2022 External Quality Review

ALLIANCE HEALTH

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Prepared on behalf of
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 Alliance. This report contains a description of the process and the results of the 2022 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the North Carolina Medicaid (NC Medicaid).

Goals of the review are to:

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

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

A. Overall Findings

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

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

Due to the COVID-19 pandemic, CCME implemented a focused review. This decision was based on the issuance by the State of the COVID-19 flexibilities PIHP Contract Amendment #9. This PIHP contract amendment stated PIHPs "shall be held harmless for any documentation or other PIHP errors identified through the EQR that are not directly related to member health and safety through the Term of the Amendment." The focused review included comprehensive evaluation of the PIHP's health systems capabilities and provider credentialing and recredentialing documentation and processes. The review includes validation of the PIHP's Performance Improvement Projects, Performance Measures, and Encounter data. Lastly, a thorough review of the PIHP's Utilization Management, Grievances, and Appeals processes were conducted. The PIHP's network adequacy, availability of services, subcontractual relationships, and Clinical Practice Guidelines (*42 CFR § 438.206, § 438.207, § 438.230, and § 438.236,* respectively*)* were not reviewed.

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

Following the Onsite, the Alliance 2022 EQR report was generated and submitted to NC Medicaid for feedback and approval. Once approved, the report was issued to Alliance. After Alliance received their report, they disputed the "Partially Met" score of an Appeals standard with NC Medicaid. The State then determined this score issued by CCME was not "directly related to member health and safety", an exception noted in the COVID-19 flexibilities *PIHP Contract Amendment #9*. As directed by the State, Alliance's Appeal EQR score was changed to a "Met" and the Corrective Action was changed to a best practice Recommendation. This change also resulted in Alliance meeting 100% of the EQR standards versus the previous overall score of 99%.

B. Overall Recommendations

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

Administration

42 CFR § 438.224 and 42 CFR § 438.242

In the 2021 EQR, Alliance met 100% of the Administrative standards and received a Recommendation around the submission of ICD-10 Procedure codes on Institutional Encounter data extracts to NCTracks.

In the 2022 EQR, Alliance again met 100% of the Administrative standards. During the Onsite, Alliance stated some progress had been made towards addressing the 2021 Recommendation, but this Recommendation has not yet been implemented. Therefore, the 2021 EQR Recommendation is carried forward to the 2022 EQR Recommendations. Also, in this EQR, it was also recommended Alliance improve their tracking and monitoring of Encounter denials and timely re-submission of denied encounters to NC Tracks.

Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

In the 2021 EQR, Alliance met 100% of the Credentialing/Recredentialing standards, resulting in no Corrective Actions. CCME issued a Recommendation focused on ensuring accuracy and consistency across documents regarding Credentialing Committee membership. Alliance did not address the Recommendation from the 2021 EQR.

Procedure 6030 Initial Credentialing Criteria and Enrollment Process for Network Participation and Procedure 6036 were not revised from the versions of these procedures submitted for the 2021 EQR and continue to list conflicting information regarding Credentialing Committee membership. Additional information is provided in this report and in the Tabular Spreadsheet.

In the 2022 EQR, Alliance met 100% of the Credentialing/Recredentialing standards. CCME issued no Corrective Actions. Per the direction of the North Carolina Department of Health and Human Services (NC DHHS), credentialing has now shifted from the PIHPs completing credentialing and recredentialing to the PIHPs verifying credentialing completed by NCTracks. Alliance completed the in-process credentialing and recredentialing files in May 2022. Therefore, although the Recommendation from the 2021 EQR was not implemented, CCME is issuing no Recommendations in the 2022 EQR of Credentialing/Recredentialing.

Quality Improvement

42 CFR § 438.330

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

For the 2022 EQR, Alliance met 100% of the standards, resulting in no Corrective Actions. All PIPs were validated in the High Confidence range with Recommendations for two PIPs related to the lack of rate improvement. Alliance was Fully Compliant for (b) Waiver and (c) Waiver PMs. The (b) Waiver measure rates from this year were compared to last year and there were no measures with substantial declines. Mental health penetration rates increased substantially (>10%) for several counties and for several age ranges. These findings suggest that Alliance has a strong behavioral health network. The five (c) Waiver measures were well above the State benchmark of 85%.

Utilization Management

42 CFR § 438.208

In the 2021 EQR, Alliance met all of the Utilization Management standards. Two Recommendations were issued around errors within the *Individual and Family Handbook* and the *Innovations Individual* and *Family Handbook,* and the file review of an enrollee participating in the Innovations Waiver.

In the 2022 EQR, Alliance again met all of the Utilization Management standards. There was evidence in the documentation submitted for this year's EQR that Alliance partially addressed the 2021 EQR Recommendations but did not fully implement them. CCME is again recommending Alliance update information in the *Individual and Family Handbook* and the *Innovations Individual* and *Family Handbook* to accurately reflect all of the counties in Alliance's catchment area. Additionally, the same concerns noted in last year's enrollee file review were also noted in the files reviewed this year. Inconsistent practices across Care Managers related to the processes of updating each enrollee's Supports Intensity Scale (SIS) and monitoring of Innovations Waiver enrollees through either face-to-face or telehealth platforms were noted. Though it is understood that these activities were waived by NC Medicaid during the pandemic, CCME is again recommending Alliance enhance its review of enrollee files to identify inconsistencies in practices. This will be particularly important when NC Medicaid lifts the pandemic flexibilities.

Grievances and Appeals

42 CFR § 438, Subpart F, 42 CFR 483.430

In the 2021 EQR, Alliance met 100% of the Grievance and Appeal standards. Four Recommendations were issued to address concerns noted primarily in the *Provider Operations Manual* which has not been updated or revised since the 2020 EQR.

In the 2022 EQR, Alliance initially met 95% of the Grievance and Appeal standards. In the Grievances EQR, all standards were met, and four Recommendations were issued to address deficiencies. Alliance did not implement two 2021 Recommendations that carried over for this EQR. There were also several documentation errors around Grievances

where Alliance extended the Grievance resolution timeframe. There were also incorrect dates and data errors noted within the Grievance notifications and Grievance Log. In two files reviewed where the Grievance was withdrawn, only one file contained a written resolution.

In the 2022 Appeals EQR, Alliance initially met all but one standard. One Corrective Action and one Recommendation were issued. The Recommendation was initially issued in the 2021 EQR and not addressed by Alliance so this Recommendation is carried over for this EQR. The Corrective Action was issued to address areas of noncompliance found in the expedited Appeal file review. CCME initially issued a Corrective Action to ensure Appeal Coordinators are trained to process expedited appeals in accordance with 42 CFR 438.410, Attachment M of their contract with NC Medicaid, and their own Appeals procedures.

Following receipt of their 2022 NC EQR report, Alliance disputed the "Partially Met" score of an Appeals standard with NC Medicaid. The State then determined this score issued by CCME was not "directly related to member health and safety", an exception noted in the COVID-19 flexibilities *PIHP Contract Amendment #9*. In this circumstance and as directed by the State, Alliance's Appeal EQR score was changed to a "Met" and the Corrective Action was changed to a best practice Recommendation. This change also resulted in Alliance meeting 100% of the EQR Grievance and Appeal standards versus the previous overall score of 95%.

Program Integrity

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

In the 2021 EQR, Alliance met 100% of Program Integrity (PI) Standards and no Corrective Actions or Recommendations were issued.

In the 2022 EQR, Alliance again met 100% PI Standards, with no identified Weaknesses, Corrective Actions, or Recommendations. There was a concern regarding the substantial number of opened investigations that may not be resolved prior to the end of the current waiver. However, NC Medicaid is aware and has made concessions that will allow the investigations to transition to the new Plan. Alliance continues to utilize effective procedures and workflows.

For the period under review, Alliance completed 23 referrals to NC Medicaid for possible fraud, waste, and abuse (FWA). During the Onsite, NC Medicaid staff said these referrals were thorough and appropriate, and most are accepted for further investigation by the NC Medicaid Investigative Division (MID).

Encounter Data Validation

Based on the analysis of Alliance's Encounter data, it is concluded the data submitted to NC Medicaid is complete and accurate in accordance with NC Medicaid standards. Alliance took multiple Corrective Actions in 2019, 2020 and 2021 to address issues that were highlighted in prior reviews. Specifically, Alliance instituted multiple claim edits and other system changes to address deficiencies in Procedure codes.

Alliance should continue to work closely with their provider community and encourage them to submit all applicable Diagnosis codes and Units. This information is key for measuring member health, identifying areas of risk, and evaluating quality of care. Additionally, Alliance should identify providers who never or very rarely submit Other Diagnosis codes and provide outreach to assist them in meeting their obligation to ensure that the claims they submit to Alliance are complete and accurate.

Corrective Actions and Recommendations from Previous EQR

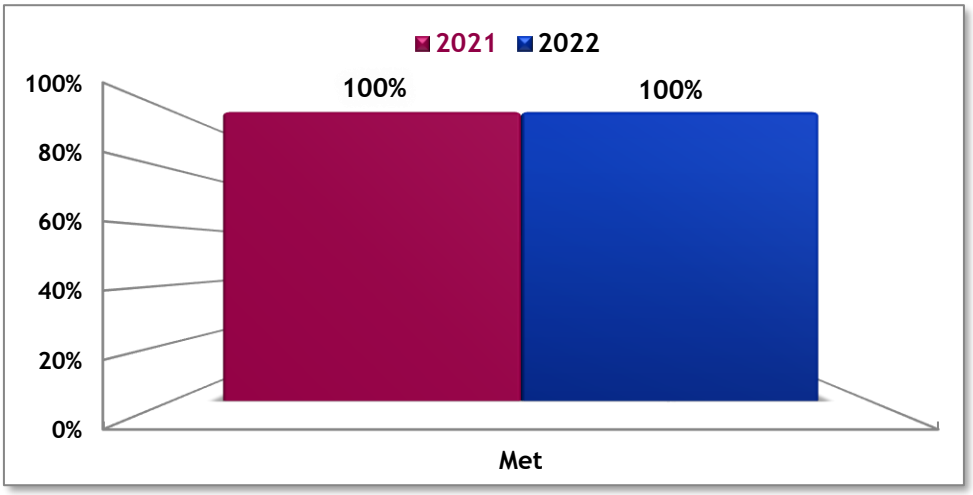
During the previous EQR, there were two standards scored as "Partially Met" which resulted in Alliance's overall score of 99%. After receiving their report, Alliance disputed the findings with the State. The State then provided the following information to CCME: "Alliance has disputed the CAPs found in the 2021 EQR report. Alliance states the CAPs should be considered recommendations due to the contractual language found in Amendment #9. Upon review by DHB Contract Manager; Contract Administrator; and Chief Legal Officer, DHB agrees with Alliance's findings. DHB requests that CCME revise the 2021 EQR report to reflect this agreement." This action changed Alliance's overall 2021 EQR score from 98% to 100% and the two Corrective Actions were changed to Recommendations.

Additional details regarding Alliance's 2021 Recommendations, the PIHP's response, and evidence, or lack thereof, of PIHP implementation of the 2021 Recommendations are detailed in each section of this report.

Conclusions

Overall, Alliance has met the requirements set forth in their contract with NC Medicaid. The 2022 Annual EQR shows that Alliance has achieved a "Met" score for 99% of the standards reviewed. As the following chart indicates, 1% of the standards were scored as "Partially Met," and no standards scored as "Not Met." *Figure 1, Annual EQR Comparative Results*, provides an overview of the current annual review scoring as compared to the findings of the 2021 review.

Figure 1: Annual EQR Comparative Results



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

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

	Strengths	Weaknesses	Corrective Actions/ Recommendations
Quality	Alliance can capture up to 40 ICD-10 Diagnosis codes via the Provider web portal and up to 40 ICD-10 Diagnosis codes via the HIPAA files on Institutional claims. Alliance can capture 12 ICD-10 Diagnosis codes on Professional claims via both the Provider web portal and HIPAA files.	Alliance does not have the ability to submit ICD-10 Procedure codes on Institutional Encounter data extracts to NCTracks.	***Recommendation: Update Alliance's Encounter data submission process to submit ICD-10 Procedure codes on Institutional Encounter data extracts to NCTracks.***
	Alliance can capture the DRG and ICD-10 Procedure codes on Institutional claims on the provider web portal and via HIPAA files.	Alliance has a large number of denied claims pending resubmission as of January 17, 2023.	***Recommendation: Improve tracking and monitoring of Encounter denials and timely re-submission of denied encounters to NC Tracks.***

	Strengths	Weaknesses	Corrective Actions/ Recommendations
	(b) Waiver Measures included all necessary documentation, and measures were reported according to specifications.	PIP indicator rates did not improve for the 7-day Super measure State DMH SUD	***Recommendation: 7-day Super measure State DMH SUD - Continue current interventions and monitoring new processes such as care management process that was reorganized in 2021 and value-based contracts.***
	(c) Waiver Measures met or exceeded State benchmark rates.	PIP indicator rates did not improve for the 7-day Super measure Medicaid DHB SUD.	***Recommendation: 7-day Super measure Medicaid DHB SUD- Continue current interventions and monitoring new processes such as care management process that was reorganized in 2021 and value-based contracts, in addition to provider network meetings with facilities.***
	All PIPs were in the High Confidence range.	The *Provider Operations Manual* does not consistently reflect one term for Grievance, Concern, and/or Complaint.	***Recommendation: Revise the Provider Operations Manual to consistently use one term reflecting an "expression of dissatisfaction about any matter other than an adverse benefit determination."***
	Overall improvements in compliance were noted in the enrollee files reviewed this year as compared to previous EQRs.	The Grievance file review found deficiencies in withdrawn and extended files related to required notifications and issues with accuracy of dates entered on the Grievance Log.	***Recommendation: Enhance the current file monitoring process to focus on withdrawn and extended Grievances, compliance with those required notifications, and the accuracy of data entered on the Grievance Log.***
	Alliance recently hired two additional supervisors to provide additional oversight of Grievance and Appeals functions.		

	Strengths	Weaknesses	Corrective Actions/ Recommendations
	One of Alliance's FWA referrals to NC Medicaid was accepted for further investigation by the NC Medicaid Investigative Unit (MID). MIDs investigation found that the allegation of FWA was occurring in other catchment areas and as a result, led to a conviction and sentencing.		
	During the Onsite, NC Medicaid staff said Alliance's FWA referrals were thorough and appropriate, and most are accepted for further investigation by the NC Medicaid Investigative Division (MID).		
Timeliness		The *Provider Operations Manual* contains incorrect information on page 62 regarding the required Grievance resolution timeframe.	***Recommendation: Correct the Provider Operations Manual on page 62 to clarify the required Grievance resolution timeframe of 90 days, as required by Alliance Procedure 6503.***
		The *Provider Operations Manual* contains incorrect information on page 62 regarding the required notification Alliance must provide when Alliance extends the Grievance resolution timeframe.	***Recommendation: Revise the Provider Operations Manual on page 62 to include that Alliance will "make reasonable efforts to give the enrollee prompt oral notice of the delay" and written notice "within 2 calendar days" when Alliance extends the Grievance Resolution timeframe. These notifications are required by Alliance Procedure 9603, 42 CFR § 438.408 (c)(2)(ii), and Attachment M of Alliance's NC Medicaid Contract.***

	Strengths	Weaknesses	Corrective Actions/ Recommendations
		The *Provider Operations Manual* did not explain Alliance will orally notify the enrollee of Alliance's extension to the Appeal resolution timeframe, nor is a timeframe identified for the oral and written notifications from Alliance regarding an extension.	***Recommendation: Correct the Provider Operations Manual to reflect the required oral and written notifications Alliance issues when Alliance extends the Appeal resolution timeframe. Include the timeframes for these oral and written notifications, as required by 42 CFR § 438.408 (c)(2)(ii) and NC Medicaid Contract, Attachment M, Section G.6.***
		Both of the expedited files reviewed showed no documentation of oral notification to the enrollee regarding Alliance's decision to deny their request to expedite the Appeal resolution. This oral notification is required by Alliance Procedure 6505, Due Process Appeals of Medical Necessity Determinations, Alliance's *NC Medicaid Contract, Attachment M, Section H.9*, and *42 CFR § 438.410 (b)(2)*.	***Recommendation: Ensure Appeals Coordinators are trained to provide and document prompt oral notification to the appellant when Alliance denies a request to expedite the Appeal resolution timeframe.*** ***Enhance the current file monitoring process to focus on expedited Appeals and the required oral notifications when Alliance denies the request to expedite the Appeal resolution timeframe. Include in the monitoring, routine review of the Appeal Log to identify data entry errors to prevent compliance issues.***
Access to Care	Providers have an assigned Provider Network Relations Specialist to assist them with questions or issues.	The *Individual and Family Handbook* and *Innovations Individual and Family Handbook* has not been revised to consistently reflect all six counties in Alliance's catchment area.	***Recommendation: Revise the Individual and Family Handbook and Innovations Individual and Family Handbook to consistently reflect the six counties in Alliance's catchment area.***

	Strengths	Weaknesses	Corrective Actions/ Recommendations
	Alliance provided funds to minority-owned businesses to assist with the transition to electronic health records and to "small and under-utilized providers" to assist with the initial operational costs for the care management platform.	All three Innovations files selected by Alliance and reviewed in this EQR showed each enrollee's Supports Intensity Scale (SIS) was not updated within the targeted timeframe. Similarly, two of the three Innovations enrollee files showed no face-to-face monitoring with the enrollee, either in person or via a telehealth platform, was attempted or implemented.	***Recommendation: Enhance the current enrollee file review process to track upcoming SIS updates and efforts to engage Innovations enrollees through face to face monitoring, either in person or through a telehealth platform. This will ensure consistent practices by Care Managers during the Appendix K flexibilities and when those flexibilities are lifted by NC Medicaid.***
	Alliance implemented a monthly learning collaborative with providers to help educate, prepare, and support providers as care management moves from the health plan to the practices.		
	Alliance can capture up to 40 ICD-10 Diagnosis codes via the Provider web portal and up to 40 ICD-10 Diagnosis codes via the HIPAA files on Institutional claims. Alliance can capture 12 ICD-10 Diagnosis codes on Professional claims via both the Provider web portal and HIPAA files.	Alliance does not have the ability to submit ICD-10 Procedure codes on Institutional Encounter data extracts to NCTracks.	***Recommendation: Update Alliance's Encounter data submission process to submit ICD-10 Procedure codes on Institutional Encounter data extracts to NCTracks.***
	Alliance can capture the DRG and ICD-10 Procedure codes on Institutional claims on the provider web portal and via HIPAA files.	Alliance has a large number of denied claims pending resubmission as of January 17, 2023.	***Recommendation: Improve tracking and monitoring of Encounter denials and timely re-submission of denied encounters to NC Tracks.***

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 the optional activity in the area of Encounter Data Validation conducted by CCME's subcontractor HMS. Additionally, as required by CCME's contract with NC Medicaid, an ISCA Audit and Medicaid program integrity (PI) review of the health plan was conducted by CCME's subcontractor IPRO.

On December 16, 2022, CCME notified 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 PIHP 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 requested by CCME.

The review consisted of two segments. The first was a Desk Review of materials and documents received from Alliance on January 27, 2023 and reviewed by CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. The Desk Review also included a review of Credentialing, Grievance, Utilization, Care Coordination, and Appeal files.

The second segment of the EQR is typically a two-day Onsite review conducted at the PIHP's offices. However, due to COVID-19, this Onsite was conducted through a teleconference platform on February 16, 2023. This 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 PIHP Administration and Staff

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

FINDINGS

The findings of the EQR are summarized in the following pages of this report and are based on the regulations set forth in *42 CFR § 438.358* and the *NC Medicaid Contract* requirements between 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

42 CFR § 438.208

Information Systems Capabilities Assessment

The review of Alliance's system capabilities involves the use of the Information Systems Capabilities Assessment (ISCA) tool and review of supporting documentation such as Alliance's claim audit reports, enrollment workflows, and Alliance's Information Technology (IT) staffing patterns. This system analysis is completed as specified in the CMS EQR protocol. During the Onsite, Alliance staff provided an enrollment and claims system overview. Questions regarding the ISCA tool were discussed with Alliance staff.

In the 2021 EQR, Alliance met 100% of the Administration EQR standards, and one Recommendation was issued. Table 2 outlines the Recommendation issued to Alliance in the 2021 EQR and CCME's follow-up in the 2022 EQR.

Table 2: 2021 EQR Administration Findings

2021 EQR Administration Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The MCO has the capabilities in place to submit the State required data elements to NC Medicaid on the Encounter data submission.	***Recommendation: Update Alliance's Encounter data submission process to submit ICD-10 Procedure codes on Institutional Encounter data extracts to NCTracks.***	**N**
2022 EQR Follow-up: In the 2022 EQR, Alliance stated that this Recommendation was expected to be implemented by the end of February 2023. Therefore the 2021 EQR Recommendation will be carried forward in EQR 2022.		

Alliance uses the Alliance Claims System (ACS) to process claims, enrollment, for submission of encounters, and generate data reports. Some new updates or changes have taken place with ACS since Alliance purchased the AlphaMCS source code from WellSky and transitioned ACS from the WellSky-hosted application to the Alliance-hosted application on May 3, 2021. The 837P Parsing Procedure has been updated to parse all 12 Diagnosis codes, the 837I Parsing Procedure has been updated to parse up to 40 Diagnosis codes, the ACS front end interface has been updated to show all Diagnosis codes in claims maintenance screens, including an update to display Institutional Claims to show all Diagnosis codes submitted by the provider. ACS can now send all Diagnosis codes submitted on claims upstream. Alliance uses the EDI tool called EDI HQ from Epicor to process Encounter data. Data coming in via 834 files are loaded into the ACS Datastore system in the IT staging environment. Data from ACS Datastore is then loaded into ACS for claims processing and then moved to the Alliance DW for reporting.

The ISCA tool and supporting documentation for enrollment systems loading processes clearly define the process for enrollment data updates in ACS for enrollment. During the ISCA Onsite discussion, Alliance provided a demonstration of the ACS enrollment system, which maintains the member enrollment history. Member eligibility is determined from daily 834 files and the Global Eligibility File (GEF). Both are parsed into Alliance's Enterprise Data Warehouse (EDW). The GEF extracts from the EDW are then loaded to the ACS. The load process is an "all or nothing" type of process. If any errors occur as part of this process, the file processing stops, and the Alliance Application Development Team is notified that the process failed. The Alliance Team reviews and makes any needed changes to the process to ensure the data is parsed and loaded correctly into the eligibility tables.

Alliance stores the Medicaid identification number received on the GEF. During the Onsite, Alliance stated that they run a report to check for possible duplicate members on a weekly basis. Alliance's staff research possible duplicate members and merge the information into one Member ID via checking member info against the GEF (social security number, date of birth, and member name). Member ID is maintained regardless of change in eligibility. The historical claims for the member are also merged into one Member ID. During system demonstration, staff displayed the enrollment system and presented the enrollment information that is viewable and captured in ACS.

Alliance enrollment counts for the past three years are presented in Table 3.

Table 3: Enrollment Counts

2019	2020	2021
216,407	254,581	115,791

Alliance's authorizations and claims are processed in the ACS system. A review of Alliance's processes for collecting and adjudicating claims as well as the process of preparing claim information for reporting was conducted through a review of its ISCA response and the provided supporting documentation. Alliance's Provider web claims entry portal and the ACS claims processing system were displayed and demonstrated during the Onsite.

Alliance receives claims from three methods, 837 electronic file, Provider web portal and paper claims. During the Onsite, Alliance stated that they received paper claims from out-of-network providers and new providers who have not been set up in ACS. Table 4 details the percentage of 2021 claims received via the three methods.

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

Source	HIPAA File	Paper	Provider Web Portal
Institutional	73.23%	0.10%	26.67%
Professional	85.74%	0.15%	14.11%

Alliance adjudicates claims on a nightly basis. Approximately 97.44% of Professional claims and 86.12% of Institutional claims were auto adjudicated. Per the Alliance's ISCA, ACS can capture up to 40 ICD-10 Diagnosis codes via the Provider web portal and up to 40 ICD-10 Diagnosis codes via the HIPAA files for Institutional claims. For Professional claims, ACS can capture up to 12 ICD-10 Diagnosis codes on both the Provider web portal and via HIPAA files, with all submitted codes being displayed. All submitted codes can be displayed in ACS for Professional as well as Institutional claims. Alliance stated that they do not currently submit ICD-10 Procedure codes on Institutional encounters to NCTracks, leading to their current 2021 EQR Recommendation continuing for the 2022 EQR.

Per information on Alliance's ISCA, the MCO conducted random weekly audits of 2.5% of all claims processed during the previous week. Paper claims are included in the weekly random audit. Alliance conducts focused audits on at least 50% of inpatient hospital claims that have a billed amount that is greater than $5,000 and a weekly audit of 3% of Emergency Department (ED) claims. Alliance also conducts non-routine-focused audits to target system errors or fraudulent claims activity.

The breakdown of Encounter data acceptance/denial rates by claim service detail counts was provided for encounters submitted in 2021. Table 5 provides a comparison of 2020 and 2021.

Table 5: Volume of 2020 and 2021 Submitted Encounter Data

2021	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	54,071	1,437	2,541	58,049
Professional	1,772,430	7,790	41,427	1,821,647
2020	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	49,008	1,620	514	51,142
Professional	1,802,672	23,583	1,638	1,827,893

Alliance has an approximate 95.62% acceptance rate for Institutional encounters and 97.73% acceptance rate for Professional encounters with dates of service in 2021. Based on data review and discussion during the Onsite, Alliance provided the top three denial reasons for encounters submitted to NCTracks:

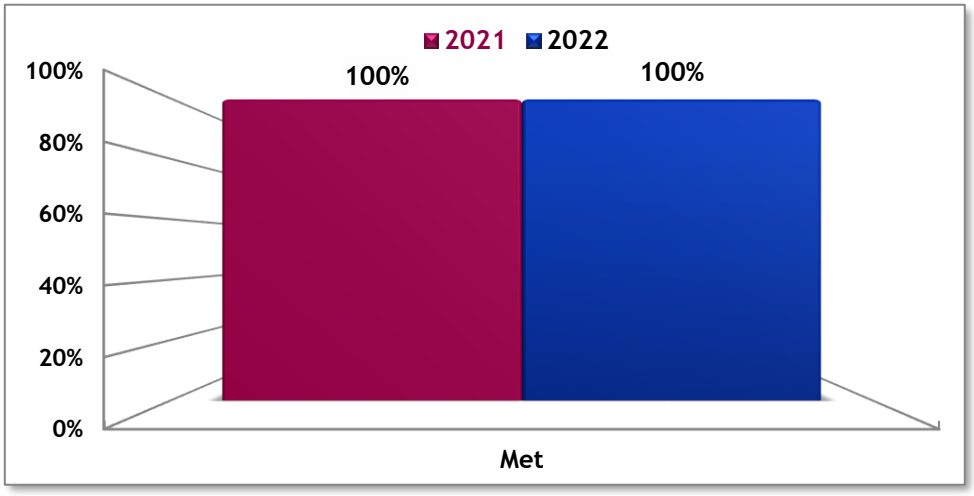
- Possible duplicate (same) provider, same Procedure code, overlapping dates of service
- Duplicate service or procedure
- Service location mismatch

On average, Alliance submits an Encounter within two days from the time of adjudication to NC Medicaid. It takes approximately 13 days to correct and resubmit an Encounter to NC Medicaid. Alliance uses Alliance Reconciliation (AR), an internally developed application, to monitor and track all Encounter claims which is a part of ACS. As stated in the ISCA, Alliance has 7,956 Institutional and 44,848 Professional denied encounters with dates of service from January 1, 2017 through January 7, 2023, that are still awaiting resubmission.

The overall Institutional denials pending resubmission has more than doubled since the prior year. This increase was discussed with Alliance during the Onsite. The Alliance team will review their processes and identify the cause for the backlog of pending denials as reported in the ISCA. Based on data submitted for only 2021 denied encounters, Alliance exceeds the NC Medicaid standards for Encounter submissions and has an approximately 2.34% denial rate of their Encounter data submissions for 2021 data.

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

Figure 2: Administration Comparative Findings



Strengths

- Alliance can capture up to 40 ICD-10 Diagnosis codes via the Provider web portal and up to 40 ICD-10 Diagnosis codes via the HIPAA files on Institutional claims. Alliance can capture 12 ICD-10 Diagnosis codes on Professional claims via both the Provider web portal and HIPAA files.
- Alliance can capture the DRG and ICD-10 Procedure codes on Institutional claims on the Provider web portal and via HIPAA files.

Weaknesses

- Alliance does not have the ability to submit ICD-10 Procedure codes on Institutional Encounter data extracts to NCTracks.
- Alliance has a large number of denied claims pending resubmission as of January 17, 2023.

Recommendations

- Update Alliance's Encounter data submission process to submit ICD-10 Procedure codes on Institutional Encounter data extracts to NCTracks.
- Improve tracking and monitoring of Encounter denials and timely re-submission of denied encounters to NC Tracks.

B. Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

The Provider Services EQR for Alliance included Credentialing and Recredentialing as well as a discussion of provider education and network adequacy. CCME reviewed relevant policies and procedures, credentialing/recredentialing files, a sample of Credentialing Committee meeting minutes, and select items on the Alliance website. Alliance staff provided additional information during an Onsite interview.

In the 2021 EQR, Alliance met 100% of the Credentialing/Recredentialing standards, resulting in no Corrective Actions. CCME issued a Recommendation focused on ensuring accuracy and consistency across documents regarding Credentialing Committee membership. Alliance did not address the Recommendation from the 2021 EQR, as presented in Table 6.

Table 6: 2021 EQR Provider Services Findings

2021 EQR Credentialing/Recredentialing findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
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.	***Recommendation: Compare Procedure 6030, Procedure 6036, the "Attendee" section of the Credentialing Committee meeting minutes, and any other documents that list Credentialing Committee membership, to ensure accuracy and consistency across documents regarding membership. For example, if the CMO is a non-voting member of the committee, ensure the CMO is included in the list of non-voting members on all relevant documents.***	**N**
2022 EQR Follow-up: In this 2022 EQR, Alliance did not implement the Recommendation from the 2021 EQR. Procedure 6030 Initial Credentialing Criteria and Enrollment Process for Network Participation and Procedure 6036 Re-Credentialing Criteria and Enrollment Process for Network Participation were not revised from the versions of these procedures submitted for the 2021 EQR and continue to list conflicting information regarding Credentialing Committee membership. Additional information is provided in Attachment 4, Tabular Spreadsheet.		

In the 2022 EQR, Alliance met 100% of the Credentialing/Recredentialing standards. CCME issued no Corrective Actions. As was the case at the last three EQRs, there is conflicting information regarding committee membership across Alliance documents. As noted, Alliance did not address the Recommendation from the 2021 EQR. Procedure 6030 and Procedure 6036 were not revised from the versions of these procedures submitted for the 2021 EQR and continue to list conflicting information regarding Credentialing Committee membership.

Per the direction of the North Carolina Department of Health and Human Services (NC DHHS), credentialing has now shifted from the PIHPs completing credentialing and recredentialing to the PIHPs verifying credentialing completed by NCTracks. Alliance completed the in-process credentialing and recredentialing files in May 2022, with the Provider Network Credentialing Committee (PNCC) disbanding after the May 17, 2022 meeting. Therefore, although Alliance did not implement the Recommendation from the 2021 EQR, CCME is issuing no Recommendations in the 2022 EQR of Credentialing/Recredentialing.

Alliance submitted Procedure 6011 Primary Source Verification, Procedure 6030 Credentialing Criteria and Enrollment Process for Network Participation, and Procedure 6036 Re-Credentialing Criteria and Enrollment Process for Network Participation as the *Credentialing Program Description*, which directed the credentialing and recredentialing processes. CCME's review of the credentialing and recredentialing files showed they were organized and contained appropriate information.

Procedure 6030 and Procedure 6036 provide information about the Provider Network Credentialing Committee (PNCC). The *PNCC Organization Chart 4.5.22* lists four Alliance employees and two providers as voting members and three Alliance employees as non-voting members. Associate Medical Director (AMD) Nadiya Kaesemeyer, MD, and AMD Heidi Middendorf, MD are Co-Chairs of the PNCC, with Dr. Kaesemeyer listed as "1st Designee" and Dr. Middendorf listed as "2nd Designee." Per Procedure 6030, the Chair does not vote "unless the vote is required to break a tie."

As requested, Alliance submitted minutes from three PNCC meetings. Dr. Kaesemeyer chaired these three PNCC meetings, and neither Dr. Middendorf nor Dr. Mehul Mankad, the Chief Medical Officer (CMO) at the time, attended any of the three meetings. Procedures 6030 and 6036 indicate a "quorum is reached when 33% of voting members are present plus the Chairperson." A quorum was present at the Credentialing Committee meetings for which minutes were submitted for this EQR.

Procedure 6030 states "The Associate Medical Director as designated by the Chief Medical Officer can review and approve all Clean Credentialing Applications." The submitted PNCC meeting minutes include lists of applications approved by the AMD and reflect discussion of, and the committee's decisions regarding, "providers who have one or more criteria that may not meet Alliance criteria for participation."

New providers receive a Welcome Letter that includes a link to the new provider orientation on the Alliance website. The new provider orientation webpage includes a link to the *Alliance Provider Operations Manual,* information about how to sign up for the provider newsletter, as well as information regarding the Provider Advisory Council and the quarterly All Provider meetings. The letter also has the name of the provider's assigned Network Specialist and information about training resources. Provider Central is a new section of the Alliance website that "consolidates our provider-focused public information and resources."

The COVID-19 flexibilities outlined in *NC Medicaid Contract Amendment #9* included a delay for the annual *Network Adequacy and Accessibility Analysis* (Gaps Analysis) report. NC DHHS notified the PIHPs in January 2021 to submit the *SFY 2020 and 2021 Network Adequacy and Accessibility Analysis* by July 1, 2021, "although we will consult with the LME-MCOs if this date needs to be extended based on the evolving state of the COVID-19 pandemic. LME-MCOs are required to complete the 2020 analysis for Medicaid in its entirety."

The most recent "gaps analysis", *The Alliance Network Adequacy and Accessibility Analysis Combined Report for 2020 and 2021* dated July 1, 2021, was reviewed for the 2021 EQR. That report states, "Standards were met for all services in Outpatient, Inpatient and C-Waiver categories." Alliance identified gaps for Medicaid-funded Partial Hospitalization, Ambulatory Detox, Facility-Based Crisis-Child, and I/DD Facility-Based Respite services, noting that some of the gaps emerged as a result of the effects of the COVID-19 pandemic, as well as due to changes in Service Categories or Access and Choice Standards. Page 69 of the report includes "Plans for Addressing Gaps."

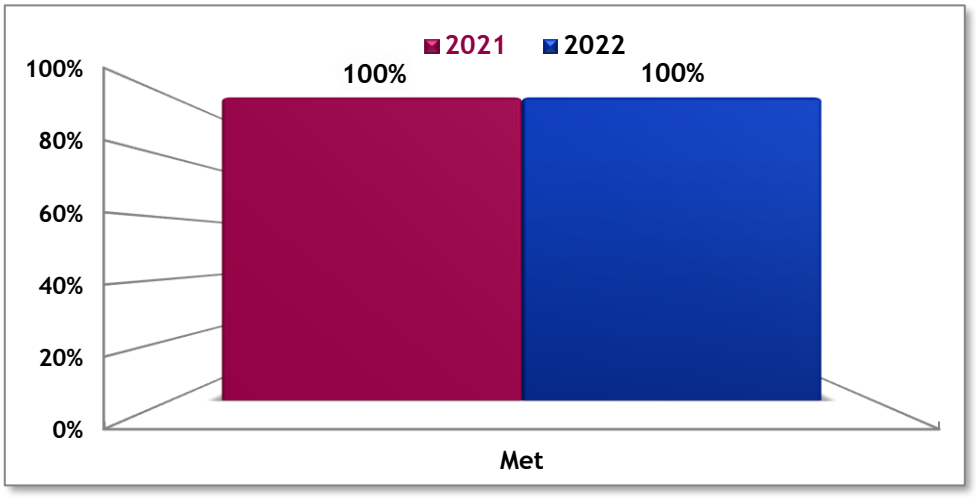
Alliance filed Exception Requests for these four services with identified gaps but has still not heard if the Exception Requests were approved, and it is not clear if Exception Requests were still required. Alliance staff reported ongoing efforts to address gaps but noted continued challenges due to the COVID-19 pandemic, including construction delays, delays in being able to obtain needed materials for construction, and delays in the availability of inspectors. A Facility-Based Crisis Center in Wake County has been in development for some time and should open soon. Alliance has "addressed some of the opioid gaps, expanding services in each county" in their catchment area. Some Ambulatory Withdrawal Management services are in development. Alliance is not yet meeting the Partial Hospital adequacy standards in every county.

Additional service development efforts have focused on Mecklenburg and Orange counties, since their transition to Alliance in December 2021. A 24/7 facility is under construction in Mecklenburg County and will include Facility-Based Crisis beds for adults. Efforts are underway to partner with Mecklenburg County to establish a crisis response service that would "work like Respite for kids who need short-term crisis respite." Alliance staff also reported "pretty substantial work in Orange County with the Latina population, addressing needs of bi-lingual/bi-cultural enrollees in that county."

Alliance staff noted their efforts have been focused on working toward the new standards and service requirements, such as the physical health network and pharmacies, scheduled to go into effect April 1, 2023, with the transition to Tailored Plans and Medicaid Direct.

Figure 3, Provider Services Comparative Findings, shows that 100% of the standards in the 2022 Credentialing/Recredentialing EQR were scored as "Met", and provides an overview of 2022 scores compared to 2021 scores.

Figure 3: Provider Services Comparative Findings



Strengths

- Providers have an assigned Provider Network Relations Specialist to assist them with questions or issues.
- Alliance provided funds to minority-owned businesses to assist with the transition to electronic health records and to "small and under-utilized providers" to assist with the initial operational costs for the care management platform.
- Alliance implemented a monthly learning collaborative with providers to help educate, prepare, and support providers as care management moves from the health plan to the practices.

C. Quality Improvement

42 CFR § 438.330

The 2021 Quality Improvement (QI) EQR included Performance Measures (PMs) and Performance Improvement Projects (PIPs) validation. CCME conducted a Desk Review of the submitted (b) and (c) Waiver Performance Measures (PMs) and a review of each PIP's Quality Improvement Project (QIP) report form for validation, using CMS standard validation protocols. An Onsite discussion occurred to clarify measurement rates for each of the areas.

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

Table 7: 2021 EQR PIP Recommendations

Project(s)	Recommendation	Recommendation Implemented in 2022 (Y/N/NA)
7 Day DHB SUD	***Recommendation: Continue working to determine reasons for low referrals in the Peer Bridger program that might impact rates. The census issues with facilities may also be a factor and should be evaluated further to determine if differences in format reporting are affecting ability to reach members for follow-up.***	**Y**
TCLI PCP Visits	***Recommendation: Continue working on staff education and tracking-based interventions. Implement actions regarding adjustments to internal workflows that might impact visit rates.***	**Y**

For the current review, six projects were submitted, and all six were validated including: 7-Day Super Measure – State DMH MH, 7-Day Super Measure – State DMH SUD, 7-Day Super Measure – Medicaid DHB SUD, Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM), Diabetes Screenings for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (HEDIS SSD), and Transitions to Community Living (TCL) PCP Visits Improvement.

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

Table 8: 2021 EQR PIP Interventions

Project(s)	Interventions
7 DAY DHB SUD	New care management process, Peer Bridger Program, follow-up phone calls
7 Day DMH MH	Provider scorecard review, new Care Management process, follow-up phone calls, value-based incentives, telehealth, Peer Bridger program
7 Day DMH SUD	Streamlining of processes to contact patients, value-based incentives, provider communication and education programs, assertive engagement, Provider scorecard review

Project(s)	Interventions
APM	HealthCrowd campaign for awareness, Point of Care testing, Provider scorecards, staff education, provider data reports
SSD	HealthCrowd campaign for awareness, Point of Care testing, staff education, data sharing
TCL PCP Visits	PCP visit tracking, staff education, provider communication programs

Performance Measure Validation

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

Table 9: (b) Waiver Measures

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

Table 10: (c) Waiver Measures

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

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

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

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

(b) Waiver Measures Reported Results

These measures' rates as reported by Alliance for FY 2021 and FY 2022 are included in the tables that follow. There were no measures with a substantial decline. There were no clinical treatments (e.g., readmission, follow-up) rates with substantial increases from FY 2021. Mental health penetration rates increased substantially (>10%) for several counties including, Cumberland, Durham, Wake, and Johnston County, for 3-12 year-olds and 13-17 year-olds. 18-20 year-olds had a substantial increase in Cumberland and Durham counties, individuals 65+ had a substantial increase in Durham County. The current rate in comparison to last year's rate is presented in Tables 11 through 20.

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

30-day Readmission Rates for Mental Health	FY 2021	FY 2022	Change
Inpatient (Community Hospital Only)	13.3%	14.9%	1.60%
Inpatient (State Hospital Only)	2.4%	6.9%	4.50%
Inpatient (Community and State Hospital Combined)	13.2%	14.8%	1.60%
Facility Based Crisis	11.6%	14.5%	2.90%
Psychiatric Residential Treatment Facility (PRTF)	13.1%	18.3%	5.20%
Combined (includes cross-overs between services)	13.0%	15.0%	2.00%

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

30-day Readmission Rates for Substance Abuse	FY 2021	FY 2022	Change
Inpatient (Community Hospital Only)	9.9%	14.3%	4.40%
Inpatient (State Hospital Only)	5.0%	2.2%	-2.80%
Inpatient (Community and State Hospital Combined)	9.1%	12.2%	3.10%
Detox/Facility Based Crisis	11.6%	15.6%	4.00%
Combined (includes cross-overs between services)	10.3%	14.1%	3.80%

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

Follow-up after Hospitalization for Mental Illness	FY 2021	FY 2022	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	40.6%	37.9%	-2.70%
Percent Received Outpatient Visit Within 30 Days	58.0%	55.3%	-2.70%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	100%*	37.5%*	NA
Percent Received Outpatient Visit Within 30 Days	100%*	62.5%*	NA
PRTF			
Percent Received Outpatient Visit Within 7 Days	17.7%	21.4%*	NA
Percent Received Outpatient Visit Within 30 Days	36.3%	35.7%*	NA
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	39.6%	37.8%	-1.80%
Percent Received Outpatient Visit Within 30 Days	57.0%	55.2%	-1.80%

NR = Denominator is equal to zero.

** = rate with small denominator; NA = not computed due to small denominator or missing data*

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

Follow-up after Hospitalization for Substance Abuse	FY 2021	FY 2022	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	33.0%	25.9%	-7.10%
Percent Received Outpatient Visit Within 30 Days	45.3%	42.9%	-2.40%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	23.1%*	56.7%	NA
Percent Received Outpatient Visit Within 7 Days	23.1%*	56.7%	NA
Percent Received Outpatient Visit Within 30 Days	30.8%*	56.7%	NA
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	32.6%	29.5%	-3.10%
Percent Received Outpatient Visit Within 30 Days	44.7%	44.5%	-0.20%

NR = Denominator is equal to zero.

** = rate with small denominator; NA = not computed due to small denominator or missing data*

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2021	FY 2022	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	29.8%	33.1%	3.30%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	12.2%	13.8%	1.60%
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	31.8%	37.0%	5.20%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	17.7%	13.3%	-4.40%
Ages 21–34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	46.0%	40.0%	-6.00%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	33.2%	25.4%	-7.80%
Ages 35–64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	43.7%	41.8%	-1.90%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	32.2%	30.5%	-1.70%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	33.9%	40.8%	6.90%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	19.1%	26.6%	7.50%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	42.7%	40.5%	-2.20%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	30.2%	27.0%	-3.20%

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

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY 2021	FY 2022	Change	FY 2021	FY 2022	Change
3–12	Male	0.1	0.2	0.1	50.7	44.8	-5.9
	Female	0.2	0.2	0.2	26.1	25.8	-0.3
	Total	0.2	0.2	0.2	36.3	36.5	0.2
13–17	Male	0.9	0.7	0.9	57.5	63.8	6.3
	Female	1.7	1.4	1.7	33.2	47.3	14.1
	Total	1.3	1.0	1.3	41.8	53.3	11.5
18–20	Male	1.3	1.5	1.3	12.9	22.9	10.0
	Female	1.3	1.3	1.3	11.6	34.6	23.0
	Total	1.3	1.4	1.3	12.2	28.2	16.0
21–34	Male	4.1	4.4	4.1	10.8	10.1	-0.7
	Female	1.2	1.6	1.2	15.9	15.5	-0.4
	Total	1.9	2.4	1.9	13.4	12.7	-0.7
35–64	Male	3.5	3.8	3.5	14.4	10.9	-3.5
	Female	1.7	2.1	1.7	9.6	10.5	0.9
	Total	2.3	2.7	2.3	12.2	10.7	-1.5
65+	Male	0.6	0.6	0.6	16.2	28.5	12.3
	Female	0.3	0.3	0.3	15.8	17.9	2.1
	Total	0.4	0.4	0.4	16.0	23.6	7.6
Unknown	Male	0.0	0.0	0.0	0.0	0.0	0.0
	Female	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0
Total	**Male**	**1.2**	**1.6**	**1.2**	**21.2**	**18.7**	**-2.5**
	Female	**1.0**	**1.2**	**1.0**	**18.2**	**20.3**	**2.1**
	Total	**1.1**	**1.3**	**1.1**	**19.6**	**19.5**	**-0.1**

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

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change
3-12	Male	9.76%	6.15%	-3.61%	0.03%	0.03%	0.00%	0.17%	0.32%	0.15%	9.72%	6.04%	-3.68%
	Female	7.72%	4.17%	-3.55%	0.01%	0.02%	0.01%	0.05%	0.15%	0.10%	7.71%	4.13%	-3.58%
	Total	8.76%	5.20%	-3.56%	0.02%	0.02%	0.00%	0.12%	0.24%	0.12%	8.73%	5.13%	-3.60%
13-17	Male	13.02%	9.96%	-3.06%	0.20%	0.08%	-0.12%	0.22%	0.42%	0.20%	12.95%	9.87%	-3.08%
	Female	17.59%	11.08%	-6.51%	0.17%	0.09%	-0.08%	0.16%	0.30%	0.14%	17.57%	11.06%	-6.51%
	Total	15.27%	10.50%	-4.77%	0.18%	0.08%	-0.10%	0.19%	0.36%	0.17%	15.22%	10.44%	-4.78%
18-20	Male	8.09%	6.80%	-1.29%	0.11%	0.08%	-0.03%	0.08%	0.07%	-0.01%	8.04%	6.76%	-1.28%
	Female	12.63%	8.55%	-4.08%	0.13%	0.02%	-0.11%	0.06%	0.11%	0.05%	12.63%	8.55%	-4.08%
	Total	10.46%	7.67%	-2.79%	0.12%	0.05%	-0.07%	0.07%	0.09%	0.02%	10.43%	7.65%	-2.78%
21-34	Male	19.61%	19.28%	-0.33%	0.25%	0.18%	-0.07%	0.12%	0.08%	-0.04%	19.60%	19.24%	-0.36%
	Female	16.78%	12.33%	-4.45%	0.06%	0.09%	0.03%	0.12%	0.11%	-0.01%	16.76%	12.33%	-4.43%
	Total	17.43%	14.37%	-3.06%	0.11%	0.12%	0.01%	0.12%	0.10%	-0.02%	17.42%	14.35%	-3.07%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change
35-64	Male	22.46%	22.30%	-0.16%	0.35%	0.22%	-0.13%	0.22%	0.25%	0.03%	22.43%	22.27%	-0.16%
	Female	22.52%	18.54%	-3.98%	0.13%	0.10%	-0.03%	0.14%	0.13%	-0.01%	22.50%	18.53%	-3.97%
	Total	22.50%	19.93%	-2.57%	0.21%	0.14%	-0.07%	0.17%	0.17%	0.00%	22.47%	19.91%	-2.56%
65+	Male	5.77%	7.43%	1.66%	0.08%	0.01%	-0.07%	0.02%	0.00%	-0.02%	5.76%	7.43%	1.67%
	Female	5.94%	7.10%	1.16%	0.01%	0.01%	0.00%	0.01%	0.01%	0.00%	5.94%	7.10%	1.16%
	Total	5.88%	7.22%	1.34%	0.03%	0.01%	-0.02%	0.01%	0.00%	-0.01%	5.88%	7.22%	1.34%
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**	**12.61%**	**11.35%**	**-1.26%**	**0.14%**	**0.09%**	**-0.05%**	**0.17%**	**0.25%**	**0.08%**	**12.57%**	**11.28%**	**-1.29%**
	Female	**14.00%**	**10.73%**	**-3.27%**	**0.08%**	**0.06%**	**-0.02%**	**0.10%**	**0.14%**	**0.04%**	**13.99%**	**10.71%**	**-3.28%**
	Total	**13.41%**	**11.00%**	**-2.41%**	**0.10%**	**0.07%**	**-0.03%**	**0.13%**	**0.18%**	**0.05%**	**13.38%**	**10.96%**	**-2.42%**

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

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change
3–12	Male	0.02%	0.03%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.03%	0.01%
	Female	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
	Total	0.01%	0.02%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.02%	0.01%
13–17	Male	0.55%	0.64%	0.09%	0.00%	0.01%	0.01%	0.07%	0.09%	0.02%	0.51%	0.56%	0.05%
	Female	0.38%	0.41%	0.03%	0.00%	0.01%	0.01%	0.03%	0.06%	0.03%	0.37%	0.36%	-0.01%
	Total	0.47%	0.52%	0.05%	0.00%	0.01%	0.01%	0.05%	0.08%	0.03%	0.44%	0.46%	0.02%
18–20	Male	1.25%	1.08%	-0.17%	0.01%	0.02%	0.01%	0.05%	0.06%	0.01%	1.22%	1.04%	-0.18%
	Female	1.10%	1.07%	-0.03%	0.00%	0.02%	0.02%	0.07%	0.08%	0.01%	1.09%	1.03%	-0.06%
	Total	1.17%	1.07%	-0.10%	0.00%	0.02%	0.02%	0.06%	0.07%	0.01%	1.15%	1.04%	-0.11%
21–34	Male	4.48%	4.29%	-0.19%	0.11%	0.18%	0.07%	0.38%	0.34%	-0.04%	4.39%	4.16%	-0.23%
	Female	4.27%	4.31%	0.04%	0.09%	0.13%	0.04%	0.52%	0.58%	0.06%	4.15%	4.13%	-0.02%
	Total	4.32%	4.30%	-0.02%	0.10%	0.15%	0.05%	0.49%	0.51%	0.02%	4.21%	4.14%	-0.07%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change
35–64	Male	7.45%	7.13%	-0.32%	0.47%	0.60%	0.13%	1.01%	1.13%	0.12%	7.15%	6.83%	-0.32%
	Female	4.79%	4.91%	0.12%	0.12%	0.18%	0.06%	0.51%	0.71%	0.20%	4.66%	4.68%	0.02%
	Total	5.73%	5.74%	0.01%	0.24%	0.34%	0.10%	0.69%	0.86%	0.17%	5.54%	5.47%	-0.07%
65+	Male	1.27%	1.35%	0.08%	0.11%	0.10%	-0.01%	0.16%	0.15%	-0.01%	1.19%	1.26%	0.07%
	Female	0.42%	0.53%	0.11%	0.00%	0.02%	0.02%	0.04%	0.05%	0.01%	0.39%	0.51%	0.12%
	Total	0.71%	0.81%	0.10%	0.04%	0.05%	0.01%	0.08%	0.08%	0.00%	0.66%	0.77%	0.11%
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**	**1.74%**	**2.09%**	**0.35%**	**0.08%**	**0.14%**	**0.06%**	**0.20%**	**0.28%**	**0.08%**	**1.67%**	**2.00%**	**0.33%**
	Female	**1.95%**	**2.17%**	**0.22%**	**0.04%**	**0.07%**	**0.03%**	**0.22%**	**0.30%**	**0.08%**	**1.90%**	**2.07%**	**0.17%**
	Total	**1.86%**	**2.14%**	**0.28%**	**0.06%**	**0.10%**	**0.04%**	**0.21%**	**0.29%**	**0.08%**	**1.80%**	**2.04%**	**0.24%**

Table 19: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change	FY 2021	FY 2022	Change
	3-12			13-17			18-20			21-34		
Cumberland	0.01%	0.16%	0.15%	1.05%	3.00%	1.95%	1.53%	3.33%	1.80%	4.88%	9.41%	4.53%
Durham	0.02%	0.04%	0.02%	0.74%	2.38%	1.64%	1.46%	4.58%	3.12%	4.25%	7.78%	3.53%
Johnston	0.01%	0.10%	0.09%	0.70%	1.50%	0.80%	2.05%	3.70%	1.65%	5.24%	10.28%	5.04%
Mecklenburg*	-	0.10%	NA	-	2.73%	NA	-	3.05%	NA	-	5.87%	NA
Orange*	-	0.19%	NA	-	2.46%	NA	-	4.21%	NA	-	12.25%	NA
Wake	0.01%	0.04%	0.03%	0.63%	2.38%	1.75%	1.30%	3.92%	2.62%	3.34%	6.84%	3.50%
	35-64			65+			Unknown			65+		
Cumberland	5.19%	6.90%	1.71%	0.66%	0.69%	0.03%	0.00%	0.00%	0.00%	2.11%	4.50%	2.39%
Durham	8.26%	10.17%	1.91%	1.49%	1.80%	0.31%	0.00%	0.00%	0.00%	2.25%	5.44%	3.19%
Johnston	5.54%	6.76%	1.22%	0.38%	0.75%	0.37%	0.00%	0.00%	0.00%	1.89%	4.39%	2.50%
Mecklenburg*	-	6.14%	NA	-	0.68%	NA	-	0.00%	NA	-	3.34%	NA
Orange*	-	10.67%	NA	-	1.15%	NA	-	0.00%	NA	-	6.32%	NA
Wake	5.00%	7.77%	2.77%	0.64%	0.71%	0.07%	0.00%	0.00%	0.00%	1.49%	4.16%	2.67%

**Note: Data for expansion counties of Orange and Mecklenburg are not reported for FY2021 as expansion occurred in December 2021.*

Table 20: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	FY2021	FY2022	Change	FY2021	FY2022	Change	FY2021	FY2022	Change	FY2021	FY2022	Change
	3-12			13-17			18-20			21-34		
Cumberland	10.09%	28.63%	18.54%	17.70%	41.67%	23.97%	12.31%	26.97%	14.66%	16.07%	25.79%	9.72%
Durham	7.49%	22.89%	15.40%	15.17%	37.68%	22.51%	10.05%	20.82%	10.77%	15.14%	23.64%	8.50%
Johnston	7.36%	19.97%	12.61%	14.68%	33.76%	19.08%	10.84%	19.18%	8.34%	14.20%	20.34%	6.14%
Mecklenburg*	-	14.08%	NA	-	28.81%	NA	-	16.57%	NA	-	20.15%	20.15%
Orange*	-	25.81%	NA	-	38.52%	NA	-	27.57%	NA	-	27.75%	27.75%
Wake	6.55%	19.39%	12.84%	14.95%	36.30%	21.35%	10.12%	19.29%	9.17%	13.83%	22.28%	8.45%
	35-64			65+			Unknown			65+		
Cumberland	19.62%	23.31%	3.69%	7.01%	7.87%	0.86%	0.00%	0.00%	0.00%	13.97%	23.11%	9.14%
Durham	22.45%	27.87%	5.42%	6.41%	9.31%	2.90%	0.00%	0.00%	0.00%	12.26%	23.19%	10.93%
Johnston	19.76%	22.72%	2.96%	7.93%	8.70%	0.77%	0.00%	0.00%	0.00%	11.78%	19.94%	8.16%
Mecklenburg*	-	21.03%	NA	-	5.19%	NA	-	0.00%	NA	-	16.16%	NA
Orange*	-	32.43%	NA	-	9.50%	NA	-	0.00%	NA	-	25.57%	NA
Wake	18.57%	23.34%	4.77%	5.67%	6.01%	0.34%	0.00%	0.00%	0.00%	10.98%	19.87%	8.89%

**Note: Data for expansion counties of Orange and Mecklenburg are not reported for FY2021 as expansion occurred in December 2021.*

(b) Waiver Validation Results

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

Table 21: (b) Waiver Performance Measure Validation Scores

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

(c) Waiver Measures Reported Results

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

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

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	3,262/3,262 = 100%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	3,262/3,262 = 100%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	85/88 = 96.6%	85%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	1,592/1,592 = 100%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	22/22 = 100%	85%

** Latest reported rates are shown in the Excel file submitted by Alliance and titled "Alliance Innovations Performance Measures Q4"*

(c) Waiver Validation

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

Table 23: C Waiver Performance Measures Validation Scores

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

Performance Improvement Project (PIP) Validation

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

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

PIP Validation Results

In the 2021 EQR, there were six PIPs submitted and all six were validated and scored in the high confidence range. There were no Corrective Actions and two Recommendations across two PIPs.

For this year's 2022 EQR, there were six PIPs submitted, and all were validated. For 7-day Super Measures DMH MH PIP that evaluates the percentage of discharges for state-funded individuals ages three through 64, who were admitted for mental health treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility-based crisis service that received a follow-up visit with a behavioral health practitioner within one to seven days of discharge, the most recent rate improved from 28% in May 2022 to 33% in June 2022. The goal is 40%.

For the TCL PCP Visits, focusing on the percentage of confirmed PCP visits for individuals who received a housing slot and/or who have transitioned to housing within 90 days of the measurement period, the rate improved from 89% in October 2022 to 91% in November 2022. This is above the goal rate of 80% and has been above the goal rate for the last three measurements.

7-day Super measure State DMH SUD that evaluates the percentage of discharges for individuals with state funding, ages three through 64, who were admitted for substance use disorder treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility-based crisis service that received a follow-up visit with a behavioral health practitioner within one to seven days of discharge. This rate has been around 25% for several measurement periods. The latest remeasurement showed a decline from 29% in May 2022 to 27% in June 2022. The goal is 40%.

7-day Super measure Medicaid DHB SUD also wanted to Increase the percentage of discharges for individuals ages three through 64 with Medicaid who were admitted for substance use disorder treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility-based crisis service that received a follow-up visit with a behavioral health practitioner within one to seven days of discharge to 40%. The most recent data available for this PIP was April 2022. The rate had declined to 31% after a rate of 37% in March 2022.

The APM HEDIS PIP has a goal to increase the percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing to 35%. The most recent measurement showed no change, with July and August 2022 having a 32% rate.

The SSD HEDIS PIP looks to increase the percentage of adults 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and receive a diabetes screening test during the measurement year to 81%. The most recent remeasurement period showed a slight improvement from 67% in July 2022 to 68% in August 2022.

Table 24: PIP Summary of Validation Scores

Project Type	Project	2021 Validation Score	2022 Validation Score
Clinical	7 DAY DHB SUD	73/74 = 99% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results
	7 Day DMH MH	79/79 = 100% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
	7 Day DMH SUD	79/79 = 100% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results
	APM	79/79 = 100% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
	SSD	79/79=100% High Confidence in Reported Results	79/79=100% High Confidence in Reported Results
Non-Clinical	TCLI PCP Visits	73/74=99% High Confidence in Reported Results	84/84=100% High Confidence in Reported Results

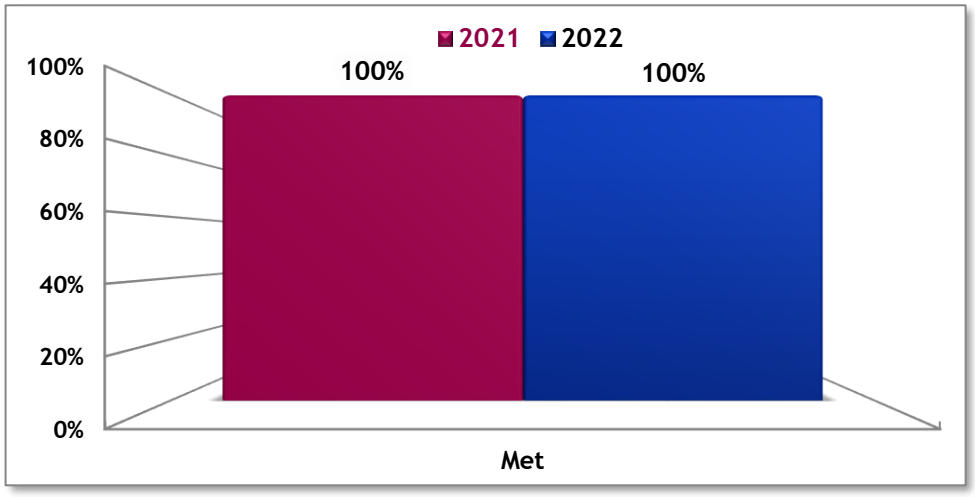
There are no Corrective Actions for the validated PIPS. For two of the six PIPs, there are Recommendations regarding the assessment and monitoring of newer interventions for PIPS which showed a decline in the most recent remeasurement period. The project, section, reason, and Recommendations are displayed in Table 25 below.

Table 25: Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
7-day Super measure State DMH SUD	Was there any documented, quantitative improvement in processes or outcomes of care?	The latest remeasurement showed a decline from 29% in May 2022 to 27% in June 2022. The goal is 40%.	Continue current interventions and monitoring new processes such as care management process that was reorganized in 2021 and value-based contracts
7-day Super measure Medicaid DHB SUD	Was there any documented, quantitative improvement in processes or outcomes of care?	The rate had declined to 31% after a rate of 37% in March 2022, and the goal is 40%.	Continue current interventions and monitoring new processes such as care management process that was reorganized in 2021 and value-based contracts, in addition to provider network meetings with facilities

There were no Corrective Actions for the PIPs. Details of the validation activities for the PMs and PIPs and specific outcomes related to each activity may be found in *Attachment 3, CCME EQR Validation Worksheets*. As demonstrated in Figure 4, Alliance met all the QI standards in the 2022 EQR.

Figure 4: Quality Improvement Comparative Findings



Strengths

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

Weaknesses

- PIP indicator rates did not improve for two PIPs: 7-day Super measure State DMH SUD and 7-day Super measure Medicaid DHB SUD.

Recommendations

- 7-day Super measure State DMH SUD - Continue current interventions and monitoring new processes such as care management process that was reorganized in 2021 and value-based contracts.

- 7-day Super measure Medicaid DHB SUD - Continue current interventions and monitoring new processes such as care management process that was reorganized in 2021 and value-based contracts, in addition to provider network meetings with facilities.

D. Utilization Management

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

In the 2021 EQR, Alliance met 100% of the UM standards and received two Recommendations related to incorrect information in the *Individual and Family Handbook* and the *Innovations Individual and Family Handbook* and the I/DD files reviewed. Table 26, outlines the 2021 findings and CCME's follow-up in the 2022 EQR regarding Alliance's implementation of those Recommendations.

Table 26: 2021 EQR Utilization Management Findings

2021 EQR Utilization Management Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Quality monitoring and continuous quality improvement;	In the 2021 EQR, it was noted that Alliance revised the I/DD Care Coordination titles and roles in the past year, resulting in a new Care Management Department. The *Care Management Program Description* reflects the most up-to-date information related to program functioning and organizational changes. However, the roles and responsibilities of the previous department, Care Coordination, are still outlined in the *Individual and Family Handbook* and the *Innovations Individual and Family Handbook*.	**N**

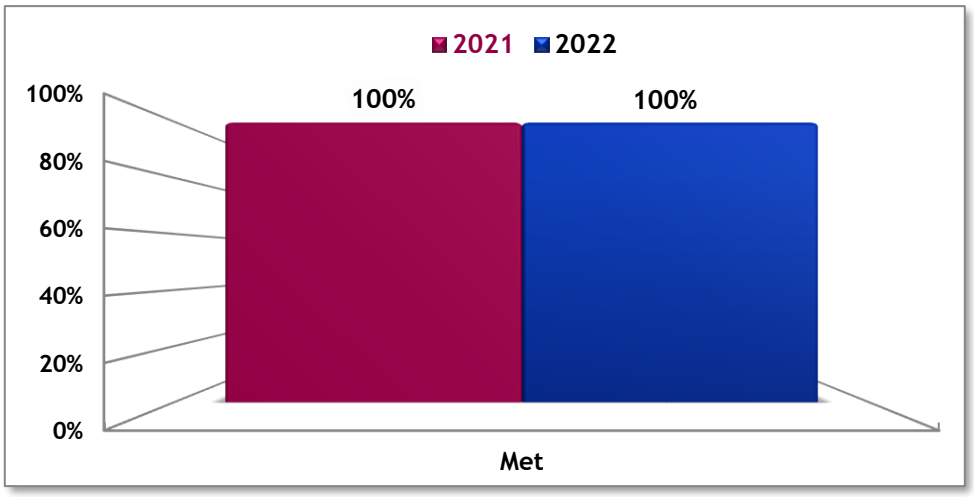
2021 EQR Utilization Management Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
	These public-facing handbooks do not reflect Alliance's recent addition of Orange and Mecklenburg counties to the Alliance catchment area. ***Recommendation: Update the Individual and Family Handbook and the Innovations Individual and Family Handbook to reflect the name changes of the Care Management team and the addition of counties to Alliance's catchment area.***	
2022 EQR Follow-up: Review of the *Individual and Family Handbook* and *Innovations Individual and Family Handbook* submitted for the 2022 review and available on the Alliance website shows the handbook was revised in October 2022 to consistently reflect the name change of Care Coordination to the Care Management Department. However, there are still six areas within these two handbooks that omit counties within Alliance's catchment area. As an example of this omission, the first page of the *Individual and Family Handbook* states, "Services described in this handbook are available only to qualified residents of Durham, Wake, Cumberland, and Johnston counties in the State of North Carolina."		
3. The PIHP applies the Care Coordination policies and procedures as formulated.	In the 2020 EQR, CCME recommended Alliance improve their review of enrollee files to target activities by Care Coordinator/Managers that are inconsistent or noncompliant with Alliance policies, clinical coverage policies, or their contract with NC Medicaid. Based on the file review in this 2021 EQR, CCME is again recommending Alliance enhance their review of enrollee files, specifically around the updating of SIS assessments for enrollees participating in the Innovations Waiver. ***Recommendation: Develop, document, and implement a tracking process that ensures SIS evaluations are completed within the timeframes required by NC Medicaid 1915(c) Appendix K: Disaster Waiver Flexibilities.***	**N**
2022 EQR Follow-up: In the 2022 EQR, three files of enrollees participating in the Innovations Waiver were selected by Alliance for review. All three files showed the Supports Intensity Scale (SIS) was not updated at the three year interval identified for adult SIS updates. It is understood that SIS updates were formally waived by NC Medicaid in 2020 during the pandemic. However, the SIS update for one of these files was due prior to the pandemic. CCME is again recommending Alliance develop a tracking process to identify inconsistencies and barriers to SIS updates. This will be particularly important when NC Medicaid lifts the pandemic flexibilities and reinstates the requirements around SIS updates as outlined by *Clinical Coverage Policy 8P*.		

In the 2022 EQR, Alliance met 100% of the UM standards. Overall improvements in compliance were noted in the enrollee files reviewed this year. All Care Management Departments showed good engagement with enrollees, completeness and accuracy of documentation, and successful completion of required activities, such as TCL Quality of Life surveys.

In the Innovations files reviewed, some concern was noted around inconsistencies of Care Management activities. All three Innovations files selected by Alliance and reviewed in this EQR showed each enrollee's SIS was not updated within the targeted timeframe. Similarly, two of the three Innovations enrollee files showed no face-to-face monitoring with the enrollee, either in person or via a telehealth platform, was attempted or implemented. While it is understood the requirement of face-to-face monitoring with enrollees has also been waived during the pandemic, the file review revealed inconsistent practices by Innovations Care Managers.

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

Figure 5: Utilization Management Comparative Findings



Strengths

- Overall improvements in compliance were noted in the enrollee files reviewed this year as compared to previous EQRs.

Weaknesses

- The *Individual and Family Handbook* and *Innovations Individual and Family Handbook* has not been revised to consistently reflect all six counties in Alliance's catchment area.

- All three Innovations files selected by Alliance and reviewed in this EQR showed each enrollee's SIS was not updated within the targeted timeframe. Similarly, two of the three Innovations enrollee files showed no face to face monitoring with the enrollee, either in person or via a telehealth platform, was attempted or implemented.

Recommendations

- Revise the *Individual and Family Handbook* and *Innovations Individual and Family Handbook* to consistently reflect the six counties in Alliance's catchment area.

- Enhance the current enrollee file review process to track upcoming SIS updates and efforts to engage Innovations enrollees through face-to-face monitoring, either in person or through a telehealth platform. This will ensure consistent practices by Care Managers during the Appendix K flexibilities and when those flexibilities are lifted by NC Medicaid.

E. Grievances and Appeals

42 CFR § 438, Subpart F

The Grievances and Appeals EQR included a Desk Review of policies and procedures, 10 Grievance and 10 Appeal files, the Grievance and Appeal Logs, the *Provider Operations Manual*, the *Individual and Family Handbook*, and information about Grievances and Appeals available on the Alliance website. There was an Onsite discussion with Grievance and Appeal staff to further clarify the PIHP's documentation and processes.

In the 2021 EQR, Alliance met 100% of the Grievance and Appeal standards. Four Recommendations were issued to address concerns noted primarily in the *Provider Operations Manual* which had not been revised or updated since October 16, 2020.

In the 2022 EQR, Following the Onsite, the Alliance 2022 EQR report was generated and submitted to NC Medicaid for feedback and approval. Once approved, the report was issued to Alliance. After Alliance received their report, they disputed the one "Partially Met" score of an Appeals standard with NC Medicaid. The State then determined this score issued by CCME was not "directly related to member health and safety", an exception noted in the COVID-19 flexibilities *PIHP Contract Amendment #9*. As directed by the State, Alliance's Appeal EQR score was changed to a "Met" and the Corrective Action was changed to a best practice Recommendation. This change also resulted in Alliance meeting 100% of the Grievance and Appeal standards versus the previous overall score of 95%.

Grievances

In the 2021 EQR of Grievances, Alliance met 100% of the standards and received three Recommendations. Two Recommendations were related to errors within the *Provider Operations Manual* and one Recommendation was related to ensuring compliant notifications to enrollees when Alliance extends the Grievance resolution timeframe. Table 27 outlines those Recommendations and whether they were addressed by Alliance.

Table 27: 2021 EQR Grievances Findings

2021 EQR Grievance Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
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:	***Recommendation: On pages 62-63 of the Provider Operations Manual in the Medicaid Grievances Section, use one term "Grievance" or "Grievant" to reflect the Grievance process.***	**N**
2022 EQR Follow-up: The *Provider Operations Manual* submitted for this EQR showed the manual has not been corrected since October 16, 2020.		
Timeliness guidelines for resolution of the grievance as specified in the contract;	***Recommendations: Revise the Provider Operations Manual on page 62 to include the correct timeframe for Grievance resolution, per Alliance's Grievance procedure of 90 days.*** ***Revise the Provider Operations Manual on page 62 to include that Alliance will "make reasonable efforts to give the enrollee prompt oral notice of the delay" and written notice "within 2 calendar days" when Alliance extends the Grievance Resolution timeframe. These notifications are required by Alliance Procedure 9603, 42 CFR § 438.408 (c)(2)(ii), and Attachment M of Alliance's NC Medicaid Contract.***	**N**
2022 EQR Follow-up: The *Provider Operations Manual* submitted for this EQR showed the manual has not been corrected since October 16, 2020.		

2021 EQR Grievance Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP applies the grievance policy and procedure as formulated.	***Recommendation: Revise the Grievance Extension Notification letter to include notification to the Grievant of their right to file a Grievance if he or she disagrees with Alliance's decision to extend the Grievance resolution timeframe. This requirement is outlined in 42 CFR § 438.408 (c)(2)(ii).*** ***Develop, document, and implement a process that includes sending a written resolution when a Grievance is withdrawn. Incorporate and document monitoring for this notification into the Grievance monitoring plan.***	**Y**
2022 EQR Follow-up: Alliance provided evidence that the Grievance Extension Notification letter had been revised to include the correct information. Alliance also provided their monitoring tools that showed review of withdrawn Grievances and related notifications was now included in their compliance monitoring of Grievance files.		

Alliance's Grievance policy requires all Grievances to be resolved within 90 days, with the option to extend that timeframe by 14 days if additional information is needed and the extension is in the best interest of the enrollee. In the 2022 EQR, 10 Grievance files were reviewed, and all Grievances were resolved in 90 days.

During the Onsite, staff reported the required timeframe for Grievance resolution is 30 days. Additionally, Grievance monitoring tools and reports cite 30 days as the required timeframe for Grievance resolution. To add further confusion, the Grievance Log noted submitted for this review showed six Grievances were documented as "extended". However, all Grievances noted as "extended" were resolved well within the 90 days required by Alliance's Grievance procedure.

Other areas of concern noted in the 2022 file review included compliance around withdrawn Grievances. In one of the two Grievance files reviewed where the Grievance was withdrawn, only one file showed written resolution was provided to the Grievant. While Alliance provided their monitoring tools that included compliance review of withdrawn Grievances and required notifications, the file review revealed Alliance is still not consistently providing the written resolution to enrollees around Grievances that are withdrawn. All of these findings reveal a need for Alliance to better monitor Grievance files to effectively identify areas of noncompliance and inconsistencies or confusion in staff practices while processing Grievances.

Appeals

In the 2021 EQR of Appeals, Alliance met 100% of the Appeals standards and CCME issued one Recommendation. The Recommendation was related to errors and inconsistencies in the *Provider Operations Manual* noted since the 2020 EQR. Table 28 outlines those Recommendations and whether they were addressed by Alliance.

Table 28: 2021 EQR Appeals Findings

2021 EQR Appeals Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Timeliness guidelines for resolution of the appeal as specified in the contract;	***Recommendation: Correct the Provider Operations Manual to reflect the required verbal and written notifications Alliance issues when Alliance extends the Appeal resolution timeframe. Include the timeframes for these verbal and written notifications, as required by 42 CFR § 438.408 (c)(2)(ii) and NC Medicaid Contract, Attachment M, Section G.6.***	**N**
2022 EQR Follow-up: The *Provider Operations Manual* submitted for this EQR showed the manual has not been corrected since October 16, 2020.		

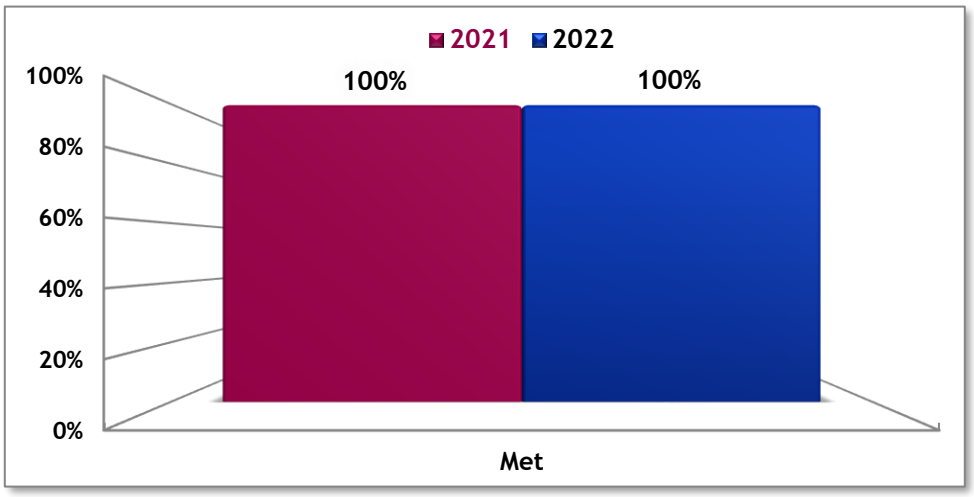
In the 2022 Appeal file review, two expedited Appeals where Alliance denied the request to expedite the resolution timeframe did not contain documentation of any effort by staff to provide oral notification that the expedited request was denied by Alliance. This oral notification is required by Alliance Procedure 6505, Due Process Appeals of Medical Necessity Determinations, Alliance's *NC Medicaid Contract, Attachment M, Section H.9,* and *42 CFR § 438.408 (b)(2)*. Based on review of the Appeal Peer Review Tool, it is also noted that Alliance is not reviewing Appeal files to ensure this oral notification is occurring. CCME initially issued a Corrective Action to ensure that Appeals staff are trained to provide and document prompt oral notifications to the appellant when Alliance denies an expedited Appeal review. This Corrective Action also included enhancing the current Appeal file monitoring process to include compliance monitoring of this oral notification. Based on feedback from NC Medicaid to change this score to a "Met", this Corrective Action was changed to a Recommendation and Alliance's overall percentage of "Met" Grievance and Appeals standards changed to 100%.

Another concern noted in the review included data entry errors found in the Appeal Log. Three files had incorrect dates documented on the Appeal Log, making the turn-around time incorrect on the Log for two of those cases. As a result, one Appeal was in 32 days

instead of the 30-days timeframe required by Alliance Procedure 6505, Due Process Appeals of Medical Necessity Determinations, Alliance's *NC Medicaid Contract, Attachment M, Section H.9,* and *42 CFR § 438.408 (b)(2).*

Figure 6, Grievances and Appeals Comparative Findings, shows 95% of the standards in the 2022 Appeal and Grievances EQR were scored as "Met" and provides an overview of 2022 scores compared to 2021 scores.

Figure 6: Grievances and Appeals Comparative Findings



Strengths

- Alliance recently hired two additional supervisors to provide additional oversight of Grievance and Appeals functions.

Weaknesses

- The *Provider Operations Manual* does not consistently reflect one term for Grievance, Concern, and/or Complaint.
- The *Provider Operations Manual* contains incorrect information on page 62 regarding the required Grievance resolution timeframe.
- The *Provider Operations Manual* contains incorrect information on page 62 regarding the required notification Alliance must provide when Alliance extends the Grievance resolution timeframe.
- The Grievance file review found deficiencies in withdrawn and extended files related to required notifications and issues with accuracy of dates entered on the Grievance Log.

- The *Provider Operations Manual* did not explain Alliance will orally notify the enrollee of Alliance's extension to the Appeal resolution timeframe, nor is a timeframe identified for the oral and written notifications from Alliance regarding an extension.
- Both of the expedited files reviewed showed no documentation of oral notification to the enrollee regarding Alliance's decision to deny their request to expedite the Appeal resolution. This oral notification is required by Alliance Procedure 6505, Due Process Appeals of Medical Necessity Determinations, Alliance's *NC Medicaid Contract, Attachment M, Section H.9,* and *42 CFR § 438.410 (b)(2).*

Recommendations

- Revise the *Provider Operations Manual* to consistently use one term reflecting an "expression of dissatisfaction about any matter other than an adverse benefit determination."
- Correct the *Provider Operations Manual* on page 62 to clarify the required Grievance resolution timeframe of 90 days, as required by Alliance Procedure 6503.
- Revise the *Provider Operations Manual* on page 62 to include that Alliance will "make reasonable efforts to give the enrollee prompt oral notice of the delay" and written notice "within 2 calendar days" when Alliance extends the Grievance Resolution timeframe. These notifications are required by Alliance Procedure 9603, *42 CFR § 438.408 (c)(2)(ii),* and *Attachment M* of Alliance's *NC Medicaid Contract*.
- Enhance the current file monitoring process to focus on withdrawn and extended Grievances, compliance with those required notifications, and the accuracy of data entered on the Grievance Log.
- Correct the *Provider Operations Manual* to reflect the required oral and written notifications Alliance issues when Alliance extends the Appeal resolution timeframe. Include the timeframes for these oral and written notifications, as required by *42 CFR § 438.408 (c)(2)(ii) and NC Medicaid Contract, Attachment M, Section G.6*.
- Ensure Appeals Coordinators are trained to provide and document prompt oral notification to the appellant when Alliance denies a request to expedite the Appeal resolution timeframe.
- Enhance the current file monitoring process to focus on expedited Appeals and the required oral notifications when Alliance denies the request to expedite the Appeal resolution timeframe. Include in the monitoring, routine review of the Appeal Log to identify data entry errors to prevent compliance issues.

E. Program Integrity

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

The 2022 Program Integrity EQR for Alliance encompassed a thorough Desk Review of PIHP Program Integrity (PI) functions. Alliance procedures related to Special Investigative Unit (SIU) investigations, Provider Overpayments, and aspects of compliance were evaluated. The EQR also included a review of PI staffing, workflows, reports, training materials, committee minutes, data mining processes, and 10 PI files investigated during the period under review. An Onsite discussion with Alliance's Chief Compliance Officer and Compliance, Program Integrity, Claims, Waiver Programs, and Special Investigations staff occurred to address questions related to Alliance's PI functions.

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

Table 29: 2021 EQR Program Integrity Findings

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

In the 2022 EQR, review of Alliance's Organizational Chart showed Alliance is currently recruiting for three SIU positions. During the Onsite, Alliance clarified that the positions in the SIU are to increase the Internal Audit Team functions are contingent upon NC Tailored Plan launch. Alliance also reported those positions have been filled.

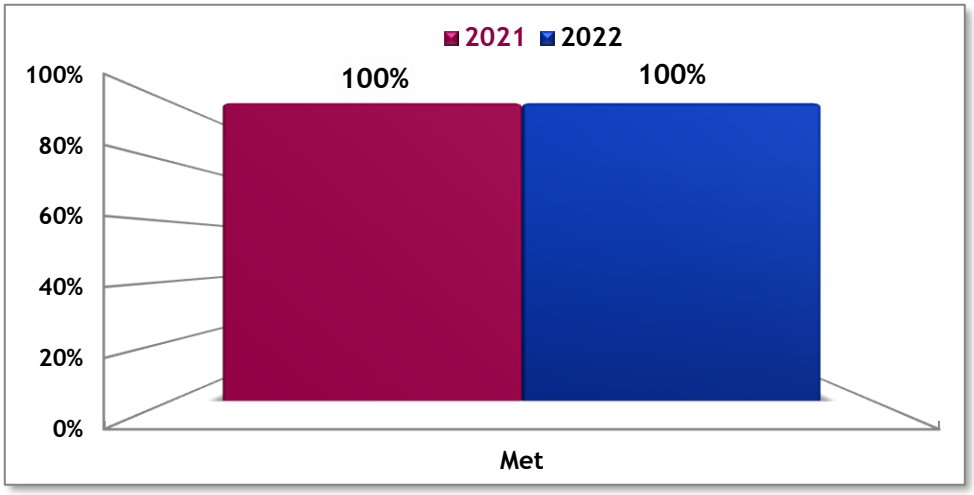
Alliances' *SIU Case List* tracks the progress of investigations. CCME's review of this list identified 41 opened investigations, which include 21 files being evaluated internally for the appropriate resolution. There was concern that Alliance would not have all files closed and investigations concluded prior to Tailored Plan launch. During the Onsite, Alliance clarified that NC Medicaid is aware of SIU investigations status and have determined that investigations can transition to Tailored Plan.

The review of the *SIU Case List* and the *Attachment Y Report* showed Alliance submitted 23 referrals to NC Medicaid for potential fraud, waste, and abuse (FWA). During the Onsite, Alliance also highlighted that one of the referrals to NC Medicaid was accepted for further investigation by the NC Medicaid Investigative Unit (MID). MIDs investigation found that the allegation of FWA was occurring in other catchment areas and as a result, led to a conviction and sentencing.

In this 2022 EQR, CCME reviewed 10 PI investigation files for timeliness of investigations and to ensure all required elements documented in referrals to NC Medicaid. Review of the files showed all requirements were met and in accordance with Alliances' *NC Medicaid Contract* and procedures.

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

Figure 7: Program Integrity Comparative Findings



Strengths

- One of Alliance's referrals to NC Medicaid was accepted for further investigation by the NC MID. Its investigation found that the allegation of FWA was occurring in other catchment areas and as a result, led to a conviction and sentencing.
- For the period under review, Alliance completed 23 referrals to NC Medicaid for possible FWA. During the Onsite, NC Medicaid staff said these referrals were thorough and appropriate and most are accepted for further investigation by the MID.

G. Encounter Data Validation

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

Results and Recommendations

Issue: Other Diagnosis Codes

The secondary diagnosis was populated in 58% of all Institutional claims but only 13% of Professional claims. Lack of Other Diagnosis codes does not necessarily impact the adjudication of claims. However, all claims should be complete and accurate at all times. The low figure among Professional claims suggests that some providers are not as diligent in coding and submitting Other Diagnosis codes, including some providers who appear to never submit Other Diagnosis codes.

Resolution:

Alliance should work closely with their provider community and encourage them to submit all applicable Diagnosis codes, and Units. This information is key for measuring member health, identifying areas of risk, and evaluating quality of care.

Issue: Other Diagnosis Codes

The Unit values were not present 100% of the time for Institutional claims. This could have an impact on accurate claim adjudication. All claims should be complete and accurate at all times.

Resolution:

Alliance should identify providers who never or very rarely submit Other Diagnosis codes and provide outreach to assist them in meeting their obligation to ensure that the claims they submit to Alliance are complete and accurate.

Conclusion

Based on the analysis of Alliance's Encounter data, it has been concluded the data submitted to NC Medicaid is complete and accurate in accordance with NC Medicaid standards. Alliance took multiple corrective actions in 2019, 2020, and 2021 to address issues that were highlighted in prior reviews. More specifically, Alliance instituted multiple claim edits and other system changes to address deficiencies in Procedure codes.

ATTACHMENTS

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

Attachment 1: Initial Notice, Materials Requested for Desk Review

December 16, 2022

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

Dear Mr. Robinson,

At the request of the North Carolina Medicaid (NC Medicaid) this letter serves as notification that the 2022 External Quality Review (EQR) of Alliance Health (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 one-day, virtual Onsite that will address contractually required services.

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

The CMS EQR protocols can be found at:

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

Due to COVID-19 and the issuance of the contractual flexibilities issued by the State outlined in Contract Amendment #9, the 2022 EQR will be a focused review. The focus of this review will be on Alliance's Corrective Actions from the previous EQR and Alliance's functions that impact enrollee health and safety. Similarly, for the 2022 EQR, the two-day Onsite previously performed at Alliance's offices will be conducted during a one-day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **February 16, 2023**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

In preparation for the Desk Review, the items on the enclosed **Desk Materials List** are to be submitted electronically. **Please note that, to facilitate a timely review, there are three items on the Desk Materials List (items 9, 10, and 19.a) that should be submitted by no later than December 22, 2022,** and the remaining items are due by no later than **January 27, 2023**. Also, as indicated in item 20 of the Desk Materials List, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted with the other Desk Materials on **January 27, 2023**.

All materials should be submitted to CCME electronically through our secure file transfer website. The location for the file transfer site is: https://eqro.thecarolinascenter.org

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

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 6

Cc: Mya Lewis, Alliance Health Contract Manager
Monica Hamlin, NC Medicaid Waiver Contract Manager
Deb Goda, NC Medicaid Associate Director, Behavioral Health and IDD
Christean Hunter, NC Medicaid Quality Management Specialist

Focused External Quality Review 2022

MATERIALS REQUESTED FOR DESK REVIEW

**__Please note that the lists requested in items 9, 10, and 19.a must be uploaded by no later than December 22, 2022. The remainder of items must be uploaded by no later than January 27, 2023.__

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

2. Organizational Chart of all staff members including names of individuals in each position including their degrees, licensure, and any certifications required for their position. Include any current vacancies. In addition, please include any positions currently filled by outside consultants/vendors.

3. Description of major changes in operations such as expansions, new technology systems implemented, etc. Include any major changes to PIHP functions related to COVID-19.

4. A summary of the status of all Corrective Action items from the previous External Quality Review. Please include evidence of Corrective Action implementation.

5. List of providers credentialed/recredentialed in the last 12 months (December 2021 through November 2022). Include the date of approval of initial credentialing and the date of approval of recredentialing.

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

7. Minutes of committee meetings for the following committees:
   a) Credentialing (for the three most recent committee meetings)
   b) UM (for the three most recent committee meetings)

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

9. **__By January 27, 2023__, a copy of the complete Appeal log for the months of December 2021 through November 2022. Please indicate on the log: the appeal type (standard, expedited, extended, withdrawn, or invalid), the service appealed, the date the appeal was received, and the date of the appeal resolution notification.

10. **__By January 27, 2023__, a copy of the complete Grievances log for the months of December 2021 through November 2022. Please indicate on the log: the nature of the grievance, the date received, and the date of the grievance resolution notification.

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

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

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

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

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

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

16. Information regarding the following selected Performance Measures:

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

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

Required information includes the following for each measure:

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

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

c. Reporting frequency and format;

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

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

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

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

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

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

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

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

18. Provide copies of the following files:

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

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

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

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

b. Insurance:

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

2. For practitioners joining already-contracted agencies, include copies of the proof of insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.
   i. All PSVs conducted during the current process, including current supervision contracts for all LPAs and all provisionally-licensed practitioners (*i.e.*, LCAS-A, LCSW-A).
   ii. Ownership disclosure information/form.

c. Recredentialing files for the four most recently credentialed practitioners (as listed below)

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

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

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

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

ii. Insurance:

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

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

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

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

iii. Ownership disclosure information/form.

19. Provide the following for Program Integrity:

a. ****File Review:** Please produce a listing of all active files during the review period (December 2021 through November 2022) by **January 27, 2023**. The list should include the following information:

i. Date case opened

ii. Source of referral

iii. Category of case (enrollee, provider, subcontractor)

iv. Current status of the case (opened, closed)

b. Program Integrity Plan and/or Compliance Plan.

c. Workflow of process of taking complaint from inception through closure.

d. All 'Attachment Y' reports collected during the review period.

e. All 'Attachment Z' reports collected during the review period.

f. Provider Manual and Provider Application.

g. Enrollee Handbook.

h. Training and educational materials for the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse and the False Claims Act.

i. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse.

j. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors, and employees.

k. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other State or Federal agency.

l. Code of Ethics and Business Conduct.

m. Internal and/or external monitoring and auditing materials.

n. Materials pertaining to how the PIHP captures and tracks complaints.

o. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting

    i. NC Medicaid approved reporting templates.

p. Sample Data Mining Reports.

q. Monthly reports of NCID holders/FAMS-users in PIHP.

r. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.

s. Corrective action plans including any relevant follow-up documentation.

20. Provide the following for the Information Systems Capabilities Assessment (ISCA):

    a. A completed ISCA.

    b. See the last page of the ISCA for additional requested materials related to the ISCA.

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

c. A copy of the IT Disaster Recovery Plan.

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

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

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

a. Include all adjudicated claims (paid and denied) from January 1, 2021 – December 31, 2021. Follow the format used to submit Encounter data to NC Medicaid (i.e., 837I and 837P). If you archive your outbound files to NC Medicaid, you can forward those to CCME for the specified time period. In addition, please convert each 837I and 837P to a pipe delimited text file or excel sheet using an EDI translator. If your EDI translator does not support this functionality, please reach out immediately to CCME.

b. Provide a report of all paid claims by service type from January 1, 2021 – December 31, 2021. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

NOTE: EDV information should also be submitted via CCME's SFTP. If you have any questions, please contact Kathy Niblock at kniblock@thecarolinascenter.org.

Attachment 2: EQR Validation Worksheets

- Mental Health (b Waiver) Performance Measures Validation Worksheets
    - 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 Worksheets
    - Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals
    - Proportion of Individual Support Plans that address identified health and safety risk factors
    - Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need
    - Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available
    - Proportion of beneficiaries reporting they have a choice between providers
    - Percentage of Level 2 and 3 incidents reported within required timeframes
    - Number and percentage of deaths where required LME/PIHP follow-up interventions were completed, as required
    - Percentage of medication errors resulting in medical treatment
    - Percentage of beneficiaries who received appropriate medication
    - Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required

- Performance Improvement Project Validation Worksheets
    - 7 DAY DHB SUD
    - 7 Day DMH MH
    - 7 Day DMH SUD
    - APM
    - SSD
    - TCL PCP Visits

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the	**Met**	Calculation of rates adhered to numerator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
	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).		
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the	**Met**	Calculation of rates adhered to numerator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
	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).		
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the	**Met**	Calculation of rates adhered to numerator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
	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).		
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member	**Met**	Calculation of rates adhered to numerator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
	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).		
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member	**Met**	Calculation of rates adhered to numerator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
	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).		
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member	**Met**	Calculation of rates adhered to numerator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
	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).		
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member	**Met**	Calculation of rates adhered to numerator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
	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).		
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member	**Met**	Calculation of rates adhered to numerator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
	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).		
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member	**Met**	Calculation of rates adhered to numerator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
	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).		
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Innovations PM Validation Worksheet

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

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with 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 Innovations PM Validation Worksheet

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Innovations PM Validation Worksheet

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Innovations PM Validation Worksheet

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

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Innovations PM Validation Worksheet

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

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Alliance**
Name of PIP:	**7 DAY DHB SUD**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by month.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The most recent data available for this PIP was April 2022. The rate had declined to 31% after a rate of 37% in March 2022. ***Recommendations: Continue current interventions and monitoring new processes such as care management process that was reorganized in 2021 and value-based contracts, in addition to provider network meetings with facilities.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement in rate
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Alliance**
Name of PIP:	**7 DAY DMH MH**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by month.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The most recent rate improved from 28% in May 2022 to 33% in June 2022. The goal is 40%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be a result of the interventions initiated including scorecard review, care management process, follow-up phone contacts, and others.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	79
Project Possible Score	79
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Alliance**
Name of PIP:	**7 DAY DMH SUD**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by month.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The latest remeasurement showed a decline from 29% in May 2022 to 27% in June 2022. The goal is 40%. ***Recommendation: Continue current interventions and monitoring newer processes such as care management process that was reorganized in 2021 and value-based contracts.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	73
Project Possible Score	74
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Alliance**
Name of PIP:	**METABOLIC MONITORING FOR CHILDREN AND ADOLESCENTS ON ANTI-SPYCHOTICS (APM)**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by month.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The most recent measurement showed no change, with July and August 2022 having a 32% rate.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	No decline in rate and interventions have sustained the rates.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling not utilized.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**79**
Project Possible Score	**79**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Alliance**
Name of PIP:	**DIABETES SCREENING FOR PEOPLE WITH SCHIZOPHRENIA OR BIPLOAR DISORDER WHO ARE USING ANYTIPSYCHOTIC MEDICATIONS (SSD)**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by month.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The most recent remeasurement period showed a slight improvement from 67% in July 2022 to 68% in August 2022.The goal is 81%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to the interventions such as HealthCrowd campaign, pilot POC testing, provider scorecards, and patient level data monitoring.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**79**
Project Possible Score	**79**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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:	**TCL PCP VISITS**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected Sharepoint platform and Johns Hopkins reporting tool.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by month.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The rate improved from 89% in October 2022 to 91% in November 2022. This is above the goal rate of 80% and has been above the goal rate for the last 3 measurements.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Interventions appear to be improving TCL PCP visit rates.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**MET**	Three consecutive measurement periods have been above the goal rate.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**84**
Project Possible Score	**84**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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.*

Attachment 3: Tabular Spreadsheet

CCME PIHP Data Collection Tool

Plan Name:	Alliance
Collection Date:	2022

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A Management Information Systems						
1. Enrollment Systems						
1.1 The PIHP capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Alliance has standard processes in place for enrollment data updates. Alliance parses the daily Global Eligibility Files (GEF) to Alliance's Enterprise Data Warehouse (EDW). A process is then run to upload the data from the EDW to the Alliance Claims System (ACS). Alliance also uses the monthly 820 file to do a reconciliation of Medicaid members. Demographic data is captured in the ACS system and patients IDs are unique to members. Historical enrollment information is captured and maintained for all members.
1.2 The PIHP is able to identify and review any errors found during, or as a result, of the State enrollment file load process.	X					During the Onsite, Alliance stated that they can identify GEF records that are unable to be loaded to ACS.
1.3 The PIHP's enrollment system member screens store and track enrollment and demographic information.	X					During the Onsite, Alliance demonstrated the ACS enrollment screens and their capability to store demographic information. All historical data for members is stored and merged under one member ID which is checked against member info in the GEF.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Claims System						
2.1 The PIHP processes provider claims in an accurate and timely fashion.	X					Most claims received are electronic on a HIPAA file or through the Provider web portal. Very few claims from out-of-network and new providers who have not gained access to the ACS are received via paper (approximately less than 0.1%). For claims received in 2021, approximately, 97.44% of Professional claims and 86.12% of Institutional claims are auto adjudicated on a nightly basis. Alliance pends claims with amounts greater than $5,000, weekly audit of 3% ED claims, or claims with exceptions for manual review. All pended claims are reviewed daily and processed within 10 days from claim receipt.
2.2 The PIHP has processes and procedures in place to monitor, review and audit claims staff.	X					Alliance audits a random sample of 2.5% of all claims processed on a weekly basis. Focused audits of at least 50% of high dollar claims that are greater than $5,000 and at least 3% of Emergency Department (ED) claims are audited on a weekly basis. Non-routine focused audits of claim overrides, COB, and claims examined by new hires are also completed to target systemic errors to understand the root cause of errors. Non-routine focused audits may also be conducted in response to reports or suspicions of fraudulent claims activity or potential error vectors.
2.3 The PIHP has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file. The PIHP has the capability of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	X					During the Onsite, Alliance demonstrated the ACS claims system and capabilities to receive and store all ICD-10 Diagnosis codes. Alliance indicated that ICD-10 Procedure codes, Revenue codes and DRG codes are captured in the ACS system electronically and via the Provider web portal. Up to four ICD-10 Diagnosis codes are captured via the web portal and up to 40 ICD-10 Diagnosis codes are captured via HIPAA files for Institutional claims. For Professional encounters, up to 12 ICD-10 Diagnosis codes are captured via the web portal and HIPAA files.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 The PIHP's claim system screens store and track claim information and claim adjudication/payment information.	X					During the Onsite, Alliance demonstrated their Provider web portal, claim system screens, and claim adjudication/payment information. Alliance demonstrated their claim systems ability to capture all the ICD-10 Diagnosis codes, DRGs, Revenue codes, CPT/HCPCS, ICD-10 Procedure codes and adjudication information.
3. Reporting						
3.1 The PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Alliance captures all required ICD-10 Diagnosis codes and can capture additional procedure, DRG, and Revenue codes that are submitted on the claims. Alliance stores the DRG and ICD-10 Procedure codes for reporting.
3.2 The PIHP has processes in place to back up the enrollment and claims data repositories.	X					During the Onsite, Alliance stated that their critical systems and ACS have two databases with shared data to ensure there is no disruption of services. Alliance also stated that there are backups at the server level and at the database level on a nightly basis. This was detailed in the disaster recovery plan which was provided along with the ISCA tool.
4. Encounter Data Submission						
4.1 The PIHP has the capabilities in place to submit the State required data elements to NC Medicaid on the Encounter data submission.	X					During the Onsite, Alliance stated that they submit up to 40 ICD-10 Diagnosis codes on Institutional encounters and up to 12 ICD-10 Diagnosis codes on Professional encounters to NCTracks. ICD-10 Procedure codes are captured in the ACS system but are not submitted on Institutional encounters to NCTracks. ***Recommendation: Update Alliance's Encounter data submission process to submit ICD-10 Procedure codes on Institutional Encounter data extracts to NCTracks.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2 The PIHP has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					Alliance's EDI Specialist reviews the incoming 999 files from NC Medicaid to ensure successful transmission and processing of the Encounter extracts. The incoming 835 response from NC Medicaid is then reviewed to identify and work on Encounter data denials.
4.3 PIHP has policies and procedures in place to reconcile and resubmit Encounter data denied by NC Medicaid.	X					Alliance uses the incoming 835 file to reconcile the data with the sent 837 Encounter extract in the internally-developed Alliance Reconciliation (AR) system. Alliance uses the remark codes to narrow down the denial reason to help staff to make appropriate corrections for any provider information to ensure matches between ACS and the NCTracks data sources. Alliance has an Encounter acceptance rate of 97.66%. However, based on the ISCA information, The overall Institutional denials pending resubmission has more than doubled since the prior year. This increase was discussed with Alliance during the Onsite. ***Recommendation: Improve tracking and monitoring of Encounter denials and timely re-submission of denied Encounters to the State.***
4.4 The PIHP has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of Encounter data to NC Medicaid.	X					As stated in Alliance's ISCA, Claims Staff review daily claims audit report of all claims processed. All denied claims are reviewed to help identify providers who are having difficulty with submitting claims. Claims staff communicate with the providers any errors and resolution needed. During the Onsite, Alliance staff outlined the Encounter data submissions and reconciliation process.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II A. Credentialing and Recredentialing						
1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					Per the direction of the North Carolina Department of Health and Human Services (NC DHHS), credentialing has now shifted from the PIHPs completing credentialing and recredentialing to the PIHPs verifying credentialing completed by NCTracks. Alliance completed the in-process credentialing and recredentialing files in May 2022. As at the 2021 EQR, Alliance submitted Procedure 6011 Primary Source Verification, Procedure 6030 Credentialing Criteria and Enrollment Process for Network Participation, and Procedure 6036 Re-Credentialing Criteria and Enrollment Process for Network Participation as their *Credentialing Program Description*. Also submitted for the 2021 EQR and the 2022 EQR, Procedure 3007 Guarding against Fraud and Abuse addresses monthly checks. Procedure 6011, Procedure 6030, and Procedure 6036, as well as relevant sections of Procedure 3007, were not revised from the versions of these procedures submitted for the 2021 EQR.
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					As was the case at the last three EQRs, there is conflicting information regarding committee membership across Alliance documents. Alliance did not implement the Recommendation from the 2021 EQR. As noted, Procedure 6011, Procedure 6030, and Procedure 6036, as well as relevant sections of Procedure 3007, were not revised from the versions of these procedures submitted for the 2021 EQR. Therefore, the information in the bulleted items regarding Procedure 6030 and Procedure 6036 Is unchanged from the 2021 EQR. However, as Alliance is no longer completing credentialing/

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						recredentialing, CCME is issuing no Recommendations in the 2022 EQR of Credentialing/Recredentialing. o Procedure 6030: - lists "Chief Medical Officer, Associate Medical Director as designated by the Chief Medical Officer, scribe, Provider Network Operations Manager, Credentialing Supervisor, and the Credentialing Specialist" as non-voting members, and states, "All other members, Alliance employees and provider representatives are voting members." - does not list a representative from the Office of Legal Affairs as a non-voting member. Therefore, based on procedure language, that representative would be a voting member. However, Erica Bing, JD, Deputy General Counsel is listed as a non-voting member on the submitted Provider Network Credentialing Committee (PNCC) meeting minutes, and Alliance staff confirmed at the 2021 EQR Onsite that Ms. Bing was a non-voting member of the PNCC. o Procedure 6036 states, "The non-voting members (of the Provider Network Credentialing Committee) are the Credentialing Committee Chair, scribe, Provider Network Operations Manager, Credentialing Supervisor, Credentialing Specialist." The Chief Medical Officer (CMO) is not listed as a non-voting member. o The procedures include a "Provider Network Operations Manager", but at the 2021 EQR Onsite, Alliance staff confirmed the Network Operations Manager position no longer exists.
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Credentialing files reviewed for the EQR were organized and contained appropriate information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 outlines insurance requirements. Procedure 6011 Primary Source Verification established acceptable verification sources for required insurance.
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
3.1.3 Valid DEA certificate; and/or CDS certificate	X					
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					
3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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;						
3.1.8 Query of the National Practitioner Data Bank (NPDB) ;	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); and query of the State Exclusion List;	X					
3.1.10 Query for the System for Awards Management (SAM);	X					
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	X					
3.1.14 Names of hospitals at which the physician has admitting privileges if any	X					
3.1.15 Ownership Disclosure is addressed.	X					
3.1.16 Criminal background Check	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files reviewed for the EQR were organized and contained appropriate information.
4.1 Recredentialing every three years;	X					Procedure 6030 Credentialing Criteria and Enrollment Process for Network Participation states, "Re-credentialing needs to be completed within the 3 years based on the month of the previous credentialing." Procedure 6036 Re-Credentialing Criteria and Enrollment Process for Network Participation states, "All providers must be re-credentialed a minimum of once every 36 months."

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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event; and query of the State Exclusion List;	X					
4.2.9 Requery of the SAM.	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (OIG LEIE);	X					
4.2.11 Requery of the Social Security Administration's Death Master File	X					
4.2.12 Requery of the NPPES;	X					
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					
4.2.14 Ownership Disclosure is addressed.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					Recredentialing Checklists include a "MCO Department Performance Summary" section that addresses Compliance Sanctions. Some files include a "Provider Profiling" section with supporting materials, including a "Compliance Sanctions" internal report that is pulled from the Compliance Action Database. 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 affiliation with the PIHP for serious quality of care or service issues.	X					Addressed in Procedure 3043, Provider Actions, and Suspensions to Ensure Patient Safety.
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					

II. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III. Quality Improvement						
III. A Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					All (c) Waiver Measures were above the State benchmark rates. The overall validation scores for all Performance Measures were in the Fully Compliant range, with an average validation score of 100% across the 10 (b) Waiver Measures and the five (c) Waiver Measures. There were no clinical treatment measures (e.g., readmission, follow-up) rates with substantial increases or substantial declines from FY 2021 to FY 2022. Mental health penetration rates increased substantially (>10%) for several counties including Cumberland, Durham, Wake, and Johnston County for 3-12 year-olds and 13-17 year-olds. 18-20 year-olds had a substantial increase in Cumberland and Durham counties, and 65+ year-olds had a substantial increase in Durham County. There are no Recommendations as changes in rates were related to Utilization by members.
III. B Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					Alliance submitted six projects for this 2022 EQR. These six were validated including: 7-Day Super Measure – State DMH MH, 7-Day Super Measure – State DMH SUD, 7-Day Super Measure – Medicaid DHB SUD, Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM), Diabetes Screenings for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (HEDIS SSD), and Transitions to Community Living (TCL) PCP Visits Improvement.

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					All six validated PIPs scored in the High Confidence range, although two PIPs had errors. See Recommendations below. ***Recommendation: 7-day Super measure State DMH SUD: Continue current interventions and monitoring new processes such as care management process that was reorganized in 2021 and value-based contracts.*** ***Recommendation: 7-day Super measure Medicaid DHB SUD: Continue current interventions and monitoring new processes such as care management process that was reorganized in 2021 and value-based contracts, in addition to provider network meetings with facilities.***

IV. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. A Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					In the 2021 EQR, it was noted that Alliance revised the I/DD Care Coordination titles and roles in the past year, resulting in a new Care Management Department. However, the roles and responsibilities of the previous department, Care Coordination, are still outlined in the *Individual and Family Handbook* and the *Innovations Individual and Family Handbook*. These public-facing handbooks also do not reflect Alliance's recent addition of Orange and Mecklenburg counties to the Alliance catchment area. CCME issued a Recommendations in the 2021 EQR to ensure these handbooks were revised to reflect up to date information. In the 2022 EQR, Review of the *Individual and Family Handbook* and *Innovations Individual and Family Handbook* showed the handbook was revised in October 2022 to consistently reflect the name change of the Care Coordination Department to the Care Management Department. However, there are still six areas within these two handbooks that omit counties within Alliance's catchment area. As an example of this omission, the first page of the *Individual and Family Handbook* states, "Services described in this handbook are available only to qualified residents of Durham, Wake, Cumberland, and Johnston counties in the State of North Carolina." CCME is again recommending these handbooks are revised to accurately reflect all of the counties in Alliance's catchment area. ***Recommendation: Revise the Review of the Individual and Family Handbook and Innovations Individual and Family Handbook to consistently reflect the six counites in Alliance's catchment area.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Alliance Procedure 2005, Identification, Referral, and Timely Initiation of Care Management Functions, describes how Care Managers ensure linkage to providers for face-to-face.
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					Alliance's Procedure 2004, Individual Support Plans, details the role of Care Managers it the development of enrollees' Individual Support Plans.
2.5 Quality monitoring and continuous quality improvement;	X					
2.6 Determination of which Behavioral Health Services are medically necessary;	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					Care Management Procedure, 2010, Hospital Follow-up, outlines the actions a Care Manager will complete to assist enrollees discharging from the hospital and/or Emergency Department.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					Alliance's Procedure 2027, Monitoring Requirements for NC Innovations and NC TBI Waiver Participants, describes the monthly and quarterly monitoring process implemented by the I/DD Care Management Program.
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					In the last two EQRs, CCME recommended Alliance better monitor enrollee files for consistency or compliance issues related to Care Management interventions. In the 2022 EQR, three files of enrollees participating in the Innovations Waiver were selected by Alliance for review. All three files showed the SIS was not updated at the three year interval identified for adult SIS updates. It is understood that SIS updates were formally waived by NC Medicaid in 2020 during the pandemic. However, the SIS update for one of these files was due prior to the pandemic. Similarly, two of the three Innovations enrollee files showed no face-to-face monitoring with the enrollee, either in person or via a telehealth platform, was attempted or implemented. While it is understood the requirement of face-to-face monitoring with enrollees has also been waived during the pandemic, the file review revealed inconsistent practices by Innovations Care Managers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						CCME is again recommending Alliance enhance their enrollee file review and activity tracking processes to identify inconsistencies in Care Management practices. This will be particularly important when NC Medicaid lifts the pandemic flexibilities and reinstates the requirements around SIS updates and face-to-face monitoring as outlined by *Clinical Coverage 8P*. ***Recommendation: Enhance the review process of Innovations enrollee files to better identify inconsistent Care Management practices around updating each Innovations enrollee's SIS and face-to-face monitoring.***
IV. B Transition to Community Living Initiative						
1. Transition to Community Living (TCL) functions are performed by appropriately licensed, or certified, and trained staff.	X					Alliance Procedure, 2034, Transition to Community Living, outlines the staffing requirements for the professionals performing transition planning functions.
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					
2.1 Care Coordination activities occur, as required.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.2 Person Centered Plans are developed as required.	X					
2.3 Assertive Community Treatment, Peer Support, Supported Employment, Community Support Team, Psychosocial Rehabilitation, and other services as set forth in the DOJ Settlement are included in the individual's transition, if applicable.	X					
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					
2.5 QOL Surveys are administered timely.	X					
3. Transition, diversion and discharge processes are in place for TCL members as outlined in the DOJ Settlement and *DHHS Contract*.	X					Alliance's Procedure 2040, Transition of Care Planning Facilitation, describes the transition, diversion, and discharge processes for enrollees participating in the TCL program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.	X					
5. The PIHP will develop a TCL communication plan for external and internal stakeholders providing information on the TCL initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					
6. A review of files demonstrates the PIHP is following appropriate TCL policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	X					In the 2022 EQR, review of the TCL enrollee files showed good engagement and transition efforts, complete and timely documentation, and all required interventions (such as Quality of Life Surveys) were conducted in compliance with Alliance procedures and TCL requirements.

V. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					In the 2020 EQR, CCME recommended Alliance revise the *Provider Operations Manual* to consistently reflect one term for Grievance, Concern, and/or Complaint. However, this revision did not occur and remained a Recommendation for the 2021 EQR. In the 2022 EQR, there was no evidence Alliance addressed this Recommendation in the *Provider Operation Manual (Revised September 16, 2020; effective October 16, 2020)*, as it has not been revised for the past two years. ***Recommendation: Revise the Provider Operations Manual to consistently use one term reflecting an "expression of dissatisfaction about any matter other than an adverse benefit determination."***
1.1 Definition of a grievance and who may file a grievance;	X					
1.2 The procedure for filing and handling a grievance;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					In the 2022 EQR, the Desk Review of the *Provider Operations Manual* identifies incorrect timeframes for a Grievance resolution. Page 62 of the manual states, "Alliance will seek to resolve Grievances…no later than thirty (30) calendar days from the date Alliance received the Grievance." Per Alliance's Grievance procedure 6503, the timeframe for Grievance resolution is 90 days. The Recommendation to review and correct this timeframe was issued in the 2020 and 2021 EQRs but the *Provider Operations Manual* has not been revised in the past two years. ***Recommendation: Correct the Provider Operations Manual to clarify the required Grievance resolution timeframe of 90 days, as required by Alliance Procedure 6503.*** The *Provider Operations Manual* (revised September 16, 2020; effective October 16, 2020) contains incorrect information on page 62 regarding the required notification Alliance must provide when Alliance extends the resolution timeframe. The manual states, "Any extension granted shall be communicated to the individual within one (1) business day either verbally or in writing. Verbal notifications shall be followed up in writing to the individual." CCME issued a Recommendation for the 2020 and 2021 EQR that Alliance correct this information to state, Alliance will "make reasonable efforts to give the enrollee prompt oral notice of the delay" and written notice "within 2 calendar days." This Recommendation has not been implemented and remains a 2022 EQR Recommendation. ***Recommendation: Revise the Provider Operations Manual on page 62 to include that Alliance will "make reasonable efforts to give the enrollee prompt oral notice of the delay" and written notice "within 2 calendar days" when Alliance extends the Grievance Resolution timeframe. These notifications are required by Alliance Procedure 9603, 42 CFR § 438.408 (c)(2)(ii), and Attachment M of Alliance's NC Medicaid Contract.***

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					
1.5 Maintenance of a grievance log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					
2. The PIHP applies the grievance policy and procedure as formulated.	X					In the 2021 EQR, CCME recommended Alliance revise the Grievance Extension Notification letter to include notification to the Grievant of their right to file a Grievance if he or she disagrees with Alliance's decision to extend the Grievance resolution timeframe. This notification is required by *42 CFR § 438.408 (c)(2)(ii)* and Alliance provided evidence that this notification had been revised. In the 2021 EQR, there was also a Recommendation to "Develop, document, and implement a process that includes sending a written resolution when a Grievance is withdrawn. Incorporate and document monitoring for this notification into the Grievance monitoring plan." Of the two files reviewed in this EQR where the Grievance was withdrawn, only one file contained the resolution notification. While Alliance provided their monitoring tools that included review of withdrawn Grievances and related notifications, the file review revealed Alliance is still not providing the written resolution notification to enrollees consistently when a Grievance is withdrawn.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						It should be noted that during the Onsite, staff reported the required timeframe for Grievance resolution is 30 days. Additionally, Grievance monitoring tools and reports cite 30 days as the required timeframe for Grievance resolution. To add further confusion, the Grievance Log noted submitted for this review showed six Grievances were documented as "extended". However, all Grievances noted as "extended" were resolved well within the 90 days required by Alliance's Grievance procedure. All of these findings reveal a need for Alliance to better monitor Grievance files to identify areas of noncompliance and inconsistencies or confusion quickly and effectively in staff practices while processing Grievances. ***Recommendation: Enhance the current file monitoring process to focus on withdrawn and extended Grievances, compliance with those required notifications, and the accuracy of data entered on the Grievance Log.***
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Grievance data are analyzed weekly, monthly, and quarterly at the department level. Data is reported to the Quality Improvement Committee.
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					Alliance's procedure governing the processing of Appeals is Procedure 6505, Due Process Appeals of Medical Necessity Determinations.
1.1 The definitions an appeal and who may file an appeal;	X					
1.2 The procedure for filing an appeal;	X					
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					In the 2020 and 2021 EQRs, there was a Recommendation for Alliance to revise the *Provider Operations Manual*. The manual did not explain Alliance will orally notify the enrollee of Alliance's extension to the Appeal resolution timeframe, nor is there a timeframe identified for the oral and written notifications from Alliance regarding an extension. For this 2022 EQR, CCME is issuing this Recommendation again as it was not implemented by Alliance, and the *Provider Operations Manual* still does not contain information regarding these required notifications. ***Recommendation: Correct the Provider Operations Manual to reflect the required oral and written notifications Alliance issues when Alliance extends the Appeal resolution timeframe. Include the timeframes for these oral and written notifications, as required by 42 CFR § 438.408 (c)(2)(ii) and NC Medicaid Contract, Attachment M, Section G.6.***
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				In the 2022 Appeal file review, two expedited Appeals where Alliance denied the request to expedite the resolution timeframe did not contain documentation of any effort by staff to provide oral notification that the expedited request was denied by Alliance. This oral notification is required by Alliance Procedure 6505, Due Process Appeals of Medical Necessity Determinations, Alliance's *NC Medicaid Contract, Attachment M, Section H.9,* and *42 CFR § 438.408 (b)(2)*. Based on review of the Appeal Peer Review Tool, it is also noted that Alliance is not reviewing Appeal files to ensure this oral notification is occurring. CCME initially issued a Corrective Action to ensure that Appeals staff are trained to provide and document

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						prompt oral notifications to the appellant when Alliance denies an expedited Appeal review. This Corrective Action also included enhancing the current Appeal file monitoring process to include compliance monitoring of this oral notification. Based on feedback from NC Medicaid to change this score to a "Met", this Corrective Action was changed to a Recommendation and Alliance's overall percentage of "Met" Grievance and Appeals standards changed to 100%. Another concern noted in the review included data entry errors found in the Appeal Log. Three files had incorrect dates documented on the Appeal Log, making the turn-around time incorrect on the Log for two of those cases. As a result, one Appeal was in 32 days instead of the 30-day timeframe required by Alliance Procedure 6505, Due Process Appeals of Medical Necessity Determinations, Alliance's *NC Medicaid Contract, Attachment M, Section H.9*, and *42 CFR § 438.408 (b)(2)*. ***Recommendation: Ensure Appeals Coordinators are trained to provide and document prompt oral notification to the appellant when Alliance denies a request to expedite the Appeal resolution timeframe.*** ***Enhance the current file monitoring process to focus on expedited Appeals and the required oral notifications when Alliance denies the request to expedite the Appeal resolution timeframe. Include in the monitoring, routine review of the Appeal Log to identify data entry errors to prevent compliance issues.***
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					

VI. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI A. General Requirements						
1. PIHP shall be familiar and comply with *Section 1902 (a)(68)* of the *Social Security Act*, *42 CFR § 438.455* and *1000* through *1008*, as applicable, including proper payments to providers and methods for detection of fraud and abuse.	X					
2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents', and subcontractors,' compliance with the requirements of this *Section 14* of the *NC Medicaid Contract*.	X					
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with *42 CFR § 438.608* that is designed to guard against fraud and abuse.	X					Alliance has a *Corporate Compliance Plan FY 2023* in place that was reviewed and approved by the Board of Directors August 2022. Alliance also has a *Compliance and Audit Work Plan* for FY 2023 with activities that correspond with the *Corporate Compliance Plan*.
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of *42 CFR 438.608* and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under NC Medicaid Contract in accordance with *42 CFR § 438.608(a)(1)(iv).*	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. PIHP shall establish and implement a special investigations or program integrity unit.	X					Alliance has an established Special Investigation Unit (SIU). Since the last EQR, four staff have been added, one Specialized claims auditor/nurse and three investigators. Currently, there are three vacancies. During the Onsite, Alliance reported that those positions are contingent upon NC Tailored Plan launch.
4. PIHP's written Compliance Plan shall, at a minimum include:						
4.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in *Section 1902 (a)(66)* of the *Social Security Act;*	X					Alliances *Corporate Compliance Plan FY 2023* includes a detailed outline for training and communicating with providers, employees, and contractors regarding Fraud, Waste and Abuse (FWA) procedures.
4.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing, and development of corrective action initiatives;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					
4.4 The PIHP supplies all data in a uniform format provided by NC Medicaid and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by the Division as provided in *NC Medicaid Contract Section 13.2-Monetary Penalties.*	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. In accordance with *42 CFR § 438.608 (a)(vii),* PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under *NC Medicaid Contract*, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under *NC Medicaid Contract*; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month.	X					Alliance has an established Internal Audit Unit (IAU). Since the last EQR, there have been three changes in staffing. During the Onsite, Alliance reported that all positions in the IAU have been filled.
6. PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse.	X					
6.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure.	X					Alliance has a detailed workflow describing the process of taking a complaint from inception to closure. The process is also included in Alliance's Procedure 3008, Special Investigations. Alliance uses the *SIU Case List* to track the progress of investigations. According to the *SIU Case List*, the SIU reviewed 112 investigations during the review period and closed 51investigations and made 23 referrals to NC Medicaid for possible FWA. The remaining 41 opened investigations included 21 files being evaluated internally for the appropriate resolution. There was a concern that Alliance would not have all investigations resolved prior to Tailored Plan launch. During the Onsite, Alliance stated that NC Medicaid is aware of SIU investigations status and have concluded that investigations can transition under the NC Tailored Plan.
6.3 In accordance with Attachment Y - Audits/Self-Audits/investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6.4 Process for tracking overpayments and collections based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on Attachment Y – Audits/Self-Audits/investigations.	X					Procedure 1517, Overpayments, outlines the process used to recover all identified overpayments. Overpayments are tracked on the NC Medicaid approved spreadsheet, the *Attachment Y* Report.
6.5 Process for handling self-audits and challenge audits.	X					
6.6 Process for using data mining to determine leads.	X					Procedure 3008 Special Investigations, includes the process for using data mining to determine leads. In this EQR, Alliance provided eight data mining reports, six are currently opened investigations.
6.7 Process for informing PIHP employees, subcontractors, and providers regarding the *False Claims Act.*	X					
6.8 PIHP shall establish and maintain written policies for all employees, contractors, or agents that detail information about the *False Claims Act* and other federal and state laws as described in the *Social Security Act 1902 (a)(66)*, including information about rights of employees to be protected as whistleblowers.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid-standardized elements or a NC Medicaid-approved template;	X					Procedure 1507 Coordination of Benefits, outlines the process used to verify that services billed by providers were rendered.
6.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available database or other search mechanism.	X					
7. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
8. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					Required investigation timeframes are found in Alliance Procedure 3008, Special Investigations. In this EQR, 10 PI Investigations were reviewed for compliance with NC Medicaid Contract and Alliance procedures. The review found that Alliance initiated all investigations within the required timeframe.
9. In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						In this EQR, two of the 10 PI investigations reviewed were referred to NC Medicaid as possible allegations of FWA. The referrals were submitted on the required template and included all the required information. A review of the *Attachment Y Report* showed that from 2021-2022, 23 referrals were submitted to NC Medicaid for possible FWA.
9.1 Subject (name, Medicaid provider ID, address, provider type);	X					
9.2 Source/origin of complaint;	X					
9.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated; and dates of suspected intentional misconduct;	X					
9.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					
9.6 All communications between PIHP and the Provider concerning the conduct at issue, when available.	X					
9.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					
9.8 Total Sample Amount of Funds Investigated per Service Type	X					
9.8.1 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.8.2 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					
9.8.3 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					
9.8.4 Information on Biller/Owner;	X					
9.8.5 Additional Provider Locations that are related to the allegations;	X					
9.8.6 Legal and Administrative Status of Case	X					
10. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
11. If PIHP uses FAMS, PIHP shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	X					
12. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP.	X					For this EQR, Alliance submitted all FAMS users reports for the year. The reports showed there were no changes to FAMS users during the review period.
VIII C. Provider Payment Suspensions and Overpayments						
1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, NC Medicaid Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If NC Medicaid determines that a full investigation is warranted, NC Medicaid shall make a referral within five (5) business days of such determination to the MFCU/ MID and will suspend payments in accordance with *42 CFR § 455.23*. At least monthly, NC Medicaid shall provide written notification to PIHP of the status of each such referral. If MFCU/ MID indicates that suspension						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
will not impact their investigation, NC Medicaid may send a payment suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates that payment suspension will impact the investigation, NC Medicaid shall temporarily withhold the suspension notice and notify PIHP. Suspension of payment actions under this *Section 14.3* shall be temporary and shall not continue if either of the following occur: PIHP or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider; or Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.						
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					

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

Attachment 4: Encounter Data Validation Report

Table of Contents

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Background

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

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

Overview

The scope of the review, guided by the Centers for Medicare and Medicaid Services (CMS) External Quality Review Protocol for Encounter Data Validation, focused on measuring the data quality and completeness of claims paid and submitted to NC Medicaid by Alliance for the period of January 2021 through December 2021. All claims paid by Alliance are expected to be submitted and accepted as valid encounters by NC Medicaid. The 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 PIHP to submit their Encounter data for all paid claims on a weekly basis via 837 Institutional and Professional transactions. The companion guides follow the standard ASC X12 transaction set with a few modifications to some segments. For example, the PIHP must submit their provider number and paid amount to NC Medicaid in the Contract Information CN104 and CN102 segment of Claim Information Loop 2300.

The 837 files are transmitted securely to NCTracks and parsed using an EDI validator to check for errors and produce a 999 response to confirm receipt and any compliance errors. The Encounter claims are then validated by applying a list of edits provided by the state (See *Appendix 1*) and adjudicated accordingly by NCTracks. Utilizing existing Medicaid pricing methodology, using the billing, or rendering provider accordingly, the appropriate Medicaid allowed amount is calculated for each Encounter claim in order to shadow price what was paid by the PIHP.
The PIHP is required to resubmit encounters for claims that may be rejected due to compliance errors or NC Medicaid edits marked as "DENY" in *Appendix 1*.

Based on claims with dates of service in 2021, Alliance submitted 1,879,696 unique encounters to the State. To date, about 2.34% of all 2021 encounters submitted have not been corrected and accepted by NC Medicaid.

2021	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
Institutional	58,049	54,071	1437	2541	4.38%
Professional	1,821,647	1,772,430	7,790	41,427	2.27%
Total	1,879,696	1,826,501	9,227	43,968	2.34%

Since 2016, Alliance has made significant improvements to their Encounter submission process, increasing their acceptance rate and quality of Encounter data year-over-year. The table below reflects the increase in acceptance rate from 93% to 99% by 2020, well above NC Medicaid expectations. However, there has been an increase in denials for 2021.

Year of Service	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
2016	2,465,320	1,694,361	595,136	175,823	7.13%
2017	2,464,787	2,299,082	126,488	39,217	1.59%
2018	2,015,327	2,004,869	7,453	3,005	0.15%
2019	2,079,891	2,069,879	6,870	3,142	0.15%
2020	1,895,693	1,888,388	5,242	2,063	0.11%
2021	1,879,696	1,826,501	9,227	43,968	2.34%

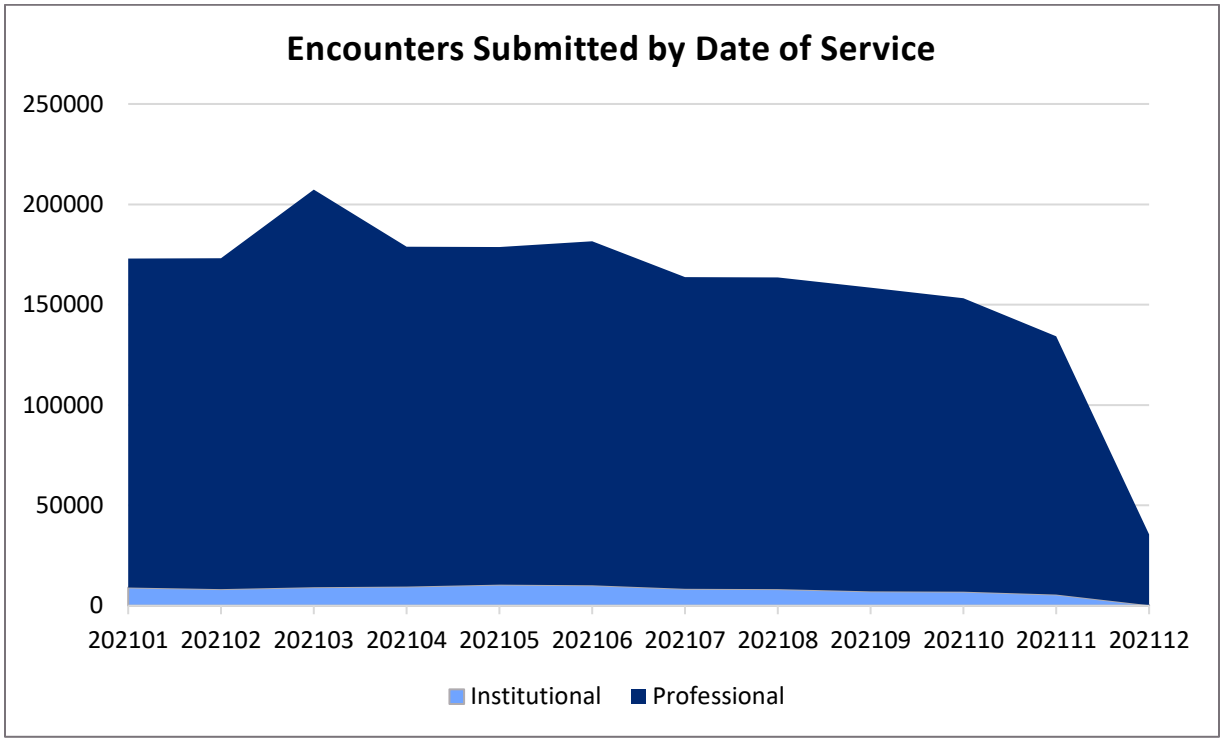
During the Onsite and as explained in the ISCA, Alliance has a detailed reconciliation and correction process in place to ensure that all denials are reviewed, corrected, and resubmitted to NC Medicaid. All 837, 835 and 999 files from NCTracks are parsed into a SQL database for use in the Alliance AR system where claim staff can review and work denials. The claim staff researches denials, adds comments or resolves the denial and rebills the claim as appropriate. Alliance has a dedicated team of three claims analysts responsible for reviewing and resubmitting denied Encounter claims. After a Checkwrite cycle, Alliance receives an 835 response file from NCTracks. Claims received on the 835 response file from NCTracks are formatted into the Alliance AR system where claim staff can review and work denials. The results are posted to the Alliance AR system so that Encounter submission results and their acceptance status is visible to its staff for each claim. Additionally, Alliance has reports and work queues that focus on the denials so that the staff can efficiently review, research, and resolve the issue(s) that caused the denials.

Encounter claims may receive one or more denial codes. Alliance relies on the remark codes to narrow down the true denial reasons and make corrections. Alliance works closely with the providers to communicate issues, make them aware of corrections, and even educate the provider on how to avoid

future Encounter denials. Historically, most denials are related to discrepancies in the provider enrollment information between NCTracks and the Alliance Claims System (ACS). Analysts verify the provider record in NCTracks and update ACS or send a provider upload file to NCTracks to update the needed information to process claims. Possible duplicates based on same provider, same procedure code, overlapping dates of service, etc. were the most common denial reasons seen in 2021. These were not true duplicate payments but a result of timing issues where Alliance submitted new transactions before adjustments to previously reported encounters finished processing in NCTracks.

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, 2021 and December 31, 2021. Alliance pulled all claims adjudicated and submitted to NC Medicaid during 2021 and sent to Aqurate via the CCME Portal. This included 2,027,102 Professional and 102,788 Institutional claim line items, for a total of 2,129,890 encounters submitted.



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

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
PIHP ID	Critical Data Element	100% valid for PIHP
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	10 digits
Attending Provider ID	Should be an enrolled provider listed in the provider enrollment file (will accept the MD license number if it is listed in the provider enrollment file).	> 85% match with provider file using either provider ID or MD license number. 10 digits
Provider Location	Minimal requirement is county code, but zip code is strongly advised.	> 95% with valid county code > 95% with valid zip code (if available)
Place of Service	Should be routinely coded, especially for physicians.	> 95% valid for physicians > 80% valid across all providers Standard UB POS
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% non-missing and valid on physician or other applicable provider type claims (e.g., other practitioners). This is the taxonomy code and is a standard code set.
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid ICD codes for practitioner providers. Codes should be within standard ICD 9 and 10 code sets. ICD-9s have generally stopped appearing on files for current records.
Other Diagnosis	This is not expected to be coded on all claims even with applicable provider types but should be coded with a fairly high frequency.	90% valid when present. Codes should be within standard ICD 9 and 10 code sets. ICD-9s have generally stopped appearing on files for current records.

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.	Valid date Dates spread throughout reporting year.
Unit of Service (Quantity)	The number should be routinely coded.	The number should be routinely coded. Current Procedural Terminology (CPT) code is in 99200–99215 or 99241–99291 range.
Procedure Code	Critical Data Element	There should be a wide range of procedures appropriate for the services covered by the PIHP
Procedure Code Modifier	Important to separate out surgical procedures/ anesthesia/assistant surgeon, not applicable for all procedure codes.	Expect a variety of modifiers both numeric (CPT) and Alpha (Healthcare Common Procedure Coding System [HCPCS])
Patient Discharge Status Code (Hospital)	Should be valid codes for inpatient claims, with the most common code being “Discharged to Home.” For outpatient claims, the code can be “not applicable.”	Expect a variety of values, with "Discharge to Home" being most common, and includes "Still-in" and transfers
Revenue Code	If the facility uses a UB04 claim form, this should always be present	Valid code is present

Encounter Accuracy and Completeness

The table below outlines the key fields that were reviewed to determine if information was present, whether the information was the correct type and size, and whether the data populated were valid. Although the complete data set was evaluated and all data values validated, the fields below are key to properly shadow pricing for the services paid by Alliance.

Table: Evaluation of Key Fields

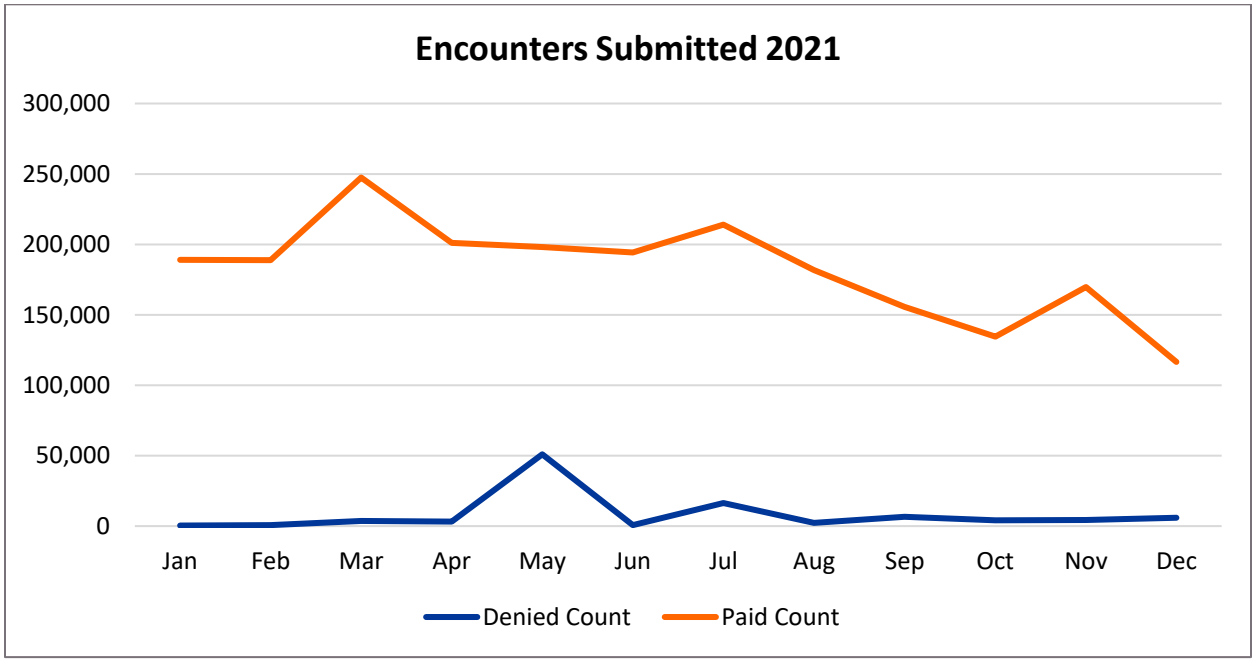
Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%
Recipient Name	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%
Recipient Date of Birth	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%
MCO/PIHP ID	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%
Provider ID	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%
Attending/Rendering Provider ID	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%
Provider Location	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%
Place of Service	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%
Specialty Code / Taxonomy - Billing	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%
Specialty Code / Taxonomy - Rendering / Attending	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%
Principal Diagnosis	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%
Other Diagnosis	322,518	15.14%	322,518	15.14%	322,518	15.14%	322,518	15.14%
Dates of Service	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%	2,130,006	100.00%
Unit of Service (Quantity)	2,126,860	99.85%	2,126,860	99.85%	2,126,860	99.85%	2,126,860	99.85%
Procedure Code	2,091,374	98.19%	2,091,374	98.19%	2,091,374	98.19%	2,091,374	98.19%
Procedure Code Modifier	1,210,202	56.82%	1,210,202	56.82%	1,210,202	56.82%	1,210,202	56.82%
Patient Discharge Status Code Inpatient	102,904	100.00%	102,904	100.00%	102,904	100.00%	102,904	100.00%
Revenue Code	102,904	100.00%	102,904	100.00%	102,904	100.00%	102,904	100.00%

Overall, there were some inconsistencies in the data. Institutional claims contained complete and valid data in 13 of the 17 key fields (76.47%). In 2020, notable improvements were seen in Procedure codes, especially among outpatient claims where over 99% of all Institutional claim lines contained Procedure codes where one was expected. However, in 2021 the Procedure code was present only for 62.46% of the encounters. A slight year-over-year improvement in Other Diagnosis codes was also noted. Over 58% of all Institutional claims contain Other Diagnosis codes, compared to 56% in the prior year. It was identified that the Units of Service field was populated only 96.94%. The Procedure Code Modifier was populated only 21.33%.

Professional Encounter claims submitted contained complete and valid data in 13 of the 15 key Professional fields (86.67 %). The review found Other Diagnosis codes in less than 13% of Professional claim lines. Procedure code modifiers are present 58% of the time.

Encounter Acceptance Report

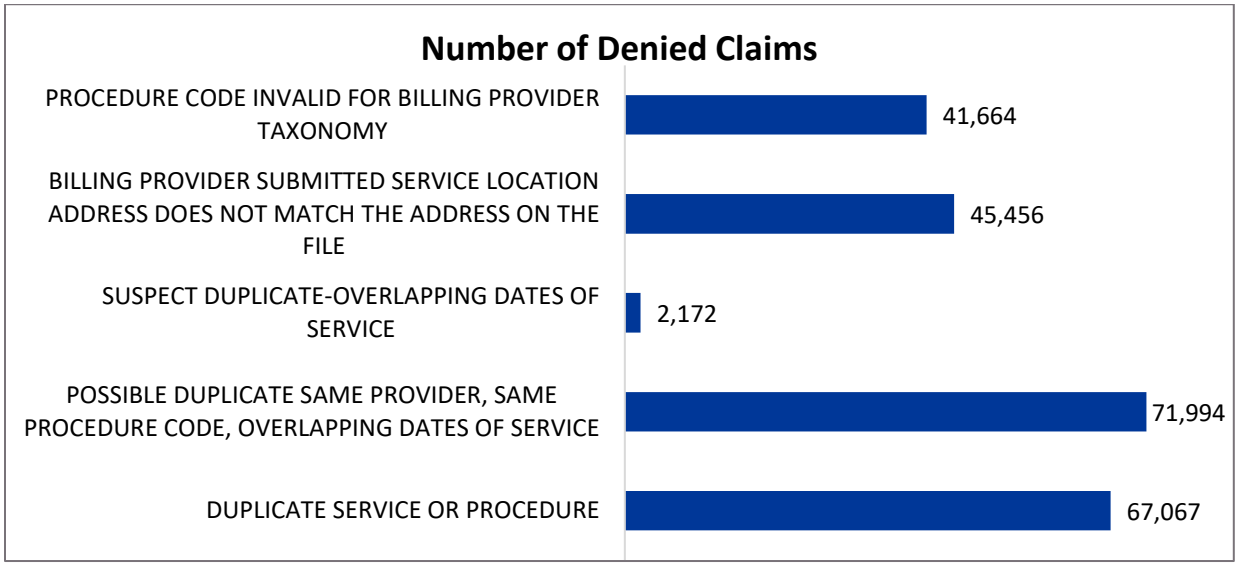
In addition to performing evaluation of the Encounter data submitted, Aqurate reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by Checkwrite and excludes duplicate or resubmitted claims, which made it difficult to tie back to the ISCA response and converted Encounter files. Data provided by PIHP's reports for the review includes all submission and resubmissions during 2021, which may include older dates of service. During the 2021 EQR, as per the weekly Checkwrite schedule, Alliance submitted a total of 2,290,038 encounters to NC Medicaid.



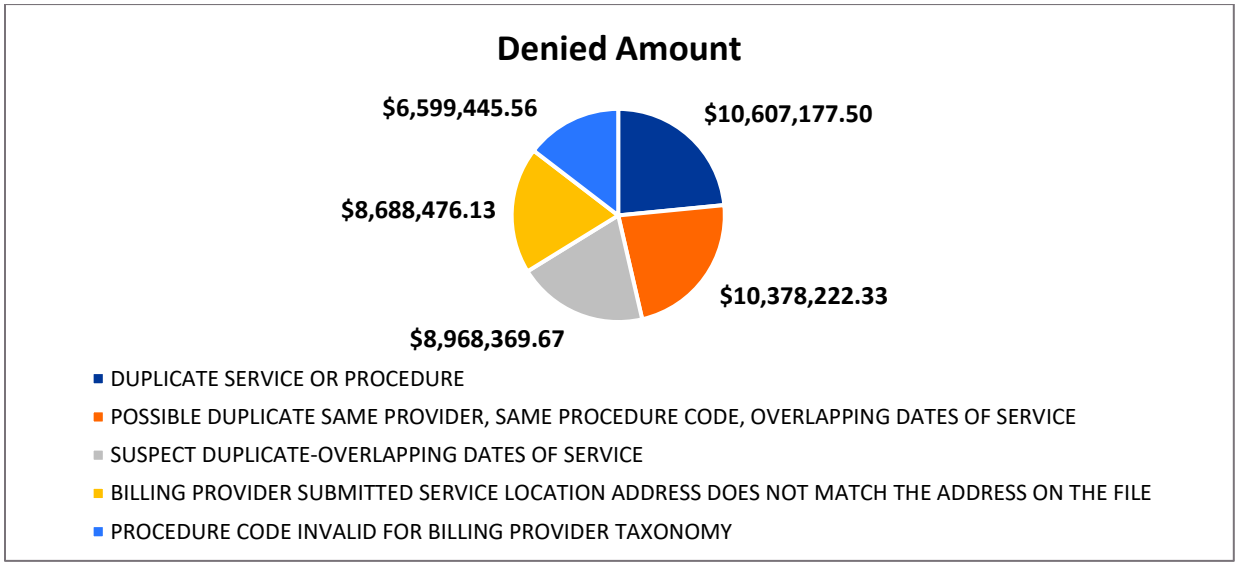
Evaluation of the top denials for Alliance encounters and the data deficiencies identified by Aqurate in the Key Field analysis and ISCA review above were used to assess the volume of denials. Encounters were denied primarily for:

- Possible duplicate same provider, same Procedure code, overlapping dates of service
- Duplicate service or procedure
- Billing provider submitted service location address does not match the address on the file
- Procedure Code invalid for billing provider taxonomy
- Suspect duplicate - overlapping dates of service

The graph below reflects the top five denials by claim volume.



The pie chart below reflects the top five denials by claim dollar amount.



Results and Recommendations

Issue: Other Diagnosis Codes

The secondary diagnosis was populated in 58% of all Institutional claims but only 13% of Professional claims. Lack of Other Diagnosis codes does not necessarily impact the adjudication of claims. However, all claims should be complete and accurate at all times. The low figure among Professional claims suggests that some providers are not as diligent in coding and submitting Other Diagnosis codes, including some providers who appear to never submit Other Diagnosis codes.

Resolution:

Alliance should work closely with their provider community and encourage them to submit all applicable Diagnosis codes and Units. This information is key for measuring member health, identifying areas of risk, and evaluating quality of care.

Issue: Missing Units

The Unit values were not present 100% of the time for Institutional claims. This could have an impact on accurate claim adjudication. All claims should be complete and accurate at all times.

Resolution:

Alliance should identify providers who never or very rarely submit Other Diagnosis codes and provide outreach to assist them in meeting their obligation to ensure that the claims they submit to Alliance are complete and accurate.

Conclusion

Based on the analysis of Alliance's Encounter data, it has been concluded the data submitted to NC Medicaid is complete and accurate in accordance with NC Medicaid standards. Alliance took multiple corrective actions in 2019, 2020, and 2021 to address issues that were highlighted in prior reviews. More specifically, Alliance instituted multiple claim edits and other system changes to address deficiencies in Procedure codes.

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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
00296	ENC PRV INV FOR DOS	IGNORE
00297	ENC PRV NOT ON FILE	IGNORE
00298	RECIP NOT ENRL W/ THIS ENC PRV	IGNORE
00299	ENCOUNTER HMO ENROLLMENT CHECK	PAY AND REPORT
00300	BILL PROV INVALID/ NOT ON FILE	DENY
00301	ATTEND PROV M/I	PAY AND REPORT
00308	BILLING PROV INVALID FOR DOS	DENY
00313	M/I TYPE BILL	PAY AND REPORT
00320	VENT CARE NO PAY TO PRV TAXON	IGNORE
00322	REND PROV NUM CHECK	IGNORE
00326	REND PROV NUM CHECK	PAY AND REPORT
00328	PEND PER DHB REQ FOR FIN REV	IGNORE
00334	ENCOUNTER TAXON M/I	PAY AND REPORT
00335	ENCOUNTER PROV NUM MISSING	DENY
00337	ENC PROC CODE NOT ON FILE	PAY AND REPORT
00339	PRCNG REC NOT FND FOR ENC CLM	PAY AND REPORT
00349	SERV DENIED FOR BEHAV HLTH LM	IGNORE
00353	NO FEE ON FILE	PAY AND REPORT
00355	MANUAL PRICING REQUIRED	PAY AND REPORT
00358	FACTOR CD IND PROC NON-CVRD	PAY AND REPORT
00359	PROV CHRGS ON PER DIEM	PAY AND REPORT
00361	NO CHARGES BILLED	DENY
00365	DRG - DIAG CANT BE PRIN DIAG	DENY
00366	DRG - DOES NOT MEET MCE CRIT.	PAY AND REPORT
00370	DRG - ILLOGICAL PRIN DIAG	PAY AND REPORT
00371	DRG - INVLD ICD-9-CM PRIN DIAG	DENY
00374	DRG PAY ON FIRST ACCOM LINE	DENY
00375	DRG CODE NOT ON PRICING FILE	PAY AND REPORT
00378	DRG RCC CODE NOT ON FILE DOS	PAY AND REPORT
00439	PROC\REV CD INVLD FOR AGE	IGNORE
00441	PROC INVLD FOR DIAG	IGNORE
00442	PROC INVLD FOR DIAG	IGNORE
00613	PRIM DIAG MISSING	DENY
00628	BILLING PROV ID REQUIRED	IGNORE
00686	ADJ/VOID REPLC TCN INVALID	DENY
00689	UNDEFINED CLAIM TYPE	IGNORE
00701	MISSING BILL PROV TAXON CODE	DENY

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
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