46%	-0.21%	17.02%	17.31%	0.29%
18-20	Male	10.57%	10.38%	-0.19%	1.34%	1.30%	-0.04%	0.19%	0.24%	0.05%	10.30%	10.15%	-0.15%
	Female	12.58%	12.72%	0.14%	1.36%	1.22%	-0.14%	0.13%	0.10%	-0.03%	12.18%	12.44%	0.26%
	Total	11.63%	11.60%	-0.03%	1.35%	1.26%	-0.09%	0.16%	0.17%	0.01%	11.30%	11.35%	0.05%
21-34	Male	24.63%	24.54%	-0.09%	2.95%	3.28%	0.33%	0.45%	0.38%	-0.07%	24.30%	24.29%	-0.01%
	Female	18.91%	18.81%	-0.10%	0.83%	1.09%	0.26%	0.31%	0.20%	-0.11%	18.71%	18.67%	-0.04%
	Total	20.16%	20.12%	-0.04%	1.29%	1.59%	0.30%	0.34%	0.24%	-0.10%	19.94%	19.95%	0.01%
35-64	Male	25.22%	25.04%	-0.18%	2.24%	2.36%	0.12%	0.83%	0.73%	-0.10%	24.63%	24.69%	0.06%
	Female	26.23%	26.58%	0.35%	1.26%	1.45%	0.19%	0.96%	0.89%	-0.07%	25.63%	26.35%	0.72%
	Total	25.87%	26.02%	0.15%	1.61%	1.78%	0.17%	0.91%	0.83%	-0.08%	25.27%	25.75%	0.48%
65+	Male	5.81%	6.03%	0.22%	0.42%	0.30%	-0.12%	0.23%	0.28%	0.05%	5.47%	5.87%	0.40%
	Female	5.88%	6.01%	0.13%	0.38%	0.23%	-0.15%	0.25%	0.23%	-0.02%	5.55%	5.88%	0.33%
	Total	5.86%	6.02%	0.16%	0.39%	0.25%	-0.14%	0.25%	0.24%	-0.01%	5.53%	5.88%	0.35%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	NR	NR	0.00%	0.00%	0.00%
Total	Male	15.80%	15.95%	0.15%	1.01%	1.06%	0.05%	0.60%	0.50%	-0.10%	15.49%	15.78%	0.29%
	Female	15.41%	15.57%	0.16%	0.84%	0.91%	0.07%	0.47%	0.37%	-0.10%	15.12%	15.42%	0.30%
	Total	15.58%	15.73%	0.15%	0.91%	0.97%	0.06%	0.52%	0.42%	-0.10%	15.28%	15.58%	0.30%

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

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2017	FY 2018	Change	FY 2017	FY 2018	Change	FY 2017	FY 2018	Change	FY 2017	FY 2018	Change
3-12	Male	0.03%	0.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%	0.03%	0.00%
	Female	0.00%	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%
	Total	0.02%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.02%	0.00%
13-17	Male	1.01%	0.86%	-0.15%	0.02%	0.04%	0.02%	0.09%	0.14%	0.05%	0.95%	0.78%	-0.17%
	Female	0.57%	0.55%	-0.02%	0.01%	0.05%	0.04%	0.03%	0.05%	0.02%	0.55%	0.48%	-0.07%
	Total	0.79%	0.70%	-0.09%	0.01%	0.05%	0.04%	0.06%	0.09%	0.03%	0.75%	0.63%	-0.12%
18-20	Male	1.69%	1.44%	-0.25%	0.08%	0.10%	0.02%	0.09%	0.13%	0.04%	1.61%	1.35%	-0.26%
	Female	1.38%	1.11%	-0.27%	0.10%	0.16%	0.06%	0.09%	0.06%	-0.03%	1.34%	1.05%	-0.29%
	Total	1.53%	1.26%	-0.27%	0.09%	0.13%	0.04%	0.09%	0.09%	0.00%	1.46%	1.19%	-0.27%
21-34	Male	5.73%	5.33%	-0.40%	0.74%	0.75%	0.01%	0.57%	0.28%	-0.29%	5.40%	5.10%	-0.30%
	Female	4.57%	5.01%	0.44%	0.39%	0.50%	0.11%	0.57%	0.59%	0.02%	4.33%	4.81%	0.48%
	Total	4.83%	5.09%	0.26%	0.47%	0.56%	0.09%	0.57%	0.52%	-0.05%	4.56%	4.87%	0.31%
35-64	Male	7.56%	7.95%	0.39%	1.28%	1.74%	0.46%	1.33%	1.36%	0.03%	6.84%	7.25%	0.41%
	Female	4.75%	5.12%	0.37%	0.54%	0.56%	0.02%	0.75%	0.75%	0.00%	4.38%	4.80%	0.42%
	Total	5.76%	6.15%	0.39%	0.80%	0.99%	0.19%	0.96%	0.97%	0.01%	5.26%	5.69%	0.43%
65+	Male	0.74%	1.08%	0.34%	0.22%	0.28%	0.06%	0.18%	0.22%	0.04%	0.48%	0.86%	0.38%
	Female	0.21%	0.20%	-0.01%	0.01%	0.02%	0.01%	0.03%	0.03%	0.00%	0.20%	0.17%	-0.03%
	Total	0.37%	0.48%	0.11%	0.07%	0.10%	0.03%	0.07%	0.09%	0.02%	0.29%	0.39%	0.10%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	Male	1.85%	1.86%	0.01%	0.25%	0.33%	0.08%	0.26%	0.27%	0.01%	1.69%	1.71%	0.02%
	Female	1.92%	2.03%	0.11%	0.18%	0.21%	0.03%	0.26%	0.26%	0.00%	1.80%	1.92%	0.12%
	Total	1.89%	1.96%	0.07%	0.21%	0.27%	0.06%	0.26%	0.26%	0.00%	1.75%	1.83%	0.08%

Table 15: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2017	FY 2018	Change	FY 2017	FY 2018	Change	FY 2017	FY 2018	Change	FY 2017	FY 2018	Change
	3-12			13-17			18-20			21-34		
Cumberland	0.02%	0.01%	-0.01%	0.53%	0.48%	-0.05%	2.02%	0.98%	-1.04%	5.62%	4.86%	-0.76%
Durham	0.02%	0.02%	0.00%	0.75%	0.70%	-0.05%	1.42%	0.77%	-0.65%	3.43%	2.60%	-0.83%
Johnston	0.02%	0.01%	-0.01%	0.53%	0.48%	-0.05%	2.02%	0.98%	-1.04%	5.62%	4.86%	-0.76%
Wake	0.02%	0.02%	0.00%	0.75%	0.70%	-0.05%	1.42%	0.77%	-0.65%	3.43%	2.60%	-0.83%
	35-64			65+			Unknown			Total		
Cumberland	4.41%	3.96%	-0.45%	0.46%	0.30%	-0.16%	0.00%	0.00%	0.00%	1.80%	1.48%	-0.32%
Durham	8.73%	8.31%	-0.42%	0.77%	1.02%	0.25%	0.00%	0.00%	0.00%	2.50%	2.17%	-0.33%
Johnston	5.78%	4.38%	-1.40%	0.60%	0.49%	-0.11%	0.00%	0.00%	0.00%	2.06%	1.51%	-0.55%
Wake	5.14%	4.58%	-0.56%	0.44%	0.44%	0.00%	0.00%	0.00%	0.00%	1.52%	1.19%	-0.33%

Table 16: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Cumberland	11.27%	10.63%	-0.64%	17.78%	20.94%	3.16%	12.19%	10.45%	-1.74%	14.46%	13.43%	-1.03%
Durham	9.37%	8.87%	-0.50%	17.65%	20.98%	3.33%	12.15%	10.69%	-1.46%	16.06%	14.28%	-1.78%
Johnston	8.56%	7.89%	-0.67%	16.03%	17.75%	1.72%	10.72%	9.49%	-1.23%	14.81%	13.76%	-1.05%
Wake	7.91%	7.68%	-0.23%	15.34%	18.85%	3.51%	10.77%	9.48%	-1.29%	13.22%	12.80%	-0.42%
	35-64			65+			Unknown			Total		
Cumberland	21.27%	21.72%	0.45%	7.52%	7.61%	0.09%	0.00%	0.00%	0.00%	14.60%	14.16%	-0.44%
Durham	25.74%	24.80%	-0.94%	9.25%	6.56%	-2.69%	0.00%	0.00%	0.00%	14.53%	13.67%	-0.86%
Johnston	21.44%	20.41%	-1.03%	9.21%	9.15%	-0.06%	0.00%	0.00%	0.00%	13.02%	12.13%	-0.89%
Wake	20.93%	20.21%	-0.72%	6.52%	6.46%	-0.06%	0.00%	0.00%	0.00%	11.94%	11.69%	-0.25%

B Waiver Validation Results

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

Table 17 contains validation scores for each of the 10 B Waiver Performance Measures.

Table 17: B Waiver Performance Measure Validation Scores 2018

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

C Waiver Measures Results

Ten C Waiver measures were validated for this review. The Desk Materials contained information on data sources, data validation, and rates for each measure. Alliance's reported percentages are presented in the *Table 18*. Documentation was from Alliance's "Innovations Waiver Performance Measures FY 2018 Excel file."

Table 18: C Waiver Performance Measures: Reported Rates

Performance Measure	Data Collected	2018 Rate
Proportion of Level of Care evaluations completed at least annually for enrolled participants	Semi Annually	909/924 = 98.38%
Proportion of Level of Care evaluations completed using approved processes and instrument	Semi Annually	905/924 = 97.94%
Proportion of New Level of Care evaluations completed using approved processes and instrument	Semi Annually	29/29 = 100%
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Annually	1/1 = 100%
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	Annually	33/34 = 97.06%
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	Annually	1853/1853 = 100%
Proportion of Individual Support Plans that address identified health and safety risk factors	Semi Annually	916/924 = 99.13%
Percentage of participants reporting that their Individual Support Plan has the services that they need	Annually	1853/1853 = 100%
Proportion of individuals for whom an annual ISP and/or needed updates took place	Annually	1853/1853 = 100%
Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval	Quarterly	16/18 = 88.89%

C Waiver Validation

Validation scores are "Fully Compliant" with an average validation score of 100% across the 10 measures. The validation scores are shown in *Table 19*, C Waiver Performance Measure Validation Scores *2018*. The validation worksheets offer detailed information on point deduction when validating each C Waiver measure.

Table 19: C Waiver Performance Measure Validation Scores 2018

Measure	Validation Score
Proportion of Level of Care evaluations completed at least annually for enrolled participants	100%
Proportion of Level of Care evaluations completed using approved processes and instruments	100%
Proportion of New Level of Care evaluations completed using approved processes and instruments	100%
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	100%
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	100%
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	100%
Proportion of Individual Support Plans that address identified health and safety risk factors	100%
Percentage of participants reporting that their Individual Support Plan has the services that they need	100%
Proportion of individuals for whom an annual ISP and/or needed updates took place	100%
Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval	100%
Average Validation Score & Audit Designation	**100% FULLY COMPLIANT**

Performance Improvement Project (PIP) Validation

CCME conducted PIP validation following the CMS-developed protocol titled, *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012*. The protocol validates project components and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

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

PIP Validation Results

In 2017, four of the six submitted projects were reviewed: Transition to Community Living Initiative (TCLI) Private Housing Project, Mental Health Services Abuse (MHSA), Care Coordination, First Responders, and Access to Care: Emergent. Two of the projects are considered clinical, and the other two are non clinical. All four projects had well organized documentation. There were a couple of issues for the TCLI Housing Project regarding the definition of the indicators and presentation of the results. For the First Responder and Access to Care: Emergent PIPs, the documentation was fine. However, the results showed no improvement, but decreased. CCME and Alliance discussed new interventions during the Onsite.

For 2018, four active PIPs were submitted and validated. One was also submitted in 2017 (Access to Care: Emergent), and three new ones were added: Access to Care: Routine/Urgent, Care Coordination Clinical Contacts, and TCLI Housing Turn Around Time. *Table 20* displays the project names and validation scores for 2017 and 2018 review years. During the Onsite, an issue regarding documentation of benchmark rates was addressed. Alliance will discuss the documentation of benchmark rates with NC Medicaid, and those two parties will determine how to report benchmark rates in the PIP reports. CCME also discussed recommendations on the new QIP form during the Onsite visit. Alliance will revise the QIP report template and CCME will provide technical assistance around this template, outside of the EQR process.

Table 20 is a summary of the validation scores for each Project in 2018 and the validation score in 2017 if applicable. As shown, each validated project received a score of “High Confidence” in reported results.

Table 20: Summary of the Validation Scores

Project Type	Project	2017 VALIDATION SCORE	2018 VALIDATION SCORE
Non-Clinical	Access to Care- Routine Urgent	Not Validated	85/90 = 94% High Confidence in Reported Results
	TCLI Housing-Turn Around Time	Not Validated	73/78 = 94% High Confidence in Reported Results
Clinical	Access to Care-Emergent	84/85 = 99% High Confidence in Reported Results	90/90 = 100% High Confidence in Reported Results
	Care Coordination Clinical Contacts	Not Validated	78/78 = 100% High Confidence in Reported Results

The tables that follow list the specific errors by project and include recommendations to correct the errors.

Table 21: Access to Care Urgent

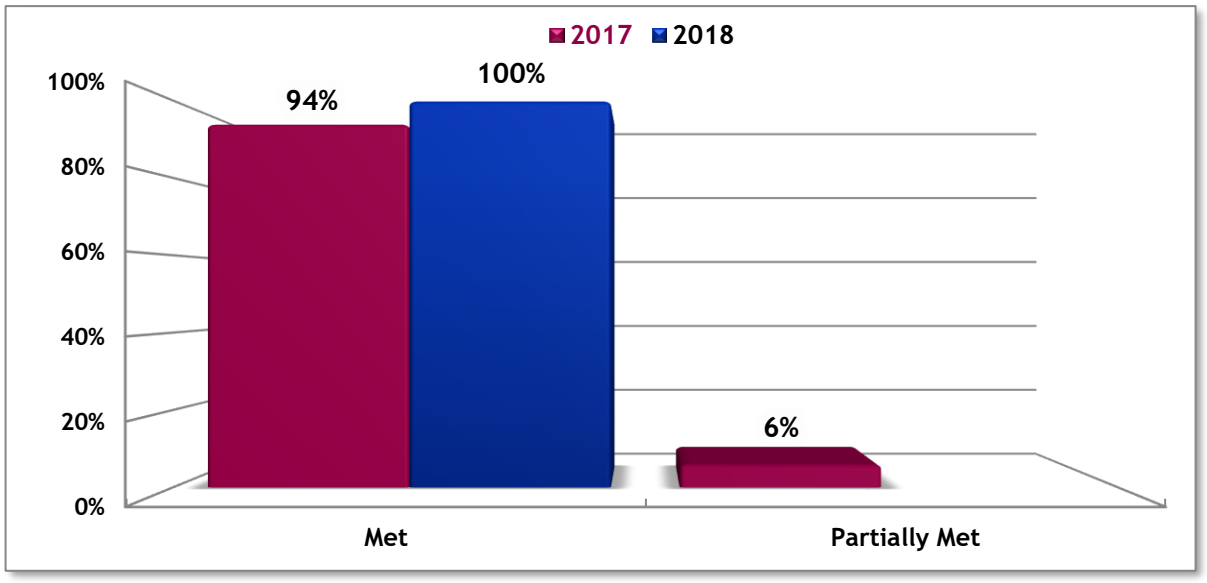
Section	Reasoning	Recommendation
Did the study use objective, clearly defined, measurable indicators?	Indicators are defined and baseline goal is documented. The benchmarks are noted as 82% for Urgent and 75% for Routine, but the objective on page 2 notes that the target rates are 63% for routine and 62% for urgent.	Revise documentation to show that benchmark is 62% for Urgent and 63% for Routine in Section I. B or according to NC Medicaid guidelines.

Table 22: TCLI Housing Turn-Around Time

Section	Reasoning	Recommendation
Did the study use objective, clearly defined, measurable indicators?	Indicators are defined and baseline goal is documented. The benchmark is noted as 80% but the objective on notes that the target rate is 60%.	Revise documentation to show that benchmark is 60% in Section I. B or according to NC Medicaid guidelines.

Alliance "Met" 100% of the Quality Standards for this year's EQR. *Figure 5* illustrates a comparison of the percentage scores for 2017 and 2018.

Figure 5: Quality Improvement Findings



Strengths

- PIPs were based on analysis of comprehensive aspects of member needs and services, and rationale for each topic was documented.
- The submitted C Waiver measure query was accurate and consistent with NC Medicaid requirements.
- Alliance documents monitoring of the Clinical Practice Guidelines in a detailed and complete, nine-page document, called *FY19-20 QM Adherence Reviews- ADHD (Adolescents) & Schizophrenia (Adults)*. This document is thorough.
- The Provider Quality Committee has increased provider leadership and engagement at Alliance.
- The *QM Work Plan* Excel document is updated monthly. It is easy to see progress each month with the updates captured and saved monthly under that month's name in the Excel file name.
- *FY 2018 Quality Management Program Evaluation* is well written and gives a summary of the FY 2018 QI activities, analysis, and outcome data when available.

E. Utilization Management

The Alliance Utilization Management (UM) Department External Quality Review (EQR) included a Desk Review of policies and procedures, the *UM Plan 2018-2019*, the *Utilization Management Program Evaluation 2017-18*, the *Provider Operations Manual*, the *Individual and Family Handbook*, 25 approval files, and 25 denial files. Onsite discussion with UM staff, who are located within the Quality Improvement (QI) Department, provided additional clarification of UM processes.

The UM Department has access to the Chief Medical Officer (CMO), two Associate Medical Directors (AMDs), a pharmacist and a psychologist through a structured case review process. The medical staff are also available for urgent/emergent case reviews as needed.

The UM standards and criteria are made available to providers and were present in the documentation of approval and denial files. The Onsite interview included discussion about requests for information necessary to make decisions for authorization requests. This was evident in the files reviewed and there was no request to extend the UM decision timeframe to obtain additional information. Within the files reviewed, all service authorizations were processed and notifications provided within the required timeframe of 14 days.

The review of the Care Coordination Program included review of policies and procedures, the *Individual and Family Handbook*, the *Care Coordination Program Description,* and 20 Care Coordination files. Care Coordination procedures are in place to confirm comprehensive coordination of care.

Procedure 2004, Individual Support Plan (ISP), identifies the functions of the Intellectual and Developmental (I/DD) Care Coordinators. *Procedure 2005, Identification, Referral, and Timely Initiation of MHSUD and IDD Care Coordination Functions*, previously noted Mental Health/Substance Use (MH/SU) Care Coordinators functions but were not found in the procedure this year. This missing information appeared to be an oversight during the annual revision process. These Care Coordination functions for the MH/SU Care Coordinators need to be added back into *Procedure 2005*.

In October 2018, Alliance implemented the Jiva software platform for the Care Coordination Program. Staff explained that this implementation resulted in a "false start" and full implementation was delayed. As a result, Care Coordinators were tasked with entering Care Coordination notes into both AlphaMCS and Jiva. While documentation from both systems was provided for this EQR, several of the Care Coordination files were incomplete. Jiva embeds scheduled Care Coordination activities and, as a result, some Jiva documentation (e.g., I/DD assessments, progress notes, scheduled face to face

visits) are only reviewable in the live Jiva platform. Therefore, a portion of the requested documentation was not provided by Alliance. Screen shots of this embedded documentation were submitted by Alliance and reviewed by CCME, but not until after the Desk Review and Onsite activities. CCME recommends Alliance develop a report that adequately extracts the full Care Coordination member record, including a chronology of Care Coordination assessments and interventions. This report could be used for audits, quality improvement interventions, court proceedings, etc.

Review of all of the submitted Care Coordination documentation revealed general inconsistencies in frequency of contact, completeness, and quality of documentation. These inconsistencies are outlined in the tabular spreadsheet. Care Coordination staff explained the Jiva platform provides a dashboard for supervisors of care coordinators to monitor care coordinators' required activities. However, it does not offer the level of monitoring needed to identify specific file concerns, such as frequency or quality of notes. Implementing any new platform comes with challenges. For that reason, CCME recommends Alliance enhance the current monitoring processes to ensure documentation is consistently and correctly entered into Jiva

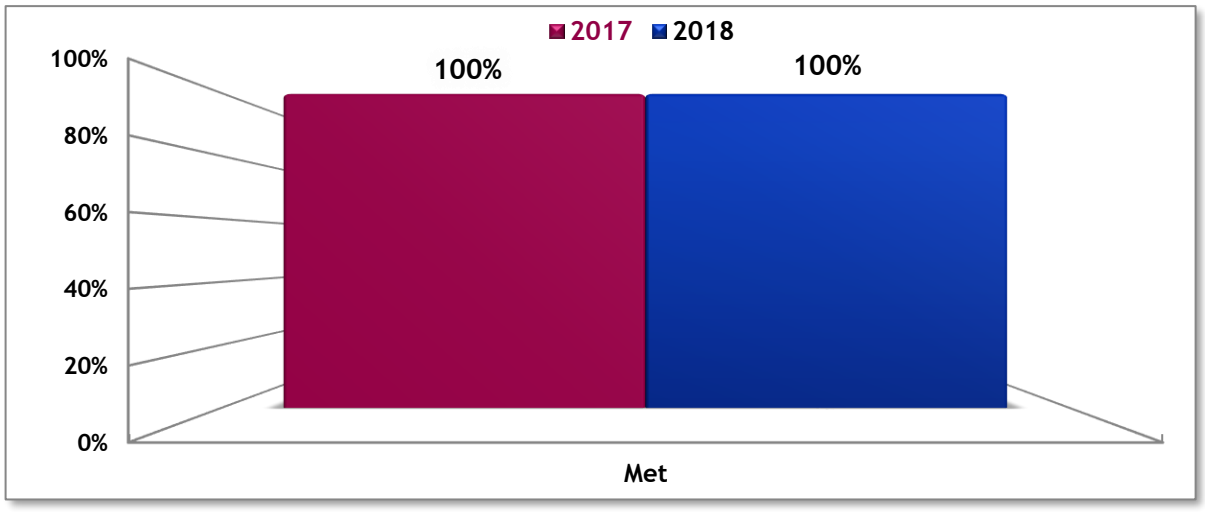
The EQR of the TCLI Program examined policies and procedures, the *Individual and Family Handbook*, the Alliance Website, and 15 TCLI files. There was evidence in the files and TCLI reports provided that TCLI members were linked most frequently with Assertive Community Treatment (ACT) and that fewer TCLI members were linked with Supported Employment, Peer Support, and other services such as Community Support Team.

Review of the Person Centered Plans showed not all identified goals are being addressed. For example, two ACT Person-Centered Plans showed no goals targeting employment, even when the TCLI member voiced a desire to obtain employment. One TCLI member expressed this desire for over three years. During the Onsite discussion with TCLI staff, it was acknowledged that, while ACT is intended to address employment goals, ACT providers are not consistently linking TCLI members with employment support. Alliance's ACT Monitoring Workgroup has been examining this barrier but a more global approach is needed. Minimally, TCLI Person Centered Plans should be more closely monitored to ensure the identified needs of TCLI members are appropriately addressed by all of their service providers.

Alliance has TCLI communication materials that provide information about services to members, external providers, and stakeholders. These materials include a housing brochure, information in the *Individual and Family Handbook,* and Alliance's website. Informational videos about the services are also available on the website. However, there are no materials designed for members with limited English proficiency. CCME recommends Alliance design and make available TCLI materials for members with limited English proficiency.

As illustrated in *Figure 6 Utilization Management Comparative Findings*, Alliance "Met" 100% of the UM standards.

Figure 6: Utilization Management Comparative Findings



Strengths

- The UM Department has access to the Chief Medical Officer, two Associate Medical Directors, a pharmacist, and a psychologist for case consultation.
- During the past year, Alliance implemented the Jiva platform for the Care Coordination Program to improve data analytics and monitoring.

Weaknesses

- *Procedure 2005, Identification, Referral, and Timely Initiation of MHSUD and IDD Care Coordination Functions,* does not include the functions of the MH/SU Care Coordinators.
- Complete Care Coordination files (e.g., I/DD assessments, notes, scheduled face to face visits) were not made available for this year's EQR Desk Review and/or Onsite Review.
- The Jiva screen shots and AlphaMCS records provided showed inconsistencies in frequency of contact, completeness and quality of documentation by Care Coordinators.
- The review of TCLI files showed the goals identified by members, such as employment, were not targeted on the Person Centered Plans.

- There are currently no TCLI materials designed for members with limited English proficiency.

Recommendations

- Add the functions of the MH/SU Care Coordinators to *Procedure 2005, Identification, Referral, and Timely Initiation of MHSUD and IDD Care Coordination Functions.*
- Develop a report that shows the full Care Coordination member record, including all assessments and Care Coordination interventions, in chronological order. This report could be used for audits, quality improvement interventions, court proceedings, etc.
- Enhance the current monitoring processes to ensure documentation is consistently and correctly entered into Jiva.
- Enhance the current monitoring process of Person Centered Plans to ensure TCLI members are receiving the support and quality of all services to address their identified needs.
- Design and make available TCLI materials for members with limited English proficiency.

F. Grievances and Appeals

Grievances

The External Quality Review (EQR) of Alliance's Grievance functions included the Desk Review of relevant policies and procedures, the *FY2018 QM Evaluation*, the *FY 2019 Quality Management Program Description*, the *Individual and Family Handbook*, the *Provider Operations Manual*, and 20 Grievance files. Onsite discussion with Alliance staff provided additional clarification around the Grievance process.

Grievances are managed by the Quality Management (QM) Department. The Director of QM oversees the Grievance and Incident Manager, and five Quality Assurance Analysts manage the day-to-day Grievance activities.

Alliance has a "No Wrong Door" process for the filing of a Grievance. When a concern is assigned to QM staff, the "Complainant" is contacted for clarification. This contact with the "Complainant" assists in determining whether the concern is a "Grievance" or a "Complaint". The Grievance and Incident Manager is well versed in the distinctions between Grievances and Complaints. It was also explained that the categorization of a concern can change as more information about the nature of the concern and the "Complainant" is obtained.

Procedure 6503, Management and Investigations of Grievances explains the process when the timeframe to resolve a Grievance is extended. However, the timeframes for the written and oral notifications of Grievance extensions are not aligned with the *DMA Contract* or federal regulations. *Procedure 6503* states, "Alliance shall communicate the extension to the consumer within one (1) business day either verbally or in writing. Verbal notifications shall be followed up in writing to the consumer." The extension process per the *DMA Contract, Attachment M* and *42 CFR § 438.408* states Alliance is required to provide, "prompt oral notice of the delay" and provide written notice "within 2 calendar days" that includes the "reason for the decision to the extend the timeframe". CCME recommends Alliance revise the language in *Procedure 6503* to align with the *DMA Contract* and federal regulations.

Per the Onsite discussion, Alliance is participating in cross functional workgroups to develop a Provider Dashboard. Staff report these efforts will lead to a more meaningful use of Grievance data.

Appeals

The EQR of Alliance's Appeals functions included 19 standard Appeal files, six expedited Appeal files, five State fair hearing files, Alliance's policies and procedures related to Appeals, the *Provider Operations Manual*, the *Individual and Family Handbook*, and other documentation related to Appeals such as Desk References and Alliance's website. During the Onsite, discussion with Alliance staff provided additional clarification of these documents and the Appeal process.

Alliance processed approximately 120 Medicaid Appeals during the year under review. The file review showed all Appeals, expedited and standard, were decided and notification to appellants sent within the required resolution timeframes. However, some of the internal notification requirements were not in compliance.

Review of the 19 standard Appeal files submitted for this EQR showed six (or 32%) of these files had acknowledgment letters that were sent to appellants outside of the "one business day" required in Alliance's *Procedure 3502, Due Process/Appeals of Medical Necessity Determinations*. Staff explained that compliance with timeliness of acknowledgment letters has been impacted by a lack of adequate Appeal staff "coverage". Additional staffing, per staff, has since been identified to assist with coverage. However, there is still a need to ensure any staff handling Appeals are trained on all requirements outlined in Alliance's procedures.

Alliance developed a *Communication Log* to capture details of oral and expedited Appeals. While staff could thoroughly describe the processes and purpose of this log, the file review showed *Communication Logs* were frequently incorrect or incomplete. For

example, one expedited Appeal was marked as standard on the *Communication Log*. In another file, staff did not document to whom Appeal staff provided oral notifications. There was also inconsistent documentation regarding the Chief Medical Officer (CMO) consultation around accepting or denying requests for expedited Appeals. As this *Communication Log* is often the only document that captures those steps and notifications required by federal regulations and *DMA Contract*, completeness and consistency of documentation is essential. Appeal Staff need additional training to ensure completeness and consistency of documentation.

Through the EQR, it was identified that minor revisions are also needed to Alliance's Appeal procedure, *Procedure 3502, Due Process/Appeals of Medical Necessity Determinations*. *DMA Contract, Attachment M, Section G.1* and *42 CFR § 438.400* requires the PIHP to define an Appeal as "the request for review of an adverse benefit determination." Alliance's Appeal procedure does not contain this updated definition of an Appeal. The procedure also still uses the word "action" when describing a service authorization decision. Both terms need to be updated within the procedure.

Who may file an Appeal is also unclear in the Appeal procedure. The procedure states, "A provider who has the member's written consent and is acting on his or her behalf can request the LME/MCO Level Appeal. Parties to the LME/MCO Level Appeal must include the member and his or her personal representative (which can be a provider, friend or family member even if not a guardian); or the legal representative of a deceased member's estate." *DMA Contract, Attachment M, Section G.1* and *42 CFR § 438.400*, define an appellant as "the Enrollee, legally responsible person, or a Provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent, may file a PIHP internal appeal." Alliance should clarify in their Appeal procedure that anyone other than the Enrollee or legal guardian can file and Appeal, if they have the Enrollee or legal guardian's written consent.

During the Onsite discussion, Alliance staff explained that extensions by Alliance to the Appeal resolution timeframe are rare. It was estimated that one Appeal had been extended in the previous year. While rare, staff still need explicit procedural guidance when extending Appeal timeframes.

Per *DMA Contract, Attachment M, Section G.5* and *6* and *42 CFR § 438.408 (c)(2)*, Appeal extension information is incomplete in Alliance's Appeal *Procedure 3502*. The elements missing from this procedure that are required by contract and federal regulations include the following:

- PIHP shall make reasonable efforts to give the Enrollee prompt oral notice of the delay

- The written notification of the extension must include the reason for the delay and that "to the satisfaction of DMA/upon DMA's request" that there is a need for information and how it is in the best interest of the Enrollee.

Procedure *3502, Due Process/Appeals of Medical Necessity Determinations* does not guide staff on how to release the Appeal record or full clinical rationale for the adverse benefit determination or Appeal decision. Alliance has procedures that detail appropriate steps staff should take prior to releasing Protected Health Information (PHI) (for example, *Procedure 3051*, Use and Disclosure-Accounting of Disclosures). Alliance needs to ensure staff follow the steps outlined in their procedures by either referencing specific PHI procedures or spelling out steps to protect PHI relative to Appeals.

Lastly, Alliance's *Provider Operations Manual* and the *IDD Care Coordination Desk Reference* need to be updated to state the Enrollee has 60 days to file an Appeal. Both documents still say the Enrollee has 30 days to file an Appeal, which was changed in July of 2017. Alliance's website, Appeal procedure, and the *Individual and Family Handbook* have the correct timeframe for filing an Appeal.

The *Figure 7* below indicates the scoring for Grievances and Appeals for 2018 compared to the scores received in the 2017 EQR.

Figure 7: Grievances and Appeals Comparative Findings

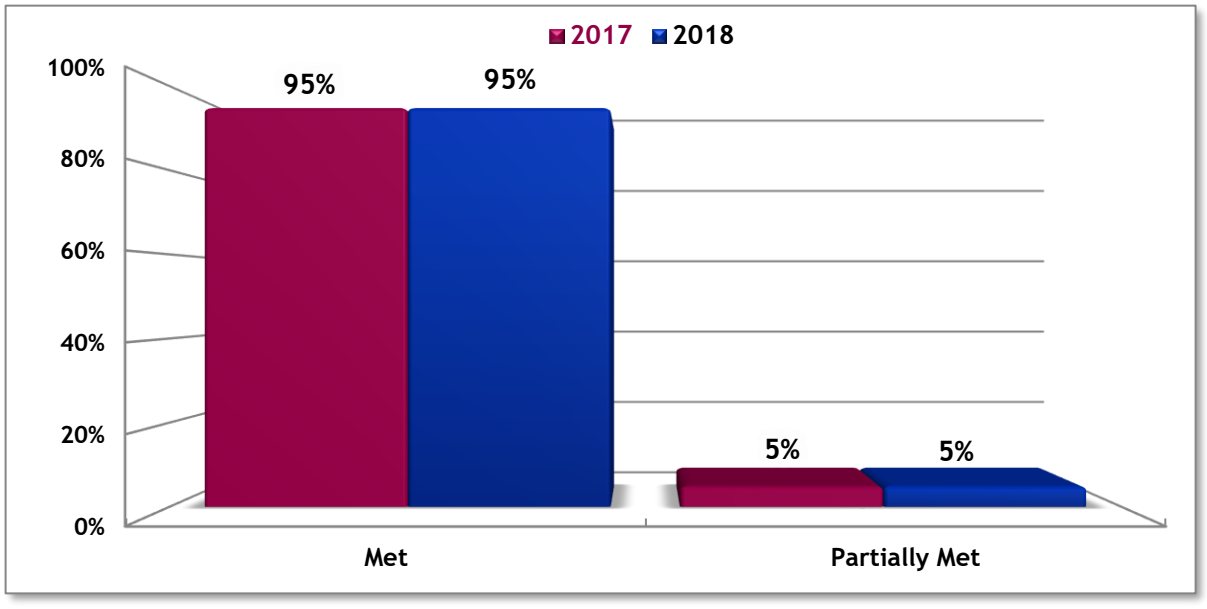


Table 23: Grievances and Appeals

Section	Standard	2018 Review
Appeals	The PIHP applies the appeal policies and procedures as formulated	**Partially Met**

Strengths

- Alliance is participating in cross functional workgroups to develop a Provider Dashboard. Staff report these efforts will lead to a more meaningful use of Grievance data. All Grievance files reviewed were processed within 90 days.
- Appeal staff are well versed in the contractual and regulatory requirements of processing Appeals.
- Appeal staff outreach and offer to provide assistance to each appellant throughout the Appeals process.

Weaknesses

- Language around Grievance extension notifications in Procedure 6503, Management and Investigations of Grievances is not aligned with DMA Contract and federal regulations.
- Review of the 19 standard Appeal files showed six (or 32%) of the Appeals had acknowledgment letters were sent to appellants outside of the "one business day" required in Alliance Appeals procedure.
- Communication Logs within the Appeal files reviewed were frequently incorrect or incomplete.
- Alliance's *Procedure 3502, Due Process/Appeals of Medical Necessity Determinations* does not contain this updated definition of an Appeal. The procedure also still uses the word "action" when describing a service authorization decision.
- Alliance should clarify in their Appeal procedure that anyone other than the Enrollee or legal guardian can file and Appeal, if they have the member's written consent.
- Per *DMA Contract, Attachment M, Section G.5 and 6*, Appeal extension information is incomplete in Alliance's Appeal *Procedure 3502*.
- *Procedure 3502* does not provide guidance to staff when they are releasing PHI (specifically, the full clinical rationale or the Appeal record).

- Some of Alliance's documents (e.g., the *Provider Operations Manual* and *IDD Care Coordination Desk Reference*) incorrectly say Enrollees have 30 days to file an Appeal.

Corrective Actions

- Ensure Appeal functions are adequately staffed to meet the acknowledgement timeframes required by Alliance Appeal procedure.
- Train staff on the processes for completing the Communication Log, including which sections within that document are required.

Recommendations

- Correct the language within *Procedure 6503, Management and Investigations of Grievances* around notifications of extensions to the Grievance resolution timeframes. Language should clarify that, per *DMA Contract, Attachment M* and *42 CFR § 438.408*, Alliance is required to provide "prompt oral notice of the delay" and provide written notice "within 2 calendar days". The written notice should also include the "reason for the decision to the extend the timeframe".
- Monitor and ensure that the Appeal acknowledgment letters are sent within the timeframes indicated in the Alliance *Procedure 6503* and *Procedure 6504*.
- Using the language within *Attachment M* of the *DMA Contract*, update Alliance's *Procedure 3502, Due Process/Appeals of Medical Necessity Determinations*, to reflect the definition of an Appeal as "the request for review of an adverse benefit determination."
- Include in this procedure the definition of an adverse benefit determination and clarify who can file an Appeal.
- Add to Appeals *Procedure 3502,* under the section discussing Appeal extensions the following:
    - that Alliance shall make "reasonable efforts" to give the Enrollee prompt oral notice of the delay
    - that the written notification to the Enrollee of the extension must include the reason for the delay
- Also include in *Procedure 3502* that staff, when Alliance extends the Appeal resolution timeframe, will document in the Appeal record why there is a need for additional information and how the extension is in the best interest of the Enrollee. This will address the requirement of having the ability to demonstrate to NC Medicaid the justification for the extension.

- Either reference in *Procedure 3502, Due Process/Appeals of Medical Necessity Determinations* specific Alliance PHI procedures to guide staff in releasing Appeal records or spell out the steps staff should take prior to releasing PHI.
- Update any documentation discussing Appeals to reflect the Enrollee has 60 days to file an Appeal.

G. Delegation

CCME's External Quality Review (EQR) of Delegation functions includes a review of the submitted Delegate List, Delegation Contracts, and Delegation Monitoring materials.

The *Delegated Contract Program Description*, *Procedure 1518, Purchasing and Vendor Contracts*, and *Procedure 4014, Monitoring of Any Delegated Call Center Functions*, guide delegation and the delegate monitoring processes.

Alliance reported five current delegation agreements, as indicated in *Table 24* that follows. Two additional delegation agreements ended on June 30, 2018. Alliance does not delegate any credentialing functions.

Table 24: Delegated Entities

Delegated Entities	Service
ProtoCall Services, Inc. (Current through 06/30/19)	Overflow call center service for 24/7/365 Alliance ACCESS and information call center
AC Eller, LLC (Current through 06/30/19)	Performs Supports Intensity Scale® (SIS) assessments as needed
Klutz Healthcare Consulting (Current through 06/30/19)	Performs Supports Intensity Scale® (SIS) assessments as needed
Realon Consulting Services (Current through 06/30/19)	Performs Supports Intensity Scale® (SIS) assessments as needed
Prest & Associates (Current through 06/30/19)	Peer Review services as needed
Quality Approaches, LLC (Contract ended 06/30/18)	Performed SIS assessments as needed
Johnston County LME (Contract ended 06/30/18)	Subcontract for certain MCO functions under *NCGS 122C-115.1*

During the Onsite discussion, Jeff Payne, Senior Director, Care Coordination, reported the Supports Intensity Scale® (SIS) Assessment delegates are monitored by Alliance's SIS Team Leader, who is a SIS Certified Mentor Trainer. Monitoring includes review of the

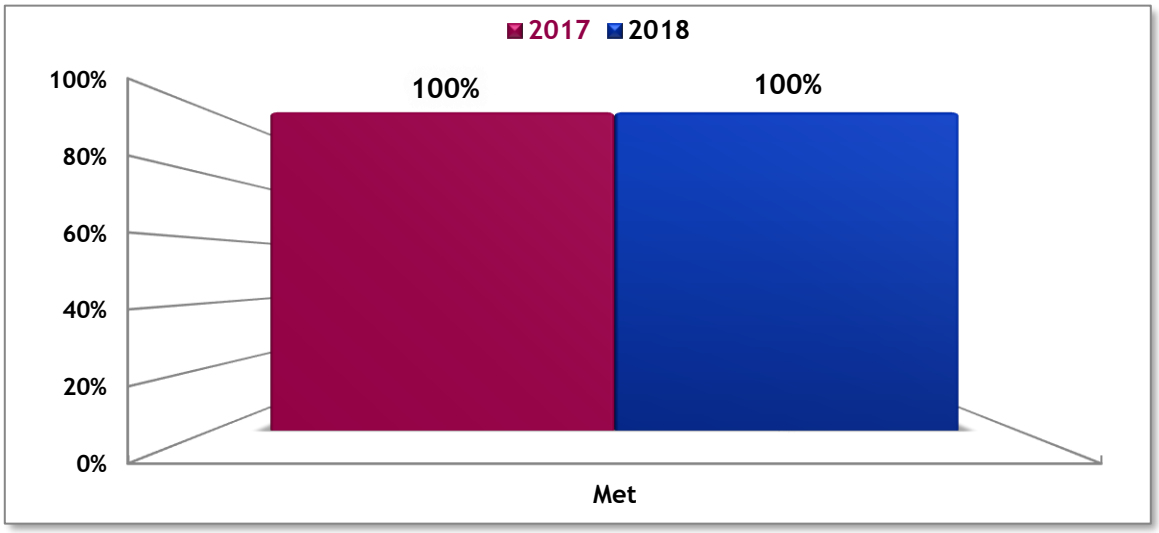
annual report of Inter-Rater Reliability (IRR) conducted by the assessors. Alliance submitted SurveyMonkey® results of "member experience with the evaluator."

Call Center Overflow (answering calls that Alliance has not answered within 30 seconds) is delegated to ProtoCall. ProtoCall submits monthly phone metrics reports, which are reported to the Utilization Management (UM) Committee. Alliance's Speed to Answer averages six seconds. ProtoCall has struggled to meet call standards, and Alliance has worked with them to improve their statistics. ProtoCall is now averaging answering less than 30 calls per month. Alliance is continuing to explore locating an alternate vendor or other options for these calls.

Alliance staff reported Prest is Utilization Review Accreditation Commission (URAC)-Accredited and conducts their own IRR. April Parker, Licensed Professional Counselor (LPC), Alliance Director of UM, is responsible for receiving, reviewing, and overseeing Prest's IRR reports. Alliance staff presented a Delegation Review to the UM Committee in October 2018. At the November 2018 meeting, the Global Quality Management Committee "Reviewed QM's 2nd level review of UM's monitoring efforts" of Prest.

Alliance "Met" both Delegation requirements. The following chart illustrates a comparison of the percentage scores for 2017 and 2018.

Figure 8: Delegation Comparative Findings



Strengths

- Alliance currently has an executed Delegation Agreement with five delegates, including Business Associate Agreements with those delegates that have access to Protected Health Information (PHI).

- Alliance conducts periodic delegation monitoring and presents results to relevant committees.

Weaknesses

- The executed Amendments extending the term of the Delegation Agreements include the statement "Contractor shall review and adhere to the related Alliance policies/ procedures in the Original Agreement" rather than referencing and including the current related Alliance policies and procedures.

Recommendations

- Revise the Delegation Agreement Amendment language that references adhering to the "related Alliance policies/procedures in the Original Agreement," and include and reference the current relevant Alliance policies and procedures.

H. Program Integrity

As required by its contract with CCME, IPRO assesses PIHP compliance with federal and state regulations on Program Integrity (PI) functions.

IPRO's review of Alliance began in February 2019 with an offsite review of Alliance's PI files and documentation. IPRO analyzed the files and documentation and conducted onsite interviews on March 7, 2019 with the Compliance and PI Managers to review the offsite documentation and file review findings.

File Review

IPRO requested the universe of PI files from Alliance for the January 2018 through December 2018 review period and, from there, selected a random sample of 15 files with a two-file oversample for a total of 17 files.

Contract Requirement: In each case where the PIHP investigates a credible allegation of fraud, the PIHP shall provide DMA Program Integrity with the following information on a DMA approved template:

- Subject (name, Medicaid provider ID, address, provider type)
- Source/origin of complaint
- Date reported to the PIHP or, if developed by the PIHP, the date the PIHP initiated the investigation
- Description of the suspected intentional misconduct, with specific details including: the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated, and dates of suspected misconduct

- Amount paid to the provider for the last three years or during the period of the alleged misconduct, whichever is greater
- All communications between the PIHP and the provider concerning the conduct at issue, when available
- Contact information for PIHP staff persons with practical knowledge of the workings of the relevant programs
- Sample/exposed dollar amount, when available

Findings: Fifteen of 15 files contained the requirements (or were non applicable).

Contract Requirement: In each case of suspected Enrollee fraud, the PIHP shall provide DMA program integrity with:

- The Enrollee's name, birth date, and Medicaid number
- The source of the allegation
- The nature of the allegation
- Copies of all communications between the PIHP and the provider concerning the conduct at issue
- Contact information for PIHP staff persons with practical knowledge of the allegation
- The date reported to the State
- The legal and administrative status of the case

Findings: No cases under review involved suspected Enrollee fraud.

Documentation

IPRO conducted an offsite review of Alliance's documentation to assess the PIHP's compliance with federal and state regulations and the PIHP's contract with NC Medicaid (formerly the Division of Medical Assistance, or DMA). The documentation review included Alliance's policies, procedures, training materials, organizational charts, job descriptions, committee meeting minutes and reports, provider agreements, enrollment application, workflows, *Provider Operations Manual*, Employee Handbook, newsletters, conflict of interest forms and the *Corporate Compliance Plan*. This information was reviewed under three topic areas: General Requirements, Fraud and Abuse, and Provider Payment Suspensions. IPRO conducted Onsite interviews on March 7, 2019 with the Compliance and PI Managers to discuss the findings within the Desk Materials and PI files.

General Requirements

Findings: All *DMA Contract* requirements were addressed in Alliance's documentation.

Fraud and Abuse

Findings: No evidence was found within Alliance policies and procedures that addresses the requirement found in *DMA Contract, Section 14.2.4,* which states, "PIHP shall participate in quarterly Program Integrity meetings with DMA Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the NC Department of Justice ("MFCU/ MID')." In addition, Alliance did not provide any record of attendance at the quarterly meetings.

During the review of the fifteen PI case files it was identified that, although all required elements could be found in the PI files, there is room to improve file documentation with a single executive summary page. Examples of data elements to include in the summary are provider name, National Provider Identification (NPI) number, Special Investigative Unit (SIU) contact person and estimated amount exposed (or recoupment amount).

Provider Payment Suspensions

Findings: No evidence was found within Alliance policies and procedures that addresses the requirement found in *DMA Contract, Section 14.3.1 (d)* which states, "In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension."

Also missing from policies and procedures was language explaining the payment suspension requirements found in *DMA Contract, Section 14.3.2* which states, "Upon receipt of a payment suspension notice from DMA Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of DMA Program Integrity's suspension and lasting until PIHP is notified by DMA Program Integrity in writing that the suspension has been lifted."

Figure 9 demonstrates that Alliance "Met" 96% of the EQR standards and provides a comparative to the 2017 Program Integrity EQR scores.

Figure 9: Program Integrity Findings

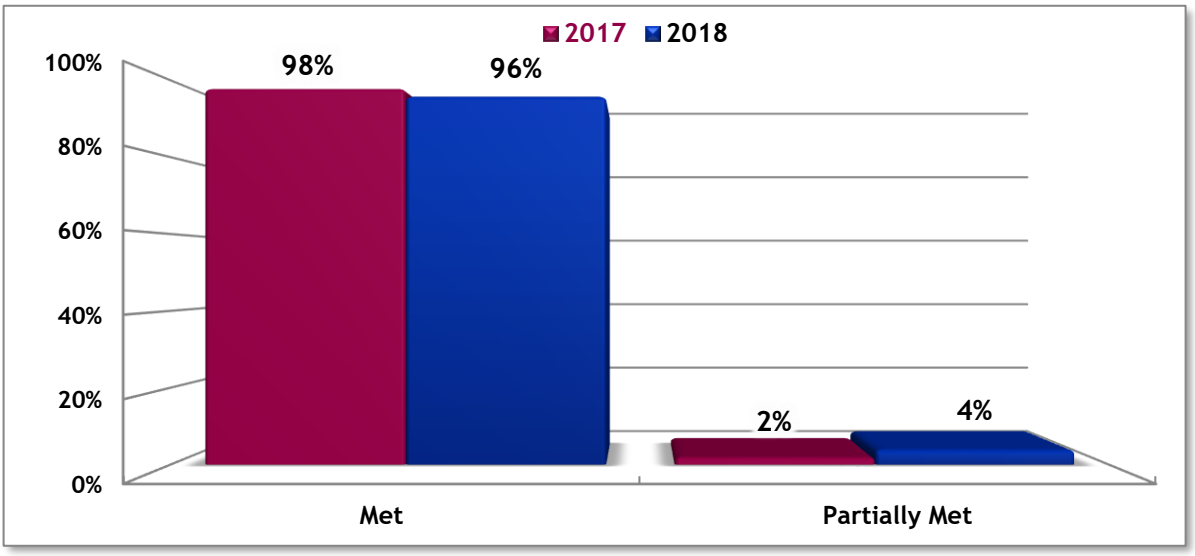


Table 25: Program Integrity

Section	Standard	2018 Review
Provider Payment Suspensions and Overpayments	In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension	Partially Met
	Upon receipt of a payment suspension notice from DMA Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of DMA Program Integrity's suspension and lasting until PIHP is notified by DMA Program Integrity in writing that the suspension has been lifted	Partially Met

Strengths

- Alliance's PI Unit is well versed in the contractual language that governs their work.
- Alliance implemented several successful data mining initiatives that uncovered potential incidents of fraud, waste, or abuse.
- Alliance's training program engages employees and providers through games, puzzles, and case studies.

Weaknesses

- Procedure wording is not fully compliant with the relevant sections of the *DMA Contract* that require Alliance to participate in Quarterly PI meetings with the State, lift payment suspensions and impose payment suspensions, as instructed by the State.
- PI file documentation lacks a single unifying executive summary section that captures all the key data points such as provider name, NPI, dates, financial exposure, or potential recoupment amount.

Corrective Actions

- Add specific language to procedures that addresses payment suspension requirements. *See DMA Contract, Section 14.3.2* which states, "In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension."
- Add specific language to procedures that addresses requirements for lifting payment suspension. See *DMA Contract, Section 14.3.2* which states, "Upon receipt of a payment suspension notice from DMA Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of DMA Program Integrity's suspension and lasting until PIHP is notified by DMA Program Integrity in writing that the suspension has been lifted."

Recommendation

- Add specific language to procedures that addresses the requirement that Alliance attend quarterly PI meetings with the state. See DMA Contract, Section 14.2.4 which states, "PIHP shall participate in quarterly Program Integrity meetings with DMA Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the NC Department of Justice ("MFCU/ MID')." In addition, Alliance should maintain a record of attendance at the quarterly meetings, either through saved emails (or screen shots), or attendance sheets.

- Alliance's final investigation report template has an example of an executive summary section at the beginning. Alliance could move to a similar format in investigation summaries and other interim documents so that the information is available in one place throughout the process. Also, financial information such as exposed amount could be added to summary.

I. Financial Services

The External Quality Review (EQR) of Alliance Financial functions included review of the following Alliance Desk Review Materials before the Onsite visit:

- Financial policies and procedures
- Audited financial statements dated June 30, 2018
- Balance sheet and income statements dated November 30, 2018 and December 31, 2018
- Medicaid monthly financial reports for November and December 2018
- Reconciliation process for claims system with accounting system and data warehouse
- Fiscal year budget for 2018-2019
- Budget to actual expenses report for November 2018 and December 2018

After reviewing Alliance's Desk Review Materials, an Onsite visit and interview were held at Alliance's office on March 7, 2019. In reviewing Alliance's financial operations, CCME used a Standardized EQR Finance Desk Review and Onsite Administrative Interview Guide. CCME determined if deficiencies noted in prior EQRs were corrected. In addition to the standardized Desk Review inquiries, CCME asked interview questions in the following areas:

- Policies and procedures
- Staffing changes in finance
- Budget variances and development
- Board of Directors' financial role
- Any audit findings/Corrective Action Plans

The EQR of Alliance's financial services identified a need to change *Procedure 3016, Records Retention and Destruction* to reflect retention for ten (10) years of all Medicaid records, in accordance with *DMA Contract, Section 8.3.2*.

Alliance demonstrates overall financial stability. Alliance's audit report dated June 30, 2018 received an unqualified audit opinion. There was one nonmaterial, noncompliance finding from the audit and a Corrective Action/Mitigation Plan was implemented. This was corrected by transitioning responsibility for the program to their Care Coordination Department. During fiscal year 2018, Alliance's total net position decreased by $8.6 million from the prior fiscal year, for a total net position at year end of $112 million, and total assets of $156 million.

Alliance exceeded NC Medicaid benchmarks for current ratio and medical loss ratio (MLR). Alliance's Medicaid current ratio was 2.67 with a total current ratio of 1.92 for December 2018. The Medicaid current ratio was 2.73 with a total current ratio of 1.97 for November 2018 (benchmark is 1.00). Alliance's Medicaid MLR was 86.8% fiscal year to date at December 31, 2018 before Health Care Quality Improvement (HCQI) activities, and 90.2% including these activities (benchmark is 85%). Alliance's Medicaid total assets on November 30, 2018, were $148,506,988, and overall total assets were $159,117,458. At December 31, 2018, Alliance's Medicaid total assets were $164,915,117, and overall total assets were $173,098,089. Alliance is monitoring their MLR monthly to ensure it exceeds the 85% benchmark.

Alliance meets standard *42 CFR § 433.32(a)* for maintaining an appropriate accounting system (Great Plains Dynamics). Great Plains 2015 modules used are purchasing, general ledger, accounts payable, and fixed assets. Alliance uses Wellsky's AlphaMCS for claims processing. There were no major financial upgrades or changes, except for engaging a new payroll service, Ultipro.

Alliance meets the minimum record retention of ten years that is required by standard *DMA Contract Section 8.3.2*. Alliance's *Procedure* 3016, *Records Retention and Destruction* addresses Alliance's plan for record storage, and Alliance stated during the interview that they are following the NC Department of Health and Human Services' (NC DHHS) records retention schedule. Alliance should change *Procedure 3016* to reflect ten (10) years for all Medicaid records, in accordance with *DMA Contract, Section 8.3.2*.

Alliance reviews their policies and procedure and modifies them, if necessary, annually. All finance policies reviewed by CCME had review dates within a year. Policies were detailed, and they included *DMA Contract* references, CFR *references, and Utilization Review Accreditation Commission (URAC) Standards*. Policies are updated by their owners. Alliance uses Compliance 360, which automates the policy and procedure update process and assists in workflow and communication. Alliance notifies staff via email and by communication in meetings if there are policies that require their review.

Alliance's Cost Allocation Plan meets the requirements for allocating the administrative costs between Medicaid, non-Medicaid, federal, state, and local entities based on revenue as required by *42 CFR § 433.34*. There were no costs disallowed per the audit report and Onsite interview. Annually, Alliance submits a Cost Allocation Plan prepared by the Senior Accountant to NC Medicaid to determine the percentage to be used monthly for allocation of Medicaid's share of administrative costs. Currently this percentage is 82.97%. The administrative expenses not specific to a funding source are recorded by journal entry monthly. Alliance's Medicaid funds are properly segregated through the chart of accounts in the general ledger of Great Plains. In addition, Alliance's

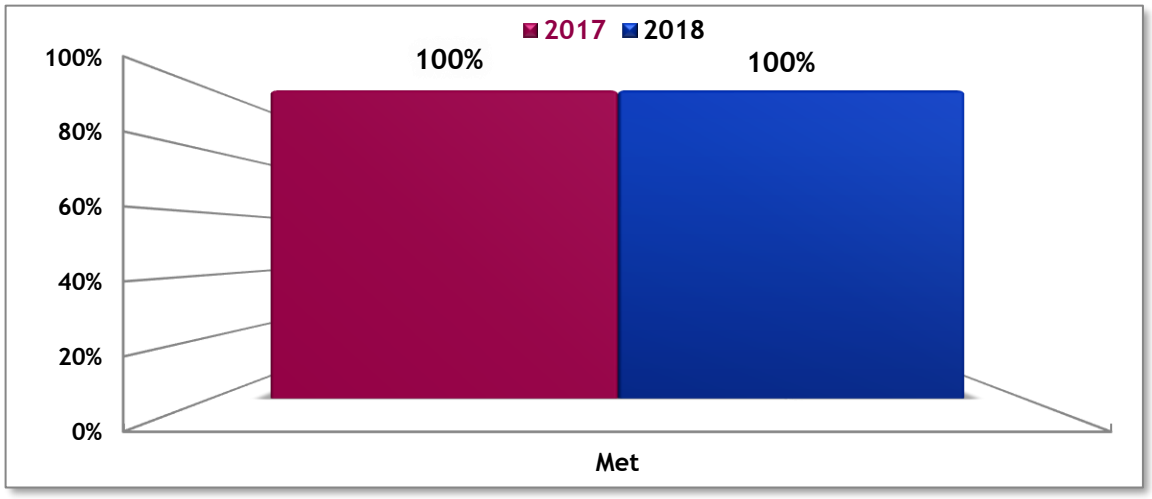
Procedure 2219, Accounting by Funding Source, addresses the segregation of funds by funding source.

Alliance's Medicaid risk reserve account meets the minimum requirement of 2% of the capitation payment per month required by *DMA Contract, Section 1.9*. Alliance reached 10.8% of their required percentage of annualized capitation maximum (15%) on December 31, 2018, with a balance of $47,315,494. Once the capitation payment is received from NC Medicaid, the Accountant calculates the risk reserve payment, which is reviewed by the Accounting Manager and paid electronically to Wells Fargo Bank by Finance staff within five business days of the capitation payment. All deposits were timely and there were no unauthorized withdrawals. Alliance provided CCME with bank statements demonstrating the risk reserve balance and deposits, which were made timely. Alliance documents their risk reserve process in *Procedure 1506, Risk Reserve Account*.

The prior EQR recommended Alliance develop a formal policy or procedure to document the allocation of administrative costs. Alliance developed *Procedure 1540, Cost Allocation*. This procedure satisfactorily documents Alliance's cost allocation method.

Figure 10, Financial Findings, shows that 100% of the standards in this section were scored as "Met." *Figure 10* provides an overview of 2017 scores compared to 2018 scores.

Figure 10: Financial Findings



Strengths

- Alliance holds a strong financial position, as demonstrated by their key Medicaid financial ratios.
- Medicaid reports were all filed timely within the EQR period.

- Alliance procedures were clear and up-to-date. Their procedure on *Management of Financial Risk, 1514,* details all that Alliance does to monitor ratios and financial reports to identify and reduce financial risk.

Weaknesses

- *Procedure 3016, Records Retention and Destruction* does not reflect that all Medicaid records are maintained for ten years.

Recommendations

- Revise *Procedure 3016, Records Retention and Destruction*, to reflect that all Medicaid records are retained for ten years. See *DMA Contract, Section 8.3.2*.

J. Encounter Data Validation

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

The scope of the EQR Encounter Data Validation review, guided by the *CMS Encounter Data Validation Protocol*, was focused on measuring the data quality and completeness of claims paid by Alliance for the period of January 2017 through December 2017. All claims paid by Partners should be submitted and accepted as a valid encounter to NC Medicaid. Our approach to the review included:

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

Results and Recommendations

Issue: Procedure Code

The procedure code for Institutional claims should populated 99% of the time. In the encounter data provided, HMS found that the field was populated 59% of the time with valid values; in all other instances the value was null. Valid procedure codes are needed to better understand the services provided and are usually required to adjudicate the claim appropriately. Given the types of services provided, the provider should have provided additional procedure codes in support of the line level revenue code supplied.

Resolution

Alliance should ensure that the appropriate data validation checks and that claims submitted through their portal or an 837 should be denied by Alliance without the proper revenue code and procedure code combination. Alliance should review their 837 encounter creation and encounter data extract process to ensure that an invalid procedure code is not transmitted to DHB, even when the data is invalid based on the provider claim submission.

Issue: Diagnosis Codes

The secondary diagnosis was not populated at all for Institutional claims. This value is not required by Alliance when adjudicating the claim, therefore, not a requirement of the provider when submitting via Provider Portal or 837.

Resolution

Alliance should work closely with their provider community and encourage them to submit all applicable diagnosis codes, behavioral and medical. This information is key for measuring member health, identifying areas of risk, and evaluating quality of care. Alliance did confirm that they are capturing additional diagnosis codes and made changes to report them to DHB in their encounter submission in 2018. HMS will validate this update in our 2018 encounter data review.

Conclusion

Based on the analysis of Alliance's encounter data, we have concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues still exist with their submission of Institutional encounters and need to be addressed in order to be compliant. Alliance should take corrective action to resolve the issues identified with procedure code and diagnosis codes, as well as continue to work on improving all up front denials. They have outlined a great approach and implemented several key practices to ensure that their front end denials continue to go down as well as their total outstanding encounter denials. It is HMS's expectation that Alliance will be able to demonstrate accurate and complete data for encounters submitted in 2018 and moving forward.

For the next review period, HMS is recommending that the encounter data from NCTracks be reviewed to look at encounters that pass front-end edits and are adjudicated to either a paid or denied status. It is difficult to reconcile the various tracking reports with the data submitted by the LME/MCO. Reviewing an extract from NCTracks would provide insight into how the State's MMIS is handling the encounter claims and could be reconciled back to reports requested from Alliance. The goal is to ensure that Alliance is reporting all paid claims as encounters to NC Medicaid.The complete Encounter Data Validation Report can be found as *Attachment 5*.

A. Initial Notice, Materials Requested for Desk Review

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

January 16, 2019

Mr. Rob Robinson
Chief Executive Officer
Alliance Behavioral Healthcare
5200 Paramount Pkwy
Morrisville, NC 27560

Dear Mr. Robinson,

At the request of the Department of Health and Human Services and NC Medicaid, this letter serves as notification that the 2018 External Quality Review (EQR) of Alliance Behavioral Healthcare (Alliance) is being initiated. The review will be conducted by us, The Carolinas Center for Medical Excellence (CCME), and is a contractual requirement. The review will include both a desk review (at CCME) and a two-day onsite visit at Alliance's office in Morrisville, North Carolina that will address all contractually required services.

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

The CMS EQR protocols can be found at:

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

The CCME EQR review team plans to conduct the onsite visit at Alliance on **March 6, 2019** through **March 7, 2019**. For your convenience, a tentative agenda for the two-day review is enclosed.

In preparation for the desk review, the items on the enclosed **Materials Requested for Desk Review** list are to be submitted electronically, and are due no later than **February 6, 2019**. As indicated in item 42 of the review list, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted by the aforementioned deadline.

Further, as indicated on item 44 of the list, Encounter Data Validation (EDV) will also be part of this review. Our subcontractor, Health Management Systems (HMS) will be evaluating this component. Please read the documentation requirements for this section carefully and make note of the submission instructions, as they differ from the other requested materials.

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

The location for the file transfer site is:

https://eqro.thecarolinascenter.org

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 5

Cc: Ken Marsh, Alliance Contract Manager
Renee Rader, NC Medicaid Quality Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager

External Quality Review 2018

MATERIALS REQUESTED FOR DESK REVIEW

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

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

3. Current Medical Director, medical staff job descriptions.

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

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

6. A summary of the status of all best practice recommendations and corrective action items from the previous External Quality Review.

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

8. List of new services added to the provider network in the past 12 months (January 2018 – December 2018) by provider.

9. List of executed single case agreements by provider and level of care during the past 12 months (January 2018 – December 2018).

10. Network turnover rate for the past 12 months (January 2018 – December 2018) including a list of providers that were terminated by cause and list of providers that did not have their contracts renewed. For five providers termed in the last 12 months (January 2018 – December 2018), who were providing service to enrollees at the time of the termination notice, submit the termination letter to or from the provider, and the notification (of provider termination) letters sent to three consumers who were seeing the provider at the time of the termination notice.

11. List of providers credentialed/recredentialed in the last 12 months (January 2018 – December 2018).

12. A current provider manual and provider directory.

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

14. The Quality Improvement work plans for 2017 and 2018.

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

16. Minutes of committee meetings for the months of January 2018 – December 2018 for **all** committees reviewing or taking action on enrollee-related activities. For example, quality committees, quality subcommittees, credentialing committees, compliance committee, etc.

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

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

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

19. Copies of the most recent provider profiling activities conducted to measure contracted provider performance.

20. Results of the most recent office site reviews, record reviews and a copy of the tools used to complete these reviews.

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

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

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

24. A copy of the Grievance, Complaint and Appeal logs for the months of January 2018 – December 2018. Please indicate the disability type (MH/SA, I/DD) and whether the enrollee is in the TCLI program for each entry.

25. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

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

27. Practice guidelines developed for use by practitioners, including references used in their development, when they were last updated and how they are disseminated. Also, policies and procedures for researching, selecting, adopting, reviewing, updating, and disseminating practice guidelines.

28. All information supplied as orientation to new providers, including a copy of the provider handbook or manual.

29. A copy of the provider contract/application.

30. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the PIHP, and any reports of activities submitted by the subcontractor to the PIHP. Also, completed evaluations of entities conducted before delegation is granted.

31. Contracts for all delegated entities.

32. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used. Include annual evaluation, if applicable.

33. Please provide an excel spreadsheet with a list of enrollees that have been placed in care coordination since April 2015. Please indicate the disability type (MH/SA, I/DD).

34. Please provide an excel spreadsheet with a list of enrollees that have been placed in the TCLI program since April 2015. Please include the following: number of individuals transitioned to the community, number of individuals currently receiving Care Coordination, number of individuals connected to services and list of services receiving, number of individuals choosing to remain in ACH connected to services and list of services receiving.

35. Information regarding the following selected Performance Measures:

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

C WAIVER MEASURES	
Proportion of Level of Care evaluations completed at least annually for enrolled participants	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals

C WAIVER MEASURES	
Proportion of Level of Care evaluations completed using approved processes and instrument	Proportion of Individual Support Plans that address identified health and safety risk factors
Proportion of New Level of Care evaluations completed using approved processes and instrument	Percentage of participants reporting that their Individual Support Plan has the services that they need
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Proportion of individuals for whom an annual plan and/or needed update took place
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval

Required information includes the following for each measure:

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

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

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

37. Summary description of quality oversight of the Transition to Community Living Initiative, including monitoring activities, performance metrics, and results.
38. Data and/or reports for the Transition to Community Living Initiative (e.g., numbers of in-reach completed, housing slots filled, completed transitions, numbers of enrollees in supported employment, numbers of enrollees assigned to assertive community treatment [ACT], etc.) for the period January 2018 – December 2018.
39. Call performance statistics for the period of January 2018 – December 2018, including average speed of answer, abandoned calls, and average call/handle time for customer service representatives (CSRs).
40. Provide electronic copies of the following files:
    a. Credentialing files for 12 most recently credentialed practitioners (should include 6 licensed practitioners who work at agencies and 6 Licensed Independent Practitioners, include at least two physicians). Please also include four files for network provider agencies and/or hospitals and/or psychiatric facilities, in any combination. The credentialing files should include all of the following:

Proof of all insurance coverages. For practitioners joining already-contracted agencies, include copies of the insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.	Notification of the effective date of credentialing.
Site visit reports. If practitioner is joining an agency that previously had a site visit, include the report; for licensed sites, include verification of DHSR licensure for the site.	Ownership disclosure information/form

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

The Recredentialing files should include all of the following:

Proof of original credentialing date and all recredentialing dates, including the current recredentialing	Site visit/assessment reports, if the provider has had a quality issue or a change of address.
Proof of all insurance coverages .For practitioners who are employed at already-contracted agencies, include copies of the insurance coverages for the agency, and verification that the practitioner is covered under the plans.	Ownership disclosure information/form

The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.	

c. Ten MH/SA, ten I/DD and five TCLI files medical necessity approvals made from January 2018 – December 2018, including any medical information and approval criteria used in the decision. Please select MEDICAID ONLY files and submit the entire file.

d. Ten MH/SA, ten I/DD and five TCLI files medical necessity denial files for any denial decisions made from January 2018 – December 2018. Include any medical information and physician review documentations used in making the denial determination. Please include all correspondence or notifications sent to providers and enrollees. Please select MEDICAID ONLY files and submit the entire file.

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

41. Provide the following for Program Integrity:
    a. File Review: Please produce a listing of all active files during the review period (January 2018 – December 2018) including:
        i. Date case opened
        ii. Source of referral
        iii. Category of case (enrollee, provider, subcontractor)
        iv. Current status of the case (opened, closed)
    b. Program Integrity Plan and/or Compliance Plan.
    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.
    e. All 'Attachment Y' reports collected during the review period.
    f. Provider Manual and Provider Application.
    g. Enrollee Handbook.
    h. Subcontractor Agreement/Contract Template.
    i. Training and educational materials for the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
    j. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse.
    k. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees.
    l. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to DMA or any other State or Federal agency.
    m. Code of Ethics and Business Conduct.
    n. Internal and/or external monitoring and auditing materials.
    o. Materials pertaining to how the PIHP captures and tracks complaints.

p. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
    i. DMA approved reporting templates.
q. Sample Data Mining Reports.
r. DMA Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
s. Monthly reports of NCID holders/FAMS-users in PIHP.
t. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
u. Corrective action plans including any relevant follow-up documentation.
v. Policies/Procedures for:

    i. Program Integrity
    ii. HIPAA and Compliance
    iii. Internal and external monitoring and auditing
    iv. Annual ownership and financial disclosures
    v. Investigative Process
    vi. Detecting and preventing fraud
    vii. Employee Training
    viii. Collecting overpayments
    ix. Corrective Actions
    x. Reporting Requirements
    xi. Credentialing and Recredentialing Policies
    xii. Disciplinary Guidelines

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

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

DMA Submissions	2b	Workflow for DMA denials
DMA Submissions	2e	DMA outstanding claims report

c. A copy of the IT Disaster Recovery Plan.

d. A copy of the most recent disaster recovery or business continuity plan test results.

e. An organizational chart for the IT/IS staff and a corporate organizational chart that shows the location of the IT organization within the corporation.

43. Provide the following for Financial Reporting:

a. Most recent annual audited financial statements.

b. Most recent annual compliance report

c. Most recent two months' State-required DMA financial reports.

d. Most recent two months' balance sheets and income statements including associated balance sheet and income statement reconciliations.

e. Most recent months' capitation/revenue reconciliations.

f. Most recent reconciliation of claims processing system, general ledger, and the reports data warehouse. Provide full year reconciliation if completed.

g. Most recent incurred but not reported claims medical expense and liability estimation. Include the process, work papers, and any supporting schedules.

h. Any other most recent month-end financial/operational management reports used by PIHP to monitor its business. Most recent two months' claims aging reports.

i. Most recent two months' receivable/payable balances by provider. Include a detailed list of all receivables/payables that ties to the two monthly balance sheets.

j. Any P&Ps for finance that were changed during the review period.

k. PIHP approved annual budget for fiscal year in review.

l. P&Ps regarding program integrity (fraud, waste, and abuse) including a copy of PIHP's compliance plan and work plan for the last twelve months.

m. Copy of the last two program integrity reports sent to DMA's Program Integrity Department.

n. An Excel spreadsheet listing all of the internal and external fraud, waste, and abuse referrals, referral agent, case activity, case status, case outcome (such as provider education, termination, recoupment and recoupment amount, recoupment reason) for the last twelve months.

o. A copy of PIHP's Special Investigation Unit or Program Integrity Unit Organization chart, each staff member's role, and each staff member's credentials.

p. List of the internal and external program integrity trainings delivered by PIHP in the past year.

q. Description and procedures used to allocate direct and overhead expenses to Medicaid and State funded programs, if changed during the review period.

r. Claims still pending after 30 days.

s. Bank statements for the restricted reserve account for the most recent two months.

t. A copy of the most recent cost allocation plan.

u. A copy of the PIHP's accounting manual.

v. A copy of the PIHP's general ledger chart of accounts.

w. Any finance Corrective Action Plan

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

i. Total incurred claims
ii. Expenditures on quality improvement activities
iii. Expenditures related to PI requirements under §438.608
iv. Non-claims costs
v. Premium revenue
vi. Federal, state and local taxes, and licensing and regulatory fees
vii. Methodology for allocation of expenditures
viii. Any credibility adjustment applied
ix. The calculated MLR
x. Any remittance owed to State, if applicable
xi. A comparison of the information reported with the audited financial report required under §438.3 (m)
xii. The number of member months

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

a. Include all adjudicated claims (paid and denied) from January 1, 2017 – December 31, 2017. Follow the format used to submit encounter data to DMA (i.e., 837I and 837P). If you archive your outbound files to DMA, you can forward those to HMS for the specified time period. In addition, please convert each 837I and 837P to a pipe delimited text file or excel sheet using an EDI translator. If your EDI translator does not support this functionality, please reach out immediately to HMS.

b. Provide a report of all paid claims by service type from January 1, 2017 – December 31, 2017. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

NOTE: EDV information should be submitted via the secure FTP to HMS. This site was previously set up during the first round of Semi-Annual audits with HMS. If you have any questions, please contact Nathan Burgess of HMS at (919) 714-8476.

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2018

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were uploaded.
2. Credentialing or recredentialing items for providers identified on the *Supplemental Documentation list*, for information obtained during the credentialing/ recredentialing process.
3. Evidence that the monthly financial reports were submitted timely to NC Medicaid in November and December of 2018.
2. Alpha screenshots showing when the provider was notified of the Appeal outcome for the Appeals listed on the *Supplemental Documentation List*.

All items can be uploaded on the CCME File Transfer Site (folder 49, Other Info):

https://eqro.thecarolinascenter.org

C. Attachment 3: EQR Validation Worksheets

- Performance Improvement Project Validation Worksheet
  - Access to Care-Routine/Urgent
  - TCLI Housing Turn-Around Time
  - Access to Care-Emergent
  - Care Coordination Clinical Contacts

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

- Innovations (C Waiver) Performance Measures Validation Worksheet
  - Innovations Measure: Level of Care Evaluation
  - Innovations Measure: Level of Care Evaluations Completed Using Approved Processes and Instruments
  - Innovations Measure: New Level of Care Evaluations Completed Using Approved Processes and Instruments
  - Innovations Measure: Proportion of Providers That Implemented an Approved Corrective Action Plan
  - Innovations Measure: Proportion of Providers Wherein All Staff Completed Mandated Training
  - Innovations Measure: Proportion of ISPs in which Services and Supports Reflect Participant Assessed Needs and Life Goals
  - Innovations Measure: ISPs Address Identified Health and Safety Risk Factors
  - Innovations Measure: Participants Reporting That ISP Has Services They Need
  - Innovations Measure: Individuals for Whom an Annual ISP and/or Needed Updates Took Place
  - Innovations Measure: New Waiver Participants are Receiving Services According to ISP within 45 Days of Approval

CCME EQR PIP Validation Worksheet

PIHP Name:	**ALLIANCE**
Name of PIP:	**ACCESS TO CARE: ROUTINE/URGENT CALLERS (NON-CLINICAL)**
Reporting Year:	**2017-2018**
Review Performed:	**2019**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Alliance has struggled to meet the state benchmarks on showing for timely care.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses enrollee access to care and services.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research questions are stated clearly on page 2 of PIP documentation.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**PARTIALLY MET**	Indicators are defined and baseline goal is documented. The benchmarks are noted as 82% for Urgent and 75% for Routine, but the objective on page 2 notes that the target rates are 63% for routine and 62% for urgent. **Recommendation: Revise documentation to show that benchmark is 62% for Urgent and 63% for Routine in Section I. B.**
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures change in processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	All enrollees to whom the study question is relevant are defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	All relevant enrollees are included in data collection.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not utilized.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not utilized.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not utilized.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted in report.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plan is noted in reported quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed in report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions were undertaken to address barriers identified**.**
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to analysis plan (quarterly).
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented clearly on page 13 of PIP report.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Initial and repeat measurements are documented. Factors that address validity were documented on page 12 regarding the report automation updates and testing.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data was conducted and is presented in the report.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Methodology did change, but changes were documented and clarified.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	From baseline, both indicators have shown improvement; although both are still well below the goal rate.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvements in rates appear to be linked to interventions that are revised or initiated.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling not used; so statistical testing is not required.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	The most recent remeasurements have shown an increase, but sustainment is not available to evaluate yet.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Not applicable.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	**85**
Project Possible Score	**90**
Validation Findings	**94%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**ALLIANCE**
Name of PIP:	**TCLI HOUSING TURN-AROUND TIME**
Reporting Year:	**2017-2018**
Review Performed:	**2019**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Alliance needs to increase timely access to permanent supporting housing for TCLI members.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses enrollee access to care and services.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question is stated clearly on page 3 of PIP documentation.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**PARTIALLY MET**	Indicators are defined and baseline goal is documented. The benchmark is noted as 80% but the objective on notes that the target rate is 60%. **Recommendation: Revise documentation to show that benchmark is 60% in Section I. B.**
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures change in processes of care.

Component / Standard (Total Points)	Score	Comments
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	All enrollees to whom the study question is relevant are defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	All relevant enrollees are included in data collection.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not utilized.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not utilized.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not utilized.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted in report.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plan is noted in report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed in report.

Component / Standard (Total Points)	Score	Comments
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions were undertaken to address barriers identified**.**
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to analysis plan (bi monthly).
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented clearly on page 12 of PIP report.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Baseline data only.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of baseline was conducted and is presented in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Baseline data only.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline data only.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Baseline data only.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling not used; so statistical testing is not required.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Baseline data only.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Not applicable.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	**73**
Project Possible Score	**78**
Validation Findings	**94%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**ALLIANCE**
Name of PIP:	**IMPROVING ACCESS TO CARE FOR EMERGENT CALLERS**
Reporting Year:	**2016-2017**
Review Performed:	**2017**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Alliance continues to fall below the benchmark of 97% (revised to 77%) for emergency callers showing for care within the specified time frame.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses enrollee access to care and services.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question is stated clearly on page 3 of PIP documentation.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicator is clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures change in processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	All enrollees to whom the study question is relevant are defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	All relevant enrollees are included in data collection.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not utilized.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not utilized.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not utilized.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted in report.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plan is noted in report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed in report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions were undertaken to address barriers identified**.**
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Initial and repeat measurements are identified.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of success of interventions is provided in documentation.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	The same methodology was used at all measurement time points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The rate has improved in the two most recent remeasurements.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be results of interventions; changes to decision support tool.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling not used; so statistical testing is not required.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	There are only two rates that are above the goal of 77%, thus sustainment cannot be assessed.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Not applicable.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	**90**
Project Possible Score	**90**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**ALLIANCE**
Name of PIP:	**CARE COORDINATION CLINICAL CONTACTS DURING HOSPITALIZATION**
Reporting Year:	**2017-2018**
Review Performed:	**2019**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Alliance does not consistently meet the benchmarks for follow up care after discharge.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses enrollee access to care and services.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question is stated clearly on page 2 of PIP documentation.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicator is defined and baseline goal is documented.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures change in processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	All enrollees to whom the study question is relevant are defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	All relevant enrollees are included in data collection.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not utilized.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not utilized.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not utilized.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted in report.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plan is noted in report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed in report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions were undertaken to address barriers identified**.**
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to analysis plan (monthly).
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented clearly on page 9 of PIP report.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Baseline data only.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of baseline data is document and follow up in noted on page 11 of the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Baseline data only.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline data only.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Baseline data only.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling not used; so statistical testing is not required.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Baseline data only.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Not applicable.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	**78**
Project Possible Score	**78**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**READMISSION RATES FOR MENTAL HEALTH**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**READMISSION RATES FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**MENTAL HEALTH UTILIZATION- INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**MENTAL HEALTH UTILIZATION**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**SUBSTANCE ABUSE PENETRATION RATE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**MENTAL HEALTH PENETRATION RATE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N2. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N3. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N4. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.
SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**READMISSION RATES FOR MENTAL HEALTH**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G2. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D3. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D4. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N7. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N8. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N9. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N10. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N11. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S4. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S5. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S6. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R4. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**READMISSION RATES FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G2. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculation was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D3. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D4. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N7. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N8. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N9. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N10. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S4. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S5. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S6. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R4. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G2. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D3. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D4. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N7. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N8. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N9. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N10. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S4. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S5. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S6. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R4. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G2. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D3. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D4. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N7. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N8. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N9. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N10. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S4. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S5. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S6. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R4. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G2. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D3. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D4. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N7. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N8. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N9. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N10. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S4. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S5. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S6. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R4. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**MENTAL HEALTH UTILIZATION- INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G2. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D3. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D4. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N7. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N8. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N9. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N10. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S4. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S5. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S6. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R4. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**MENTAL HEALTH UTILIZATION**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G2. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D3. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D4. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N7. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N8. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N9. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N10. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S4. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S5. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S6. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R4. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G2. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D3. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D4. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N6. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.
N7. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N8. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N9. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N10. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S4. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S5. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S6. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R4. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**SUBSTANCE ABUSE PENETRATION RATE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G2. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D3. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D4. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N6. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.
N7. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N8. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N9. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N10. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S4. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S5. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S6. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R4. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance Behavioral Healthcare**
Name of PM:	**MENTAL HEALTH PENETRATION RATE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	03/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G2. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D3. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D4. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N12. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.
N5. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N6. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N7. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N8. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S4. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S5. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S6. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R4. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Alliance Behavioral Healthcare**
Name of PM	**INNOVATIONS MEASURE: LEVEL OF CARE EVALUATION**
Reporting Year	2017-2018
Review Performed	03/19

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N13. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N14. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R5. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in Innovations Waiver Excel file
R6. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Alliance Behavioral Healthcare**
Name of PM	**INNOVATIONS MEASURE: LEVEL OF CARE EVALUATIONS COMPLETED USING APPROVED PROCESSES AND INSTRUMENTS**
Reporting Year	2017-2018
Review Performed	03/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Alliance Behavioral Healthcare**
Name of PM	**INNOVATIONS MEASURE: NEW LEVEL OF CARE EVALUATIONS COMPLETED USING APPROVED PROCESSES AND INSTRUMENTS**
Reporting Year	2017-2018
Review Performed	03/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Alliance Behavioral Healthcare**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF PROVIDERS THAT IMPLEMENTED AN APPROVED CORRECTIVE ACTION PLAN**
Reporting Year	2017-2018
Review Performed	03/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Alliance Behavioral Healthcare**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF PROVIDERS WHEREIN ALL STAFF COMPLETED MANDATED TRAINING**
Reporting Year	2017-2018
Review Performed	03/19

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in Innovations Waiver Excel file
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Alliance Behavioral Healthcare**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF ISPS IN WHICH SERVICES AND SUPPORTS REFLECT PARTICIPANT ASSESSED NEEDS AND LIFE GOALS**
Reporting Year	2017-2018
Review Performed	03/19

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

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

NUMERATOR ELEMENTS			
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REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in Innovations Waiver Excel file
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Alliance Behavioral Healthcare**
Name of PM	**INNOVATIONS MEASURE: ISPS ADDRESS IDENTIFIED HEALTH AND SAFETY RISK FACTORS**
Reporting Year	2017-2018
Review Performed	03/19

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in Innovations Waiver Excel file
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VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Alliance Behavioral Healthcare**
Name of PM	**INNOVATIONS MEASURE: PARTICIPANTS REPORTING THAT ISP HAS SERVICES THEY NEED**
Reporting Year	2017-2018
Review Performed	03/19

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
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DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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NUMERATOR ELEMENTS			
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REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Alliance Behavioral Healthcare**
Name of PM	**INNOVATIONS MEASURE: INDIVIDUALS FOR WHOM AN ANNUAL ISP AND/OR NEEDED UPDATES TOOK PLACE**
Reporting Year	2017-2018
Review Performed	03/19

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
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Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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Element	Standard Weight	Validation Result
G1	**10**	**10**
G2	**2**	**2**
D1	**10**	**10**
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N2	**5**	**5**
R1	**10**	**10**
R2	**3**	**3**

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Alliance Behavioral Healthcare**
Name of PM	**INNOVATIONS MEASURE: NEW WAIVER PARTICIPANTS RECEIVING SERVICES ACCORDING TO ISP WITHIN 45 DAYS OF APPROVAL**
Reporting Year	2017-2018
Review Performed	03/19

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

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

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REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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VALIDATION SUMMARY

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G1	**10**	**10**
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R1	**10**	**10**
R2	**3**	**3**

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

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

AVERAGE VALIDATION PERCENTAGE & AUDIT DESIGNATION
100% FULLY COMPLIANT

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

D. Attachment 4: Tabular Spreadsheet

CCME PIHP Data Collection Tool

Plan Name:	Alliance Behavioral Healthcare
Collection Date:	2018

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A. General Approach to Policies and Procedures						
1. The PIHP has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Within the reference grid of each procedure, relevant URAC standards, codes of federal regulations, *Division of Mental Health (DMH)* and *DMA Contracts* are generally referenced. However, throughout the procedures, URAC language, and requirements are often all that is referenced. For example, there is no reference to *Attachment M* of the *DMA Contract* in the Appeals procedure. Yet that attachment governs state requirements for processing Appeals. It is understood that URAC requirements are, at times, more restrictive. However, not all contracts and accreditation requirements align procedurally. For example, the *DMA Contract* requirements for Appeals differ from those of URAC. Referencing *DMA Contract, Attachment M, Section G.5* and *6* in the Appeal procedure would better guide staff through the required procedural notification steps when Alliance extends the resolution timeframe for a Medicaid Appeal. CCME recommends that Alliance remove the specific references to URAC within the body of their procedures and add the specific *DMA Contract* requirements in the reference grid.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Remove the specific references to URAC within the body of procedures and add the specific DMA Contract requirements in the reference grid of each procedure.
I. B. Organizational Chart / Staffing						
1. The PIHP's resources are sufficient to ensure that all health care products and services required by the State of North Carolina are provided to enrollees. At a minimum, this includes designated staff performing in the following roles:						
1.1 A full time administrator of day-to-day business activities;	X					Rob Robinson continues in his role as CEO of Alliance and oversees the day-to-day business activities.
1.2 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities.	X					In July 2018, Dr. Don Fowls joined Alliance as Interim Chief Medical Officer (CMO).
2. Operational relationships of PIHP staff are clearly delineated.	X					During the Onsite discussion, Dr. Fowls described the additional support and oversight provided by the two Associate Medical Directors (AMDs), Drs. Middendorf and Kaesemeyer. CCME recommends adding to the *Organizational Chart* this AMD oversight to highlight the level of physician support the Medical Department provides. ***Recommendation: Add to the Organizational Chart the support and oversight by the Associate Medical Directors.***
3. Operational responsibilities and appropriate minimum education and	X					Alliance's *Organizational Chart* is accompanied by a listing of staff and their education, certification, and licensure information. This list

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
training requirements are identified for all PIHP staff positions, including those that are required by DMA contract.						shows staff meet minimum educational and training requirements as required by the *DMA Contract*.
I. C. Confidentiality						
1. The PIHP formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					
2. The PIHP provides HIPAA/confidentiality training to new employees and existing staff.	X					Alliance trains new staff on confidentiality on the first day of their employment and requires new staff to sign a confidentiality agreement prior to accessing the electronic record system. Alliance conducts annual training for existing staff that includes confidentiality.
I D. Management Information Systems						
1. Enrollment Systems						
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					WellSky daily imports the GEF file into the AlphaMCS system. The daily eligibility file is compared to existing eligibility in the AlphaMCS system and adds, changes, or deletions to records are updated in the system. A new Medicaid ID# and a former Medicaid ID# is stored in AlphaMCS enrollment system and Alliance can see the claims history for the prior member record since the data is merged. Alliance stores a member's demographic information in the AlphaMCS system. Historical member eligibility is also captured in the system.
1.2 The MCO is able to identify and review any errors identified during or as a result of the State enrollment file load process	X					Alliance's process determines the differences between the GEF and AlphaMCS system. Alliance staff review the two reports that are processed daily.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Alliance reconciles eligibility records with the monthly 820 Capitation file and the quarterly GEF full file received from NC Medicaid.
1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.	X					A review of the ISCA submission and a discussion of the AlphaMCS enrollment screens and the Provider Direct (provider web portal) demonstrated compliance with this area. All members' enrollment history is retained in the AlphaMCS system.
2. Claims System						
2.1 The MCO processes provider claims in an accurate and timely fashion.	X					Alliance processes paper claims within 10 days of receipt. Electronic claims are processed nightly with an auto-adjudication rate of 84% for Institutional claims and almost 99% for Professional claims.
2.2 The MCO has processes and procedures in place to monitor review and audit claims staff.	X					Alliance Claims Staff conducts routine and non-routine claim audits. Audits include a random weekly sample of 2.5% of all claims adjudicated during the previous week; 50% focused audit of inpatient hospital claims over $5,000; weekly 3% focused audit of Emergency Department (ED) claims.
2.3 The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 procedure codes on an 837 Institutional file.	X					Alliance captures all primary and secondary diagnosis codes that are submitted by providers. All codes are stored in the AlphaMCS system. While the screen doesn't show all codes, staff can drill down to see all submitted codes. Alliance indicated it receives and stores any DRG codes that are submitted but does not require or store ICD-10 procedure codes. Most providers do not bill with DRG and procedures are not common with behavior health services.
2.4 The MCO's claim system screens store and track claim information and claim adjudication/payment information.	X					During the Onsite, Alliance demonstrated the AlphaMCS claim screens (for Institutional and Professional) claim entry interface. The system captures all necessary claim information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Reporting						
3.1 The MCO's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					In addition to the AlphaMCS system, there is a near real-time replication of the data into a Structured Query Language (SQL) database. The enrollment reporting system is updated daily from the production system.
3.2 The MCO has processes in place to back up the enrollment and claims data repositories.	X					Alliance performs backups of the AlphaMCS enrollment, claims, and reporting systems nightly. Separate backups are stored at offsite locations as part of their Disaster Recovery Plan.
4. Encounter Data Submission						
4.1 The MCO has the capabilities in place to submit the State required data elements to DMA on the encounter data submission.		X				Alliance's submission process to the NCTracks portal is created through the AlphaMCS system. Weekly, Alliance submits claims/encounters to NCTracks using 837I and 837P files. Alliance indicated it receives and stores any DRG and ICD-10 procedure code that is submitted but does not submit them to NCTracks. Alliance did not submit Institutional secondary ICD-10 diagnosis codes during the review period. While Alliance updated the submission process in December 2018, Institutional secondary diagnosis codes were not sent to NCTracks during this EQR. ***Corrective Action: Confirm Institutional secondary diagnosis codes are currently being sent to NCTracks.***
4.2 The MCO has the capability to identify, reconcile and track the encounter data submitted to DMA.	X					Alliance's tracking and reconciliation processes identify encounter status. Upon receipt at NCTracks, they receive a 999 acknowledgement file. All files are documented with date and name as sent for tracking purposes. Alliance's EDI Specialist tracks the encounter files on a spreadsheet by file name along with the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						accepted 999 file and rejected files. When the 835 file is returned to Alliance, it is reconciled with the 837 file sent to NCTracks.
4.3 MCO has policies and procedures in place to reconcile and resubmit encounter data denied by DMA.	X					Alliance provided several policies and procedures as well as workflows regarding the reconciliation and resubmittal process. A total of 106,893 Institutional and 2,376,456 Professional encounters were submitted to NCTracks with 2017 service dates. Alliance identified 1,998 denied and not yet accepted Institutional and 37,219 Professional encounters with 2017 dates of service. Based on discussion at the Onsite, Alliance worked with NC Medicaid to resubmit as many historical claims as possible. ***Recommendation: Even though Alliance's denial rate is near 1%, they identified 1,998 denied and not yet accepted Institutional and 37,219 Professional encounters with 2017 dates of service. They should continue to work with NC Medicaid to re-submit these to NCTracks.***
4.4 The MCO has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to DMA	X					Alliance reported in their ISCA response that they employ a Director of Data Science and Analytical Research, an additional Data Scientist, a staff of 6 BI Developers, 2 Data Architects, 1 Extract, Transfer, and Load (ETL) Developer and 4 Power Business Analysts, that support the Data Analytics Program and are knowledgeable on the structure of WellSky/AlphaMCS system and databases. Alliance noted at the Onsite that they added two staff to the department that perform advanced research analytics.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II. A. Credentialing and Recredentialing						
1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					Alliance identifies *Procedure 6030, Credentialing Criteria and Enrollment Process for Network Participation*, and *Procedure 6011 Primary Source Verification*, as their *Credentialing Plan*. *Procedure 6011, Primary Source Verification*, provides details and guidelines for Primary Source Verification (PSV) during the credentialing and recredentialing processes.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	X					The Credentialing Committee has delegated authority to the Chief Medical Officer (CMO) or designee to approve clean credentialing applications. Both the Sign-In Sheet and the Credentialing Committee Meeting Minutes clearly identify the voting members. There were 29 Credentialing Committee meetings between January 16, 2018 and December 18, 2018, with a quorum present at each meeting. Credentialing Committee Meeting Minutes clearly reflect committee discussion and decisions.
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of provider.	X					Credentialing files reviewed were well-organized and contained appropriate information. CCME identified the following issues in the file review:
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					*Procedure 6030, Credentialing Criteria and Enrollment Process for Network Participation* and page 33 of the *Provider Operations Manual* outline insurance requirements. One reviewed credentialing file was for an M.D. who was credentialed only for his practice at a hospital. The file includes a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Certificate of Insurance (COI) for professional liability insurance in the practitioner's name, attestations for auto and workers' compensation in the practice name he bills under, and COIs for Umbrella Liability and Workers' Compensation/Employers' Liability in the name of the hospital where he practices. The file lacked proof of general liability insurance (as required by *DMA Contract Attachment B, Section 7.7.4*), and a statement that the practitioner is covered under the hospital insurance. In response to the Onsite Request List, Alliance provided a statement from the hospital confirming the physician is covered under their insurance policies. No proof of general liability insurance was provided. During Onsite discussion, CCME reminded Alliance that an umbrella policy is not a standalone policy and Alliance should obtain proof of all required insurance coverage, including general liability, irrespective of an umbrella liability policy.
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					The credentialing application for one Licensed Independent Practitioner (LIP) lists both a Licensed Professional Counselor (LPC) license and a Licensed Clinical Additions Specialist-Associate (LCAS-A) license, but the file does not include a supervision agreement for the LCAS-A license. When asked about this, Alliance provided the following response: • "Alliance Health only enters into LIP Solo contracts with fully licensed clinicians. To that end, the only license that was used for credentialing for his LIP Solo contract was his LPC license. • The Credentialing Approval Letter and Contract were both issued to _____ (the provider's name), LPC."
3.1.3 Valid DEA certificate; and/or CDS certificate	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					The *DMA Contract, Attachment O* states, "PIHP shall complete Primary Source Verification (PSV) of the following minimum credentialing requirements, as applicable to the Provider type, except that PIHP may rely on the relevant licensure board's PSV of educational status of Licensed Practitioner applicants." PSV of a NC Medical License cannot serve as PSV of education, as the NC Medical Board only randomly conducts PSV of education for physicians. If a physician is board certified, the PSV of board certification serves as PSV for education, as the board conducts PSV of education. If the physician graduated from an international medical school, the PSV of the Educational Commission for Foreign Medical Graduates (ECFMG) certification serves as PSV for education, as ECFMG conducts PSV of education. Two initial credentialing files were submitted for physicians. One of the physicians is board certified. The application for the other physician indicates he is board-certified, but the PSV of board certification indicates "no record was found." Though there is a copy of the ECFMG certificate in that file, Alliance did not conduct PSV of the ECFMG. The file for that MD does not include documentation of PSV of education. Alliance Procedure 6011, Primary Source Verification, states, "For MDs only, Alliance verifies Education via Intellicorp or the Educational Commission for Foreign Medical Graduates certificate or via a Certified copy of Medical School transcripts." (The referenced MD file also does not contain PSV of education on the Intellicorp report.) During Onsite discussion, Alliance staff confirmed they have not discussed with NC Medicaid the Alliance practice of using Intellicorp as PSV for physician education. NC Medicaid staff present at the Onsite review asked that Alliance send them an email regarding using this source as PSV of physician education.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendations: If the physician is board certified, ensure PSV of board certification is in the credentialing file. If the physician graduated from an international medical school, ensure PSV of ECFMG certification is in the file. Correct Procedure 6011, Primary Source Verification, and any other documents containing the list of required materials, to indicate that: a.) if the physician is board certified, Alliance will conduct PSV of board certification; b.) if the physician graduated from an international medical school, Alliance will conduct PSV of ECFMG certification; and c.) if the physician is neither board certified nor has ECFMG certification, Alliance will conduct PSV of the physician's education. See DMA Contract, Attachment O. Discuss with NC Medicaid Alliance's practice of using Intellicorp PSV of physician education. Retain evidence of the discussion with NC Medicaid.
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					
3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.8 Query of the National Practitioner Data Bank (NPDB) ;	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					One credentialing file included a screenshot of the DHHS *State Exclusion List (SEL)* dated before the application attestation was signed. ***Recommendation: Ensure all credentialing files include evidence of the query of the State Exclusion List conducted as part of/during the credentialing process. See Alliance Procedure 6011, Primary Source Verification, and DMA Contract, Section 7.6.4.***
3.1.10 Query for the System for Awards Management (SAM);	X					
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	X					
3.1.14 In good standing at the hospital designated by the	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
provider as the primary admitting facility;						
3.1.15 Ownership Disclosure is addressed.	X					The submitted Ownership Disclosure forms were not signed nor dated (there is no space indicated for obtaining signature or date). At the Onsite review, Alliance staff confirmed this is because the Ownership Disclosure form is part of the full application.
3.1.16 Criminal background Check	X					
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.	X					
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files were well-organized and contained appropriate information. CCME identified the following issues in the file review:
4.1 Recredentialing every three years;	X					*Procedure 6030, Credentialing Criteria and Enrollment Process for Network Participation,* states, "All Providers must be re-credentialed a minimum of once every three (3) years." Four of the nine recredentialing practitioners were recredentialed from a week to over three weeks late. ***Recommendation: Per Procedure 6030, ensure providers are recredentialed within three years of the date of the approval of initial credentialing or the most recent recredentialing.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
4.2.3 Valid DEA certificate; and/or CDS certificate	X					
4.2.4 Board certification if claimed by the applicant;	X					
4.2.5 Malpractice claims since the previous credentialing event;	X					
4.2.6 Practitioner attestation statement;	X					
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event;	X					Two recredentialing files include a screenshot of the DHHS *State Exclusion List (SEL)* dated before the application attestation was signed. ***Recommendation: Ensure all recredentialing files include evidence of the query of the State Exclusion List conducted as part of/during the recredentialing process. See Alliance Procedure 6011, Primary Source Verification, and DMA Contract, Section 7.6.4.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.9 Requery of the SAM.	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event;	X					
4.2.11 Query of the Social Security Administration's Death Master File	X					
4.2.12 Query of the NPPES;	X					
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.2.14 Ownership Disclosure is addressed.	X					The submitted Ownership Disclosure forms were not signed nor dated (there is no space indicated for obtaining signature or date). At the Onsite review, Alliance staff confirmed this is because the Ownership Disclosure form is part of the full application. The recredentialing file of one licensed practitioner/MD at an agency does not include the Ownership Disclosure.
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					Recredentialing files include a "Provider Profiling" section. Credentialing Committee Meeting Minutes reflect committee consideration of issues such as quality of care concerns, issues identified during monitoring, and plans of correction.
5. The PIHP formulates and acts within written policies and procedures for suspending or terminating a practitioner's	X					*Procedure 3043, Provider Sanctions, Administrative Actions, and Suspensions to Ensure Patient Safety*, defines "the process for Alliance Behavioral Healthcare (Alliance) to impose sanctions or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
affiliation with the PIHP for serious quality of care or service issues.						administrative actions against Network Providers or to impose an emergency suspension whenever the Chief Medical Officer or Executive VP of Care Management determine that a Network Provider is engaged in activity that may pose a risk to the health, welfare, or safety of any consumer."
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					
II B. Adequacy of the Provider Network						
1. The PIHP maintains a network of providers that is sufficient to meet the health care needs of enrollees and is consistent with contract requirements.	X					*Procedure 6012, Provider Network Capacity and Network Development*, defines "the process for assessing network capacity and addressing gaps in access to services for consumers." The procedure indicates "Alliance will conduct an annual Needs Assessment analysis of its Provider Network to determine the appropriate number, mix, and geographic distribution of providers, including an analysis of geographic access of its memberships to practitioners and facilities."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 Enrollees have a Provider location within a 30 – mile distance of 30 minutes' drive time of their residence. Rural areas are 45 miles and 45 minutes. Longer distances as approved by DMA are allowed for facility based or specialty providers.	X					Page 74 of the *Provider Operations Manual* (effective March 2, 2019) states "The geographic access standard for services is thirty (30) miles or thirty (30) minutes driving time in urban areas, and forty-five (45) miles or forty-five (45) minutes driving time in rural areas." Page 39 of the *Individual and Family Handbook* states "Most services will be available within 30 miles from your home through in-network providers. However, some specialty providers may be located in another county. Alliance will assist you in locating a provider that can meet your needs as close to your home as possible." Page 46 of the *Network Adequacy and Accessibility Analysis* submitted in September 2018 states, "the Alliance service network meets geographic access and choice expectations for Outpatient, Community/Mobile, Crisis, Inpatient and C-Waiver service categories." Alliance identified Child and Adolescent Day Treatment and Opioid Treatment services as Location-based Medicaid-funded services that did not meet geographic access and choice expectations. Alliance submitted Exception Requests for both services.
1.2 Enrollees have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the enrollee may utilize an out-of-network specialist with no benefit penalty.	X					Page 39 of the *Individual and Family Handbook* provides information about receiving services from an out-of-network provider and page 43 addresses medical necessity. The *Individual and Family Handbook* does not clearly communicate that, if medically necessary treatment is required but specialty services are not available in-network, the member may use an out-of-network specialist with no benefit penalty. ***Recommendation: Revise the Individual and Family Handbook to clearly indicate that, if a network specialist is not available, the member may use an out-of-network specialist with no benefit penalty. See 42 CFR § 438.206 and DMA Contract Attachment B, Section 6.4.5.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 The sufficiency of the provider network in meeting enrollee demand is formally assessed at least annually.	X					Alliance annually conducts the DMA-required *LME-MCO Network Adequacy and Accessibility Analysis*, previously called the *Gaps and Needs Analysis*.
1.4 Providers are available who can serve enrollees with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Page 27 of the *Provider Operations Manual* states "Language interpretation services shall be made available by telephone or in-person to ensure that Enrollees are able to communicate with Alliance and Network Providers. Providers and Alliance shall make oral interpretation services available free of charge to each Enrollee. This applies to non-English languages as specified in *42 CFR § 438.10(c)(5)*. TDD (telecommunication devices for the deaf) must also be made available by providers for persons who have impaired hearing or a communication disorder." The "Provider Resources" section of the Alliance website has a link to the "Cultural Competence" section, with links to a variety of websites. Providers are required to have a Cultural Competency Plan. The *Provider Directory* and the online Provider Search include providers who use American Sign Language. The state manages a contract with a provider for assessments for hard of hearing members. Alliance recently completed a Request for Proposal (RFP) process to add Allied Health providers due to the Traumatic Brain Injury (TBI) Waiver.
1.5 The PIHP demonstrates significant efforts to increase the provider network when it is identified as not meeting enrollee demand.	X					Per *Procedure 6012, Provider Network Capacity and Network Development*, "The Network Development and Evaluation Department in collaboration with other Departments will use the results of the analysis to create a Network Development Plan." Current service needs are posted on the Alliance website. Whenever possible, Alliance reaches out to existing providers, to see if they can expand to add a needed service. When needed, Requests for Information (RFI), RFPs or Requests for Quotes (RFQs) are posted

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						(including a recent Request for Information for a provider for transportation services).
2. Provider Accessibility						
2.1 The PIHP formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					*Procedure 4017, Service Calls*, addresses access standards.
II C. Provider Education						
1. The PIHP formulates and acts within policies and procedures related to initial education of providers.	X					See *Procedure 6034, Provider Orientation and Education*.
2. Initial provider education includes:						The New Provider Orientation webpage includes a link to the *Provider Operations Manual* and other publications and forms. Links are provided to Provider News as well as information about provider meetings and the Alliance Provider Advisory Council.
2.1 PIHP purpose and mission;	X					
2.2 Clinical Practice Standards;	X					Page 72 of the *Provider Operations Manual* has a link to the Clinical Guidelines posted on the Alliance website.
2.3 Provider responsibilities;	X					
2.4 PIHP closed network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements,	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability.						
2.5 Access standards related to both appointments and wait times;	X					Access standards are addressed on pages 74 -76 of the *Provider Operations Manual*.
2.6 Authorization, utilization review, and care management requirements;	X					
2.7 Care Coordination and discharge planning requirements;	X					
2.8 PIHP dispute resolution process;	X					
2.9 Complaint investigation and resolution procedures;	X					
2.10 Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements;	X					
2.11 Enrollee rights and responsibilities	X					
2.12 Provider program integrity requirements that include how to report suspected fraud, waste and abuse, training requirements as outlined in the False Claims Act, and	X					Page 101 of the *Provider Operations Manual* provides information about fraud, waste, and abuse, including the notation on that "All Providers must monitor for the potential for fraud and abuse and take immediate action to address reports or suspicion", and information about how to report suspected fraud, waste, and abuse. The Home page of the Alliance website has the phone number for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
other State and Federal requirements.						the Confidential Fraud and Abuse Line, and a link to the Reporting Provider Fraud and Abuse webpage. The "Reporting Provider Fraud and Abuse" webpage includes reporting information and provides a link to the U.S. Health and Human Services' Office of Inspector General "Compliance 101" page and a link to the CMS Medicaid Fraud Prevention Toolkit webpage.
3. The PIHP provides ongoing education to providers regarding changes and/or additions to its programs, practices, enrollee benefits, standards, policies and procedures.	X					During Onsite discussion, Alliance staff reported providers are encouraged to sign up for news feeds, "which include anything Alliance posts." Providers can choose to receive these daily or weekly. Communication Bulletins convey important information to providers.
II D. Clinical Practice Guidelines for Behavioral Health Management						
1. The PIHP develops clinical practice guidelines for behavioral health management of its enrollees that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					*Procedure 7506, Clinical Guidelines,* indicates the development of clinical guidelines is the responsibility of the Chief Medical Officer. The guidelines are based on scientific evidence and/or consensus of community standards and may be adopted from nationally recognized professional organizations. The clinical guidelines are approved by the Committee on Provider Quality, which is comprised of practitioners, provider medical directors from the Alliance network, the local community of providers, and Alliance clinicians.
2. The PIHP communicates the clinical practice guidelines for behavioral health management and the expectation that they will be followed for PIHP enrollees to providers.	X					Page 72 of the *Provider Operations Manual* informs providers they are "required to follow the clinical guidelines adopted by Alliance in the provision of care and Alliance will measure adherence to these guidelines." A link to the Alliance Clinical Guidelines is posted on the website, and providers are informed they can obtain a hard copy by contacting Alliance.
II E. Continuity of Care						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1. The PIHP monitors continuity and coordination of care between providers.	X					During Onsite discussion, Alliance staff indicated coordination and continuity of care is part of the monitoring process.
II F. Practitioner Medical Records						
1. The PIHP formulates policies and procedures outlining standards for acceptable documentation in the Enrollee medical records maintained by providers.	X					*Procedure 3036, Required Service Record Documentation,* details "the required components of the clinical service records of persons who receive mental health, intellectual/developmental disability or substance abuse treatment by Alliance Behavioral Healthcare (Alliance) providers and to provide information and education to the Alliance Provider Network regarding documentation requirements for the clinical record." Pages 41-44 of the *Provider Operations Manual* include links to NC DHHS Records Management requirements and to the *NCMMIS Provider Claims and Billing Assistance Guide*.
2. The PIHP monitors compliance with medical record documentation standards through formal periodic medical record audit and addresses any deficiencies with the providers.	X					During Onsite discussion, Alliance staff indicated compliance with medical record documentation standards is part of the monitoring process.
3. The PIHP has a process for handling abandoned records, as required by the contract.	X					*Procedure 3019, Medicaid Funded Service Records Transfer and Storage*, includes the abandoned records process required by *DMA Contract 8.2.1.*

III. ENROLLEE SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III A. Enrollee Rights and Responsibilities						
1. The PIHP formulates policies outlining enrollee rights and procedures for informing enrollees of these rights.	X					*Procedure 3500, Individual Rights and Responsibilities* details of how Alliance notifies members of their rights.
2. Enrollee rights include, but are not limited to, the right:	X					Member rights are outlined in *Procedure 3500* and on pages 46-50 of the *Individual and Family Handbook*. The Alliance Human Rights Committee (HRC) protects the rights of people receiving services. The HRC reviews complaints about violations of member rights, including privacy concerns. HRC meets at least quarterly and reports to the Alliance Board of Directors, the Alliance Continuous Quality Improvement (CQI) Committee, and state authorities.
2.1 To be treated with respect and due consideration of dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;						
2.3 To participate in decisions regarding health care;						
2.4 To refuse treatment;						
2.5 To be free from any form of restraint of seclusion used as a means of coercion, discipline, convenience or retaliation;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.6 To request and receive a copy of his or her medical record, except as set forth in 45 C.F.R. §164.524 and in N.C.G.S. § 122C-53(d), and to request that the medical record be amended or corrected in accordance with 45 CFR Part 164.						
2.7 Of enrollees who live in Adult Care Homes to report any suspected violation of their enrollee rights, to the appropriate regulatory authority as outlined in NCGS§ 131-D21.						This was part of the 2017 EQR Corrective Action Plan (CAP) and is included in documentation of member rights for 2018 EQR.
III B. Enrollee PIHP Program Education						
1. Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid waiver managed care program which they are contractually entitled, including:		X				*Procedure 3500, Individual Rights and Responsibilities* states, "Individuals will be given access to the most recent *Individual and Family Handbook* within fourteen (14) days of enrollment by the Customer Service Department. This handbook contains a list of rights and responsibilities, civil rights and human rights. This handbook must be made available in both English and Spanish." The *Welcome Letter* is sent within 14 business days of enrollment. It directs members to the Access and Information phone number for help providing needed information. It also directs members to the AllianceBHC.org website for written materials including the *"Alliance Consumer and Family Handbook"* and information about rights and responsibilities. The handbook name changed to "*Individual and Family Handbook,*" and that needs to be updated in the *Welcome Letter*. Also, printed copies are available by calling or sending a request in writing.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Update the Welcome Letter's reference to "Alliance Consumer and Family Handbook" to say Individual and Family Handbook. Information in the sub-standards are found in the *Individual and Family Handbook*, unless noted differently.
1.1 A description of the benefits and services provided by the PIHP and of any limitations or exclusions applicable to covered services. These descriptions must have sufficient detail to ensure the Enrollees understand the benefits to which they are entitled and may include a web link to the PIHP Benefit Plan. This includes a descriptions of all Innovations Waiver services and supports;						An explanation starts on page 12 of the *Individual and Family Handbook*.
1.2 Benefits include access to a 2nd opinion from a qualified health care professional within the network, or arranges for the enrollees to obtain one outside the network, at no cost to the enrollee;						This is explained on page 12 of the *Individual and Family Handbook*.
1.3 Updates regarding program changes;						This is explained on page 27 of the *Individual and Family Handbook*.
1.4 A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;						This is explained on pages 27-28 of the *Individual and Family Handbook*.
1.5 An explanation of the Enrollee's responsibilities and rights and protection;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.6 An explanation of the Enrollee's rights to select and change Network Providers						This is explained on page 37 of the *Individual and Family Handbook*.
1.7 The restrictions, if any, on the enrollee's right to select and change Network Providers						
1.8 The procedure for selecting and changing Network Providers						This is explained on pages 36-37 of the *Individual and Family Handbook*.
1.9 Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request);						The online provider search allows searching by service, provider, or clinician. All required fields are present in the online search. The PDF version of the *Provider Directory* gives an error code "blank" page when clicked on and states, "404 page not found. Please try searching using the mega menu." There was a hard copy provided in Desk Materials that has all required fields. The week of the onsite visit, the website was displaying the PDF *Provider Directory* correctly.
1.10 The non-English languages, if any, spoken by each Network Provider;						Spoken Languages are listed in the online service, provider, and clinician search. Languages are listed in the printed *Provider Directory*.
1.11 The extent to which, and how, after-hours and emergency coverage are provided, including:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.11.1 What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services in accordance with 42 CFR § 438.114 and EMTALA;						Page 21 of the *Individual and Family Handbook* states, "Providers will also assist with post-stabilization services (offered after the emergency occurs). Post-stabilization services do not require pre-authorization, and Alliance helps ensure you receive the services you need." At the bottom of page 15 (in red type) of the *Individual and Family Handbook*, emergency care is explained as "A life-threatening emergency is when you or another responsible person thinks you need care immediately so that you or someone else does not get hurt."
1.11.2 The fact that prior authorization is not required for emergency services;						
1.11.3 The process and procedures for obtaining Emergency Services, the use of 911 telephone services or the equivalent;						
1.11.4 The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract;						The locations at which providers and hospitals furnish post stabilization services is not stated in member written materials. ***Corrective Action: Within member written materials, add examples of where post stabilization services are available. (DMA Contract 6.9.1)***
1.11.5 A statement that, subject to the provisions of the DMA this contract, the Enrollee has a right to use any hospital or other setting for Emergency care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.12 The PIHP's policy on referrals for Specialty Care to include cost sharing, if any, and how to access Medicaid benefits that are not covered under this Contract;						Page 24 of the *Individual and Family Handbook*, states, "For Medicaid services, your local DSS decides Medicaid eligibility and any co-payment or deductibles. Page 25 of the *Individual and Family Handbook* states, "If you are a Medicaid beneficiary, you cannot be charged a co-pay for any of the services managed by Alliance. However, you may be charged a co-pay for services managed by the NC Division of Health Benefits. For example, non-pregnant adults over age 21 may be charged a $3 co-pay for prescriptions. In addition, if you receive non-Medicaid services, your provider can charge a fee based on your income."
1.13 Any limitations that may apply to services obtained from Out-of Network Providers, including disclosures of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of Network Providers, and the procedures for obtaining authorization for such services.						Out-of-network provider services are explained to members on page 39 of the *Individual and Family Handbook*.
1.14 How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost-sharing;						This is explained on page 41 of the *Individual and Family Handbook*.
1.15 Procedures for obtaining out-of-area or out-of-state coverage or services, if special procedures exist;						Page 39 of the *Individual and Family Handbook* has sections for out-of-area and out-of-network. In the out-of-network section, the 2nd paragraph changes subjects to out-of-area. There is no reference to out-of-state.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The procedures for members to obtain out-of-area or out-of-state coverage of services, if special procedures exist, is not explained in member written materials. ***Corrective Action: Re-word the out-of-area section in the Individual and Family Handbook so that the member knows the procedures for obtaining out-of-area coverage of services, if special procedures exist. Add similar documentation explaining the procedures for obtaining out-of-state coverage or services, if special procedures exist. (DMA Contract 6.9.1)***
1.16 Information about medically necessary transportation services by the department of Social Services in each country;						This is explained on page 19 of the *Individual and Family Handbook*.
1.17 Identification and explanation of State laws and rules Policies regarding the treatment of minors;						The rights of minors are explained on page 47 of the *Individual and Family Handbook*.
1.18 The enrollee's right to recommend changes in the PIHP's policies and procedures						The member's right to recommend changes in the PIHP's policies and procedures is not listed in the *Individual and Family Handbook* or other member written materials. "The right to make recommendations regarding the organization's member rights and responsibilities policy" is listed as a member right in the *Individual and Family Handbook* and in *Procedure 3500, Individual Rights and Responsibilities*. *Page 4 of Procedure 3500* correctly states, "Members have the right to recommend changes to Alliance policies and services. To do so, they may email their recommendations to the Director of Individual and Family Affairs, dwright@alliancebhc.org

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						or mail to…" The mailing address for Alliance Behavioral Health is included. This needs to be included in member rights documentation. ***Corrective Action: Ensure all printed materials are updated to include the member's right to recommend changes in the PIHP's policies and procedures. (DMA Contract, Section 6.9.1)***
1.19 The procedure for recommending changes in the PIHP's policies and procedures;						The procedures for members to recommend changes in the PIHP's policies and procedures are not included in member written materials. *Page 4 of Procedure 3500* correctly states, "Members have the right to recommend changes to Alliance policies and services. To do so, they may email their recommendations to the Director of Individual and Family Affairs, dwright@alliancebhc.org or mail to…" The mailing address for Alliance Behavioral Health is included. ***Corrective Action: Ensure all printed materials are updated to include the procedure for members to recommend changes in the PIHP's policies and procedure. (DMA Contract, Section 6.9.1)***
1.20 The Enrollee's right to formulate Advance Directives;						This right is explained on page 51 of the *Individual and Family Handbook*. It details information about the 3 advance directives.
1.21 The Enrollee's right to file a grievance concerning non-actions, and the Enrollee's right to file an appeal if PIHP takes an action against an Enrollee;						This process is explained beginning on page 60 of "Section 10: How Do I Make an Appeal or file a Grievance" in the *Individual and Family Handbook*.
1.22 The accommodations made for non-English speakers, as specified in 42 CFR § 438.10(c)(5);						Page 17 of the *Individual and Family Handbook states,* "How can I get assistance in languages other than English? Alliance staff can connect you to an interpretation service for languages other than English. This is a free service to you, and available on any call. You may have to wait briefly for the conference call with the interpreter to begin. Free interpretive service is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						available when working with Alliance providers as well. Alliance can also translate this member handbook, forms and brochures into other languages in addition to English and Spanish. Please call the Access and Information Center at (800) 510-9132 to request translation of materials into other languages."
1.23 Written information shall be made available in the non-English languages prevalent in the PIHP's services area.						
1.24 The availability of oral interpretation service for non-English languages and how to access the service;						
1.25 The availability of interpretation of written information in prevalent languages and how to access those services						The website has a Google Translate function to allow for many translated languages on the website; however, this may be hard for members to find since it is at the bottom on the page.
1.26 Information on how to report fraud and abuse; and						This is found in "Section 11: How can I help prevent fraud and abuse?" of the *Individual and Family Handbook*.
1.27 Upon an Enrollee's request, the PIHP shall provide information on the structure and operation of the agency and any physician incentive plans.						Page 37 of *Individual and Family Handbook states*: "A network provider has a contract with us to provide services. Alliance does not offer any physician incentive plans to members of its provider network."
1.28 Information on grievance, appeal and fair hearing procedures and information specified in CFR § 438.10 (g) and CFR § 438.10 (f) (6).						
2. Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.	X					Alliance sends an *Annual Mailing* letter to all members.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in CFR § 438.10 (f) (61) and 438.10 (g) at least 30 days before calendar days before the intended effective date of the change; and (2) . termination of their provider within fifteen (15) calendar days after PIHP receives notice that DMA or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.	X					Only one set of letters to members explaining their provider's termination from the network included the date of their provider's termination. Onsite discussion revealed that Alliance does not routinely include the provider's termination date because the provider has the right to Appeal. However, providers that voluntarily leave the network are unlikely to Appeal. Five terminated provider files were reviewed. 1 provider failed credentialing standards. 4 providers voluntary resigned from the network. As stated in the *Individual and Family Handbook*, "When a provider leaves the network (either by choice or otherwise), Alliance will contact all members currently in treatment with the provider. Alliance will make every effort to notify each member in writing 30 days prior to the provider leaving the network." ***Recommendation: Include the date of the provider's termination from the network in the member communication letters when the provider requests to leave the network. (DMA Contract, Section 6.10)***
4. Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation of prevalent non-English languages as required by the contract.	X					The *Individual and Family Handbook* was re-written since the last EQR for easier readability, targeting an eight-grade reading level.
5. The PIHP maintains and informs Enrollees of how to access a toll-free vehicle for 24-hours Enrollee access to coverage information from the PIHP, including the availability of free oral translation services for all languages and	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
care management services such as crisis interventions.						
III C. Behavioral Health and Chronic Disease Management Education						
1. The PIHP enables each enrollee to choose a Provider upon enrollment and provides assistance as needed.	X					
2. The PIHP informs enrollees about the behavioral health education services that are available to them and encourages them to utilize these benefits.	X					The *Individual and Family Handbook* does not describe the Alliance Recovery University, which is intended for provider, member, and staff education. The handbook directs members to the website's home page for member educational materials. However, it's unclear where and how to access member education from the home page. ***Recommendation: Update the Individual and Family Handbook to explain the Alliance Recovery University and how it is useful to members. Add detail in the handbook to direct members to the Alliance Recovery University website and other website pages for member education.***
3. The PIHP tracks the participation of enrollees in the behavioral health education services.	X					This is tracked internally and available.
III D. Call Center						
1. The PIHP provides customer services that are responsible to the needs of the Enrollees and their families. Services include:	X					The website video is a nice feature to explain Alliance and direct members and families to the Access and Information Center.
1.1 Respond appropriately to inquiries by enrollees and their family members (including those with limited English proficiency);	X					The Access and Information Center engages interpretation services via phone when needed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 Connect enrollees, family members and stakeholders to crisis services when clinically appropriate;	X					A Qualified Profession (QP) answers first. If the call is non-routine, the QP escalates to a licensed clinician. The licensed clinician or licensed supervisor answers first if all QPs are busy. The licensed clinician or supervisor completes the call and makes the needed referral. Supervisors monitor the call for aggression or signs of homicidal behavior.
1.3 Provide information to enrollees and their family members on where and how to access behavioral health services;	X					
1.4 Train its staff to recognize third-party insurance issues, recipient appeals, and grievances and to route these issues to the appropriate individual;	X					
1.5 Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;	X					
1.6 Process referrals twenty-four (24) hours per day, seven (7) days per week; 365 days per year; and	X					The Access and Information Center is staffed 24/7/365. Positions include teleworkers and onsite staff. All staff start onsite and go through a 6-9 week training that includes competency modules and mentoring with peers.
1.7 Process Call Center linkage and referral requests for services twenty-four (24) hours per day, seven (7) days per week, 365 days per year.	X					The Access and Information Center handles most calls. Protocall, a delegated contractor, handles rollover calls. Alliance samples calls that Protocall handles. Alliance randomly selects calls semiannually for review. Protocall's statistics and percentages are not as good as the Access and Information Center data. But aggregated, they continue to meet NC Medicaid call standards.

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV A. The Quality Improvement (QI) Program						
1. The PIHP formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to enrollees.	X					Alliance's *FY 2019 Quality Management Program Description* explains the formal Quality Improvement (QI) Program with clearly defined goals, structure, scope, and methodology.
2. The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.	X					Page 20 of the *FY 2019 Quality Management Program Description* states: "QM Department has developed process to assess provider compliance with the clinical practice guidelines adopted by Alliance. This process involves: identifying two or more milestone elements in a clinical practice guideline; determining provider compliance via data analysis or record reviews; informing providers of any compliance issues via training and other communications; and identifying outlier providers for focused training. In FY 2019, the QM Department will focus on provider compliance with clinical practice guidelines for Autism Spectrum Disorder in children and will continue to follow up on the two previous best practice recommendations: (1) ADHD in children and (2) schizophrenia in adults. Additionally, Alliance is working to create an automated report for the ADHD clinical guideline so that reviews can be automated, and feedback given on a more regular basis." Alliance documents the monitoring of chosen Clinical Practice Guidelines in a detailed and complete, nine-page document, called *FY19-20 QM Adherence Reviews- ADHD (Adolescents) & Schizophrenia (Adults)*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Several reports were reviewed showing monitoring for utilization of services. The Global Quality Management (GQM) Utilization presentation in October 2018 and *UM Program Evaluation 2017-2018* documents provided evidence of monitoring and addressing utilization issues. Monitoring, as well as outcomes of the analysis and lesson learned are noted in the documents. The *UM Plan* for 2018-2019 includes interventions and systems in place to ensure that "service utilization and expenditures are within expected ranges, trends and drivers are identified, responses are implemented, and effectiveness of responses are measured."
4. The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.	X					Page 21 of the *FY 2019 Quality Management Program Description* states, "QM staff also review the findings of surveys conducted by the state and other external parties. These include the annual Perception of Care survey and Provider Satisfaction Survey conducted by the state, and the Provider ECHO Survey conducted as part of the federal EQR process. The QM Department works with the relevant departments and committees to develop, implement and track improvements identified in the survey results." Alliance tracks and compares the survey results year to year to analyze trends. The *FY 2018 Quality Management Program Evaluation* identifies areas for improvement from all surveys combined.
5. The PIHP reports the results of the enrollee satisfaction survey to providers.	X					The "All Provider Presentation June 2018" has high level ECHO Survey report results for 5 composite adult survey areas and 4 composite child survey areas. The Perception of Care and Provider Satisfaction Survey results were shared, too. Meeting documents from GQMC on 5/3/18 included the *ECHO 2017 Analysis* PowerPoint presentation. Minutes explain that ECHO Survey results were discussed. The 2017 ECHO Child and Adult Reports are on the Alliance website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. The PIHP reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					The ECHO 2017 Analysis PowerPoint was included in the March 2018 CQI meeting folder. This presents areas that scored lower and higher when compared to the 2016 ECHO Survey. The Child Survey categorized measures as Top Priority (2 measures), high, and medium priority. The Adult ECHO Survey didn't have these categories assigned to any measures in this PowerPoint presentation. From May 18, 2018 Board meeting: "The committee reviewed results from two statewide surveys—consumer (called ECHO) and Provider Satisfaction. The ECHO survey noted some slight decreases in satisfaction, while the provider survey indicated continued high satisfaction. It is important to note the very small sample size with the ECHO survey. Data from these surveys, along with another survey expected to be received in the next month or two will be combined with quantitative data to create an action plan". Onsite interview discussion revealed that Alliance is using all survey results improvement efforts to align with specific performance data. When interventions are applied, performance data measurements are trended.
7. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, time frame for implementation and completion, and the person(s) responsible for the project(s).	X					The QM Work Plan Excel document that is updated monthly. Progress for each month is evident and updates are captured and saved monthly under that month's name in the Excel file name. The Excel document has 3 tabs: Project Status Tracking, Other Efforts, and Completed. Each tab has several initiatives listed, each with an assigned owner, start date, projected go live date, completion dated, percentage complete, and an update/comments section.
IV B. Quality Improvement Committee						
1. The PIHP has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Quality Improvement Committee (QIC) is the main formal quality committee. There are QIC representatives who attend other committees share information from those other committees at QIC.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The composition of the QI Committee reflects the membership required by the contract.	X					The QIC met monthly, except for September and December, with a quorum at each meeting. No members attended less than 50% of the meetings. The average member attendance was 85% for the 2017/2018 Fiscal Year. Other quality committees include the Provider Quality Committee and the Global Quality Management Committee (GQMC). Provider Quality Committee was formed by pulling 3 committees together into this one committee that meets monthly. Voting members include 3 physicians, 1 peer support services provider representative, and at least 4 clinicians with other licensures (PhD, LCSW, NP/PA, etc.). The Provider Quality Committee has increased provider leadership and engagement at Alliance. GQMC meets monthly and has 4 voting members (3 area board members/ 1 CFAC), 3 non-voting members (1 area board member/ 2 providers), and Alliance staff (6).
3. The QI Committee meets at regular intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are maintained for all committees and they adequately document the proceedings within the committees.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					As a part of the validation process, recommendations are required for PIPs scoring in the high confidence and confidence ranges. ***Recommendation: See recommendations listed on Table 21 for the Access to Care- Urgent PIP and Table 22 for the TCLI Housing Turn-Around Time PIP.***
IV E. Provider Participation in Quality Improvement Activities						
1. The PIHP requires its providers to actively participate in QI activities.	X					Certain QI activities are network facing. Alliance gives providers notification that they are measured on QI activities and feedback with the data of how well they are doing. Some providers are directing and advising within the Provider Quality Committee. Participation varies on how much involvement providers want to give.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					With the 7-day follow up project, Alliance breaks data down by county, facility, and provider and sends providers that data. Barriers are tracked and Alliance works with providers on overcoming the barriers. There are larger workgroup collaboratives focused on specific service lines, such as Assertive Community Treatment (ACT), and Intensive In Home services (IIH). These groups will share performance and see it compared to their peers. Then they discuss what's working best. Regular updates are given to providers on PIPs and performance is shared within provider meetings. In this venue, no provider specific information is shared. Providers are later informed of their individual QI performance.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					*FY 2018 Quality Management Program* Evaluation is well written and gives a summary of the FY 2018 QI activities, analysis, and outcome data when available.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The annual report of the QI program is submitted to the QI Committee and to the PIHP Board of Directors.	X					The Alliance Board of Directors and the Global Quality Management Committee reviewed the *FY 2018 Quality Management Program Evaluation* on 9/6/2018.

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. The Utilization Management (UM) Program						
1. The PIHP formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The Utilization Management (UM) Program policies and describe and support the functions of the UM Program.
1.1 structure of the program;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					*Procedure 7502, Clinical Peer Review* provides the timeframes consistent with the NC Medicaid Contract.
1.5 consideration of new technology;	X					*Procedure 7503, Applying Clinical Criteria to Medical Necessity*, Section D. Request for New Technology shows consideration of new technology.
1.6 the appeal process, including a mechanism for expedited appeal;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.7 the absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					
1.8 mechanisms to detect underutilization and overutilization of services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The Onsite interview provided information about the Interim Chief Medical Officer's (CMO) involvement in the UM functions as well as the changes within the medical staff over the past review year. The UM staff have access to two Associate Medical Directors (AMDs), a pharmacist and a psychologist. There are regularly scheduled meetings to review cases and medical staff are available for urgent/emergent case reviews.
3. The UM program design is reevaluated annually, including Provider input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The *UM Plan* is evaluated annually.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					The review of the 20 UM files included the predetermined criteria used for to make determinations.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Utilization management standards/criteria are consistently applied to all enrollees across all reviewers.	X					
5. Emergency and post stabilization care are provided in a manner consistent with contract and federal regulations.	X					
6. Utilization management standards/criteria are available for Providers.	X					Several procedures provide information about UM standards and criteria. *The Provider Operations Manual* provides the standards/criteria for providers. The Alliance website provides a list of the standards/criteria for providers; it is in the "For Provider" dropdown menu.
7. Utilization management decisions are made by appropriately trained reviewers	X					
8. Initial utilization decisions are made promptly after all necessary information is received	X					All UM decisions and notifications were timely.
9. Denials						
9.1 A reasonable effort that is not burdensome on the enrollee or the provider is made to obtain all pertinent information prior to making the decisions to deny services	X					Alliance asserted during the Onsite discussion that, during the past year a concerted effort was made to request only information necessary for the determination of the request. Peer-to-Peer reviews are completed and documented in the files.
9.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					*Procedure 7502* describes Peer Reviewer qualification for I/DD and MH/SU files. A PhD or MD reviews the I/DD denial files and an MD reviews MH/SU denial files.
9.3 Denial decisions are promptly communicated to the provider and enrollee and include the basis for the	X					In all 25 files, the service authorization request was processed and notification provided within 14 days.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
denials of service and the procedure for appeal						
V C. Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					Care Coordination procedures are in place to confirm comprehensive coordination of care. In October 2018, Alliance implemented the Jiva platform that should enhance Care Coordination functions and data.
2. The Care Coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					*Procedure 2004, Individual Support Plan (ISP)* identifies the functions of the I/DD Care Coordinators. *Procedure 2005, Identification, Referral, and Timely Initiation of MHSUD and IDD Care Coordination Functions* previously noted MH/SU Care Coordinators functions but were not found in the procedure this year. This missing information appeared to be an oversight during the annual revision process. These Care Coordination functions for the MH/SU Care Coordinators. need to be added back into *Procedure 2005*. ***Recommendation: Add the functions of the MH/SU Care Coordinators to Procedure 2005, Identification, Referral, and Timely Initiation of MHSUD and IDD Care Coordination Functions.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 Develop treatment plans for enrollees that meet all requirements;	X					
2.5 Quality monitoring and continuous quality improvement;	X					Complete Care Coordination files (e.g., I/DD assessments, notes, scheduled face to face visits) were not made available for this year's EQR Desk Review or Onsite Review. ***Recommendation: Develop a report that shows the full Care Coordination member record, including all assessments and Care Coordination interventions, in chronological order. This report could be used for audits, quality improvement interventions, court proceedings, etc.***
2.6 Determine of which Behavioral Health Services are medically necessary;	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					
2.10 Ensure privacy for each Enrollee is protected.	X					*Procedure 2007, Training and Monitoring and Supervision of I/DD Care Coordinators* includes in the onboarding training of new Care Coordinators on confidentiality and client rights.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					
V. D Transition to Community Living Initiative						
1. Transition to Community Living functions are performed by appropriately licensed, or certified, and trained staff.	X					Staff within the TCLI program are appropriately licensed, certified and/or trained per Alliance's job descriptions and Organizational Chart.
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements includes all required elements.	X					
2.1 Care Coordination activities occur as required.	X					
2.2 Person Centered Plans are developed as required.	X					*Procedure 2034, In-Reach and Transition Process* requires "The Transition Coordinator will provide oversight and technical assistance to service providers to ensure Person-Centered Plans include integrated goals as identified by the individual in transition."
2.3 Assertive Community Treatment, Peer Support Services, and Supported Employment services are included in the individual's transition, if applicable.	X					
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					
2.5 QOL Surveys are administered timely.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. A diversion process is in place for individuals considering admissions into an Adult Care Home (ACH).	X					*Quality of Life (QOL) Surveys* were present in files that required them.
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to DMA within the timeframes determined by DMA.	X					The TCLI Dashboard was uploaded for this EQR and is submitted quarterly to the state.
5. The PIHP will develop a TCLI communication plan that includes materials and training about crisis hotline, services for enrollees with limited English proficiency and to for external and internal stakeholders providing information on the TCL initiative, resources, and system navigation tools, etc.	X					Alliance's communication materials provide information about TCLI to members, external providers, and stakeholders. These materials include a housing brochure and information in the *Individual and Family Handbook*. The Alliance Website includes information for housing and landlords. Alliance also includes staff presentations for internal staff and external stakeholders, and informational videos regarding TCLI services. However, there are no TCLI materials designed for members with limited English proficiency. ***Recommendations: Design and make available TCLI materials for members with limited English proficiency.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. A review of files demonstrates the PIHP is following appropriate TCL policies, procedures and processes, as required by NC DMA, and developed by the PIHP.	X					Review of all of the Care Coordination documentation submitted revealed general inconsistencies in frequency of contact, completeness and quality of documentation. TCLI File Review findings: ●3 files appeared to be missing monitoring notes. ●In at least 3 files the date, location or duration of services were intermittently missing. ●In 3 files, notes abruptly ended and CCME was unable to discern if TCLI services were discontinued or documentation was incomplete. ***Recommendations: Enhance the current monitoring processes to ensure documentation is consistently and correctly entered into Jiva.*** ***Enhance the current monitoring process of Person Centered Plans to ensure TCLI members are receiving the support and quality of all services to address their identified needs.***

VI. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					Alliance has a "No Wrong Door" process for the filing of a Grievances.
1.1 Definition of a grievance and who may file a grievance;	X					During the Onsite interview it was clear that the Grievance staff, were able to discern the difference between a "Grievance" and a "Complaint".
1.2 The procedure for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					Language around Grievance extension notifications in *Procedure 6503, Management and Investigations of Grievances* is not aligned with DMA Contract and federal regulations. ***Recommendation: Align the language within Procedure 6503, Management and Investigations of Grievances around notifications of extensions to the Grievance resolution timeframes to the DMA Contract and federal regulations language. This procedure should clarify that, per DMA Contract, Attachment M and 42 CFR § 438.408, Alliance is required to provide "prompt oral notice of the delay" and provide written notice "within 2 calendar days". The written notice should also include the "reason for the decision to the extend the timeframe".***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					*Procedure 6503* provides detail regarding the CMO involvement when there is a medical concern. This involvement is documented in the AlphaMCS system.
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					
2. The PIHP applies the grievance policy and procedure as formulated.	X					All Grievances were completed within 90 days.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The Grievance data is analyzed and reviewed by Quality Management Committee (QMC) quarterly. Alliance is developing a Provider Dashboard that will further utilize Grievance data.
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					
VI. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to enrollee and/or provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 The definitions of an action and an adverse benefit determination and who may file an appeal;	X					*DMA Contract, Attachment M, Section G. 1 and 42 CFR § 438.400 requires the PIHP to define an Appeal as "the request for review of an adverse benefit determination".* Alliance's *Procedure 3502, Due Process/Appeals of Medical Necessity Determinations* does not contain this updated definition of an Appeal. The procedure also still uses the word "action" when describing a service authorization decision. Both terms need to be updated within the procedure. Who may file an Appeal is also unclear in the Appeal procedure. The procedure states, "A provider who has the member's written consent and is acting on his or her behalf can request the LME/MCO Level Appeal. Parties to the LME/MCO Level Appeal must include the member and his or her personal representative (which can be a provider, friend or family member even if not a guardian); or the legal representative of a deceased member's estate." *DMA Contract, Attachment M, Section G.1* and *42 CFR § 438.400,* define an appellant as "the Enrollee, legally responsible person, or a Provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent, may file a PIHP internal appeal." Alliance should clarify in their Appeal procedure that anyone other than the Enrollee or legal guardian can file and Appeal, if they have the Enrollee or legal guardian's written consent. ***Recommendations: Using the language within Attachment M of the DMA Contract, update Alliance's Procedure 3502, Due Process/Appeals of Medical Necessity Determinations, to reflect the definition of an Appeal as "the request for review of an adverse benefit determination."*** ***Also include in this procedure the definition of an adverse benefit determination and clarify who can file an Appeal.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 The procedure for filing an appeal;	X					Alliance's *Provider Operations Manual* and the *IDD Care Coordination Desk Reference* need to be updated to state the Enrollee has 60 days to file an Appeal. Both documents still say the Enrollee has 30 days to file an Appeal. ***Recommendation: Update any documentation discussing Appeals to reflect the Enrollee has 60 days to file an Appeal.***
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Per *DMA Contract, Attachment M, Section G.5* and *6*, Appeal extension information is incomplete in Alliance's Appeal *Procedure 3502*. The elements missing are as follows: •PIHP shall make "reasonable efforts" to give the Enrollee prompt oral notice of the delay. •The written notification of the extension must include the reason for the delay and •To "the satisfaction of DMA/upon DMA's request" there is a need for information and how it is in the best interest. ***Recommendations: Add to Appeals Procedure 3502 the following:*** ***•that Alliance shall make "reasonable efforts" to give the***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Enrollee prompt oral notice of the delay, • ***that the written notification of the extension must include the reason for the delay*** ***Also include that staff, when Alliance extends the Appeal resolution timeframe, will document in the Appeal record why there is a need for additional information and how the extension is in the best interest of the Enrollee. This will address the requirement of having the ability to demonstrate to NC Medicaid the justification for the extension.***
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The PIHP applies the appeal policies and procedures as formulated.		X				Review of the 19 standard Appeal files showed six (or 32%) of the Appeals had acknowledgment letters sent to Appellants outside of the "one business day" required in Alliance's Appeals procedure. Alliance developed a *Communication Log* to capture details of oral and expedited Appeals. These logs were frequently incorrect or incomplete. One expedited Appeal was marked as standard on the *Communication Log*. Staff did not capture names of staff or appellants that were contacted when processing the Appeal (e.g., oral notifications). There was also inconsistent documentation regarding the CMO consultation around accepting or denying requests for expedited Appeals.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Corrective Action: Ensure Appeal functions are adequately staffed to meet the acknowledgement timeframes required by Alliance's Appeal procedure. ***Train staff on the processes for completing the Communication Log, including which sections within that document are required.***
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					*Procedure 3502, Due Process/Appeals of Medical Necessity Determinations* does not guide staff on how to release the Appeal record or full clinical rationale for the Appeal decision. Alliance has procedures that detail the steps staff should take prior to releasing Protected Health Information (PHI) (for example, *Procedure 3051, Use and Disclosure-Accounting of Disclosures*). Alliance needs to ensure staff follow the steps outlined in their confidentiality procedures by either referencing specific PHI procedures or spelling out steps to protect PHI relative to Appeals. ***Recommendation: Either reference in Procedure 3502, Due Process/Appeals of Medical Necessity Determinations specific Alliance PHI procedures to guide staff in releasing Appeal records or spell out the steps staff should take prior to releasing PHI.***

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. Delegation						
1. The PIHP has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Alliance has current written agreements with 5 delegated entities. Delegated Agreements with 2 other vendors ended on June 30, 2018. Executed Amendments extending the term of the Delegation Agreements include the statement "Contractor shall review and adhere to the related Alliance policies/procedures in the Original Agreement." The referenced policies and procedures in the Original Agreements were dated as early as 2014 and were not updated when Amendments were executed. Only 1 Delegation Agreement (which was executed in December 2018) included updated policies and procedures. At the Onsite review, Alliance provided a print-out of an email from a Senior Compliance Analyst-Internal Auditor to the SIS Team Lead in July 2018, indicating the SIS Team Lead would "provide current copies of the indicated procedures" to the SIS Evaluators. Alliance did not provide any other evidence of updated policies and procedures, nor documentation proving that updated policies and procedures were provided to the SIS Evaluators or to the other delegates (Prest and ProtoCall). ***Recommendation: Revise the Delegation Agreement Amendment language that references adhering to the "related Alliance policies/procedures in the Original Agreement," and include and reference the current relevant Alliance policies and procedures.***
2. The PIHP conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the PIHP if the PIHP were directly performing the delegated functions.	X					Alliance conducts periodic delegation monitoring and presents results to relevant committees.

VIII. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII A. General Requirements						
1. PIHP shall be familiar and comply with Section 1902(a)(68) of the Social Security Act, 42 C.F.R. Parts 438,455 and 1000 through 1008, as applicable, including proper payments to Providers and methods for detection of fraud and abuse.	X					This requirement is addressed in the *Alliance Corporate Compliance Plan*.
2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents' and subcontractors,' compliance with the requirements of this Section 14.	X					This requirement is addressed in the *Alliance Corporate Compliance Plan* and in *Procedure 3007 Guarding against Fraud and Abuse*.
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					This requirement is addressed in Alliance provider contract language as evidenced in group, solo, and agency contracts.
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					This requirement is addressed in the *Alliance Corporate Compliance Plan*.
VIII B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with 42 C.F.R. 438.608 that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to	X					This requirement is addressed in the *Alliance Corporate Compliance Plan*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
the DMA Contract Administrator on an annual basis.						
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of 42 C.F.R. 438.608 and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under DMA Contract in accordance with 42 CFR 438.608(a)(1)(iv).	X					This requirement is addressed in the *Alliance Corporate Compliance Plan*.
3. PIHP shall establish and implement a special investigations or program integrity unit, however named, that is responsible for PIHP program integrity activities, including identification, detection, and prevention of fraud, waste and abuse in the PIHP Closed Provider Network. PIHP shall identify an appropriately qualified contact for Program Integrity and Regulatory	X					This requirement is addressed in the *Alliance Corporate Compliance Plan*. Alliance shared its detailed *Organizational Chart* identifying sufficient staffing and autonomy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
Compliance issues as mutually agreed upon by PIHP and DMA. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator.						
4. PIHP shall participate in quarterly Program Integrity meetings with DMA Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').	X					No evidence was found within Alliance policies and procedures that addresses the requirement found in *DMA Contract, Section 14.2.4*, which states, "PIHP shall participate in quarterly Program Integrity meetings with DMA Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the NC Department of Justice ("MFCU/ MID')." In addition, Alliance should maintain a record of attendance at the quarterly meetings, either through saved emails (or screen shots), or attendance sheets. ***Recommendation: Add specific language to procedures that addresses the requirement that Alliance attend quarterly PI meetings with the state. See DMA Contract, Section 14.2.4 which states, "PIHP shall participate in quarterly Program Integrity meetings with DMA Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the NC Department of Justice ("MFCU/ MID')."*** ***In addition, Alliance should maintain a record of attendance at the quarterly meetings, either through saved emails (or screen shots), or attendance sheets.***
5. PIHP shall participate in monthly meetings with DMA Program Integrity, in the most productive setting, either telephonically or in person at PIHP's discretion, to review and discuss	X					This requirement is addressed on page 8 of the *Alliance Procedure 3007, Guarding against Fraud and Abuse*. Alliance provided monthly meeting minutes.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
relevant Program Integrity and/or Regulatory Compliance issues.						
6. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information	X					This requirement is addressed on page 8 of the *Alliance Procedure 3007, Guarding against Fraud and Abuse*. Alliance provided monthly meeting minutes.
7. PIHP shall also make Regulatory Compliance minutes and Program Integrity minutes, redacted as deemed appropriate by PIHP, available for review upon request by DMA.				X		No requests were made during the review period.
8. PIHP's written Compliance Plan shall, at a minimum include:						
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(66) of the Social Security Act;	X					This requirement is addressed in the *Alliance Corporate Compliance Plan* and in the *Program Integrity Workplan*. Alliance shared the *Provider Operations Manual*, *Individual and Family Handbook*, and screen shots from the member website which detail the fraud, waste and abuse program and methods for reporting. Alliance provided PowerPoint slides from quarterly trainings, screen shots of internal employee communications, and announcements of fraud training, member mailings that identified methods of reporting fraud, waste and abuse, SIU Newsletters, and sign in sheets showing attendance in annual compliance training and quarterly fraud, waste and abuse training.
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing	X					This requirement is addressed in the *Alliance Corporate Compliance Plan*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
and development of corrective action initiatives;						
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					This requirement is addressed in the *Alliance Corporate Compliance Plan*.
8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including DMA or MFCU/MID, and including promptly supplying all data and information requested for their respective investigations	X					This requirement is addressed in the *Alliance Corporate Compliance Plan*.
9. In accordance with 42 CFR 436.606(a)(vii), PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under DMA Contract, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under DMA Contract; and making documentation of investigations and	X					This requirement is addressed in the *Alliance Corporate Compliance Plan*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
compliance available as requested by the State.						
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					This requirement is addressed in the Alliance *Procedure 3007, Guarding against Fraud and Abuse*.
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse;	X					This requirement is addressed in the Alliance *Procedure 3007, Guarding against Fraud and Abuse*.
10.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure. This process shall include procedures for logging the complaint, determining if the complaint is valid, assigning the complaint, investigating, appeal, recoupment, and closure. The detailed workflow needs to differentiate the steps taken for fraud versus abuse; PIHP shall establish and implement policies for treatment of recoveries of all overpayments from PIHP to Providers and contracted agencies, specifically including retention policies for treatment of recoveries of overpayments due to fraud, waste, or abuse. The retention policies shall include processes, timeframes, and required documentation for payment of recoveries of overpayments to the State in situations where PIHP is not	X					Alliance provided the SIU incidents workflow diagram. The SIU team also provided a look at the specific instructions that are a part of the Alliance workflow in its native One Note environment which has a drill down to the steps to be taken at each step in the flow. Alliance provided *Procedure 3008, Special Investigations* which has a narrative outline of the full process from reporting of a complaint through closure and referral to NC Medicaid if warranted. This process narrative does show a divergent path for those cases where evidence of fraud appears as opposed to abuse. Alliance provided Description of Complaint Tracking.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
permitted to retain some or all of the recoveries of overpayments. This provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.						
10.3 In accordance with Attachment Y – Audits/Self-Audits/Investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					This requirement is addressed in Alliance *Procedure 1517, Overpayments*. Alliance also provided copies of their monthly *Attachment Y* submissions.
10.4 Process for tracking overpayments and collections, and reporting on Attachment Y – Audits/Self-Audits/Investigations;	X					This requirement is addressed in the *Attachment Y* submissions from the review period.
10.5 Process for handling self-audits and challenge audits;	X					This requirement is addressed in Alliance *Procedure 3030, Auditing of Claims.*
10.6 Process for using data mining to determine leads;	X					Alliance provided *Procedure 3030, Auditing of Claims*. Section A describes Random Sample Audits details a procedure for weekly automated audits via machine algorithm. Alliance also provided sample data mining reports written to filter for aberrations such as billing for deceased members, evidence of overlapping services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.7 Process for informing PIHP employees, subcontractors and providers regarding the False Claims Act;	X					Alliance provided copies of the internal SIU newsletter for employees.
10.8 If PIHP makes or receives annual payments of at least $5,000,000, PIHP shall establish and maintain written policies for all employees, contractors or agents that detail information about the False Claims Act and other Federal and State laws as described in the Social Security Act 1902(a)(66), including information about rights of employees to be protected as whistleblowers.	X					This requirement is addressed in Alliance *Policy C5, Employee Code of Ethics and Conduct*.
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains DMA-standardized elements or a DMA-approved template;	X					This requirement is addressed on page 5 of Alliance *Procedure 3007 Guarding against Fraud and Abuse*.
10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available	X					This requirement is addressed on page 3 of Alliance *Procedure 3007, Guarding against Fraud and Abuse* as well as page 2 of *Procedure 6030, Credentialing Criteria and Enrollment Process for Network Participation*. Alliance also provided template credentialing and re-credentialing applications that capture the required information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
database or other search mechanism.						
11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.	X					This requirement is addressed in Alliance *Procedure 1517, Overpayments* and *Procedure 3044, Provider Dispute Resolution*.
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to DMA within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					This requirement is addressed in *Alliance Procedure 3008, Special Investigations*.
13. In each case where PIHP refers to DMA an allegation of fraud involving a Provider, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:						This requirement is addressed in *Alliance Procedure 3008, Special Investigations*. Alliance uses Compliance 360 system for all compliance issues including investigations. The system has a summary and the final investigation report has one, too.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Alliance's final investigation report template has an example of an executive summary section at the beginning. Alliance could move to a similar format in investigation summaries and other interim documents so that the information is available in one place throughout the process. Also, financial information, such as exposed amount, could be added to summary.
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					All 15 of the files reviewed "Met" the requirement.
13.2 Source/origin of complaint;	X					All 15 of the files reviewed "Met" the requirement.
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					All 15 of the files reviewed "Met" the requirement.
13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations or policies violated; and dates of suspected intentional misconduct;	X					All 15 of the files reviewed "Met" the requirement.
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					Five of the files reviewed were resolved at a point in the investigation before claims history or dollar exposure calculation was necessary. All 10 of the remaining files "Met" the requirement.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.6 All communications between PIHP and the Provider concerning the conduct at issues, when available.	X					Seven of the files reviewed were resolved at a point in the investigation where no communication with the provider took place. All eight of the files reviewed "Met" the requirement.
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					All 15 of the files reviewed "Met" the requirement.
13.8 Sample/exposed dollar amount, when available.	X					Five of the files reviewed were resolved at a point in the investigation before claims history or dollar exposure calculation was necessary. All 10 of the remaining files "Met" the requirement.
14. In each case where PIHP refers suspected Enrollee fraud to DMA, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:						This requirement is addressed in Alliance *Procedure 3008, Special Investigations*. No cases of Enrollee fraud were provided in the sample.
14.1 The Enrollee's name, birth date, and Medicaid number;					X	
14.2 The source of the allegation;					X	
14.3 The nature of the allegation, including the timeframe of the allegation in question;					X	
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;					X	

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;					X	
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and					X	
14.7 The legal and administrative status of the case.					X	
15. PIHP and DMA shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of State and Federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.	X					The only change to previously approved tools and letters was the referral form, which was approved by NC Medicaid.
16. PIHP shall use the DMA Fraud and Abuse Management System (FAMS) or a DMA approved alternative data mining technology solution to detect and prevent fraud, waste and abuse in managed care.	X					Alliance stated they have contracted with IBM to begin using FAMS. Their current process is a dedicated Data Analyst who uses claims data and business intelligence software to create in-house detection and MicroStrategy for reporting. Alliance provided several examples of robust data mining reports.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
17. If PIHP uses FAMS, PIHP shall work with the DMA designated Administrator to submit appropriate claims data to load into the DMA Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the DMA designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.				X		
18. PIHP shall submit to the DMA Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month. Section 9.8 Fraud and Abuse Reports. In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to DMA Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to DMA Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including	X					This requirement is addressed on page eight of the Alliance *Procedure 3007, Guarding against Fraud and Abuse*. Alliance also provided copies of their monthly *Attachment Z* submissions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.						
19. On a quarterly basis, DMA shall review a sample of cases where the PIHP's Special Investigation Unit has identified overpayments, investigated or audited a provider. The results of these reviews will be discussed during the PIHP monthly Program Integrity meetings to assure that DMA is providing consistent guidance on expectations with regard to referrals for potential cases of fraud. DMA shall also determine what additional technical assistance may be available to PIHP to support PIHP's efforts in making referrals.	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
completed and the Provider is cleared of any wrongdoing.						
1.1 In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.		X				No evidence was found within Alliance policies and procedures that addresses the requirement found in *DMA Contract, Section 14.3.1 (d)* which states, "In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension." ***Corrective Action: Add specific language to procedures that addresses payment suspension requirements. See DMA Contract, Section 14.3.2 which states, "In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension."***
2. Upon receipt of a payment suspension notice from DMA Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of DMA Program Integrity's suspension and lasting until PIHP is notified by DMA Program Integrity in writing that the suspension has been lifted.		X				There is no language explaining the payment suspension requirements found in *DMA Contract, Section 14.3.2* which states, "Upon receipt of a payment suspension notice from DMA Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of DMA Program Integrity's suspension and lasting until PIHP is notified by DMA Program Integrity in writing that the suspension has been lifted." ***Corrective Action: Add specific language to procedures that addresses requirements for lifting payment suspension. See DMA Contract, Section 14.3.2 which states, "Upon receipt of a payment suspension notice from DMA Program Integrity, PIHP***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of DMA Program Integrity's suspension and lasting until PIHP is notified by DMA Program Integrity in writing that the suspension has been lifted."
3. PIHP shall provide to DMA all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					This requirement is addressed in the *Alliance Corporate Compliance Plan*.
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to DMA Program Integrity due to allegations of suspected fraud without prior written approval from DMA Program Integrity or the MFCU/MID.	X					This requirement is addressed in Alliance *Procedure 3008, Special Investigations*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. Notwithstanding the foregoing, nothing herein shall be construed as prohibiting PIHP from taking any action against a Network Provider in accordance with the terms and conditions of any written agreement with a Network Provider, including but not limited to prepayment review, identification and collection of overpayments, suspension of referrals, de-credentialing, contract nonrenewal, suspension or termination or other sanction, remedial or preventive efforts necessary to ensure continuous, quality care to Enrollees, regardless of any ongoing investigation being conducted by DMA, MFCU/MID or other oversight agency, to the extent that such action shall not interfere with Enrollee access to care or with any such ongoing investigation being conducted by DMA, MFCU/MID or other oversight agency.	X					This requirement is addressed in Alliance *Procedure 3043, Provider Sanctions, Administrative Actions, and Suspensions to Ensure Patient Safety*.
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by	X					This requirement is addressed in Alliance *Procedure 1538, NC DHHS Mandated Recovery of Funds*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.						
7. Recovery Audit Contactors (RACs) for the Medicaid program may audit Providers in the PIHP Network and may work collaboratively with PIHP on identification of overpayments. DMA shall require RACs to give PIHP prior written notice of such audits and the results of any audits as permitted by law.						
8. The MFCU/MID reserves the right to prosecute or seek civil damages regardless of payments made by the Provider to PIHP. The Parties shall work collaboratively to develop a plan for the disbursement of the share of monies that are recovered and returned to the state by the MFCU/MID for fraudulent claims paid by PIHP. DMA will examine options to refund returned funds to PIHP and/or to appropriately account for these recoveries in the rate setting process.						

IX. FINANCIAL SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IX. Financial						
1. The PIHP has policies and systems in-place for submitting and reporting financial data.	X					This requirement is addressed in *Procedure 1527, DMA Financial Reporting*.
2. The PIHP has and adheres to a cost allocation plan that meets the requirements of 42 CFR § 433.34.	X					This requirement is addressed in *Procedure 1540, Cost Allocation,* under which Item C explains the administrative expense allocation between their funding/revenue sources.
3. PIHP maintains detailed records of the administrative costs and expenses incurred as required by the DMA contract. (DMA Contract, Section 8.3).	X					This requirement is addressed in *Procedure 1540, Cost Allocation.* Administrative costs are recorded monthly to their natural expense account and are allocated by journal entries to the respective accounts using the percentages calculated at the beginning of the fiscal year.
4. Maintains an accounting system in accordance with 42 CFR § 433.32 (a).	X					Alliance uses Microsoft GP Dynamics version 2015.
5. The PIHP follows a record retention policy of retaining records for ten years.	X					This requirement is addressed in *Procedure 3016, Records Retention and Destruction.* ***Recommendation: Alliance should change* Procedure *3016, Records Retention and Destruction to reflect retention for ten (10) years of all Medicaid records, in accordance with DMA Contract, Section 8.3.2.***
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution.	X					Alliance maintains their restricted risk reserve account at Wells Fargo Bank. They provided bank statements for November and December 2018. These balances agree with the November and December 2018 Medicaid reports. The November 2018 deposit was made on November 8, and the balance was $46,515,252.81. The December 2018 deposit was made on December 6, and the balance was $47,315,493.89.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
7. The required minimum balance of the Risk Reserve Account meets the requirements of the DMA contract. (DMA Contract, Section 1.8 Restricted Risk Reserve Account)	X					This requirement is addressed *in Procedure 1506, Risk Reserve Account*.
8. All funds received by PIHP are accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as required by the DMA contract (DMA Contract, Section 1.9).	X					This requirement is addressed in *Procedure 1500, Accounting by Funding Source*. To confirm that they are correctly coded, the general ledger accounts are coded in segments by funding source. Alliance provided a copy of their general ledger chart of accounts, as well as a breakdown of the segments of the chart of account segments.
9. The Medical Loss Ratio (MLR) meets the requirements of 42 CFR § 438.8 and the DMA contract (Amendment 2, Section 12.3 Item k).	X					This requirement is addressed in *Procedure 1537, Medical Loss Ratio*. The Accounting Manager reviews and changes the Medical Loss Ratio (MLR) activities template based on federal regulation, reviewing changes to activities designed to improve healthcare quality. This review in done in May, and seeks input from the Care Management Division, Office of Legal Affairs, and financial senior leadership. The updated signed MLR activities are due back to the accounting team by June 1. The changes must include an update to the rationale used to determine the basis for inclusion and basis for percentage calculated. Each month, the Senior Accountant will compile and save information in order to accurately calculate and support the MLR. This will include invoice detail and support, salary information. The MLR will be reported on Schedule O of the financial reporting template and submitted monthly. It is reported back to the Board of Directors monthly.

E. Attachment 5: Encounter Data Validation Report

Alliance Behavioral Healthcare

Encounter Data Validation Report

performed on behalf of

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

March 27, 2019

Prepared By:

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Background

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

In order to utilize the encounter data as intended and provide proper oversight, NC Medicaid must be able to confirm the data submitted to the Division of Health Benefits (DHB) is complete and accurate.

Overview

The scope of our review, guided by the CMS Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid by Alliance for the period of January 2017 through December 2017. All claims paid by Alliance should be submitted and accepted as a valid encounter to NC Medicaid. Our approach to the review included:

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

Review of Alliance's ISCA response

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

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

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

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

Looking at claims with dates of service in 2017, Alliance submitted 2,464,787 unique encounters to the state. To date, 2% of all encounters submitted have not been corrected and accepted by NC Medicaid.

2017	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	106,893	102,277	2,618	1,998	2%
Professional	2,357,894	2,196,805	123,870	37,219	2%
Total	2,464,787	2,299,082	126,488	39,217	2%

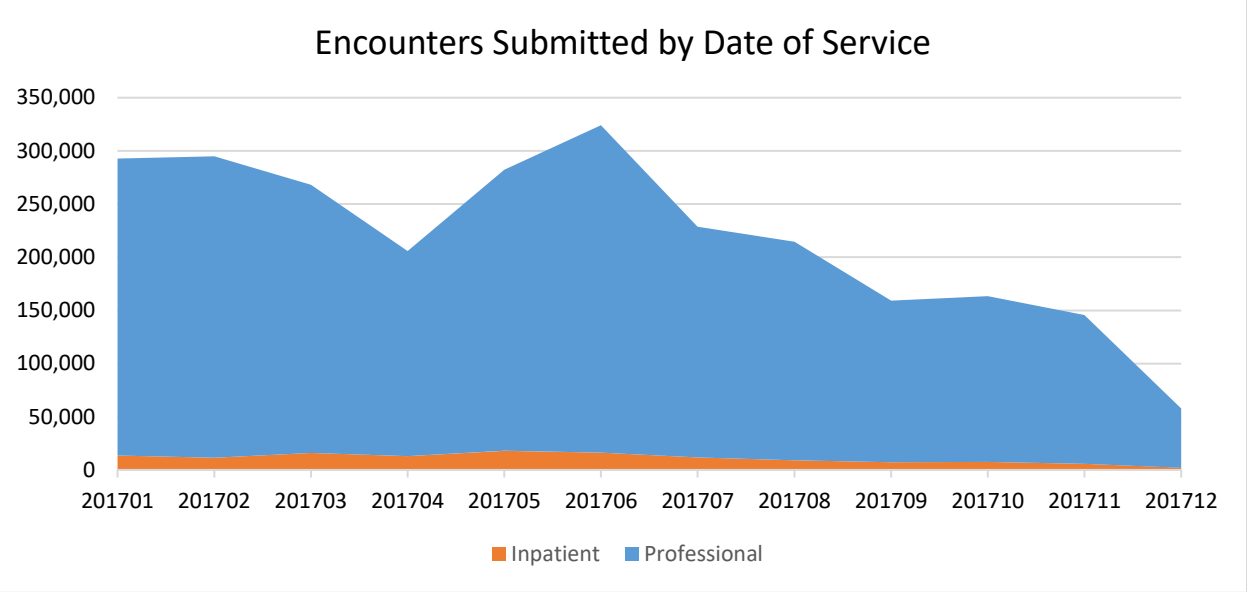
Compared to claims submitted and accepted in 2016, Alliance has improved on the number of initial denials and total number of outstanding denials for claims submitted in 2017. Looking at denials month over month, Alliance showed significant improvements in the number of claims initially accepted starting in September of 2017.

According to Alliance's response and review of NC Medicaid's acceptance report, 50% of all outstanding and ongoing denials are still related to invalid taxonomy codes for the billing and rendering provider or invalid combination of procedure code and taxonomy. Alliance's strategy to continue to reduce, correct and resubmit encounter denials includes the following steps:

- Provide continuous provider education
- Rebilling corrected encounter denials
- Utilize internal Account Receivables application to monitor and track encounter claims
- Dedicate claims staff to reviewing and resubmitting denied encounters

Analysis of Encounters

The analysis of encounter data evaluated whether Alliance submitted complete, accurate, and valid data to NC Medicaid for all claims paid between January 1, 2017 through December 31, 2017. Alliance pulled all claims adjudicated and submitted to NC Medicaid during 2017 and sent to HMS via SFTP. This included more than 3 million Professional claims and just over 498,000 Institutional claims. Data transmitted included resubmissions for previously denied claims, so the numbers do not reconcile back to the metrics reported in the ISCA response.



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

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

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

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

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

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

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

Encounter Accuracy and Completeness

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

Table: Evaluation of Key Fields

Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	3,591,793	100.00%	3,591,516	99.99%	3,591,516	99.99%	3,591,516	99.99%
Recipient Name	3,591,793	100.00%	3,591,793	100.00%	3,591,793	100.00%	3,591,793	100.00%
Recipient Date of Birth	3,591,793	100.00%	3,591,793	100.00%	3,591,793	100.00%	3,591,793	100.00%
MCO/PIHP ID	3,591,793	100.00%	3,591,793	100.00%	3,591,793	100.00%	3,591,793	100.00%
Provider ID	3,590,584	99.97%	3,590,584	99.97%	3,590,584	99.97%	3,590,584	99.97%
Attending/Renderring Provider ID	3,590,514	99.96%	3,590,479	99.96%	3,590,479	99.96%	3,590,479	99.96%
Provider Location	3,591,793	100.00%	3,591,793	100.00%	3,591,793	100.00%	3,591,793	100.00%
Place of Service	3,591,777	100.00%	3,591,777	100.00%	3,591,777	100.00%	3,591,777	100.00%
Specialty Code / Taxonomy - Billing	3,591,793	100.00%	3,591,793	100.00%	3,591,793	100.00%	3,591,793	100.00%
Specialty Code / Taxonomy - Rendering / Attending	3,591,793	100.00%	3,591,782	100.00%	3,591,782	100.00%	3,591,782	100.00%
Principal Diagnosis	3,591,777	100.00%	3,591,777	100.00%	3,591,777	100.00%	3,591,777	100.00%
Other Diagnosis	3,093,471	86.13%	3,093,471	86.13%	3,093,471	86.13%	3,093,471	86.13%
Dates of Service	3,591,793	100.00%	3,591,793	100.00%	3,591,793	100.00%	3,591,793	100.00%
Unit of Service (Quantity)	3,591,793	100.00%	3,591,793	100.00%	3,591,793	100.00%	3,591,793	100.00%
Procedure Code	3,386,275	94.28%	3,386,254	94.28%	3,386,254	94.28%	3,386,254	94.28%
Procedure Code Modifier	325,765	9.07%	325,765	9.07%	325,765	9.07%	325,765	9.07%
Patient Discharge Status Code Inpatient	498,322	100.00%	498,322	100.00%	498,322	100.00%	498,322	100.00%
Revenue Code	498,322	100.00%	498,215	99.98%	498,215	99.98%	498,215	99.98%

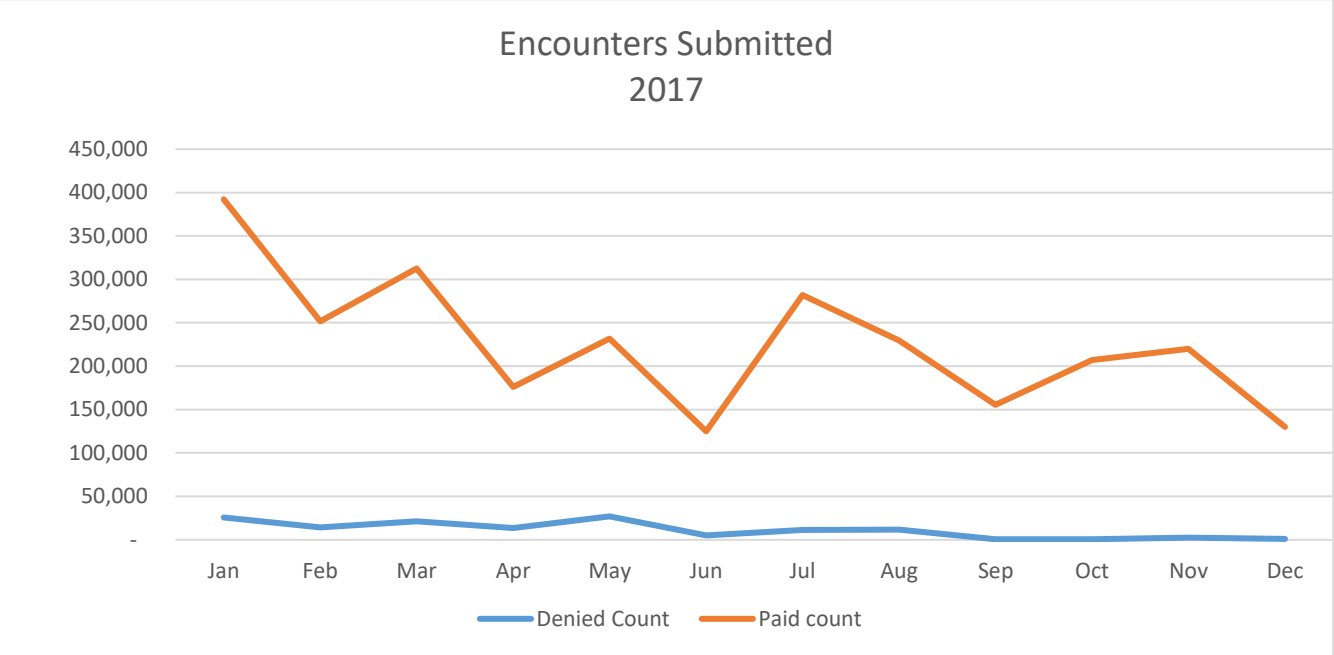
Alliance has put a lot of effort into improving the accuracy of their encounter data, making significant improvements in quality and accuracy. Improvements were noted for both Institutional and Professional claims. Based upon the onsite review and additional feedback from Alliance via email, the issues should be addressed in the 2018 claims data.

Institutional claims contained complete and valid data in 16 of the 18 key fields (88%) with noted issues for procedure code and other diagnoses being reported. The procedure code was missing or invalid for 41% of the claims. Given the services provided and revenue codes submitted, the procedure code should have been more consistently populated with valid values. A secondary nor any additional diagnosis code was not provided for the Institutional claims submitted.

Professional encounter claims submitted contained complete and accurate data in 15 of the 15 key Professional fields (100%). There were minor anomalies associated with a few key fields, but none of the data inconsistencies exceeded the thresholds defined in the data quality standards table above on page 4 and 5.

Encounter Acceptance Report

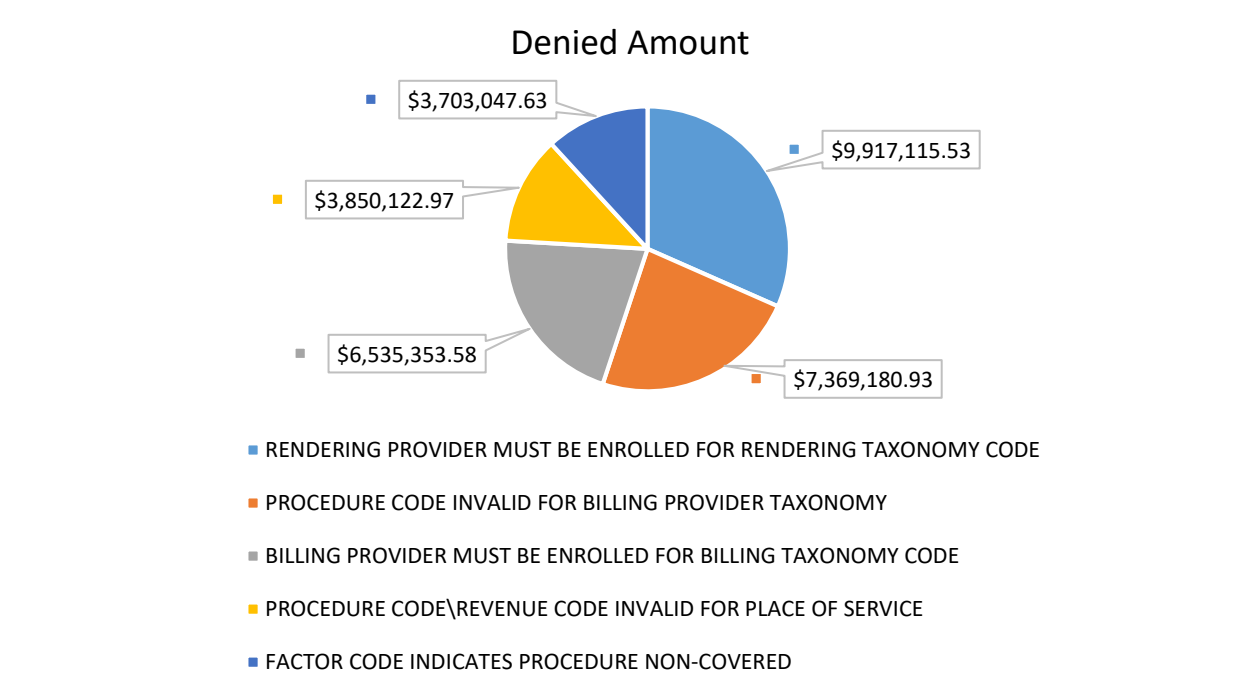
In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each LME/MCO. The report is tracked by check write, which made it difficult to tie back to the ISCA response and the submitted encounter files since only the Date of Service for each is available. During the 2017 weekly check write schedule, Alliance submitted 2,713,308 encounters to NC Medicaid. On average, 5% of all encounters submitted were initially denied. Approximately 2% of claims denied are still outstanding -- the rest have been reviewed, resubmitted, and accepted by NC Medicaid.

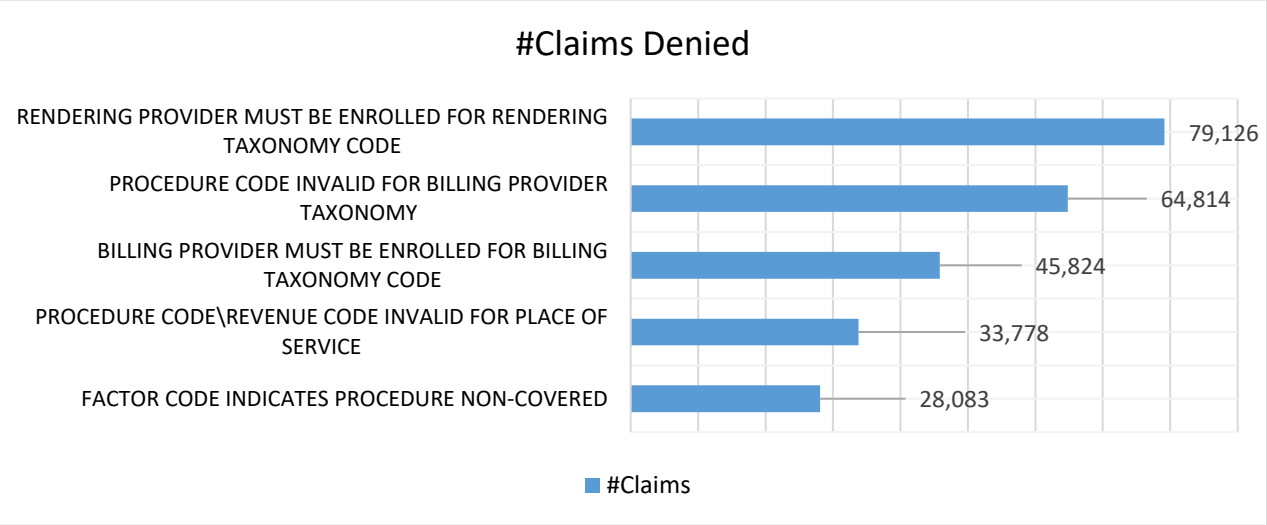


Evaluation of the top denials for Alliance encounters correlates with the some of the data deficiencies identified by the HMS analyst in the Key Field analysis above. Encounters were denied primarily for:

- Rendering provider must be enrolled for rendering taxonomy code
- Procedure code invalid for billing provider taxonomy
- Billing provider must be enrolled for billing taxonomy code
- Procedure code / revenue code invalid for place of service
- Factor code indicates procedure non-covered

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





Results and Recommendations

Issue: Procedure Code

The procedure code for Institutional claims should populated 99% of the time. In the encounter data provided, HMS found that the field was populated 59% of the time with valid values; in all other instances the value was null. Valid procedure codes are needed to better understand the services provided and are usually required to adjudicate the claim appropriately. Given the types of services provided, the provider should have provided additional procedure codes in support of the line level revenue code supplied.

Resolution:

Alliance should ensure that the appropriate data validation checks and that claims submitted through their portal or an 837 should be denied by Alliance without the proper revenue code and procedure code combination. Alliance should review their 837 encounter creation and encounter data extract process to ensure that an invalid procedure code is not transmitted to DHB, even when the data is invalid based on the provider claim submission.

Issue: Diagnosis Codes

The secondary diagnosis was not populated at all for Institutional claims. This value is not required by Alliance when adjudicating the claim, therefore, not a requirement of the provider when submitting via Provider Portal or 837.

Resolution:

Alliance should work closely with their provider community and encourage them to submit all applicable diagnosis codes, behavioral and medical. This information is key for measuring member health, identifying areas of risk, and evaluating quality of care. Alliance did confirm that they are capturing additional diagnosis codes and made changes to report them to DHB in their encounter submission in 2018. HMS will validate this update in our 2018 encounter data review.

Conclusion

Based on the analysis of Alliance's encounter data, we have concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues still exist with their submission of Institutional encounters and need to be addressed in order to be compliant. Alliance should take corrective action to resolve the issues identified with procedure code and diagnosis codes, as well as continue to work on improving all up front denials. They have outlined a great approach and implemented several key practices to ensure that their front end denials continue to go down as well as their total outstanding encounter denials. It is HMS's expectation that Alliance will be able to demonstrate accurate and complete data for encounters submitted in 2018 and moving forward.

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

Appendix 1

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
00001	HDR BEG DOS INVLD/ > TCN DATE	DENY
00002	ADMISSION DATE INVALID	DENY
00003	HDR END DOS INVLD/ > TCN DATE	DENY
00006	DISCHARGE DATE INVALID	PAY AND REPORT
00007	TOT DAYS CLM GTR THAN BILL PER	PAY AND REPORT
00023	SICK VISIT BILLED ON HC CLAIM	IGNORE
00030	ADMIT SRC CD INVALID	PAY AND REPORT
00031	VALUE CODE/AMT MISS OR INVLD	PAY AND REPORT
00036	HEALTH CHECK IMMUNIZATION EDIT	IGNORE
00038	MULTI DOS ON HEALTH CHECK CLM	IGNORE
00040	TO DOS INVALID	DENY
00041	INVALID FIRST TREATMENT DATE	IGNORE
00044	REQ DIAG FOR VITROCERT	IGNORE
00051	PATIENT STATUS CODE INVALID	PAY AND REPORT
00055	TOTAL BILLED INVALID	PAY AND REPORT
00062	REVIEW LAB PATHOLOGY	IGNORE
00073	PROC CODE/MOD END-DTE ON FILE	PAY AND REPORT
00076	OCC DTE INVLD FOR SUB OCC CODE	PAY AND REPORT
00097	INCARCERATED - INPAT SVCS ONLY	DENY
00100	LINE FDOS/HDR FDOS INVALID	DENY
00101	LN TDOS BEFORE FDOS	IGNORE
00105	INVLD TOOTH SURF ON RSTR PROC	IGNORE
00106	UNABLE TO DETERMINE MEDICARE	PAY AND REPORT
00117	ONLY ONE DOS ALLOWED/LINE	PAY AND REPORT

00126	TOOTH SURFACE MISSING/INVALID	IGNORE
00127	QUAD CODE MISSING/INVALID	IGNORE
00128	PROC CDE DOESNT MATCH TOOTH #	IGNORE
00132	HCPCS CODE REQ FOR REV CODE	IGNORE
00133	HCPCS CODE REQ BILLING RC 0636	IGNORE
00135	INVL POS INDEP MENT HLTH PROV	PAY AND REPORT
00136	INVLD POS FOR IDTF PROV	PAY AND REPORT
00140	BILL TYPE/ADMIT DATE/FDOS	DENY
00141	MEDICAID DAYS CONFLICT	IGNORE
00142	UNITS NOT EQUAL TO DOS	PAY AND REPORT
00143	REVIEW FOR MEDICAL NECESSITY	IGNORE
00144	FDOS AND TDOS MUST BE THE SAME	IGNORE
00146	PROC INVLD - BILL PROV TAXON	PAY AND REPORT
00148	PROC\REV CODE INVLD FOR POS	PAY AND REPORT
00149	PROC\REV CD INVLD FOR AGE	IGNORE
00150	PROC CODE INVLD FOR RECIP SEX	IGNORE
00151	PROC CD/RATE INVALID FOR DOS	PAY AND REPORT
00152	M/I ACC/ANC PROC CD	PAY AND REPORT
00153	PROC INVLD FOR DIAG	PAY AND REPORT
00154	REIMB RATE NOT ON FILE	PAY AND REPORT
00157	VIS FLD EXAM REQ MED JUST	IGNORE
00158	CPT LAB CODE REQ FOR REV CD	IGNORE
00164	IMMUNIZATION REVIEW	IGNORE
00166	INVALID VISUAL PROC CODE	IGNORE
00174	VACCINE FOR AGE 00-18	IGNORE
00175	CPT CODE REQUIRED FOR RC 0391	IGNORE

00176	MULT LINES SAME PROC, SAME TCN	IGNORE
00177	HCPCS CODE REQ W/ RC 0250	IGNORE
00179	MULT LINES SAME PROC, SAME TCN	IGNORE
00180	INVALID DIAGNOSIS FOR LAB CODE	IGNORE
00184	REV CODE NOT ALLOW OUTPAT CLM	IGNORE
00190	DIAGNOSIS NOT VALID	DENY
00192	DIAG INVALID RECIP AGE	IGNORE
00194	DIAG INVLD FOR RECIP SEX	IGNORE
00202	HEALTH CHECK SHADOW BILLING	IGNORE
00205	SPECIAL ANESTHESIA SERVICE	IGNORE
00217	ADMISSION TYPE CODE INVALID	PAY AND REPORT
00250	RECIP NOT ON ELIG DATABASE	DENY
00252	RECIPIENT NAME/NUMBER MISMATCH	PAY AND REPORT
00253	RECIP DECEASED BEFORE HDR TDOS	DENY
00254	PART ELIG FOR HEADER DOS	PAY AND REPORT
00259	TPL SUSPECT	PAY AND REPORT
00260	M/I RECIPIENT ID NUMBER	DENY
00261	RECIP DECEASED BEFORE TDOS	DENY
00262	RECIP NOT ELIG ON DOS	DENY
00263	PART ELIG FOR LINE DOS	PAY AND REPORT
00267	DOS PRIOR TO RECIP BIRTH	DENY
00295	ENC PRV NOT ENRL TAX	IGNORE
00296	ENC PRV INV FOR DOS	IGNORE
00297	ENC PRV NOT ON FILE	IGNORE
00298	RECIP NOT ENRL W/ THIS ENC PRV	IGNORE
00299	ENCOUNTER HMO ENROLLMENT CHECK	PAY AND REPORT

00300	BILL PROV INVALID/ NOT ON FILE	DENY
00301	ATTEND PROV M/I	PAY AND REPORT
00308	BILLING PROV INVALID FOR DOS	DENY
00313	M/I TYPE BILL	PAY AND REPORT
00320	VENT CARE NO PAY TO PRV TAXON	IGNORE
00322	REND PROV NUM CHECK	IGNORE
00326	REND PROV NUM CHECK	PAY AND REPORT
00328	PEND PER NC MEDICAID REQ FOR FIN REV	IGNORE
00334	ENCOUNTER TAXON M/I	PAY AND REPORT
00335	ENCOUNTER PROV NUM MISSING	DENY
00337	ENC PROC CODE NOT ON FILE	PAY AND REPORT
00339	PRCNG REC NOT FND FOR ENC CLM	PAY AND REPORT
00349	SERV DENIED FOR BEHAV HLTH LM	IGNORE
00353	NO FEE ON FILE	PAY AND REPORT
00355	MANUAL PRICING REQUIRED	PAY AND REPORT
00358	FACTOR CD IND PROC NON-CVRD	PAY AND REPORT
00359	PROV CHRGS ON PER DIEM	PAY AND REPORT
00361	NO CHARGES BILLED	DENY
00365	DRG - DIAG CANT BE PRIN DIAG	DENY
00366	DRG - DOES NOT MEET MCE CRIT.	PAY AND REPORT
00370	DRG - ILLOGICAL PRIN DIAG	PAY AND REPORT
00371	DRG - INVLD ICD-9-CM PRIN DIAG	DENY
00374	DRG PAY ON FIRST ACCOM LINE	DENY
00375	DRG CODE NOT ON PRICING FILE	PAY AND REPORT
00378	DRG RCC CODE NOT ON FILE DOS	PAY AND REPORT
00439	PROC\REV CD INVLD FOR AGE	IGNORE

00441	PROC INVLD FOR DIAG	IGNORE
00442	PROC INVLD FOR DIAG	IGNORE
00613	PRIM DIAG MISSING	DENY
00628	BILLING PROV ID REQUIRED	IGNORE
00686	ADJ/VOID REPLC TCN INVALID	DENY
00689	UNDEFINED CLAIM TYPE	IGNORE
00701	MISSING BILL PROV TAXON CODE	DENY
00800	PROC CODE/TAXON REQ PSYCH DX	PAY AND REPORT
00810	PRICING DTE INVALID	IGNORE
00811	PRICING CODE MOD REC M/I	IGNORE
00812	PRICING FACTOR CODE SEG M/I	IGNORE
00813	PRICING MOD PROC CODE DTE M/I	IGNORE
00814	SEC FACT CDE X & % SEG DTE M/I	IGNORE
00815	SEC FCT CDE Y PSTOP SEG DT M/I	IGNORE
01005	ANTHES PROC REQ ANTHES MODS	IGNORE
01060	ADMISSION HOUR INVALID	IGNORE
01061	ONLY ONE DOS PER CLAIM	IGNORE
01102	PRV TAXON CHCK - RAD PROF SRV	IGNORE
01200	INPAT CLM BILL ACCOM REV CDE	DENY
01201	MCE - ADMIT DTE = DISCH DTE	DENY
01202	M/I ADMIT AND DISCH HRS	DENY
01205	MCE: PAT STAT INVLD FOR TOB	DENY
01207	MCE - INVALID AGE	PAY AND REPORT
01208	MCE - INVALID SEX	PAY AND REPORT
01209	MCE - INVALID PATIENT STATUS	DENY
01705	PA REQD FOR CAPCH/DA/CO RECIP	PAY AND REPORT

01792	DME SUPPLIES INCLD IN PR DIEM	DENY
02101	INVALID MODIFIER COMB	IGNORE
02102	INVALID MODIFIERS	PAY AND REPORT
02104	TAXON NOT ALLOWED WITH MOD	PAY AND REPORT
02105	POST-OP DATES M/I WITH MOD 55	IGNORE
02106	LN W/ MOD 55 MST BE SAME DOS	IGNORE
02107	XOVER CLAIM FOR CAP PROVIDER	IGNORE
02111	MODIFIER CC INTERNAL USE ONLY	IGNORE
02143	CIRCUMCISION REQ MED RECS	IGNORE
03001	REV/HCPCS CD M/I COMBO	IGNORE
03010	M/I MOD FOR PROF XOVER	IGNORE
03012	HOME HLTH RECIP NOT ELG MCARE	IGNORE
03100	CARDIO CODE REQ LC LD LM RC RI	IGNORE
03101	MODIFIER Q7, Q8 OR Q9 REQ	IGNORE
03200	MCE - INVALID ICD-9 CM PROC	DENY
03201	MCE INVLD FOR SEX PRIN PROC	PAY AND REPORT
03224	MCE-PROC INCONSISTENT WITH LOS	PAY AND REPORT
03405	HIST CLM CANNOT BE ADJ/VOIDED	DENY
03406	HIST REC NOT FND FOR ADJ/VOID	DENY
03407	ADJ/VOID - PRV NOT ON HIST REC	DENY
04200	MCE - ADMITTING DIAG MISSING	DENY
04201	MCE - PRIN DIAG CODE MISSING	DENY
04202	MCE DIAG CD - ADMIT DIAG	DENY
04203	MCE DIAG CODE INVLD RECIP SEX	PAY AND REPORT
04206	MCE MANIFEST CODE AS PRIN DIAG	DENY
04207	MCE E-CODE AS PRIN DIAG	DENY

04208	MCE - UNACCEPTABLE PRIN DIAG	DENY
04209	MCE - PRIN DIAG REQ SEC DIAG	PAY AND REPORT
04210	MCE - DUPE OF PRIN DIAG	DENY
04506	PROC INVLD FOR DIAG	IGNORE
04507	PROC INVLD FOR DIAG	IGNORE
04508	PROC INVLD FOR DIAG	IGNORE
04509	PROC INVLD FOR DIAG	IGNORE
04510	PROC INVLD FOR DIAG	IGNORE
04511	PROC INVLD FOR DIAG	IGNORE
07001	TAXON FOR ATTND/REND PROV M/I	DENY
07011	INVLD BILLING PROV TAXON CODE	DENY
07012	INVLD REND PROV TAXONOMY CODE	DENY
07013	INVLD ATTEND PROV TAXON CODE	PAY AND REPORT
07100	ANESTH MUST BILL BY APPR PROV	IGNORE
07101	ASC MODIFIER REQUIREMENTS	IGNORE
13320	DUP-SAME PROV/AMT/DOS/PX	DENY
13420	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
13460	POSSIBLE DUP-SAME PROV/PX/DOS	PAY AND REPORT
13470	LESS SEV DUPLICATE OUTPATIENT	PAY AND REPORT
13480	POSSIBLE DUP SAME PROV/OVRLAP	PAY AND REPORT
13490	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13500	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13510	POSSIBLE DUP/SME PRV/OVRLP DOS	PAY AND REPORT
13580	DUPLICATE SAME PROV/AMT/DOS	PAY AND REPORT
13590	DUPLICATE-SAME PROV/AMT/DOS	PAY AND REPORT
25980	EXACT DUPE. SAME DOS/ADMT/NDC	PAY AND REPORT

34420	EXACT DUP SAME DOS/PX/MOD/AMT	PAY AND REPORT
34460	SEV DUP-SAME PX/PRV/IM/DOS/MOD	DENY
34490	DUP-PX/IM/DOS/MOD/$$/PRV/TCN	PAY AND REPORT
34550	SEV DUP-SAME PX/IM/MOD/DOS/TCN	PAY AND REPORT
39360	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
39380	EXACT/LESS SEVERE DUPLICATE	PAY AND REPORT
49450	PROCDURE CODE UNIT LIMIT	PAY AND REPORT
53800	Dupe service or procedure	PAY AND REPORT
53810	Dupe service or procedure	PAY AND REPORT
53820	Dupe service or procedure	PAY AND REPORT
53830	Dupe service or procedure	PAY AND REPORT
53840	Limit of one unit per day	PAY AND REPORT
53850	Limit of one unit per day	PAY AND REPORT
53860	Limit of one unit per month	PAY AND REPORT
53870	Limit of one unit per day	PAY AND REPORT
53880	Limit of 24 units per day	DENY
53890	Limit of 96 units per day	DENY
53900	Limit of 96 units per day	DENY