CCME

2021 External Quality Review

ALLIANCE HEALTH

Submitted: March 23, 2022
Revised: April 15, 2022

Prepared on behalf of
North Carolina Medicaid

Table of Contents

EXECUTIVE SUMMARY

The *Balanced Budget Act of 1997* requires State Medicaid Agencies that contract with Prepaid Inpatient Health Plans (PIHPs) to evaluate their compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358 (42 CFR § 438.358)*. This review determines the level of performance demonstrated by Alliance Health (Alliance). This report contains a description of the process and the results of the 2021 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 #11. This PIHP contract amendment stated PIHPs "shall be held harmless for any documentation or other PIHP errors identified through the EQR that are not directly related to member health and safety through the Term of the Amendment."

The focused review included comprehensive review of the PIHP's health systems capabilities and provider credentialing and recredentialing documentation and processes. The review includes validation of the PIHP's Performance Improvement Projects, Performance Measures, and Encounter data. Lastly, a thorough review of the PIHP's Utilization Management (UM), Grievances, and Appeals processes was conducted. The PIHP's network adequacy, availability of services, Sub contractual relationships, and Clinical Practice Guidelines (*42 CFR § 438.206, § 438.207, § 438.230*, and *§ 438.236*, respectively) were not reviewed.

To access Alliance'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, such as Strengths, Weaknesses, and Recommendations, are included in the narrative of this report.

REVISION: On April 8,2022, the State 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 #11. 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%.

B. Overall Recommendations

The following provides a global or high-level summary of the status of the Recommendations and Corrective Action items from the 2020 EQR and the findings of the 2021 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 2020 EQR, Alliance met 100% of the Administrative standards and received one Recommendation. The Recommendation targeted the need for Alliance to increase the number of ICD-10 Diagnosis codes submitted on Institutional encounter data extracts to NCTracks. During the 2021 Onsite, Alliance staff confirmed that they have implemented the Recommendation and can submit up to 24 ICD-10 Diagnosis codes on Institutional encounter data extracts to NCTracks.

In the 2021 EQR, Alliance met 100% of the Administrative EQR standards. One Recommendation has been issued related to Alliance submitting the ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks.

Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

In Alliance's 2020 EQR of Credentialing/Recredentialing, there were no items requiring Corrective Action. Alliance partially addressed the one Recommendation from the 2020 EQR; however, some issues persist, resulting in a Recommendation in the current EQR. Additional information is provided in the Tabular Spreadsheet. In the current EQR, Alliance met 100% of the Provider Services standards.

Quality Improvement

42 CFR § 438.330

In the 2020 EQR, Alliance met 100% of the Quality standards and received four Recommendations related to four PIPs that were validated. Two Recommendations were implemented and two were not applicable because two PIPs were not submitted for the 2021 EQR.

For the 2021 EQR, Alliance met all standards with no Corrective Actions. There are two Recommendations regarding the assessment of interventions and consideration for additional interventions to improve PIP rates, which were validated in the High Confidence range. Alliance was Fully Compliant for (b) Waiver and (c) Waiver 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.

Utilization Management

42 CFR § 438.208

For the 2020 EQR, Alliance initially met 92% of UM standards. CCME issued two Corrective Actions and three Recommendations. However, NC Medicaid reviewed one Corrective Action issued to Care Coordination and one Corrective Action issued to TCLI and determined those should be changed to Recommendations. The scores on those standards changed to "Met", as the finding did not relate to enrollee health and safety. This changed Alliance's 2020 UM score from a 92% to 100% and left five Recommendations for Alliance to address. In the 2021 EQR, there was evidence that Alliance implemented all five of the 2020 EQR Recommendations.

In the 2021, EQR Alliance met 96% of the UM standards. Alliance was issued one Corrective Action related to the I/DD file review. In one of the three files selected by

Alliance for this review, the SIS evaluation occurred well outside of the required timeframe and the flexibilities allowed in the *NC Medicaid 1915(c) Appendix K: Disaster Waiver Flexibilities*.

REVISION: This Corrective Action was later changed to a Recommendation, based on feedback from the State. This change resulted in Alliance meeting 100% of the Utilization Management standards.

The second issue identified related to out-of-date language in Alliance's *Individual and Family Handbook* and *Innovations Individual and Family Handbook*. In the past year, Alliance changed the titles, roles, and functions of the Care Coordination Department. The newly formed Care Management Department titles, roles, and functions are not explained in these two public-facing handbooks. Additionally, neither of these handbooks noted the inclusion of Orange and Mecklenburg counties to Alliance's catchment area. CCME has issued a Recommendation to ensure Alliance's *Individual and Family Handbook* and *Innovations Individual* and *Family Handbook* reflect clear and current information for Alliance's members.

For the 2021 EQR, review of the submitted MH/SUD and I/DD Care Coordination files found that the frequency of Care Coordinator contact with members met *NC Medicaid Contract* requirements. Alliance updated the *Care Coordination Monitoring Tool and the Care Management Dept Documentation Summary* to capture, track and report the outcome of the monitoring process. There was evidence in the MH/SUD, I/DD, and TCLI files reviewed in this EQR that file documentation improved from the previous EQR regarding completeness, accuracy, and timeliness.

Grievances and Appeals

42 CFR § 438, Subpart F, 42 CFR 483.430

In the 2020 EQR, Alliance met 95% of the Grievance and Appeal standards and received a total of two Corrective Actions and nine Recommendations. There was evidence in the 2021 EQR that Alliance implemented all Corrective Actions and five of the nine Recommendations. Four Recommendations, which targeted missing or incorrect language within Alliance's *Provider Operations Manual* effective October of 2020, were not implemented. For the 2021 EQR, Alliance submitted the *Provider Operations Manual* effective October 2020 again. This was the same manual published on Alliance's website at the time of the 2021 Onsite. As no corrections or revisions were made to the *Provider Operations Manual*, CCME is issuing those four Recommendations not addressed by Alliance again.

In the 2021 EQR, Alliance met 95% of the Grievance and Appeal standards. In addition to the four 2020 EQR Recommendations Alliance did not address, CCME issued two Corrective Actions in the 2021 EQR. These Corrective Actions were related to the 10

Grievance files reviewed. Three of the Grievance files showed Alliance extended the Grievance resolution timeframe. However, Alliance's Grievance extension notification letters did not inform the enrollee of their right to file a grievance if he or she disagreed with Alliance's extension to the Grievance resolution timeframe. Another Grievance file showed the Grievance was withdrawn three days after receipt. There was no written resolution notification sent confirming in writing the Grievant's decision to withdraw the Grievance. *NC Medicaid Contract Attachment M and 42 CFR 438.408 (a)* states the PIHP "must resolve each grievance and appeal and provide notice."

REVISION: These two Corrective Actions were later changed to Recommendations, based on feedback from the State. This change resulted in Alliance meeting 100% of the Grievance standards.

In the 2021 EQR Appeal file review, there was one file containing an Appeal of an administrative denial, one invalid Appeal, one expedited Appeal, and one Appeal where expedited resolution was requested but denied by Alliance. All files showed verbal and written notifications occurred and within the required timeframes. This was a significant improvement from the 2020 EQR file review.

Program Integrity

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

In the 2020 EQR, Alliance met 100% of the Program Integrity (PI) standards. No Corrective Actions or Recommendations were issued in that EQR. In the 2021 EQR, Alliance has again met all of the PI standards and no Corrective Actions or Recommendations issued.

In the 2021 EQR, it was noted that Alliance case files were well documented and consistently organized. Referrals to NC Medicaid, where applicable, were complete and concise using standard forms. Alliance's use of internal data reporting systems has led to several credible allegations of fraud being referred to NC Medicaid. Of the 13 cases referred to NC Medicaid during the review period, 10 (76.9%) were a result of either the direct report of an Alliance Employee (7 of 10) or data analysis (3 of 10). Alliance uses innovative and meaningful data analytics. For example, Alliance runs a perfect attendance report for substance use services, a population that typically shows a lower attendance rate. Alliance continues to use technologies to provide PI training to staff and providers. PI trainings are recorded and posted to Alliance's intranet for ease of access.

Encounter Data Validation

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

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

2020 EQR Corrective Actions and Recommendations from Previous EQR

In the 2020 EQR, Alliance initially met 98% of the EQR standards. After receiving their report, Alliance reached out to NC Medicaid regarding their 2020 EQR Corrective Actions and scores. The State then determined that three of the four standards scored as "Partially Met" should be scored as "Met", and the Corrective Actions associated with those standards that were partially met changed to Recommendations. This decision by the State was based on Amendment #11 to the PIHPs' contract. This amendment provided flexibilities during the COVID-19 pandemic and states, "PIHP 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." As a result, Alliance's percentage of "Met" standards increasing from 98% to 99%. The remaining standard still scored as "Partially Met" was in Appeals and two Corrective Actions were issued for that standard. The following is a high-level summary of those deficiencies:

- Alliance's Appeal procedure had missing and incorrect information regarding the notifications required when Alliance extends the Appeal resolution timeframe. These required notifications are specified in 42 *CFR § 438.408 (c)(2)* and Alliance's *NC Medicaid Contract, Attachment M, Section G.6*.
- Alliance's *Individual and Family Handbook* had missing and incorrect information regarding expedited appeals and appeals when the resolution timeframe was extended by Alliance. This information is outlined in *42 CFR § 438.408* and Alliance's *NC Medicaid Contract, Attachment M*.

During the 2020 Corrective Action process, Alliance submitted draft versions of their Appeal procedure and *Individual and Family Handbook* showing the required revisions. CCME reviewed the 2020 Corrective Action Plan and revised documents and accepted Alliance's responses.

During the 2021 EQR, CCME assessed the degree to which the PIHP implemented the actions to address these deficiencies and found the Corrective Action Plan was implemented. The revised versions of Alliance's Appeals procedure and *Individual and Family Handbook* remained intact in the final, published versions of the documents.

Additional details regarding the Alliance's 2020 Corrective Action Plan are detailed in the Appeals sections of this report.

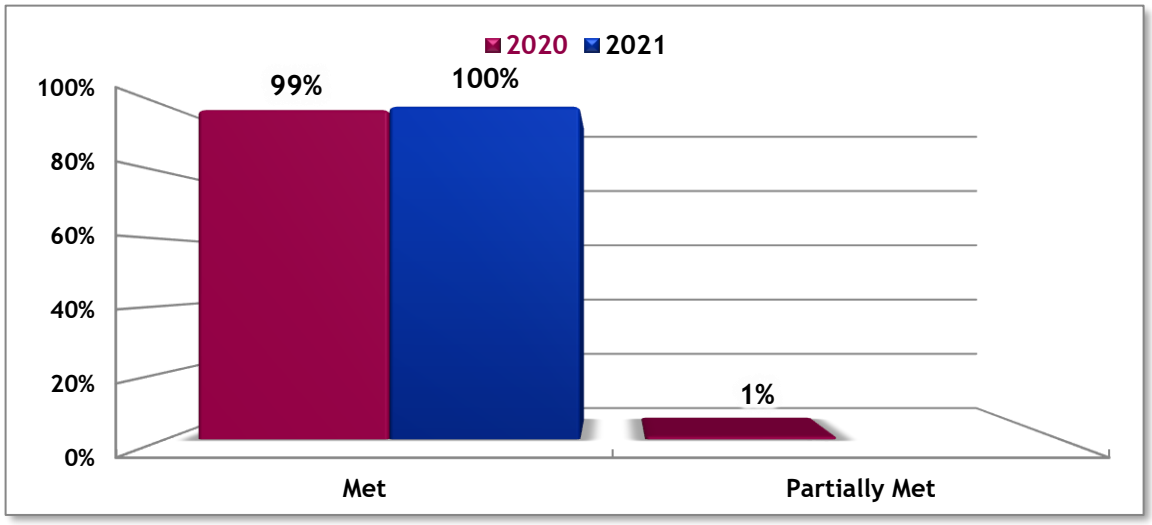
Conclusions

Overall, Alliance has met the requirements set forth in their contract with NC Medicaid. The 2021 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 were scored as "Not Met."

Figure 1, Annual EQR Comparative Results, provides an overview of the scoring of the current annual review as compared to the findings of the 2020 review.

REVISION: It should be noted Alliance initially met 99% of the 2021 EQR standards. The State later requested that Alliance's score change to 100% based on the flexibilities outlined in the PIHP Contract Amendment #11.

Figure 1: Annual EQR Comparative Results



The following is a summary of 2021 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 2021 Overall Strengths, Weaknesses, and Recommendations

	Strengths	Weaknesses	Corrective Actions/ Recommendations
Quality	Alliance can capture of up to 25 ICD-10 Diagnosis codes via the Provider web portal and up to 32 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 submit up to 24 ICD-10 Diagnosis codes on Institutional encounters and up to 12 ICD-10 Diagnosis codes on Professional encounters to NC Medicaid.	The (b) Waiver measure validation noted substantial decline for three PMs.	***Recommendation: Continue to monitor (b) Waiver performance measure rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the PMs.***
	All Performance Improvement Projects were in the High Confidence range.	PIP indicator rates did not improve for the TCLI PCP Contacts PIP	***Recommendation: Continue working on staff education and tracking-based interventions. Implement actions regarding adjustments to internal workflows that might impact visit rates- TCLI PCP Visit PIP.***
	Alliance added a new Data Science Team to the Quality Management Department to boost predictive analytics.	PIP indicator rates did not improve for the 7 Day Follow Up for DHB SUD PIP	***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 7 Day Follow Up for DHB SUD.***

	Strengths	Weaknesses	Corrective Actions/ Recommendations
	Alliance has a newer relationship with a HEDIS vendor with the goal to achieve higher data integrity.		
	Within the past year, Alliance has achieved NCQA Accreditation.		
	Alliance has implemented data-driven monitoring processes that produce staff performance measures (PMs) around Appeal and Grievance compliance. These measures are tied directly to annual performance reviews for staff.		
	The sample of Alliance PI files reviewed showed a high level of detail and organization.		
	During the Onsite, Alliance detailed several innovative PI data analytics and unique reports used to identify possible cases of fraud.		
	Alliance continues to use technologies to provide PI training to staff and providers. PI trainings are recorded and posted to Alliance's intranet for ease of access.		

	Strengths	Weaknesses	Corrective Actions/ Recommendations
Timeliness	Alliance auto-adjudicates claims: 92.8% of Institutional claims and 94.8% of Professional claims.	The *Provider Operations Manual* identified incorrect timeframes for a Grievance resolution. On page 62 of the manual, it states, "Alliance will seek to resolve Grievances…no later than thirty (30) calendar days from the date Alliance received the Grievance." Per Alliance's procedure, the timeframe for Grievance resolution is 90 days.	***Recommendation: Revise the Provider Operations Manual on page 62 to include the correct timeframe for Grievance resolution, per Alliance's Grievance procedure of 90 days.***
	The Care Coordination files reviewed in this year's EQR showed overall improvement in the completeness, timeliness, and accuracy of documentation.	The *Provider Operations Manual* contained 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 state 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 NC Medicaid Contract, Attachment M.***
		Alliance extended Grievance resolutions in three of the 10 files reviewed in this EQR. None of the extension notification letters informed the enrollee of the right to file a Grievance if he or she disagreed with the extension. This notice is required by *42 CFR § 438.408 (c)(2)(ii)* and *NC Medicaid Contract Attachment M.*	***~~Corrective Action~~ *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).***

	Strengths	Weaknesses	Corrective Actions/ Recommendations
Access to Care	Alliance staff reported having a collaborative approach to working with providers, including a focus on problem resolution, and providing training and technical assistance to address challenges and barriers with credentialing and recredentialing processes.	There is conflicting information regarding committee membership across Procedure 6030, Procedure 6036, the *Provider Network Credentialing Committee (PNCC) Organization Chart 12.21.21*, and the Credentialing Committee meeting minutes.	***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***
	Credentialing and recredentialing files contain checklists to help guide the process.	Alliance's *Individual and Family Handbook* and *Innovations Individual and Family Handbook* do not reflect the changes in the Care Coordination titles and roles, nor are Mecklenburg and Orange counties represented as a part of Alliance's catchment areas in these public-facing documents.	***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.***
	Alliance staff reported stability in Credentialing staff, despite the fact that credentialing at PIHPs will end later this year, as a part of System Transformation.	In one of the I/DD files reviewed, the SIS revaluation occurred well outside the timeframe required in *Appendix K*.	***~~Corrective Action~~ *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.***

	Strengths	Weaknesses	Corrective Actions/ Recommendations
		The *Provider Operations Manual* references concerns, complainant, and complaint when explaining the Grievance processes instead of the term "Grievance" or "Grievant", making this section confusing and misleading.	***Recommendation: On pages 62-63 of the Provider Operations Manual in the Medicaid Related Grievances section, use one term "Grievance" or "Grievant" to reflect the Grievance process.***
		One of the 10 Grievance files reviewed showed the Grievance was withdrawn three days after receipt. There was no written resolution notification sent confirming in writing the Grievant's decision to withdraw the Grievance. *NC Medicaid Contract*	***~~Corrective Action~~ *Recommendation: 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.***

REVISION: One Corrective Action in Utilization Management and two Corrective Actions in Grievances were disputed by Alliance and changed to Recommendations, per the State's agreement with this dispute.

METHODOLOGY

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

On January 10, 2022, CCME sent notification to Alliance that the annual EQR was being initiated (see *Attachment 1*). This notification included:

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

Further, an invitation was extended to the 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 February 1, 2022 and reviewed by CCME (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. Also included in the Desk Review was a review of Credentialing, Grievance, Utilization, Care Coordination, and Appeal files.

The second segment of the EQR is typically a two-day, Onsite review conducted at the PIHP's offices. However, due to COVID-19, this Onsite was conducted through a teleconference platform on February 24, 2022. 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 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. Information Systems Capabilities Assessment (ISCA)

42 CFR § 438.224 and 42 CFR § 438.242

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 Centers for Medicaid and Medicare Services (CMS) protocol. During the Onsite, staff presented a member and claims systems review. Questions regarding the ISCA tool were discussed with Alliance staff.

In the 2020 EQR, Alliance met 100% of the Administrative standards and received one Recommendation related to increasing the number of ICD-10 Diagnosis codes submitted on Institutional encounters to NCTracks. Originally, this finding was a Corrective Action but the State requested the standard be scored as "Met" and the Corrective Action changed to a Recommendation. This decision was based on the COVID-19 Flexibilities Contract Amendment that hold PIHPs faultless for any EQR finding not related to enrollee health and safety. During the 2021 Onsite discussion, Alliance reported they are submitting up to 24 ICD-10 Diagnosis codes for Institutional encounters and up to 12 ICD-10 Diagnosis codes for Professional encounters. Table 2, outlines the Recommendations issued to Alliance in the 2020 EQR and CCME's follow up in the 2021 EQR.

Table 2: 2020 EQR Administrative Findings

2020 EQR Administrative Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP 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 allow submission of up to 25 ICD-10 Diagnosis codes included on Institutional encounters into NCTracks.***	**Y**
2021 EQR Follow up: During the 2021 Onsite discussion, Alliance reported they are submitting up to 24 ICD-10 Diagnosis codes for Institutional encounters and up to 12 ICD-10 Diagnosis codes for Professional encounters.		

Alliance uses the Alliance Claims System (ACS) to process member enrollment, claims, submit encounters, and generate reports. 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 ISCA tool and supporting documentation for enrollment systems loading processes clearly define the process for enrollment data updates in the ACS enrollment system. During the ISCA Onsite, Alliance provided a demonstration of the ACS enrollment system, which maintains a member's enrollment history. The Global Eligibility File (GEF) file is first parsed into Alliance's Enterprise Data Warehouse (EDW). The GEF extracts from the EDW are then loaded to the ACS. During the Onsite, Alliance stated that alerts have been set up to notify Alliance's staff of errors that may occur during the GEF file upload process. Alliance also stated that they have not encountered any errors in the past.

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 are able to research the possible duplicate members and merge the information into one Member ID. The historical claims for the member are also

merged into one Member ID. During the Onsite system demonstration, staff displayed the enrollment information that is viewable and captured within ACS.

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

Table 3: Enrollment Counts

2018	2019	2020
220,968	216,407	255,244

Alliance's authorizations and claims are processed in the ACS system. A review of Alliance's processes for collecting, adjudicating and reporting claims was conducted through a review of its ISCA response and supporting documentation provided. A demonstration of Alliance's Provider web claims entry portal and the ACS claims processing system was performed 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 receive paper claims from out-of-network providers and new providers who have not been set up in ACS. Table 4 details the percentage of 2020 claims received via the three methods.

Table 4: Percent of claims with 2020 dates of service that were received via Electronic (HIPAA, Provider Web Portal) or Paper forms.

Source	HIPAA File	Paper	Provider Web Portal
Institutional	67.14%	0.06%	32.8%
Professional	81.9%	0.01%	18.09%

Alliance adjudicates claims on a nightly basis. Approximately, 94.8% of Professional claims and 92.8% of Institutional claims are auto adjudicated.

During the Onsite, Alliance stated that the ACS can capture up to 25 ICD-10 Diagnosis codes via the provider web portal and up to 32 ICD-10 Diagnosis codes via the HIPAA files for Institutional claims. For Professional claims, the plan has the ability to receive and store up to 12 ICD-10 Diagnosis codes on both the provider web portal and via HIPAA files. Alliance captures ICD-10 Procedure codes and Diagnosis Related Groups (DRGs), if they are submitted on the claim. During the Onsite, Alliance stated that they currently do not receive ICD-10 Procedure codes on a claim. Alliance confirmed that they are able to capture and submit Telehealth modifier codes during the ongoing COVID-19 pandemic. As

a follow-up after the Onsite, Alliance stated that they do not submit ICD-10 Procedure codes on Institutional encounters to NCTracks.

During the Onsite, Alliance stated that staff conduct random audits of 3% of all claims processed on a weekly basis. Paper claims are included in the weekly random audit. Alliance conducts focused audits on at least 50% of high dollar claims that have a billed amount that is greater than $5,000 and at least 3% of Emergency Department (ED) claims. Alliance also conducts non-routine focused audits on claim overrides, Coordination of Benefits (COB) and claims examined by new hire claim examiners.

During the Onsite discussion, Alliance stated that their critical systems and ACS have two databases with shared data to ensure there is no disruption of services. If one of the databases becomes unavailable, Alliance uses the other database to run their critical systems. Alliance also stated that there are backups at the server level and at the database level on a nightly basis.

The breakdown of encounter data acceptance/denial rates by claim service detail counts was provided for encounters submitted in 2020. Table 5 provides a comparison of 2019 and 2020.

Table 5: Volume of 2019 and 2020 Submitted Encounter Data

2020	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	66,218	399	327	66,944
Professional	1,822,170	4,843	1,736	1,828,749
2019	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	68,341	364	360	69,065
Professional	1,886,348	2,268	2,249	1,890,865

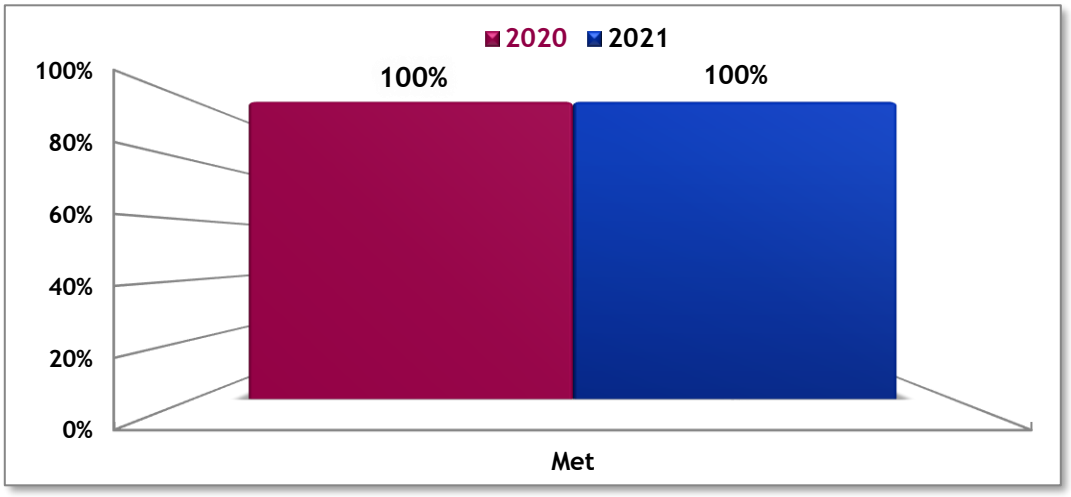
Alliance has an approximate 99.9% acceptance rate for both Professional and Institutional encounters with dates of service in 2020. During the Onsite, Alliance provided the top three denial reasons for encounters submitted to NCTracks:

- Provider Taxonomy Assignments
- Health Plans Missing
- Member Eligibility Issues

On average, Alliance submits an encounter within four 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 an internally developed Alliance Reconciliation (AR) application to monitor and track all encounter claims. As stated in the ISCA, Alliance has 2,777 Institutional and 43,312 Professional encounters with dates of service from January 1, 2017 through January 12, 2022 that are still awaiting resubmission. Alliance exceeds the NC Medicaid standards for encounter submissions and has an approximately 0.1% denial rate of their encounter data submissions.

Figure 2 demonstrates that Alliance met all of the standards in the 2020 and 2021 Administrative EQRs.

Figure 2: ISCA Findings



Strengths

- Alliance uses the monthly 820 Capitation file to record revenue, estimate future lives, update the membership lag schedule, and record receivables. Alliance also uses the 820 Capitation file to do a reconciliation of Medicaid lives.

- Alliance auto-adjudicates claims: 92.8% of Institutional claims and 94.8% of Professional claims.

- Alliance can capture of up to 25 ICD-10 Diagnosis codes via the Provider web portal and up to 32 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 submit up to 24 ICD-10 Diagnosis codes on Institutional encounters and up to 12 ICD-10 Diagnosis codes on Professional encounters to NC Medicaid.

Weaknesses

- Alliance does not have the ability to submit ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks.

Recommendations

- Update Alliance's encounter data submission process to submit ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks.

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 2020 EQR, Alliance met 100% of the Credentialing/Recredentialing standards, resulting in no Corrective Actions. CCME issued one Recommendation that Alliance partially addressed from the last EQR; however, some issues persist, as presented in Table 6.

Table 6: 2020 EQR Provider Services Findings

2020 EQR Provider Services 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: Revise Procedure 6030, the Credentialing Committee meeting minutes template, and any other documents that list Credentialing Committee membership to accurately reflect membership and voting status. For example, as the CMO is a non-voting member of the committee, include the CMO in the list of non-voting members in Procedure 6030. As the CMO and Credentialing Supervisor are non-voting members of the Credentialing Committee, ensure that designation is clear on the Credentialing Committee meeting minutes.***	**N**
2021 EQR Follow up: In this 2021 EQR, Alliance partially addressed the Recommendation. Alliance revised Procedure 6030 to include the Chief Medical Officer (CMO) as a non-voting member and revised the Credentialing Committee meeting minutes to clearly delineate the voting members and the non-voting members. However, some documents continue to list conflicting information regarding Credentialing Committee membership. Additional information is provided in the Tabular Spreadsheet.		

As was the case in the last two EQRs, there is conflicting information across documents related to the Credentialing Committee. In response to the Recommendation from the last EQR, Alliance revised documents, partially addressing the Recommendation, but issues regarding committee membership persist across Procedure 6030 Credentialing Criteria and Enrollment Process for Network Participation, and Procedure 6036 Re-Credentialing Criteria and Enrollment Process for Network Participation, the *Provider Network Credentialing Committee (PNCC) Organization Chart 12.21.21*, and the submitted Credentialing Committee meeting minutes. Additional information is provided in the Tabular Spreadsheet. During the Onsite for the current EQR, Alliance staff reported internal discussions regarding future Alliance staff committee membership, as NC DHHS is moving to a centralized credentialing process that means the PIHPs will no longer complete credentialing functions.

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 guides the credentialing and recredentialing processes. CCME's review of the credentialing and recredentialing files showed they were organized and contained appropriate information.

Procedure 6030 outlines criteria for credentialing and enrollment in the Alliance provider network and provides details regarding the Provider Network Credentialing Committee (PNCC). The committee is "chaired by an Associate Medical Director as designated by the Chief Medical Officer" and is "comprised of an interdisciplinary team that includes providers from across disciplines, in order to be able to access peer input when discussing standards of care for providers." The procedure notes, "Quorum is reached when 33% of voting members are present plus the Chairperson."

Associate Medical Directors (AMDs) and board-certified psychiatrists Dr. Heidi Middendorf and Dr. Nadiya Kaesemeyer are listed on the *Committee Matrix* as Co-Chairs of the PNCC. Dr. Kaesemeyer chaired the committee meetings for which minutes were submitted. Dr. Middendorf was not present at any of those meetings. A quorum was present at the Credentialing Committee meetings for which minutes were submitted for this EQR.

The Chief Medical Officer (CMO) designated the AMD to review and approve clean applications. The Credentialing Committee 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."

Procedure 6034, Provider Orientation and Education, outlines "orientation and education expectations for providers joining and participating in the Alliance Provider Network." New providers receive a Welcome Letter that includes the name of the provider's assigned Network Specialist and information about training resources that may be

accessed via the Alliance website. The letter includes a "link to the Alliance website that outlines additional key publications and contacts for each functional area." New providers are informed that they may request an orientation with Alliance Network staff.

Orange County and Mecklenburg County realigned from Cardinal Innovations to Alliance in December 2021. Alliance offered a virtual Provider Orientation in November 2021 for providers "affected by Cardinal realignment." Representatives from Provider Network, Access, Utilization Management (UM), and Claims departments provided information to assist providers with the transition. In February 2022, Alliance offered a "Virtual Billing and Enrollment Training for Orange & Mecklenburg Providers."

The COVID-19 flexibilities outlined in *NC Medicaid Contract Amendment #11* included a delay for the annual *Network Adequacy and Accessibility Analysis* (Gaps Analysis) report. NC DHHS notified 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." Alliance reported they completed and submitted the combined 2020/2021 report, but they "understand that the submission requirement may have been reversed."

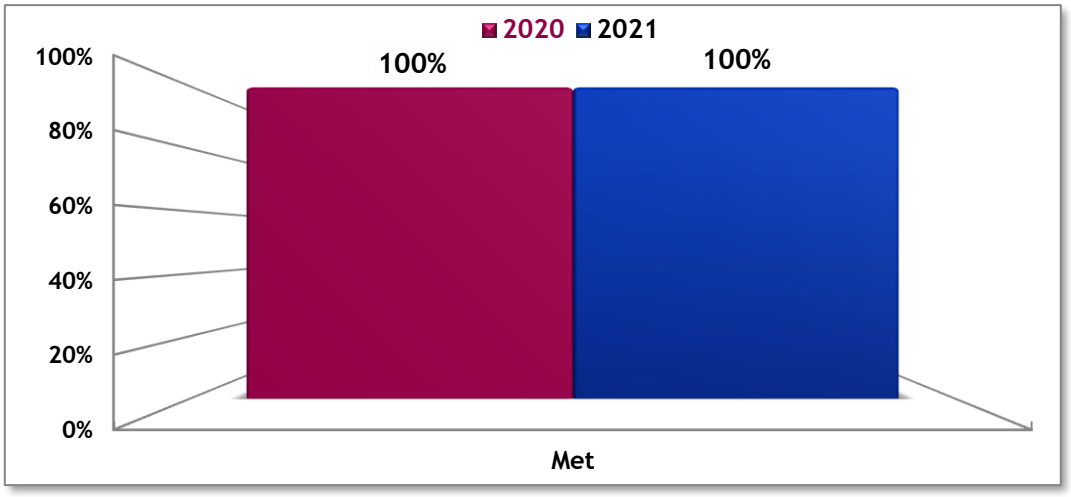
At the last EQR, Alliance staff reported they have continued to work with the school system to look at meeting needs in Cumberland County, "once face-to-face services can be reinstituted" (post COVID-19 pandemic) and noted the addition of a second Medicaid funded program to address the opioid treatment gap.

The *Alliance Network Adequacy and Accessibility Analysis Combined Report for 2020 and 2021* dated July 1, 2021 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 not yet heard if the *Exception Requests* are approved. Alliance staff reported updates on efforts to address gaps but noted continued challenges due to the COVID-19 pandemic, challenges associated with this being a "transition year" (referring to becoming a Tailored Plan), and with the realignment of Mecklenburg and Orange counties from Cardinal Innovations to Alliance. Alliance added contracts in Cumberland, Durham, and Wake counties to address the State-Funded gap in opioid treatment. A Crisis Facility for children, located in Wake County, has a projected opening date in August 2022, and Alliance staff reported they have "partnered with DSS and providers to implement two crisis group homes, with additional homes coming online next year", to address issues in Mecklenburg County.

Figure 3, Provider Services Comparative Findings, shows that 100% of the standards in the 2021 Credentialing/Recredentialing EQR were scored as "Met", and provides an overview of 2021 scores compared to 2020 scores.

Figure 3: Provider Services Comparative Findings



Strengths

- Alliance staff reported having a collaborative approach to working with providers, including a focus on problem resolution, and providing training and technical assistance to address challenges and barriers.
- Credentialing and recredentialing files contain checklists to help guide the process.
- Alliance staff reported stability in Credentialing staff, despite the fact that credentialing at PIHPs will end later this year, as a part of System Transformation.

Weaknesses

- There is conflicting information regarding committee membership across Procedure 6030, Procedure 6036, the *Provider Network Credentialing Committee (PNCC) Organization Chart 12.21.21*, and the Credentialing Committee meeting minutes.

Recommendations

- 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.

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 and a review of each PIP's Quality Improvement Project (QIP) report for validation, using CMS standard validation protocols. There was an Onsite discussion to clarify measurement rates for each of the areas.

In the 2020 EQR, Alliance met 100% of the Quality standards and received four Recommendations related to four PIPs that were validated. The Recommendations and the status of implementation in the 2021 EQR are presented in Table 7.

Table 7: 2020 EQR PIP Recommendations

Project(s)	Recommendation	Recommendation Implemented in 2021 (Y/N/NA)
APM	***Recommendation: Continue the current interventions of HealthCrowd campaign, planning for point of care testing, provider scorecards, and patient level data analysis. Determine if additional interventions should be implemented to improve rate toward the 35% benchmark.***	**Y**
7 Day DMH MH	***Recommendation: Continue the current interventions of incentives, education, open access, provider scorecards, and Peer Bridger Programs. Determine if additional interventions should be implemented to improve the rate toward the 40% benchmark.***	**Y**
SAA	***Recommendation: Continue the current interventions of HealthCrowd campaign, provider scorecards, and patient level data analysis. Determine if additional interventions should be implemented to improve rate toward the 60% benchmark.***	**N/A**
TCLI	***Recommendation: Continue the current interventions of data tracking/monitoring, assignments, and 80 day no contact tracking to determine if the rate will improve to the goal of 95%.***	**N/A**

N/A: PIP no longer active/not submitted for current review cycle

Performance Measure Validation

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

Table 8: (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 9: (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 2020 and FY 2021 are included in the table that follows. There were three measures with a substantial decline from FY 2020, including Follow Up After Hospitalization for Mental Illness in the PRTF population. Rate declined 20.9% for 7-Day Follow Up and 25.1% for 30-Day Follow Up. The Initiation rate for AODD Treatment reduced 10.7% for 13–17-year-olds. There were no rates with substantial increases from FY 2020.

Table 10: A.1. Readmission Rates for Mental Health

30-day Readmission Rates for Mental Health	FY 2020	FY 2021	Change
Inpatient (Community Hospital Only)	15.0%	13.3%	-1.70%
Inpatient (State Hospital Only)	0.0%	2.4%	2.40%
Inpatient (Community and State Hospital Combined)	14.7%	13.2%	-1.50%
Facility Based Crisis	8.9%	11.6%	2.70%
Psychiatric Residential Treatment Facility (PRTF)	11.6%	13.1%	1.50%
Combined (includes cross-overs between services)	14.0%	13.0%	-1.00%

Table 11: A.2. Readmission Rate for Substance Abuse

30-day Readmission Rates for Substance Abuse	FY 2020	FY 2021	Change
Inpatient (Community Hospital Only)	13.2%	9.9%	-3.3%
Inpatient (State Hospital Only)	4.0%	5.0%	1.0%
Inpatient (Community and State Hospital Combined)	11.3%	9.1%	-2.2%
Detox/Facility Based Crisis	12.2%	11.6%	-0.6%
Combined (includes cross-overs between services)	11.7%	10.3%	-1.4%

Table 12: A.3. Follow-Up after Hospitalization for Mental Illness

Follow-up after Hospitalization for Mental Illness	FY 2020	FY 2021	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	43.9%	40.6%	-3.3%
Percent Received Outpatient Visit Within 30 Days	61.9%	58.0%	-3.9%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	62.5%	100%*	NA*
Percent Received Outpatient Visit Within 30 Days	78.6%	100%*	NA*
PRTF			
Percent Received Outpatient Visit Within 7 Days	38.6%	17.7%	-20.9%
Percent Received Outpatient Visit Within 30 Days	61.4%	36.3%	-25.1%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	44.5%	39.6%	-4.9%
Percent Received Outpatient Visit Within 30 Days	62.6%	57.0%	-5.6%

Table 13: A.4. Follow-Up After Hospitalization for Substance Abuse

Follow-up after Hospitalization for Substance Abuse	FY 2020	FY 2021	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NR
Percent Received Outpatient Visit Within 7 Days	29.6%	33.0%	3.4%
Percent Received Outpatient Visit Within 30 Days	44.6%	45.3%	0.7%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	18.8%	23.1%*	NA*
Percent Received Outpatient Visit Within 7 Days	29.7%	23.1%*	NA*
Percent Received Outpatient Visit Within 30 Days	46.5%	30.8*	NA*
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	29.6%	32.6%	3.0%
Percent Received Outpatient Visit Within 30 Days	45.0%	44.7%	-0.3%

NR = Denominator is equal to zero

**Small denominator, rate unreliable*

Table 14: B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2020	FY 2021	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	40.5%	29.8%	-10.7%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	21.6%	12.2%	-9.4%
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	28.7%	31.8%	3.1%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	13.5%	17.7%	4.2%
Ages 21–34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	46.7%	46.0%	-0.7%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	33.9%	33.2%	-0.7%
Ages 35–64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	42.7%	43.7%	1.0%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	30.6%	32.2%	1.6%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	35.3%	33.9%	-1.4%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	25.9%	19.1%	-6.8%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	42.7%	42.7%	0.0%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	29.8%	30.2%	0.4%

Table 15: D.1. Mental Health Utilization-Inpatient Discharges and Average Length of Stay

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3–12	Male	0.2	0.1	-0.1	37.9	50.7	12.8
	Female	0.2	0.2	0.0	32.1	26.1	-6.0
	Total	0.2	0.2	0.0	35.3	36.3	1.0
13–17	Male	1.0	0.9	-0.1	59.0	57.5	-1.5
	Female	1.7	1.7	0.0	28.1	33.2	5.1
	Total	1.4	1.3	-0.1	39.8	41.8	2.0
18–20	Male	1.5	1.3	-0.2	12.5	12.9	0.4
	Female	1.8	1.3	-0.5	14.9	11.6	-3.3
	Total	1.7	1.3	-0.4	13.8	12.2	-1.6
21–34	Male	5.6	4.1	-1.5	11.6	10.8	-0.8
	Female	1.7	1.2	-0.5	8.3	15.9	7.6
	Total	2.6	1.9	-0.7	10.0	13.4	3.4
35–64	Male	4.9	3.5	-1.4	10.2	14.4	4.2
	Female	2.2	1.7	-0.5	8.7	9.6	0.9
	Total	3.2	2.3	-0.9	9.5	12.2	2.7
65+	Male	0.6	0.6	0.0	32.7	16.2	-16.5
	Female	0.3	0.3	0.0	19.5	15.8	-3.7
	Total	0.4	0.4	0.0	25.7	16.0	-9.7
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**	**1.6**	**1.2**	**-0.4**	**19.3**	**21.2**	**1.9**
	Female	**1.2**	**1.0**	**-0.2**	**15.0**	**18.2**	**3.2**
	Total	**1.4**	**1.1**	**-0.3**	**17.2**	**19.6**	**2.4**

Table 16: 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 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3-12	Male	12.67%	9.76%	-2.91%	0.04%	0.03%	-0.01%	0.28%	0.17%	-0.11%	12.62%	9.72%	-2.90%
	Female	9.18%	7.72%	-1.46%	0.04%	0.01%	-0.03%	0.09%	0.05%	-0.04%	9.16%	7.71%	-1.45%
	Total	10.96%	8.76%	-2.20%	0.04%	0.02%	-0.02%	0.18%	0.12%	-0.06%	10.93%	8.73%	-2.20%
13-17	Male	14.80%	13.02%	-1.78%	0.31%	0.20%	-0.11%	0.24%	0.22%	-0.02%	14.72%	12.95%	-1.77%
	Female	17.72%	17.59%	-0.13%	0.28%	0.17%	-0.11%	0.14%	0.16%	0.02%	17.69%	17.57%	-0.12%
	Total	16.24%	15.27%	-0.97%	0.30%	0.18%	-0.12%	0.19%	0.19%	0.00%	16.19%	15.22%	-0.97%
18-20	Male	9.73%	8.09%	-1.64%	0.07%	0.11%	0.04%	0.01%	0.08%	0.07%	9.71%	8.04%	-1.67%
	Female	12.83%	12.63%	-0.20%	0.11%	0.13%	0.02%	0.03%	0.06%	0.03%	12.82%	12.63%	-0.19%
	Total	11.35%	10.46%	-0.89%	0.09%	0.12%	0.03%	0.02%	0.07%	0.05%	11.34%	10.43%	-0.91%
21-34	Male	24.51%	19.61%	-4.90%	0.44%	0.25%	-0.19%	0.01%	0.12%	0.11%	24.51%	19.60%	-4.91%
	Female	19.32%	16.78%	-2.54%	0.14%	0.06%	-0.08%	0.06%	0.12%	0.06%	19.32%	16.76%	-2.56%
	Total	20.56%	17.43%	-3.13%	0.21%	0.11%	-0.10%	0.05%	0.12%	0.07%	20.55%	17.42%	-3.13%

2021 External Quality Review

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
35-64	Male	24.46%	22.46%	-2.00%	0.45%	0.35%	-0.10%	0.03%	0.22%	0.19%	24.44%	22.43%	-2.01%
	Female	25.63%	22.52%	-3.11%	0.21%	0.13%	-0.08%	0.04%	0.14%	0.10%	25.61%	22.50%	-3.11%
	Total	25.20%	22.50%	-2.70%	0.30%	0.21%	-0.09%	0.04%	0.17%	0.13%	25.18%	22.47%	-2.71%
65+	Male	5.60%	5.77%	0.17%	0.02%	0.08%	0.06%	0.00%	0.02%	0.02%	5.60%	5.76%	0.16%
	Female	5.98%	5.94%	-0.04%	0.01%	0.01%	0.00%	0.01%	0.01%	0.00%	5.97%	5.94%	-0.03%
	Total	5.85%	5.88%	0.03%	0.01%	0.03%	0.02%	0.01%	0.01%	0.00%	5.85%	5.88%	0.03%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**Male**	**14.98%**	**12.61%**	**-2.37%**	**0.18%**	**0.14%**	**-0.04%**	**0.18%**	**0.17%**	**-0.01%**	**14.94%**	**12.57%**	**-2.37%**
	Female	**15.32%**	**14.00%**	**-1.32%**	**0.13%**	**0.08%**	**-0.05%**	**0.07%**	**0.10%**	**0.03%**	**15.31%**	**13.99%**	**-1.32%**
	Total	**15.17%**	**13.41%**	**-1.76%**	**0.15%**	**0.10%**	**-0.05%**	**0.12%**	**0.13%**	**0.01%**	**15.15%**	**13.38%**	**-1.77%**

Table 17: 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 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3–12	Male	0.02%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.02%	0.00%
	Female	0.00%	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%
	Total	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
13–17	Male	0.70%	0.55%	-0.15%	0.03%	0.00%	-0.03%	0.11%	0.07%	-0.04%	0.64%	0.51%	-0.13%
	Female	0.56%	0.38%	-0.18%	0.02%	0.00%	-0.02%	0.02%	0.03%	0.01%	0.54%	0.37%	-0.17%
	Total	0.63%	0.47%	-0.16%	0.02%	0.00%	-0.02%	0.07%	0.05%	-0.02%	0.59%	0.44%	-0.15%
18–20	Male	1.29%	1.25%	-0.04%	0.02%	0.01%	-0.01%	0.05%	0.05%	0.00%	1.29%	1.22%	-0.07%
	Female	1.40%	1.10%	-0.30%	0.00%	0.00%	0.00%	0.04%	0.07%	0.03%	1.38%	1.09%	-0.29%
	Total	1.35%	1.17%	-0.18%	0.01%	0.00%	-0.01%	0.05%	0.06%	0.01%	1.34%	1.15%	-0.19%
21–34	Male	5.79%	4.48%	-1.31%	0.18%	0.11%	-0.07%	0.49%	0.38%	-0.11%	5.65%	4.39%	-1.26%
	Female	5.03%	4.27%	-0.76%	0.10%	0.09%	-0.01%	0.57%	0.52%	-0.05%	4.92%	4.15%	-0.77%
	Total	5.21%	4.32%	-0.89%	0.12%	0.10%	-0.02%	0.55%	0.49%	-0.06%	5.10%	4.21%	-0.89%

35–64	**Male**	7.84%	7.45%	-0.39%	0.54%	0.47%	-0.07%	1.21%	1.01%	-0.20%	7.60%	7.15%	-0.45%
	Female	5.37%	4.79%	-0.58%	0.13%	0.12%	-0.01%	0.66%	0.51%	-0.15%	5.16%	4.66%	-0.50%
	Total	6.27%	5.73%	-0.54%	0.28%	0.24%	-0.04%	0.86%	0.69%	-0.17%	6.05%	5.54%	-0.51%
65+	**Male**	1.33%	1.27%	-0.06%	0.14%	0.11%	-0.03%	0.17%	0.16%	-0.01%	1.20%	1.19%	-0.01%
	Female	0.31%	0.42%	0.11%	0.02%	0.00%	-0.02%	0.05%	0.04%	-0.01%	0.27%	0.39%	0.12%
	Total	0.65%	0.71%	0.06%	0.06%	0.04%	-0.02%	0.09%	0.08%	-0.01%	0.58%	0.66%	0.08%
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**	**1.87%**	**1.74%**	**-0.13%**	**0.11%**	**0.08%**	**-0.03%**	**0.25%**	**0.20%**	**-0.05%**	**1.80%**	**1.67%**	**-0.13%**
	Female	**2.10%**	**1.95%**	**-0.15%**	**0.05%**	**0.04%**	**-0.01%**	**0.24%**	**0.22%**	**-0.02%**	**2.04%**	**1.90%**	**-0.14%**
	Total	**2.00%**	**1.86%**	**-0.14%**	**0.07%**	**0.06%**	**-0.01%**	**0.24%**	**0.21%**	**-0.03%**	**1.93%**	**1.80%**	**-0.13%**

Table 18: D.5. 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		
	2020	2021	Change	2020	2021	Change	2020	2021	Change	2020	2021	Change
	3-12			13-17			18-20			21-34		
Cumberland	0.03%	0.01%	-0.02%	1.01%	1.05%	0.04%	1.82%	1.53%	-0.29%	4.89%	4.88%	-0.01%
Durham	0.00%	0.02%	0.02%	0.70%	0.74%	0.04%	1.39%	1.46%	0.07%	4.62%	4.25%	-0.37%
Johnston	0.01%	0.01%	0.00%	0.84%	0.70%	-0.14%	1.40%	2.05%	0.65%	5.30%	5.24%	-0.06%
Wake	0.01%	0.01%	0.00%	0.83%	0.63%	-0.20%	1.49%	1.30%	-0.19%	3.37%	3.34%	-0.03%
	35-64			65+			Unknown			Total (Ages 3+)		
Cumberland	4.72%	5.19%	0.47%	0.44%	0.66%	0.22%	0.00%	0.00%	0.00%	2.00%	2.11%	0.11%
Durham	8.56%	8.26%	-0.30%	1.33%	1.49%	0.16%	0.00%	0.00%	0.00%	2.34%	2.25%	-0.09%
Johnston	5.41%	5.54%	0.13%	0.46%	0.38%	-0.08%	0.00%	0.00%	0.00%	1.82%	1.89%	0.07%
Wake	5.13%	5.00%	-0.13%	0.74%	0.64%	-0.10%	0.00%	0.00%	0.00%	1.51%	1.49%	-0.02%

Table 19: 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		
	2020	2021	Change	2020	2021	Change	2020	2021	Change	2020	2021	Change
	3-12			13-17			18-20			21-34		
Cumberland	11.76%	10.09%	-1.67%	17.99%	17.70%	-0.29%	11.28%	12.31%	1.03%	16.47%	16.07%	-0.40%
Durham	9.37%	7.49%	-1.88%	16.31%	15.17%	-1.14%	10.12%	10.05%	-0.07%	14.49%	15.14%	0.65%
Johnston	8.20%	7.36%	-0.84%	14.56%	14.68%	0.12%	9.69%	10.84%	1.15%	14.18%	14.20%	0.02%
Wake	7.40%	6.55%	-0.85%	14.46%	14.95%	0.49%	9.49%	10.12%	0.63%	13.81%	13.83%	0.02%
	35-64			65+			Unknown			Total (Ages 3+)		
Cumberland	20.28%	19.62%	-0.66%	6.83%	7.01%	0.18%	0.00%	0.00%	0.00%	14.72%	13.97%	-0.75%
Durham	23.80%	22.45%	-1.35%	6.77%	6.41%	-0.36%	0.00%	0.00%	0.00%	13.40%	12.26%	-1.14%
Johnston	20.57%	19.76%	-0.81%	10.51%	7.93%	-2.58%	0.00%	0.00%	0.00%	12.27%	11.78%	-0.49%
Wake	19.86%	18.57%	-1.29%	6.33%	5.67%	-0.66%	0.00%	0.00%	0.00%	11.34%	10.98%	-0.36%

(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 20 contains validation scores for each of the 10 (b) Waiver Performance Measures.

Table 20: (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 21: (c) Waiver Measures Reported Results 2020 - 2021*. Documentation on data sources, data validation, source code, and calculated rate for the five measures was provided. All measures were above the 85% State benchmark rate.

Table 21: (c) Waiver Measures Reported Results 2020-2021

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	1922/1930 = 99.6%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	1922/1930 = 99.6%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	26/30 = 86.7%	85%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	956/956 = 100%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	8/8 = 100%	85%

** Latest reported rates are shown in Table from Excel files: Alliance Innovations Waiver FY 21 Q4 Excel file*

(c) Waiver Validation

All (c) Waiver Measures met the validation requirements and were Fully Compliant as shown in *Table 22, (c) Waiver Performance Measure Validation Scores*. The validation worksheets offer detailed information on validation and calculation steps for (c) Waiver Measures.

Table 22: 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 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:

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

PIP Validation Results

For the 2020 EQR, there were seven PIPs submitted and all were validated. All PIPs scored in the High Confidence range. In the 2021 EQR, there were six PIPs submitted and all six were validated: 7 DAY DHB SUD (Clinical), 7 Day DMH MH (Clinical), 7 Day DMH SUD (Clinical), APM (Clinical), SSD (Clinical) and TCLI PCP Visits PIP (New: Non-Clinical). The validation was conducted using *the CMS Protocol 1: Validating Performance Improvement Projects*. As of the 2021 review, the TCLI In-Reach and SAA PIPs were no longer active and were not validated.

Table 23: PIP Summary of Validation Scores

Project Type	Project	2020 Validation Score	2021 Validation Score
Clinical	7 DAY DHB SUD	79/79 = 100% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results
	7 Day DMH MH	73/74 = 98.6% 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	79/79 = 100% High Confidence in Reported Results
	APM	73/74 = 98.6% 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	Not Active	73/74=99% High Confidence in Reported Results

Table 24 displays the PIP project title and interventions reported by Alliance for the current review year aimed at improving PIP outcomes.

Table 24: 2021 Review 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
7 Day DMH SUD	Streamlining of processes to contact patients, value-based incentives, provider communication and education programs, assertive engagement, Provider scorecard review
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
TCLI PCP Visits	PCP visit tracking, staff education, provider communication programs

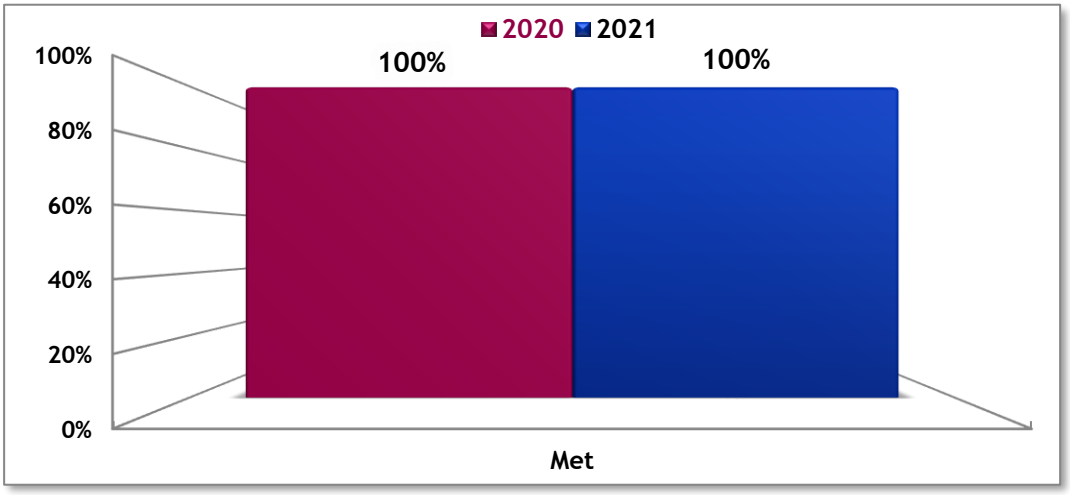
There are no Corrective Actions for the validated PIPS. For two of six PIPs, there are Recommendations regarding the assessment of interventions and barriers to implement the interventions. The project, section, reason, and Recommendations are displayed in Table 25.

Table 25: Performance Improvement Project Recommendations

Project(s)	Section	Reason	Recommendation
7 Day DHB SUD	Was there any documented, quantitative improvement in processes or outcomes of care?	Rate declined from 34% in April 2021 to 31% in May 2021. Goal is 40%.	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.
TCLI PCP Visits	Was there any documented, quantitative improvement in processes or outcomes of care?	Rate declined from 84% in October 2021 to 78% in November 2021. The goal is 80%.	Continue working on staff education and tracking-based interventions. Implement actions regarding adjustments to internal workflows that might impact visit rates.

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 Quality Improvement (QI) standards in the 2020 and 2021 EQRs.

Figure 4: Quality Improvement Comparative Findings



Strengths

- All PIPs were in the High Confidence range.
- Alliance added a new Data Science Team to the Quality Management Department to boost predictive analytics.
- Alliance has a newer relationship with a HEDIS vendor with the goal to achieve higher data integrity.
- Within the past year, Alliance has achieved NCQA Accreditation.

Weaknesses

- The (b) Waiver measure validation noted substantial decline for three PMs.
- PIP indicator rates did not improve for two PIPs: TCLI PCP Contacts and 7 Day Follow Up for DHB SUD.

Recommendations

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

- Continue working on staff education and tracking-based interventions. Implement actions regarding adjustments to internal workflows that might impact visit rates-TCLI PCP Visit PIP.
- 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 7 Day Follow Up for DHB SUD.

D. Utilization Management

42 CFR § 438.208

The EQR of Utilization Management (UM) included a review of the Care Coordination and Transition to Community Living (TCLI) programs. CCME reviewed relevant policies and procedures, 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 TCLI Care Coordination.

For the 2020 EQR, Alliance initially met 92% of UM standards. CCME issued two Corrective Actions and three Recommendations. However, NC Medicaid reviewed the one Corrective Action issued to Care Coordination and one Corrective Action issued to TCLI and determined those should be changed to Recommendations. The scores on those standards then changed to "Met", as the finding did not relate to enrollee health and safety. Alliance's 2020 UM score was updated from a 92% to 100%. Table 26 displays the 2020 findings and evidence presented in the 2021 EQR showing Alliance addressed these findings in the past year.

Table 26: 2020 EQR Utilization Management Findings

2020 EQR Utilization Management findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Assess each Medicaid enrollee identified as having special health care needs	***Recommendation: Revise the Individual and Family Handbook to reflect the ages to administer the CANS and the CALOCUS to children and adolescents as listed in the NC Medicaid Contract Sections 7.4.2. and 7.4.3.***	**Y**
2021 EQR Follow up: The 2021 review of the *Individual and Family Handbook* found that Alliance updated the ages to administer the CANS and the CALOCUS as listed in the *NC Medicaid Contract Sections 7.4.2. and 7.4.3.*		

2020 EQR Utilization Management findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Determination of which Behavioral Health Services are medically necessary;	***Recommendation: Revise Procedure 2009 and the Innovations Individual and Family Handbook to include the exemption to the waiver cost limits/funding cap as listed in NC Joint Communication Bulletin #J362.***	**Y**
2021 EQR Follow up: For the 2021 EQR, Alliance updated Procedure 2009 ICF-IID Deinstitutionalization Planning by removing the reference regarding funding caps. Though the *Innovations Individual and Family Handbook* still states, "The individual budget cannot total more than the Innovations Waiver cost limit of $135,000 per year", it also states that enrollees can request services and supports to exceed the base budget.		
Provide follow-up activities for Enrollees;	***Recommendation: Include in Procedure 2015, Management of New/Open NC Innovations Slots, a follow-up process that confirms the member or Legally Responsible Person (LRP) requests to delay or decline to participate in the Innovations Waiver.***	**Y**
2021 EQR Follow up: For the 2021 EQR, Alliance updated Procedure 2015, Management of New/Open NC Innovations Slots to include a thorough follow up process that confirms the request made by the member or Legally Responsible Person (LRP) to delay or decline participation in the Innovations Waiver.		
The PIHP applies the Care Coordination policies and procedures as formulated.	***Recommendation: Enhance the current monitoring process to include a manual record review that routinely reviews the frequency of Care Coordinator contact with members receiving residential support.*** ***Ensure that the monitoring process includes the frequency of monitoring, departmental benchmarks for compliance, and how and when outcomes of monitoring are reviewed and reported.***	**Y**
2021 EQR Follow up: For the 2021 EQR, the review of the MH/SUD and I/DD Care Coordination files submitted found that the frequency of Care Coordinator contact with members met *NC Medicaid Contract* requirements. Alliance also updated the *Care Coordination Monitoring Tool and the Care Management Dept Documentation Summary* to capture, track, and report the outcome of the monitoring process.		
QOL Surveys are administered timely.	***Recommendation: Develop, document, and implement a comprehensive monitoring plan that will review the timeliness and completeness of Quality of Life Surveys at the required timeframes.***	**Y**
2021 EQR Follow up: For the 2021 EQR, Alliance submitted The Care Coordination Documentation Monitoring Tool template and a completed tool demonstrating six months of TCLI files monitoring. In further support of the use of this tool, the 2021 review of TCLI files showed all Quality of Life Surveys were implemented, which was an improvement from the previous EQR.		

In the 2021 EQR, it was noted that the I/DD Care Coordination titles and roles had been revised by Alliance 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 *Innovations Individual and Family Handbook*. These public-facing handbooks do not reflect Alliance's recent addition of Orange and Mecklenburg counties to the Alliance catchment area. CCME recommends Alliance ensure revision of these handbooks to reflect the change from Care Coordination titles and roles and the addition of Orange and Mecklenburg counties to Alliance's catchment area.

In the 2021 I/DD file review, it was noted that one I/DD Care Coordination member file selected by Alliance for this year's EQR contained a Support Intensity Scale (SIS) that was expired for more than 250 days. This SIS expired on February 13, 2020. *Section E* of *Appendix K* of the *NC Medicaid 1915(c) Appendix K: Disaster Waiver Flexibilities* (*Appendix K*) contract amendment allows members and/or their Legally Responsible Persons (LRPs) to delay level of care evaluations or SIS re-evaluations for up to 365 calendar days from the previous assessment. According to case notes, this year extension expired on April 30, 2021. During the Onsite, Alliance acknowledged the delay in the timely completion of this member's SIS and cited staffing issues as contributing to the delay. Alliance was able to produce the most recent SIS during the Onsite. However, this SIS was completed on January 13, 2022, which is well outside of the timeframe allowed in *Appendix K*. As the SIS assessment ties into evaluation of the enrollee's current needs and supports, including potential health and safety issues, CCME is issuing a Corrective Action. Additional tracking mechanisms are needed by Alliance to ensure SIS evaluations for which the enrollee or their LRP has requested a delay are still occurring within the timeframes required in *Appendix K*.

REVISION: On April 8, 2022, the State 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 #11. 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 Utilization Management 2021 EQR score from 98% to 100% and the Corrective Action issued by CCME to a Recommendation.

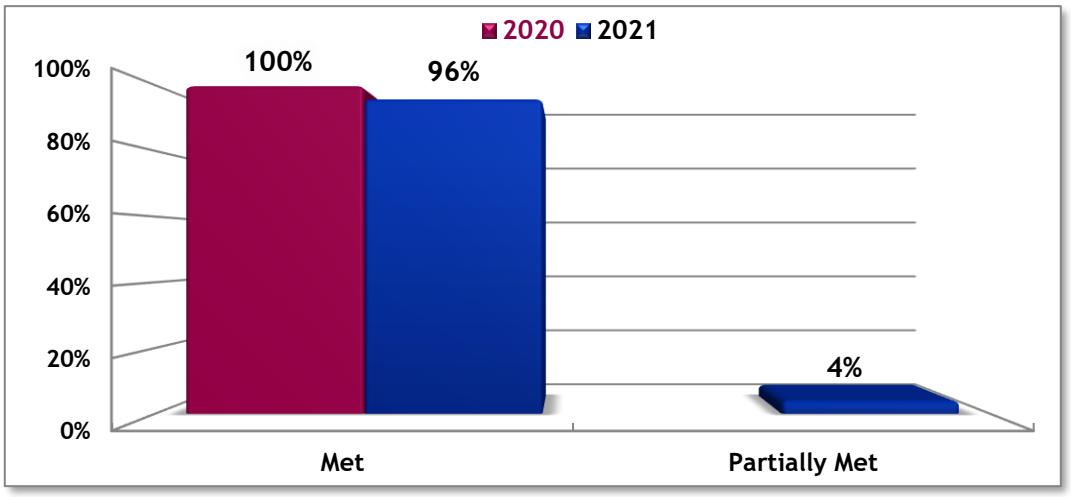
Outside of this finding, the 2021 review of MH/SUD, I/DD, and TCLI files showed overall improvement in the completeness, accuracy, and timeliness of Care Coordination documentation when compared to the previous EQR. Files were compliant with the monitoring and engagement requirements outlined in Alliance's contract with NC

Medicaid and Alliance policies and procedures. Within this year's EQR Desk Materials, Alliance submitted updated monitoring tool templates along with the results of six months of file monitoring. This monitoring showed that Alliance is routinely reviewing Care Coordination documentation for compliance issues and further supports the improvement in the files noted in this year's EQR.

Figure 5 shows 96% of the Utilization Management standards were scored as "Met" and provides an overview of 2021 scores compared to the 2020 scores.

REVISION: It should be noted Alliance initially met 96% of the 2021 EQR Utilization Management standards. The State later requested that Alliance's score change to 100% based on the flexibilities outlined in the PIHP Contract Amendment #11.

Figure 5: Utilization Management Comparative Findings



Strengths

- The files reviewed in this year's EQR showed overall improvement in the completeness, timeliness, and accuracy of Care Coordination documentation.

Weaknesses

- Alliance's *Individual and Family Handbook* and *Innovations Individual and Family Handbook* do not reflect the changes in the Care Coordination titles and roles, nor are Mecklenburg and Orange counties represented as a part of Alliance's catchment areas in these public-facing documents.

- In one of the I/DD files reviewed, the SIS revaluation occurred well outside the timeframe required in *Appendix K*.

Recommendations

- 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*.
- 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.

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 2020 EQR, Alliance met 95% of the Grievance and Appeal standards and received a total of two Corrective Actions and nine Recommendations. Updates Follow up to the 2020 EQR Grievance and Appeal Corrective Actions and Recommendations is detailed in the respective Grievance and Appeal sections.

In this 2021 EQR, Alliance met 95% of the Grievance and Appeal standards, resulting in two Corrective Actions and four Recommendations. The version of the *Provider Operations Manual* provided in the Desk Materials was revised on September 16, 2020 and went into effect on October 16, 2020. This was the same version on the Alliance website and the same version reviewed for the 2020 EQR. As a result, there were four Recommendations in the 2020 EQR for documentation updates to the *Provider Operations Manual* that were not implemented in the 2021 EQR. Those four Recommendations remain Recommendations for the 2021 EQR.

REVISION: On April 8,2022, the State 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 #11. 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 Appeal and Grievance 2021 EQR score from 98% to 100%.

Grievances

In the 2020 EQR, five Recommendations were issued, primarily targeting incorrect or missing language within Alliance's Procedure 6503, Management, and Investigation of Grievances and within the *Provider Operations Manual*. In the 2021 EQR, there was evidence that Alliance addressed the 2020 EQR Recommendations related to the Grievance procedure revisions. Alliance did not address the Recommendations issued for the *Provider Operations Manual*. As a result, there were three Grievance Recommendations from the 2020 EQR related to *Provider Operations Manual* revisions that were not implemented in the 2021 EQR. As a result, these Recommendations have been issued again in this year's EQR.

Table 27 outlines CCME's review of 2020 Corrective Actions and Recommendations that were or were not implemented by Alliance.

Table 27: 2020 EQR Grievance Findings

2020 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:	***Recommendations: Revise Procedure 6503, Management, and Investigation of Grievances to consistently use the term "Grievance".***	**Y**
2021 EQR Follow Up: Alliance updated the procedure in the version revised on July 11, 2021. The term Grievance is consistently used now.		
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: Within the Provider Operations Manual in the For Medicaid Related Grievances section, on pages 62-63, use one term "Grievance" or "Grievant" to reflect the Grievance process.***	**N**
2021 EQR Follow Up: The *Provider Operations Manual* provided in the 2021 EQR Desk Materials was revised on September 16, 2020, went into effect on October 16, 2020, and is the same manual published on Alliance's website. This was the same version of the *Provider Operations Manual* reviewed in the 2020 EQR, so there was no evidence this Recommendation was implemented by Alliance.		

2020 EQR Grievance Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Definition of a Grievance and who may file a Grievance	***Recommendations: Within Procedure 6503, Management, and Investigation of Grievances, include the definition of "Grievant" in the "Definitions" section.***	**Y**
2021 EQR Follow Up: The term "Grievant" was added to the Definitions section of Procedure 6503, Management and Investigation of Grievances.		
Timeliness guidelines for resolution of the Grievance as specified in the contract;	***Recommendation: Revise the Provider Operations Manual (pg. 62) to reflect that Grievances are resolved in 90 days, as required by Alliance Procedure 6503.***	**N**
2021 EQR Follow Up: The *Provider Operations Manual* provided in the 2021 EQR Desk Materials was revised September 16, 2020, effective October 16, 2020 and is the same manual published on Alliance's website. This was the same version of the *Provider Operations Manual* reviewed in the 2020 EQR. Therefore, there was no evidence this Recommendation was implemented by Alliance.		
Timeliness guidelines for resolution of the Grievance as specified in the contract;	***Recommendations: Revise the Provider Operations Manual (pg.62) to include, 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 as required by Alliance Procedure 9603, 42 CFR § 438.408 (c)(2)(ii), and Attachment M of Alliance's NC Medicaid Contract.***	**N**
2021 EQR Follow Up: The *Provider Operations Manual* provided in the 2021 EQR Desk Materials was revised on September 16, 2020, went into effect on October 16, 2020, and is the same manual published on Alliance's website. This was the same version of the *Provider Operations Manual* reviewed in the 2020 EQR, so there was no evidence this Recommendation was implemented by Alliance.		

In the 2021 EQR, there were 10 Grievance files reviewed. All files showed acknowledgement letters were mailed within five working days after the Grievance was received, as required by Alliance procedure. All Grievances were resolved within the required timeframes. Alliance tries to resolve all Grievances within 30 calendar days but allows 90 days per the Grievance procedure. They initiate the 14-day extension process when more than 30 days is needed to resolve the Grievance and is in the best interest of the Grievant. Alliance extended resolutions in three of the 10 files. None of the extension notification letters informed the enrollee of their right to file a Grievance if he or she disagreed with Alliance's decision to extend the Grievance resolution timeframe. This notice is required by *NC Medicaid Contract, Attachment M* and *42 CFR § 438.408 (c)(2)(ii)* which says, "Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision". CCME has issued a Corrective Action for Alliance to revise the Grievance extension notification letter to include this requirement.

Another Grievance file reviewed showed the Grievance was withdrawn three days after receipt. There was no written resolution notification sent confirming in writing the Grievant's decision to withdraw the Grievance. *NC Medicaid Contract, Attachment M* and *42 CFR 438.408 (a)* state the PIHP "must resolve each grievance and appeal, and provide notice". CCME has issued a Corrective Action to ensure all Grievances submitted to Alliance are resolved in writing, even if that resolution is the withdraw of the Grievance.

REVISION: These two Grievance Corrective Actions were later changed to a Recommendation, based on feedback from the State. This change resulted in Alliance meeting 100% of the Grievance standards.

Appeals

In the 2020 EQR of Appeals, CCME issued two Corrective Actions and four Recommendations. One Corrective Action was issued for Alliance to add documentation to the Appeals procedure to explain the required notifications when Alliance extends the Appeal resolution timeframe. The second Corrective Action outlined four revisions needed in the *Individual and Family Handbook*. Both Corrective Actions were implemented. One of the four Recommendations issued was not implemented and remains a Recommendation for the 2021 EQR. That Recommendation targeted corrections in the *Provider Operations Manual* to accurately reflect the required verbal and written notifications when Alliance extends the Appeal resolution timeframe. The remaining three Recommendations were implemented and maintained by Alliance.

Table 28 outlines CCME's review of 2020 Corrective Actions and Recommendations that were or were not implemented by Alliance.

Table 28: 2020 EQR Appeals Findings

2020 EQR Appeal Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Timeliness guidelines for resolution of the Appeal as specified in the Contract	***Corrective Action: Within Procedure 6505, correct the language explaining the required written and verbal notifications from Alliance when Alliance extends the Appeal resolution timeframe. The language within these documents should reflect the language in 42 CFR § 438.408 (c)(2) and Alliance's NC Medicaid Contract, Attachment M, Section G.6 and should be added to both the standard Appeals and expedited Appeals sections of the procedure.***	**Y**
2021 EQR Follow Up: Alliance revised Procedure 6505 for both the standard Medicaid Appeal and Expedited Medicaid Appeal sections to now accurately state, "Alliance shall make reasonable efforts to give the Enrollee prompt oral notice of the delay. Alliance will notify the member of the extension in writing within 2 calendar days".		
Timeliness guidelines for resolution of the Appeal as specified in the Contract	***Corrective Action: Correct the Individual and Family Handbook to state:*** ***1. Written resolution of an expedited Appeal will be provided within 72 hours of the receipt of the Appeal (See Alliance's Procedure 6505, III. Medicaid Appeals, Section C.8)*** ***2. The 30-day Appeal resolution timeframe can be expedited (See 42 CFR § 438.408, Section (b) 2, NC Medicaid Contract, Attachment M, Section G.4 and Procedure 6505, III. Medicaid Appeals, Section B.1.g)*** ***3. Written notification of an extension to the Appeal resolution timeframe by Alliance will be provided "within 2 calendar days" (See 42 CFR § 438.408 (c)(2), NC Medicaid Contract, Attachment M, Section G.6 (ii)).*** ***4. Alliance will notify the enrollee of their right to file a Grievance if they disagree with Alliance's decision to extend the Appeal resolution timeframe. (See 42 CFR § 438.408 (c)(2)(ii), NC Medicaid Contract, Attachment M, Section G.6.ii and Alliance's Procedure 6505, III. Medicaid Appeals, Sections B.1.g and C.5).***	**Y**

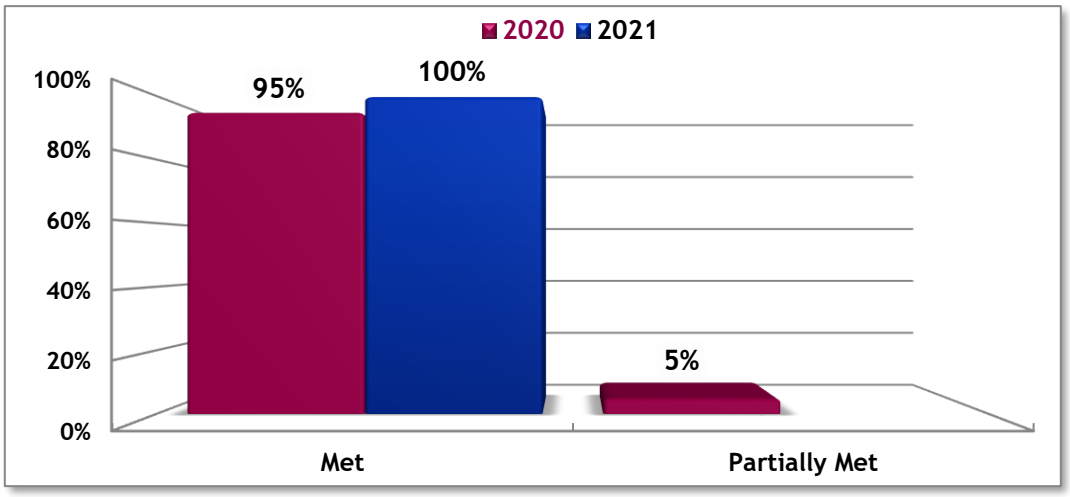
2020 EQR Appeal Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
2021 EQR Follow Up: There was evidence in the 2021 EQR that Alliance revised *the Individual and Family Handbook* to include the requirements around expedited Appeals and Appeals where Alliance extends the Appeal resolution timeframe.		
The procedure for filing an Appeal	***Recommendation: Update the Provider Operations Manual Table of Contents to reflect the correct pages for Appeal information.***	**Y**
2021 EQR Follow Up: Review of the *Provider Operations Manual* submitted for this 2021 EQR showed the Table of Contents directs readers to the correct page numbers for Appeal information.		
The procedure for filing an Appeal	***Recommendation: Revise page 64 of the Individual and Family Handbook to reflect enrollees have 60 days from the mailing date of the Adverse Benefit Determination timeframe to file an Appeal.***	**Y**
2021 EQR Follow Up: Page 62 of the *Individual and Family Handbook* now correctly reflects that enrollees have 60 days from the mailing date of the Adverse Benefit Determination to file an Appeal.		
Timeliness guidelines for resolution of the Appeal as specified in the Contract	***Recommendation: Correct the Provider Operations Manual to reflect the 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) and NC Medicaid Contract, Attachment M, Section G.6.***	**N**
2021 EQR Follow Up: The *Provider Operations Manual* provided in the 2021 EQR Desk Materials was revised on September 16, 2020, went into effect on October 16, 2020, and is the same manual published on Alliance's website. This was the same version of the *Provider Operations Manual* reviewed in the 2020 EQR, so there was no evidence this Recommendation was implemented by Alliance.		
The PIHP applies the Appeal policies and procedures as formulated.	***Recommendation: Revise the monitoring process and Peer Review Tool to ensure expedited, extended, invalid, and withdrawn Appeals are routinely reviewed for compliance issues. For these Appeals, check to ensure all verbal and written notifications are provided in compliance with NC Medicaid Contract, Attachment M and 42 CFR § 438.406 and § 408.***	**Y**
2021 EQR Follow Up: Alliance revised the Peer Review Tool to ensure required verbal and written notifications for expedited, extended, invalid, and withdrawn Appeals are reviewed to identify compliance issues.		

In the 2021 EQR Appeal file review, there was one file containing an Appeal of an administrative denial, one invalid Appeal, one expedited Appeal, and one Appeal where expedited resolution was requested but denied by Alliance. All files showed verbal and written notifications occurred and within the required timeframes. This was a significant improvement over the 2020 EQR file review.

Figure 6 provides an overview of the scoring of the current annual review as compared to the findings of the 2020 review.

REVISION: It should be noted Alliance initially met 95% of the 2021 EQR Grievances and Appeals standards. The State later requested that Alliance's score change to 100% based on the flexibilities outlined in the PIHP Contract Amendment #11.

Figure 6: Grievances and Appeals Comparative Findings



Strengths

- Alliance has implemented data-driven monitoring processes that produce staff performance measures (PMs) around Appeal and Grievance compliance. These measures are tied directly to annual performance reviews for staff.
- Alliance has increased staffing in the Appeals and Grievance Department and crossed trained all staff to work in both areas. This, along with the established monitoring processes, has had a positive impact on compliance issues noted in the previous EQR.

Weaknesses

- The *Provider Operations Manual* references concerns, complainant, and complaint when explaining the Grievance processes instead of the term "Grievance" or "Grievant", making this section confusing and misleading.

- The *Provider Operations Manual* identified incorrect timeframes for a Grievance resolution. On page 62 of the manual, it states, "Alliance will seek to resolve Grievances…no later than thirty (30) calendar days from the date Alliance received the Grievance." Per Alliance's procedure, the timeframe for Grievance resolution is 90 days.

- The *Provider Operations Manual* contained incorrect information on page 62 regarding the required notification Alliance must provide when Alliance extends the Grievance resolution timeframe.

- Alliance extended Grievance resolutions in three of the 10 files reviewed in this EQR. None of the extension notification letters informed the enrollee of the right to file a Grievance if he or she disagreed with the extension. This notice is required by *42 CFR § 438.408 (c)(2)(ii)* and *NC Medicaid Contract Attachment M*.

- One of the 10 Grievance files reviewed showed the Grievance was withdrawn three days after receipt. There was no written resolution notification sent confirming in writing the Grievant's decision to withdraw the Grievance. *NC Medicaid Contract Attachment and 42 CFR 438.408 (a)* state the PIHP "must resolve each grievance and appeal, and provide notice".

- Alliance did implement the 2020 Recommendation to revise the *Provider Operations Manual*. The current manual still contains incorrect information regarding required notifications and the timeframes for these notifications when Alliance extends the Appeal resolution timeframe.

Recommendations

- 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.

- On pages 62-63 of the *Provider Operations Manual* in the Medicaid Related Grievances section, use one term "Grievance" or "Grievant" to reflect the Grievance process.

- 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 state 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 *NC Medicaid Contract, Attachment M*.

- 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)* and *NC Medicaid Contract, Attachment M, Section G.6*.

F. Program Integrity

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

The 2021 Program Integrity EQR for Alliance encompassed a thorough Desk Review of PIHP Program Integrity (PI) function. The review included policies and procedures related to Special Investigative Unit (SIU) investigations, Provider Overpayments, and related aspects of compliance. The EQR also reviews PI staffing, workflows, reports, training materials, committee minutes, and data mining as well as a file review of randomly sampled cases that were active during the review period. There was also an Onsite discussion with Alliance Compliance, Program Integrity, Claims, Waiver Programs, and Special Investigations staff in addition to Alliance's Chief Compliance Officer (CCO) and Chief of Staff.

In the 2020 EQR, Alliance met 100% of the PI standards. There were no Recommendations or Corrective Actions issued.

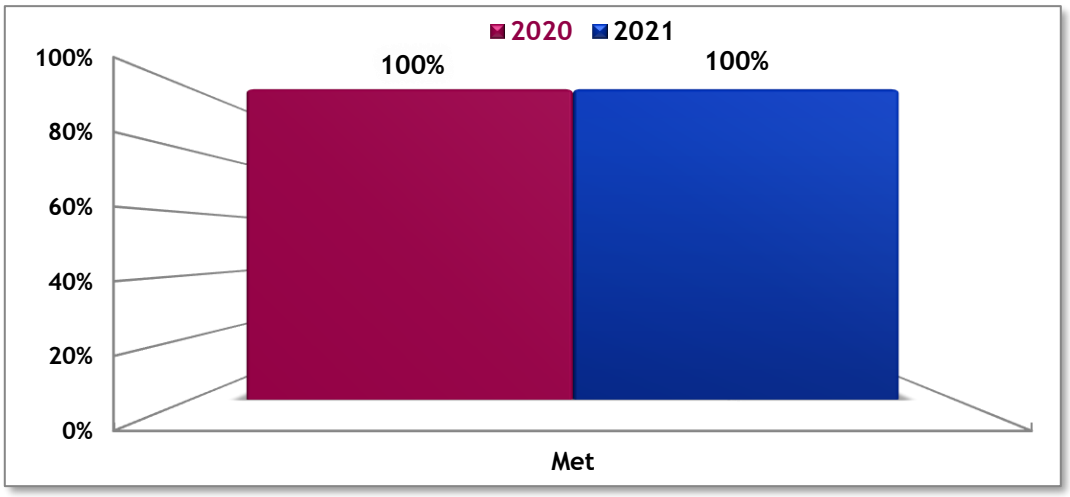
During the 2021 Desk Review and PIHP Onsite interviews, it was noted there were no organizational changes within the Program Integrity Unit. Alliance provided curriculum for training of staff, providers, and the Board of Directors. A review of Alliance's PI case report confirmed that of 87 total PI cases during the review period, 54 cases (62.1%) had been closed, 13 (14.9%) had been reported to NC Medicaid as credible allegations, and 20 (23%) remained open. Of the 20 open cases, nine were receiving action at the PIHP level and seven were in full investigation. It was discussed that Alliance has been using its internal claims auditing and data-mining analytics to proactively identify possible cases of fraud. Some of the specific reports run periodically include reports of billing outliers, overlap reports, improbable billing days, claims involving deceased members, and perfect attendance for substance use services.

Fifteen PI case files that were active during the review period were requested for the 2021 EQR of PI. The file review evaluates the timeliness of initiating the investigation as well as ensuring required elements are within the referred to NC Medicaid. Alliance case

files were well documented and consistently organized. Referrals to NC Medicaid, where applicable, were complete and concise using standard forms.

Figure 7 shows that Alliance met 100% of the PI standards in both the 2020 and 2021 EQRs.

Figure 7: Program Integrity Findings



Strengths

- The sample of Alliance PI files reviewed showed a high level of detail and organization.
- During the Onsite, Alliance detailed several innovative PI data analytics and unique reports used to identify possible cases of fraud.
- Alliance continues to use technologies to provide PI training to staff and providers. PI trainings are recorded and posted to Alliance's intranet for ease of access.

G. Encounter Data Validation

The scope of our review, guided by the CMS Encounter Data Validation Protocol, focused on measuring the data quality and completeness of claims paid and submitted to NC Medicaid by Alliance for the period of January 2020 through December 2020. All claims paid by Alliance are expected to be To utilize the encounter data as intended and provide proper oversight, NC Medicaid must be able to deem the data complete and accurate. CCME's subcontractor, HMS, has completed a review of the encounter data submitted by Alliance to NC Medicaid, as specified in the CCME agreement with NC Medicaid.

The scope of the EQR Encounter Data Validation review, guided by the CMS Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid by Alliance for the period of January 2020 through December 2020. All claims paid by Alliance should be submitted and accepted as a valid encounter to NC Medicaid. Our approach to the review included:

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

Results and Recommendations

Issue: Additional Diagnosis Codes

The secondary diagnosis was populated in 56% of all institutional claims but only 13.9% 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 suggest 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 collaborate with their provider community and encourage them to submit all applicable Diagnosis codes, behavioral and medical. This information is key for measuring member health, identifying areas of risk, and evaluating quality of care. In addition, we recommend that Alliance identify providers who never or very rarely submit Other Diagnosis codes and perform an outreach to remind them of 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, we have concluded that the data submitted to NC Medicaid is complete and accurate in accordance with NC Medicaid standards. Alliance took multiple corrective actions in 2019 to address issues that were highlighted in prior reviews. More specifically, Alliance instituted multiple claiming edits and other system changes to address deficiencies in Procedure codes.

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

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

January 10, 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 2021 External Quality Review (EQR) of 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 2021 EQR will be a focused review. The focus of this review will be on the PIHP's Corrective Actions from the previous EQR and PIHP functions that impact enrollee health and safety. Similarly, for the 2021 EQR, the two day Onsite previously performed at PIHP offices will conducted during a one day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **February 24, 2022**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

In preparation for the Desk Review, the items on the enclosed **Desk Materials List** are to be submitted electronically. **Please note that, to facilitate a timely review, there are three items on the Desk Materials List (items 9, 10, and 19.a) that should be submitted by no later than January 14, 2022,** and the remaining items are due by no later than **February 1, 2022**. Also, as indicated in item 20 of the Desk Materials List, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted with the other Desk Materials on **February 1, 2022.**

Also, please note that for this year's upload of Encounter Data, the data should be uploaded into the folder labelled "EDV" within CCME's secure documentation portal along with all other EQR materials. The location for the file transfer site is:
https://eqro.thecarolinascenter.org

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

We are encouraging all health plans to schedule an education session (via webinar) on how to utilize the file transfer site. At that time, we will conduct a walk-through of the written desk instructions provided as an enclosure. Ensuring successful upload of Desk Materials is our priority and we value the opportunity to provide support. 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) – 5

Cc: Sara Wilson, Alliance Senior Director, Government Relations
Monica Hamlin, NC Medicaid Waiver Contract Manager
Deb Goda, NC Medicaid Associate Director, Behavioral Health and IDD
Hope Newsome, NC Medicaid Quality Specialist
Doreatha McCoy, NC Medicaid Quality Specialist

Alliance

Focused External Quality Review 2021

MATERIALS REQUESTED FOR DESK REVIEW

****Please note that the lists requested in items 9, 10, and 19.a must be uploaded by no later than January 14, 2022. The remainder of items must be uploaded by no later than February 1, 2022.**

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 2020 through November 2021). 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)
   c) Any clinical committee meeting minutes showing discussion of Clinical Practice Guidelines impacted by COVID-19.

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 14, 2022**, a copy of the complete Appeal log for the months of December 2020 through November 2021. 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 appeal resolution notification.

10. **By January 14, 2022**, a copy of the complete Grievances log for the months of December 2020 through November 2021. Please indicate on the log: the nature of the grievance, the date received, and the date of 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 enrollees files, please provide:

    a. three MH/SU Care Coordination enrollee files (two active since 2019 and one recently discharged)
    b. three I/DD Care Coordination enrollee files (two active since 2019 and one recently discharged)
    c. four TCLI Care Coordination enrollee files (one active since 2019, 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:

        i. 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.

ii. 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).

iii. 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 include 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.

iii. 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).

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

v. Ownership disclosure information/form.

NOTE: Appeals, Grievances, and Program Integrity files will be selected from the logs submitted on January 14, 2022. A request will then be sent to the plan to send electronic copies of the files to CCME. The entire file will be needed.

19. Provide the following for Program Integrity:
    a. **__File Review__: By January 14, 2022**, Please produce a listing of all active files during the review period (December 2020 through November 2021). 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. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.
    e. All 'Attachment Y' reports collected during the review period.
    f. All 'Attachment Z' reports collected during the review period.
    g. Provider Manual and Provider Application.
    h. Enrollee Handbook.
    i. Subcontractor Agreement/Contract Template.
    j. 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.
    k. 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.
    l. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors, and employees.
    m. 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.
    n. Code of Ethics and Business Conduct.
    o. Internal and/or external monitoring and auditing materials.
    p. Materials pertaining to how the PIHP captures and tracks complaints.
    q. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
        i. NC Medicaid approved reporting templates.
    r. Sample Data Mining Reports.
    s. NC Medicaid Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
    t. Monthly reports of NCID holders/FAMS-users in PIHP.

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

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

w. Policies/Procedures for:

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

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.

Section	Question Number	Attachment
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):

b. Include all adjudicated claims (paid and denied) from January 1, 2020 – December 31, 2020. 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 HMS for the specified time period. In addition, please convert each 837I and 837P to a pipe delimited text file or excel sheet using an EDI translator. If your EDI translator does not support this functionality, please reach out immediately to HMS.

c. Provide a report of all paid claims by service type from January 1, 2020 – December 31, 2020. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

NOTE: THIS IS A CHANGE FROM PREVIOUS EQRS: Please upload the Encounter Data, along with the other Desk Materials, to CCME's secure portal into the folder labelled "EDV".

Attachment 2: EQR Validation Worksheets

- Mental Health (b Waiver) Performance Measures Validation Worksheet
  - Readmission Rates for Mental Health
  - Readmission Rates for Substance Abuse
  - Follow-up after Hospitalization for Mental Illness
  - Follow-up after Hospitalization for Substance Abuse
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
  - Mental Health Utilization –Inpatient Discharge and Average Length of Stay
  - Mental Health Utilization
  - Identification of Alcohol and Other Drug Services
  - Substance Abuse Penetration Rate
  - Mental Health Penetration Rate
- Innovations (c Waiver) Performance Measures Validation Worksheet
  - Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available
  - Proportion of beneficiaries reporting they have a choice between providers
  - Percentage of Level 2 and 3 incidents reported within required timeframes
  - Percentage of beneficiaries who received appropriate medication
  - Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required
- Performance Improvement Project Validation Worksheet
  - TCLI 90-Day Contact
  - Supermeasures MH
  - Supermeasures SU
  - ED Utilization
  - MST Utilization

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Readmission Rates for Mental Health**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
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 state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Readmission Rates for Substance Abuse**
Reporting Year:	**2021**
Review Performed:	**2022**

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 state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Follow-up After Hospitalization for Mental Illness**
Reporting Year:	**2021**
Review Performed:	**2022**

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 state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Follow-up After Hospitalization for Substance Abuse**
Reporting Year:	**2021**
Review Performed:	**2022**

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 state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**
Reporting Year:	**2021**
Review Performed:	**2022**

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 state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Mental Health Utilization- Inpatient Discharged and Average Length of Stay**
Reporting Year:	**2021**
Review Performed:	**2022**

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 state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Mental Health Utilization**
Reporting Year:	**2021**
Review Performed:	**2022**

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 state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Identification of Alcohol and Other Drug Services**
Reporting Year:	**2021**
Review Performed:	**2022**

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 state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Substance Abuse Penetration Rate**
Reporting Year:	**2021**
Review Performed:	**2022**

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 state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Mental Health Penetration Rate**
Reporting Year:	**2021**
Review Performed:	**2022**

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 state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid 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 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:	**2021**
Review Performed:	**2022**

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 NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	Proportion of beneficiaries reporting they have a choice between providers. IW D10
Reporting Year:	**2021**
Review Performed:	**2022**

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 NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	Percentage of level 2 and 3 incidents reported within required timeframes. IW G2
Reporting Year:	**2021**
Review Performed:	**2022**

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 NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	Percentage of beneficiaries who received appropriate medication. IW G5
Reporting Year:	**2021**
Review Performed:	**2022**

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 NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**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:	**2021**
Review Performed:	**2022**

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 NC Medicaid 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:	2021
Review Performed:	2022

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collection methods are documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are documented.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using programming logic.
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**	Rate declined from 34% in April 2021 to 31% in May 2021. Goal is 40%. ***Recommendations: Continue working to determine reasons for low referrals in 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 member for follow-up.***
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:	2021
Review Performed:	2022

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**	Rate was 29% in May 2021 and in June 2021 it was 35%. 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 including scorecard review, care management process, and follow-up phone contacts.
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	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:	**7 DAY DMH SUD**
Reporting Year:	2021
Review Performed:	2022

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.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collection methods are documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are documented.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
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.

Component / Standard (Total Points)	Score	Comments
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**	Rate was 28% in May 2021 and improved to 38% in June 2021. The goal rate 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 related to the interventions which includes value-based incentives, provider communication and education, and assertive engagement.
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	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 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:	**METABOLIC MONITORING FOR CHILDREN AND ADOLESCENTS ON ANTI-SPYCHOTICS (APM)**
Reporting Year:	2021
Review Performed:	2022

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**	Rate improved from 31% in July 2021 to 33% in August 2021. The goal is 38%.
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 results of POC testing, provider data reports, and other interventions.
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:	2021
Review Performed:	2022

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**	Rate was 72% in July 2021 and improved to 75% in August 2021.
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 in place including the 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	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 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:	2021
Review Performed:	2022

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?	**NA**	Sampling was not used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators?	**MET**	Measures are defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collection methods are documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are documented.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected SharePoint platform and Johns Hopkins reporting tool.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by month.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Rate was 84% in October 2021 and declined to 78% in November 2021. The goal is 80%. ***Recommendation: Continue working on staff education and tracking-based interventions Implement actions regarding adjustments to internal workflows that might impact visit rates.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

Attachment 3: Tabular Spreadsheet

CCME PIHP Data Collection Tool

PIHP Name:	**Alliance Health**
Collection Date:	2021

I. Information Systems Capabilities Assessment (ISCA)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I A. Management Information Systems						
1. Enrollment Systems						
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Alliance has standard processes in place for enrollment data updates. Alliance parses the daily GEF files to Alliance's EDW. A process is then run to upload the data from the EDW to ACS. Alliance uses the monthly 820 file to record revenue, estimate future lives, update the membership lag schedule, and record receivables. Alliance also uses the monthly 820 file to do a reconciliation of Medicaid lives. 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 MCO is able to identify and review any errors identified during, or as a result, of the State enrollment file load process.	X					During the Onsite, Alliance stated that they are able to capture GEF records that are unable to be loaded to ACS. Alliance has not encountered any errors in the past.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 the demographic information. All historical data for members is stored and merged under one member ID.
2. Claims System						
2.1 The MCO processes provider claims in an accurate and timely fashion.	X					The majority of 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 2020, 92.8% of Institutional and 94.86% of Professional claims were auto-adjudicated on a nightly basis. Alliance pends claims with amounts greater than $5,000, 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 MCO has processes and procedures in place to monitor review and audit claims staff.	X					Alliance audits a random sample of 3% 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 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 abusive or fraudulent claims activity or incorrect claims adjudication.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.3 The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	X					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 25 ICD-10 Diagnosis codes are captured via the web portal and up to 32 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.
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 MCO's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Alliance captures all required ICD-10 Diagnosis codes and is capable of capturing 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 MCO 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. If one of the databases becomes unavailable, Alliance uses the other database to run their critical systems. Alliance also stated that there are backups at the server level and at the database level on a nightly basis. A disaster recovery plan was provided along with the ISCA tool.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Encounter Data Submission						
4.1 The MCO 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 24 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.***
4.2 The MCO 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 from NC Medicaid is then reviewed to identify and work on encounter data denials.
4.3 MCO 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 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 99.9% and has been able to maintain the very high encounter acceptance rate that was observed in last year's EQR review as well.
4.4 The MCO has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to NC Medicaid	X					As stated in the ISCA, Alliance's 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					Alliance identifies 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*. During the Onsite, Alliance staff reported that monthly checks of the North Carolina *State Exclusion List*, the OIG/LEIE, and the SAM are addressed in Procedure 3007 Guarding against Fraud and Abuse and in the *Initial Primary Source Verification Desk Procedure*, both of which were uploaded during the Onsite.
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 two EQRs, there is conflicting information regarding committee membership across Alliance documents, as indicated in the information that follows. 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.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						○ 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 CMO is not listed as a non-voting member. ○ *PNCC Organization Chart 12.2.21*: - does not list the CMO or a Credentialing Specialist as voting or non-voting members (even though those positions are listed in Procedure 6030 as non-voting members). - lists Erica Bing, JD, Assistant General Counsel, as a non-voting member. Also of note, Ms. Bing's title is listed as "Deputy General Counsel" on the submitted Credentialing Committee meeting minutes and on the submitted Alliance *Organizational Chart January 2022*, Office of Legal Affairs page. ○ Credentialing Committee meeting minutes, "Attendee" section: - for the 1/30/21 and 12/7/21 meetings list "Paul Dalton, Credentialing Specialist" as a nonvoting member, though he did not attend those meetings. Mr. Dalton is listed as "PN Evaluator I" on the *Alliance Organizational Chart January 2022*. - for the 12/21/21 meeting do not include Mr. Dalton nor any Credentialing Specialist. - for all 3 meetings include Erica Bing, JD, Deputy General Counsel and Mehul Mankad, MD, Chief Medical Officer, as non-voting committee members. Ms. Bing attended the 11/30/21 and 12/7/21 meetings, but not the 12/21/21 meeting. Dr. Mankad did not attend any of the three meetings (or any meetings since he was added to the minutes in 12/19). The procedures include a "Provider Network Operations Manager", but that position is not on the *Alliance Organizational Chart January 2022*, the *PNCC 12.2.21* (committee organization chart), or any of the three submitted Credential Committee meeting minutes. During

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						the Onsite, Alliance staff confirmed the Network Operations Manager position no longer exists. Further, staff noted that the Alliance committee members may change due to credentialing functions ceasing at the PIHPs, likely in December 2022. ***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.***
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Credentialing files reviewed for the EQR were organized and contained appropriate information.
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					Procedure 6030, Credentialing Criteria and Enrollment Process for Network Participation outlines insurance requirements.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					
3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.8 Query of the National Practitioner Data Bank (NPDB) ;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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. CCME identified the following issues in the file review:
4.1 Recredentialing every three years;	X					Procedure 6030 Credentialing Criteria and Enrollment Process for Network Participation states, "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." In the files reviewed for the current EQR, the recredentialing of one practitioner was late by about one month and the agency recredentialing was late by about three months. Alliance submitted information for the last EQR regarding COVID-19 flexibilities, which included "Alliance is allowing an additional 90 days from the standard to recredential providers within 36 months." Therefore, in the current EQR, CCME is not issuing a Recommendation related to recredentialing within three years. However, after the end of the COVID flexibilities, "Re-credentialing needs to be completed within the 3 years based on the month of the previous credentialing", to comply with Alliance Procedure 6030 and Procedure 6036.

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					In one recredentialing file with an application and attestation date of July 7, 2021, the *State Exclusion List* query was dated April 2021, and the *Re-Credentialing Primary Source Verification Checklist – L P* lists March 31, 2021 as the query "Document or Expiration Date". Alliance submitted information for the last EQR regarding COVID-19 flexibilities, which included, "Adjustments were also made to Alliance credentialing procedures in accordance with URAC allowances, including accepting an application that was signed 210 days prior to a credentialing decision, allowing primary and secondary source verification to be collected eight months prior to a credentialing decision, and allowing an additional 90 days from the standard to recredentialed providers within 36 months." Therefore, in the current EQR, CCME is not issuing a Recommendation related to this exclusion check occurring prior to the application being received. During the Onsite, Alliance staff concurred that a *State Exclusion List* query should have been done during the recredentialing process for this practitioner. However, after the end of the COVID-19 flexibilities, Alliance needs to complete the *State Exclusion List* query as part of the verification process, to comply with Alliance Procedure 6011 Primary Source Verification.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					Recredentialing files include a "Provider Profiling" section 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					

III. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III. Quality Improvement						
III. A Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					The overall validation scores for all Performance Measures (PMs) were in the Fully Compliant range, with an average validation score of 100% across the 10 (b) Waiver Measures and the five (c) Waiver Measures. The (b) Waiver measure validation noted substantial improvement for one measure and substantial decline for three PMs. ***Recommendation: Continue to monitor (b) Waiver performance measure rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the PMs.***
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 active projects for this 2021 EQR, and all six were validated: 7 Day DHB SUD (Clinical), 7 Day DMH MH (Clinical), 7 Day DMH SUD (Clinical), APM (Clinical), SSD (Clinical) and TCLI PCP Visits PIP (New: Non-Clinical).

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 sections with concerns that should be addressed by the Recommendations. ***Recommendations:*** • ***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 in the 7 Day DHB SUD PIP.*** • ***Continue working on staff education and tracking-based interventions. Implement actions regarding adjustments to internal workflows that might impact visit rates for the TCLI PCP Visit PIP.***

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					
2. The case coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					During the 2020 EQR, CCME issued a Recommendation for Alliance to revise the *Individual and Family Handbook* to reflect the ages to administer the CANS and the CALOCUS to children and adolescents that aligns with the *NC Medicaid Contract*. The Recommendation was addressed by Alliance as evidenced by the revised *Individual and Family Handbook* submitted for the 2021 EQR and published on Alliance's website. This handbook now lists the ages for administration of the CANS and the CALOCUS as required by *NC Medicaid Contract Sections 7.4.2. and 7.4.3.*
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.5 Quality monitoring and continuous quality improvement;	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. 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*. These public-facing handbooks do not reflect Alliance's recent addition of Orange and Mecklenburg counties to the Alliance catchment area. CCME recommends Alliance ensure revision of these handbooks to reflect the change from Care Coordination titles and roles and to include the addition of Orange and Mecklenburg counties to Alliance's 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.***
2.6 Determination of which Behavioral Health Services are medically necessary;	X					During the 2020 EQR, CCME identified that Alliance Procedure 2009 ICF-IID Deinstitutionalization Planning and the *Innovations Individual and Family Handbook* needed revision related to the waiver cost limits/funding cap to align with *NC Joint Communication Bulletin #J362*. There was evidence in the 2021 EQR that Alliance addressed this Recommendation. While the *Innovations Individual and Family Handbook* still states, "The individual budget cannot total more than the Innovations Waiver cost limit of $135,000 per year", there is also information for members that additional information on exceeding the base budget is available upon request.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					During the 2020 EQR, a recommendation was issued for Alliance to include in Procedure 2015, Management of New/Open NC Innovations Slots, a follow-up process that confirms the member or LRP requests to delay or declines to participate in the Innovations Waiver. In the 2021 EQR, Alliance submitted a revised Procedure 2015, Management of New/Open NC Innovations Slots that now includes a process staff should follow when a member or LRP requests to delay or decline participation in the Innovations Waiver.
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					
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					A Recommendation was issued in the 2020 EQR. This Recommendation was for Alliance to closely monitor I/DD Care Coordination documentation to ensure the frequency of monitoring members receiving Residential Supports aligns with the member's treatment plan and is compliant with the requirements outlined in *NC Medicaid Contract*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						In the 2021 EQR, there was evidence that Care Coordination (now called Care Management) documentation demonstrated improved engagement with members receiving Residential Supports. CCME is issuing a Corrective Action. Additional tracking mechanisms are needed by Alliance to ensure SIS evaluations for which the enrollee or their LRP has requested a delay are still occurring within the timeframes required in *Appendix K*. Outside of this finding, the 2021 review of MH/SUD, I/DD, and TCLI files showed overall improvement in the completeness, accuracy, and timeliness of Care Coordination documentation when compared to the previous EQR. ***REVISION: This finding was initially issued a Corrective Action. This was later changed to a Recommendation, based on feedback from the State.*** ***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.***
IV. B Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					
2.1 Care Coordination activities occur, as required.	X					
2.2 Person Centered Plans are developed as required.	X					
2.3 Assertive Community Treatment, Peer Support, Supported Employment, Community Support Team, Psychosocial Rehabilitation, and other services as set forth in the DOJ Settlement are included in the individual's transition, if applicable.	X					
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.5 QOL Surveys are administered timely.	X					In the 2020 EQR, review of Quality of Life (QOL) surveys found that two of three TCLI files submitted by Alliance contained QOL surveys administered outside of the timeframes required for these surveys. CCME recommended that Alliance develop, document, and implement a comprehensive monitoring plan that will review the timeliness and completeness of Quality of Life Surveys at the required timeframes. In the 2021 EQR file review, there was evidence that Alliance implemented this Recommendation. The 2021 file review found that all QOL Surveys were complete and submitted within the required intervals.
3. Transition, diversion and discharge processes are in place for TCLI members as outlined in the DOJ Settlement and *DHHS Contract*.	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI 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					The review of TCLI files found that Alliance is compliant with its policies and procedures, the *NC Medicaid Contract*, and the *NC TCLI In-Reach and Transition Manual* regarding engagement of TCLI members and the completeness, accuracy, and timeliness of TCLI documentation.

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					The primary procedure guiding the Alliance Grievance processes is Procedure 6503, Management and Investigation of Grievances. In the 2020 EQR, CCME recommended Alliance revise Procedure 6503 to consistently reflect one term for Grievance, Concern, and/or Compliant. Alliance updated the procedure and term Grievance is consistently used now. A similar Recommendation was issued regarding the *Provider Operations Manual*. However, this revision did not occur since the current manual has not been updated or revised since October 2020. As this Recommendation was not implemented by Alliance, CCME again recommends this revision occur. ***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.***
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 2020 EQR, the Desk Review of the *Provider Operations Manual* identified incorrect timeframes for a Grievance resolution. On page 62 of the manual, it is stated, "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, the timeframe for Grievance resolution is 90 days. The Recommendation to review and correct this timeframe was not completed for this 2021 EQR, and the *Provider Operations Manual* has not been updated. ***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.*** Also, in the 2020 EQR, the *Provider Operations Manual* contained incorrect information on page 62 regarding the required notification Alliance must provide when Alliance extends the resolution timeframe. The manual stated, "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 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 was not implemented in the 2021 EQR and remains a 2021 Recommendation. ***Recommendations: 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, there were 10 Grievance files reviewed. All files showed acknowledgement letters were mailed within 5 working days after the Grievance was received, as required by Alliance procedure. All Grievances were resolved within the required timeframes. Alliance tries to resolve all Grievances within 30 calendar days but allows 90 days per the Grievance procedure. They initiate the 14-day extension process when more than 30 days is needed to resolve the Grievance and is in the best interest of the Grievant. Alliance extended resolutions in three of the 10 files. None of the extension notification letters informed the enrollee of their right to file a Grievance if he or she disagrees with Alliance's decision to extend the Grievance resolution timeframe. This notice is required by *NC Medicaid Contract, Attachment M* and *42 CFR § 438.408 (c)(2)(ii)* which says, "Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision".

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						REVISION: This finding was initially issued a Corrective Action. This was later changed to a Recommendation, based on feedback from the State. ***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).*** Another Grievance file reviewed showed the Grievance was withdrawn three days after receipt. There was no written resolution notification sent confirming in writing the Grievant's decision to withdraw the Grievance. *NC Medicaid Contract Attachment* and *42 CFR 438.408 (a)* state the PIHP "must resolve each grievance and appeal, and provide notice". ***REVISION: This finding was initially issued a Corrective Action. This was later changed to a Recommendation, based on feedback from the State.*** ***Recommendation: 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.***
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Alliance uses the *Daily Grievance Aging Report* to monitor and analyze Grievances for timeliness of resolution. The Appeals Manager follows up with staff to assess the status of the Grievance investigation and decide if an extension is needed and in the best interest of the Grievant. This process has improved resolution timeliness. The Clinical Quality Review committee reviews and provides input on all level three Grievances and those Grievances related to prescribing.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					
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 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					In the 2020 EQR the *Individual and Family Handbook* had the incorrect timeframe for filing an Appeal and CCME issued a Recommendation. For this 2021 EQR, page 62 of the *Individual and Family Handbook* now correctly reflects enrollees have 60 days from the mailing date of the Adverse Benefit Determination to file an Appeal.
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					In the 2020 EQR of Appeals, one Corrective Action was issued regarding Procedure 6505, Due Process Appeals of Medical Necessity. Revision of the procedure was needed to correct the language detailing the required written and verbal notifications when Alliance extends the Appeal resolution timeframe. In this 2021 EQR, it was noted the corrections were made to that procedure for both the standard Medicaid Appeal and Expedited Medicaid Appeal sections. Both sections now state, "Alliance shall make reasonable efforts to give the Enrollee prompt oral notice of the delay. Alliance will notify the member of the extension in writing within 2 calendar days". In the 2020 EQR, there was a Recommendation for Alliance to revise *Provider Operations Manual*. The manual did not explain Alliance will verbally notify the enrollee of Alliance's extension to the Appeal resolution timeframe, nor is a timeframe identified for the verbal and written notifications from Alliance regarding an extension. CCME is issuing this Recommendation again as it was not implemented by Alliance and the *Provider Operations Manual* still contains incorrect information regarding these required notifications. ***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.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The 2020 EQR issued one Corrective Action addressing four areas of the In*dividual and Family Handbook*. *In the 2021 EQR, there was evidence* Alliance revised the handbook and all four areas were corrected. These corrections included: ○ Written resolution of an expedited Appeal will be provided within 72 hours of the receipt of the Appeal (See Alliance's Procedure 6505, III. Medicaid Appeals, Section C.8) ○ The 30-day Appeal resolution timeframe can be expedited (See *42 CFR § 438.408, Section (b) 2, NC Medicaid Contract, Attachment M, Section G.4* and Procedure 6505, III. Medicaid Appeals, Section B.1.g) ○ Written notification of an extension to the Appeal resolution timeframe by Alliance will be provided "within 2 calendar days" (See *42 CFR § 438.408 (c)(2) and NC Medicaid Contract, Attachment M, Section G.6 (ii).* ○ Alliance will notify the enrollee of their right to file a Grievance if they disagree with Alliance's decision to extend the Appeal resolution timeframe. (*See 42 CFR § 438.408 (c)(2)(ii), NC Medicaid Contract, Attachment M, Section G.6.ii* and Alliance's Procedure 6505, III. Medicaid Appeals, Sections B.1.g and C.5.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP applies the appeal policies and procedures as formulated.	X					In the 2020 EQR, CCME issued a Recommendation to improve the *Peer Review Tool*. This tool is used to review Appeal files for compliance issues but did not encompass review of verbal and written notifications related to expedited Appeals or required elements within invalid, extended, and withdrawn Appeals. In the 2021 EQR, it was noted the *Peer Review Tool* was updated and, subsequently, compliance improved within the Appeal files reviewed in the 2021 EQR was noted. In the 2021 EQR Appeal file review, there was one file containing an Appeal of an administrative denial, one invalid Appeal, one expedited Appeal, and one Appeal where expedited resolution was requested but denied by Alliance. All files showed verbal and written notifications occurred and within the required timeframes. This was a significant improvement from the 2020 EQR file review.
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					The requirement that the PIHP be familiar and comply with *Section 1902 (a)(68) of the Social Security Act, 42 CFR § 438.455* and *1000* through *1008*, is addressed in the Post Payments Reviews Procedure 6001 and in the *Alliance Corporate Compliance Plan FY22*.
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					The requirement that the PIHP include Program Integrity (PI) requirements in its written agreements with providers is addressed in the Compliance Plan. This is also included in template provider contracts provided for review.
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	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. The Compliance Plan shall be submitted to the NC Medicaid Contract Administrator on an annual basis.	X					Alliance's *Compliance Plan FY22* outlines the methods Alliance implements to guard against fraud and abuse.
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					Alliance's *Corporate Compliance Plan FY22*, Procedure 3000 Corporate Compliance Plan, Compliance Organizational Chart and accompanying job description documents, and several training materials provided for review address the requirements within this standard.

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, however named, that is responsible for PIHP program integrity activities, including identification, detection, and prevention of fraud, waste, and abuse in the PIHP Closed Provider Network. PIHP shall identify an appropriately qualified contact for Program Integrity and Regulatory Compliance issues as mutually agreed upon by PIHP and NC Medicaid. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator. In addition, PIHP shall identify a primary point of contact within the Special Investigations Unit to receive and respond to data requests from MFCU/MID. The MFCU/ MID will copy the PIHP Contract Administrator on all such requests.	X					
4. PIHP shall participate in quarterly Program Integrity meetings with NC Medicaid Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. PIHP shall send staff to participate in monthly meetings with NC Medicaid Program Integrity staff either telephonically or in person, at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.	X					
6. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information	X					
7. Within seven (7) business days of a request by the Division, PIHP shall also make portions of the PIHP's Regulatory Compliance and Program Integrity minutes relating to Program Integrity issues available for review, but the PIHP may, redact other portions of the minutes not relating to Regulatory Compliance or Program Integrity issues.	X					
8. PIHP's written Compliance Plan shall, at a minimum include:						
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
and procedures and the False Claims Act as identified in *Section 1902 (a)(66)* of the *Social Security Act;*						
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing, and development of corrective action initiatives;	X					The requirement that the Compliance Plan shall include a provision for prompt response to offenses identified through internal and external monitoring, auditing, and development of corrective action initiatives is addressed in the *Alliance Corporate Compliance Plan FY22* and in Procedure 3008 Special Investigations Procedures.
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					
8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including NC Medicaid or MFCU/MID, and including supplying 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	
9. 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. PIHP shall be penalized One Hundred Dollars ($100) for each overpayment that is not specified in an Attachment Y Report within the applicable month. In addition, 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	
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse.	X					
10.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure. This process shall include procedures for logging the complaint, determining if the complaint is valid, assigning the complaint, investigating, appeal, recoupment, and closure. The detailed workflow needs to differentiate the steps taken for fraud versus abuse; PIHP shall establish and implement policies for treatment of recoveries of all overpayments from PIHP to Providers and contracted agencies, specifically including retention policies for treatment of recoveries of overpayments due to fraud, waste, or abuse. The retention policies shall include processes, timeframes, and required documentation for payment of recoveries of overpayments to the State in situations where PIHP is not permitted to retain some or all of the recoveries of overpayments.	X					The requirement that the policies and procedures to guard against fraud and abuse shall include a detailed workflow of the PIHP process for taking a complaint from inception through closure is addressed in the workflow of complaint to closure in Procedure 3008 Special Investigations Procedures and in the Alliance SIU Detailed Workflow, Investigation Chronology, and Investigation Resources. Recovery of repayments is addressed in Procedure 1517 Overpayments, and Description for Tracking Overpayments and Recoveries.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
This provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.						
10.3 In accordance with Attachment Y - Audits/Self-Audits/investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					
10.4 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					The PIHP provided Attachment Y reports for each month during the review period.
10.5 Process for handling self-audits and challenge audits.	X					
10.6 Process for using data mining to determine leads.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.7 Process for informing PIHP employees, subcontractors, and providers regarding the *False Claims Act.*	X					The PIHP provided for review Procedure 3026 False Claims to demonstrate compliance with the requirement that it has a process for informing PIHP employees, subcontractors, and providers regarding the False Claims Act.
10.8 If PIHP makes or receives annual payments of at least $5,000,000, PIHP shall establish and maintain written policies for all employees, contractors, or agents that detail information about the *False Claims Act* and other federal and state laws as described in the *Social Security Act 1902 (a)(66)*, including information about rights of employees to be protected as whistleblowers.	X					
10.9 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					
10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding	X					The PIHP provided template Credentialing Checklists, which capture required information. This required information is also detailed within the Schedule K spreadsheet.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						
11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.	X					.
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					Investigation timeframes are found in the *Alliance Corporate Compliance Plan FY22 and* in Procedure 3008 Special Investigations Procedures. This procedure details the timely initiation, reporting, to NC Medicaid, and subsequent electronic storage of records. The Alliance SIU Detailed Workflow demonstrates the forwarding of investigations to NC Medicaid. Of the 17 PI cases provided by the PIHP for review, 15 cases were reviewed with an oversample of two. Six of the 17 cases had been referred by the PIHP to NC Medicaid as allegations of fraud. All six files were initiated within 10 days of receipt of allegation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13. 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:						Of the 17 PI cases provided by the PIHP for review, 15 cases were reviewed with an oversample of two. Six of the 15 cases had been referred by the PIHP to NC Medicaid as allegations of fraud. Case File Review Results: 6 of 6 applicable files reviewed met the requirement that a description of suspected intentional misconduct is included.
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					
13.2 Source/origin of complaint;	X					
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					
13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated; and dates of suspected intentional misconduct;	X					
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					
13.6 All communications between PIHP and the Provider concerning the conduct at issue, when available.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					
13.8 Total Sample Amount of Funds Investigated per Service Type	X					
13.8.1 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					
13.8.2 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					
13.8.3 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					
13.8.4 Information on Biller/Owner;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.8.5 Additional Provider Locations that are related to the allegations;	X					
13.8.6 Legal and Administrative Status of Case.	X					
14. 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:						Two cases involving allegations of Enrollee Fraud, Waste, and/or Abuse were provided for this year's EQR. One of the two cases had been referred by Alliance to NC Medicaid, and this file contained all documentation required when referring to NC Medicaid.
14.1 The Enrollee's name, birth date, and Medicaid number;	X					
14.2 The source of the allegation;	X					
14.3 The nature of the allegation, including the timeframe of the allegation in question;	X					
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;	X					
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and	X					
14.7 The legal and administrative status of the case.	X					
14.8 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					
14.9 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					
14.10 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					
14.11 Information on Biller/Owner;	X					
14.12 Additional Provider Locations that are related to the allegations;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.13 Legal and Administrative Status of Case.	X					
15. PIHP and NC Medicaid shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of State and Federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.	X					
16. PIHP shall use the NC Medicaid Fraud and Abuse Management System (FAMS) or a NC Medicaid approved alternative data mining technology solution to detect and prevent fraud, waste, and abuse in managed care.	X					The requirement that the PIHP use the NC Medicaid Fraud and Abuse Management System (FAMS) or a NC Medicaid approved alternative data mining technology solution was demonstrated through submission of FAMS User and data mining reports. The use of FAMS is also described in Procedure 3008 Special Investigations.
17. If PIHP uses FAMS, PIHP shall work with the NC Medicaid designated Administrator to submit appropriate claims data to load into the NC Medicaid Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. 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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
18. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month or the next business day if the 10th day is a non-business day (i.e., weekend or State or PIHP holiday). In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to NC Medicaid Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59 p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to NC Medicaid Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.	X					The requirement that the PIHP submit FAMS user reports and timely submission of Attachments Y and Z is addressed in Procedure 3053 Coordination of Program Integrity Activity. Additionally, the PIHP provided monthly NCID-FAMS User lists covering the review period. The monthly report submission requirement is addressed by the monthly Attachment Y and Z Reports provided for review.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII C. Provider Payment Suspensions and Overpayments						
1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, NC Medicaid Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. 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 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						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					The requirement that the PIHP shall lift the payment suspension within three business days of notification and process all clean claims suspended is addressed in Procedure 3043 Provider Sanctions, Administrative Actions, and Suspensions to Ensure Patient Safety and in Procedure 3053 Coordination of Program Integrity Activity.
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					Information and requirements regarding Provider payment suspensions is addressed in Procedure 3043, Provider Sanctions, Administrative Actions, and Suspensions to Ensure Patient Safety and in Procedure 3053, Coordination of Program Integrity Activity.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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. If PIHP takes administrative action, including issuing a Notice of Overpayment based on such fraud that precedes the submission date of a Division referral, the State will adjust the PIHP capitated payment in the amount of the original overpayment identified or One Thousand Dollars ($1,000) per case, whichever amount is greater.	X					The requirement that the PIHP not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid Program Integrity is addressed in Procedure 3053, Coordination of Program Integrity Activity Procedure.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. Notwithstanding the foregoing, nothing herein shall be construed as prohibiting PIHP from taking any action against a Network Provider in accordance with the terms and conditions of any written agreement with a Network Provider, including but not limited to prepayment review, identification and collection of overpayments, suspension of referrals, de-credentialing, contract nonrenewal, suspension or termination or other sanction, remedial or preventive efforts necessary to ensure continuous, quality care to Enrollees, regardless of any ongoing investigation being conducted by NC Medicaid, MFCU/MID or other oversight agency, to the extent that such action shall not interfere with Enrollee access to care or with any such ongoing investigation being conducted by NC Medicaid, MFCU/MID or other oversight agency.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with *NCGS 108C-5*, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.	X					Collection of overpayments is addressed in Procedure BO-6. Alliance also provided for review a Description for Tracking Overpayments and Recoveries, and related Tracking document templates.

Attachment 4: Encounter Data Validation Report

Alliance Health

Encounter Data Validation Report

performed on behalf of

North Carolina Medicaid

March 9, 2022

Prepared By:

hms

4601 Six Forks Road / Suite 306 / Raleigh, NC 27609

Table of Contents

This page intentionally left blank.

Background

Health Management Systems (HMS) 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 HMS to perform encounter data validation for each PIHP. North Carolina Senate Bill 371 requires that each PIHP submit encounter data "for payments made to providers for Medicaid and State-funded mental health, intellectual and developmental disabilities, and substance abuse disorder services. NC Medicaid may use encounter data for purposes including, but not limited to, setting PIHP capitation rates, measuring the quality of services managed by PIHPs, assuring compliance with State and federal regulations, and for oversight and audit functions."

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

Overview

The scope of our review, guided by the CMS Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid and submitted to NC Medicaid by Alliance for the period of January 2020 through December 2020. All claims paid by Alliance should be submitted and accepted as valid encounters to NC Medicaid. Our approach to the review included:

- A review of Alliance's response to the Information Systems Capability Assessment (ISCA)
- Analysis of Alliance's 2020 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 CSRA and parsed using an EDI validator to check for errors and produce a 999 response to confirm receipt and any compliance errors. The behavioral health encounter claims are then validated by applying a list of edits provided by the state (See *Appendix 1*) and adjudicated accordingly by the Medicaid Management Information System (MMIS). Utilizing existing Medicaid pricing methodology and 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*.

Looking at claims with dates of service in 2020, Alliance submitted 1,895,693 unique encounters to the State. To date, less than 1% of all 2020 encounters submitted have not been corrected and accepted by NC Medicaid.

2020	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
Institutional	66,944	66,218	399	327	0.49%
Professional	1,828,749	1,822,170	4,843	1,736	0.09%
Total	1,895,693	1,888,388	5,242	2,063	0.11%

Each year 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 over 99%, well above NC Medicaid's expectations.

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%

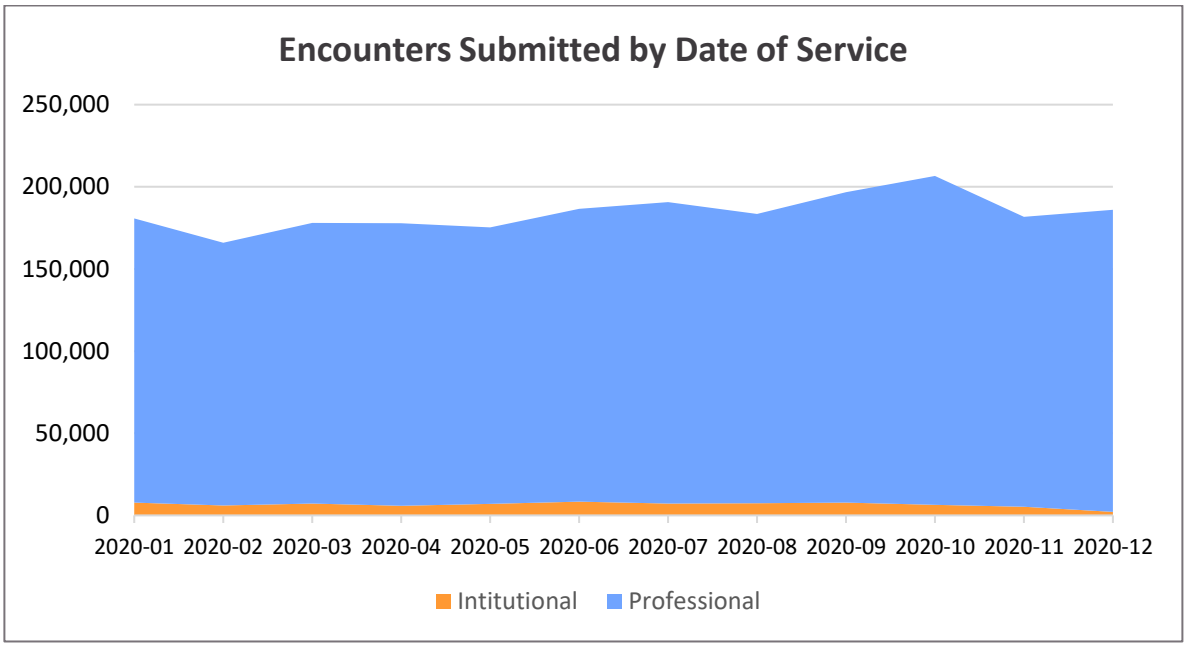
The PIHP has a detailed reconciliation and correction process in place to ensure that all denials are reviewed, corrected, and resubmitted to NC Medicaid. Alliance has a dedicated team of two claims analysts responsible for reviewing and resubmitting denied encounter claims. After a check write cycle, Alliance receives an 835 response file from NCTracks. Those results are posted to Alliance's internal system so that encounter submission results and their acceptance status is visible to its staff for each claim. Additionally, Alliance has reports and work queue that focus on the denials so that the staff can efficiently review, research, and resolve the issue(s) that caused the denial.

To do this, the team 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 Alliance's AlphaMCS. Analysts verify the provider record in NCTracks and update the AlphaMCS

system or send a provider upload file to NCTracks to update the needed information and to process claims. Additionally, suspected duplicates were the most common denial reason seen in 2020. These were not true duplicate payments but a result of timing issues where Alliance submitted new debit transactions before adjustments to previously reported encounters finished processing in NCTracks. Lastly, Alliance maintains a tool that allows its senior staff to modify its claiming edits. This allows Alliance to quickly update its edits if the review of denials reveals any issues that can be addressed by applying tighter edits to incoming claims.

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, 2020 and December 31, 2020. Alliance pulled all claims adjudicated and submitted to NC Medicaid during 2020 and sent to HMS via CCME Portal. This included more than two million professional claims and over 90,000 institutional claim line items.



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

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

Data Element	*Expectation*	*Validity Criteria*
Recipient ID	Should be valid ID as found in the State's eligibility file. Can use State's ID unless State also accepts Social Security Number.	100% valid
Recipient Name	Should be captured in such a way that makes separating pieces of name easy. Expect data to be present and of good quality	85% present. Lengths should vary, but there should be at least some last names of >8 digits and some first names of < 8 digits, validating that fields have not been truncated. Also, a high percentage of names should have at least a middle initial.
Recipient Date of Birth	Should not be missing and should be a valid date.	< 2% missing or invalid
PIHP ID	Critical Data Element	100% valid
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	95% valid
Attending Provider ID	Should be an enrolled provider listed in the provider enrollment file (will accept the MD license number if it is listed in the provider enrollment file).	> 85% match with provider file using either provider ID or MD license number
Provider Location	Minimal requirement is county code, but zip code is strongly advised.	> 95% with valid county code > 95% with valid zip code (if available)
Place of Service	Should be routinely coded, especially for physicians.	> 95% valid for physicians > 80% valid across all providers
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% nonmissing and valid on physician or other applicable provider type claims (e.g., other practitioners)
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid codes (using International Statistical Classifications of Diseases, Ninth Revision, Clinical Modification [ICD-9-CM] lookup tables) for practitioner providers (not including transportation, lab, and other ancillary providers)

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

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

Encounter Accuracy and Completeness

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

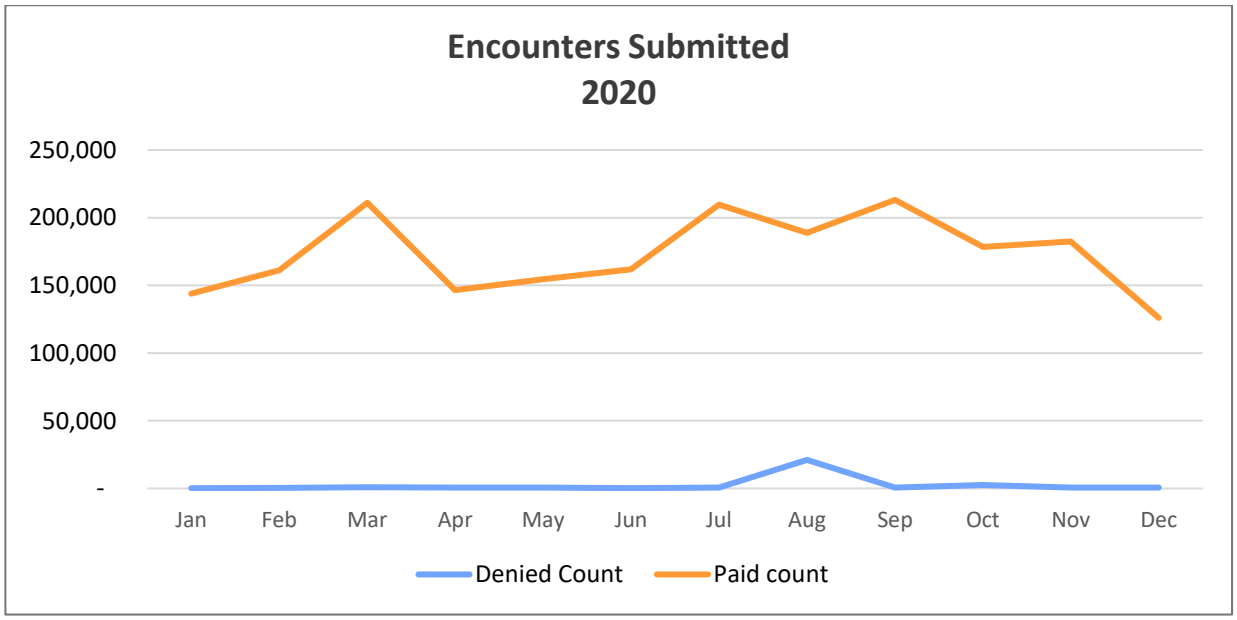
Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	2,223,892	100.00%	2,223,852	100.00%	2,223,852	100.00%	2,223,852	100.00%
Recipient Name	2,223,892	100.00%	2,223,892	100.00%	2,223,892	100.00%	2,223,892	100.00%
Recipient Date of Birth	2,223,892	100.00%	2,223,892	100.00%	2,223,892	100.00%	2,223,892	100.00%
PIHP ID	2,223,892	100.00%	2,223,892	100.00%	2,223,892	100.00%	2,223,892	100.00%
Provider ID	2,222,608	99.94%	2,222,608	99.94%	2,222,608	99.94%	2,222,608	99.94%
Attending/Rendering Provider ID	2,222,608	99.94%	2,222,608	99.94%	2,222,608	99.94%	2,222,608	99.94%
Provider Location	2,223,892	100.00%	2,223,890	100.00%	2,223,890	100.00%	2,223,890	100.00%
Place of Service	2,223,892	100.00%	2,223,892	100.00%	2,223,892	100.00%	2,223,892	100.00%
Specialty Code / Taxonomy - Billing	2,223,876	100.00%	2,223,907	100.00%	2,223,907	100.00%	2,223,907	100.00%
Specialty Code / Taxonomy - Rendering / Attending	2,223,892	100.00%	2,223,892	100.00%	2,223,892	100.00%	2,223,892	100.00%
Principal Diagnosis	2,223,892	100.00%	2,223,892	100.00%	2,223,892	100.00%	2,223,892	100.00%
Other Diagnosis	347,706	15.64%	347,706	15.64%	347,706	15.64%	347,706	15.64%
Dates of Service	2,223,892	100.00%	2,223,892	100.00%	2,223,892	100.00%	2,223,892	100.00%
Unit of Service (Quantity)	2,223,892	100.00%	2,223,892	100.00%	2,223,892	100.00%	2,223,892	100.00%
Procedure Code	2,204,099	99.11%	2,203,815	99.10%	2,203,815	99.10%	2,203,815	99.10%
Procedure Code Modifier	1,217,878	54.76%	1,217,878	54.76%	1,217,878	54.76%	1,217,878	54.76%
Patient Discharge Status Code Inpatient	92,969	100.00%	92,969	100.00%	92,969	100.00%	92,969	100.00%
Revenue Code	92,968	100.00%	92,968	100.00%	92,968	100.00%	92,968	100.00%

Overall, there were very few inconsistencies in the data. Institutional claims contained complete and valid data in all 18 key fields (100%). Notable improvements were seen in Procedure codes, especially among outpatient claims. In 2020, over 99% of all institutional claim lines contained Procedure codes where one is expected. We believe this improvement was a direct result of Alliance's 2019 implementation of additional edits to deny line items that are missing a valid Procedure code where one is expected. Additionally, Alliance implemented additional changes to ensure Procedure code field does not populate with Revenue code when the former is missing. A slight year-over-year improvement in Other Diagnosis codes was also noted. Over 56% of all institutional claims contain Other Diagnosis codes, compared to 54% in the prior year and less than 1% in 2018.

Professional encounter claims submitted contained complete and valid data in 14 of the 15 key Professional fields (93%). The review found Other Diagnosis codes in less than 14% of professional claim lines. In 2018, Alliance made changes to ensure they are reporting all Other Diagnosis codes to NC Medicaid in their encounter submission. As a result of fixing the mapping issues, there were noticeable improvements in 2019. Since then, however, the figures have been ranged between 13% and 16%.

Encounter Acceptance Report

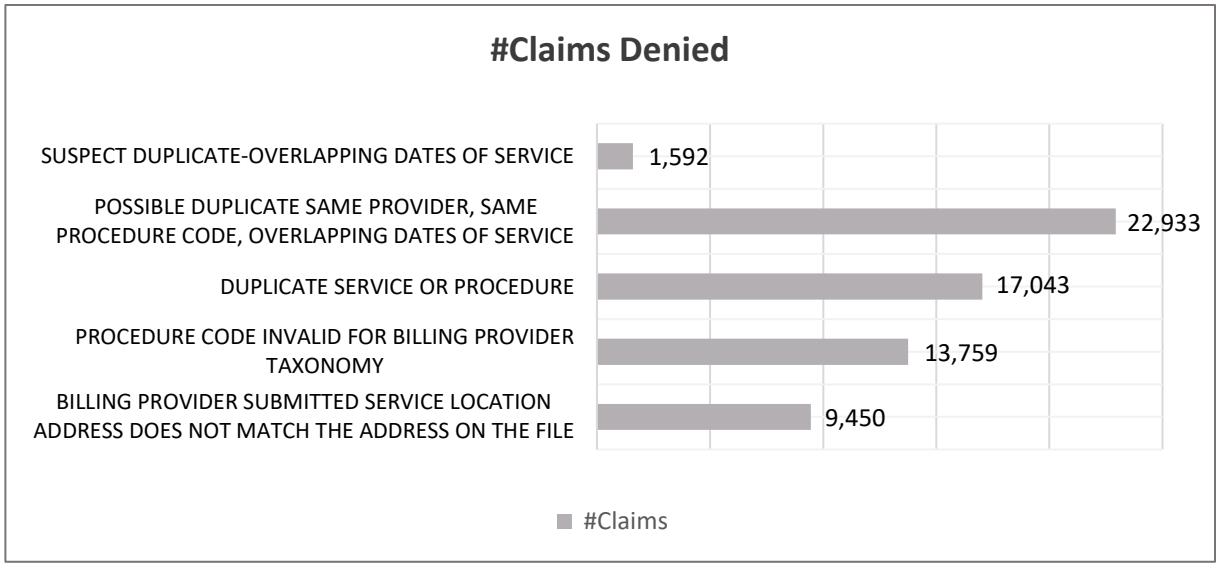
In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write and excludes duplicates or resubmission, 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 2020, which may include older dates of service. During the 2020 weekly check write schedule, Alliance submitted a total of 2,223,892 encounters to NC Medicaid. Approximately less than 1% of claims denied are still outstanding. The rest have been reviewed, resubmitted, and accepted by NC Medicaid.



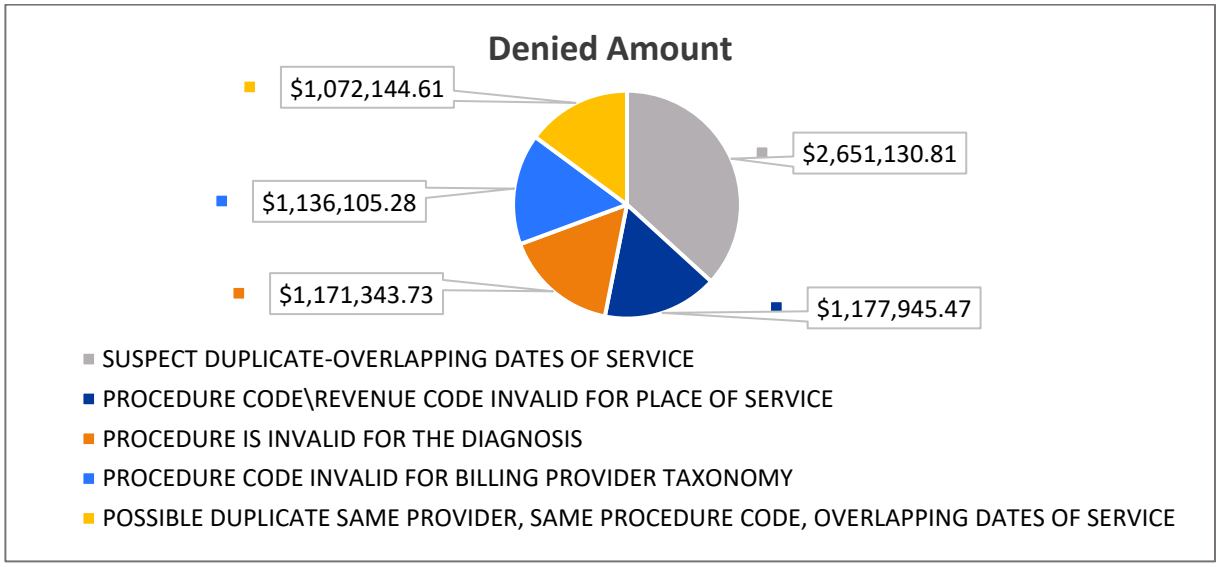
Evaluation of the top denials for Alliance encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis an ISCA review above. Encounters were denied primarily for:

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

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 56% of all institutional claims but only 13.9% 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 suggest 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 collaborate with their provider community and encourage them to submit all applicable Diagnosis codes, behavioral and medical. This information is key for measuring member health, identifying areas of risk, and evaluating quality of care. In addition, it is recommended that Alliance identify providers who never or very rarely submit Other Diagnosis codes and perform an outreach to remind them of 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 to address issues that were highlighted in prior reviews. More specifically, Alliance instituted multiple claiming edits and other system changes to address deficiencies in Procedure codes.

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

Appendix 1

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
00001	HDR BEG DOS INVLD/ > TCN DATE	DENY
00002	ADMISSION DATE INVALID	DENY
00003	HDR END DOS INVLD/ > TCN DATE	DENY
00006	DISCHARGE DATE INVALID	PAY AND REPORT
00007	TOT DAYS CLM GTR THAN BILL PER	PAY AND REPORT
00023	SICK VISIT BILLED ON HC CLAIM	IGNORE
00030	ADMIT SRC CD INVALID	PAY AND REPORT
00031	VALUE CODE/AMT MISS OR INVLD	PAY AND REPORT
00036	HEALTH CHECK IMMUNIZATION EDIT	IGNORE
00038	MULTI DOS ON HEALTH CHECK CLM	IGNORE
00040	TO DOS INVALID	DENY
00041	INVALID FIRST TREATMENT DATE	IGNORE
00044	REQ DIAG FOR VITROCERT	IGNORE
00051	PATIENT STATUS CODE INVALID	PAY AND REPORT
00055	TOTAL BILLED INVALID	PAY AND REPORT
00062	REVIEW LAB PATHOLOGY	IGNORE
00073	PROC CODE/MOD END-DTE ON FILE	PAY AND REPORT
00076	OCC DTE INVLD FOR SUB OCC CODE	PAY AND REPORT
00097	INCARCERATED - INPAT SVCS ONLY	DENY
00100	LINE FDOS/HDR FDOS INVALID	DENY
00101	LN TDOS BEFORE FDOS	IGNORE
00105	INVLD TOOTH SURF ON RSTR PROC	IGNORE
00106	UNABLE TO DETERMINE MEDICARE	PAY AND REPORT
00117	ONLY ONE DOS ALLOWED/LINE	PAY AND REPORT
00126	TOOTH SURFACE MISSING/INVALID	IGNORE
00127	QUAD CODE MISSING/INVALID	IGNORE
00128	PROC CDE DOESNT MATCH TOOTH #	IGNORE
00132	HCPCS CODE REQ FOR REV CODE	IGNORE
00133	HCPCS CODE REQ BILLING RC 0636	IGNORE
00135	INVL POS INDEP MENT HLTH PROV	PAY AND REPORT
00136	INVLD POS FOR IDTF PROV	PAY AND REPORT
00140	BILL TYPE/ADMIT DATE/FDOS	DENY
00141	MEDICAID DAYS CONFLICT	IGNORE
00142	UNITS NOT EQUAL TO DOS	PAY AND REPORT
00143	REVIEW FOR MEDICAL NECESSITY	IGNORE

00144	FDOS AND TDOS MUST BE THE SAME	IGNORE
00146	PROC INVLD - BILL PROV TAXON	PAY AND REPORT
00148	PROC\REV CODE INVLD FOR POS	PAY AND REPORT
00149	PROC\REV CD INVLD FOR AGE	IGNORE
00150	PROC CODE INVLD FOR RECIP SEX	IGNORE
00151	PROC CD/RATE INVALID FOR DOS	PAY AND REPORT
00152	M/I ACC/ANC PROC CD	PAY AND REPORT
00153	PROC INVLD FOR DIAG	PAY AND REPORT
00154	REIMB RATE NOT ON FILE	PAY AND REPORT
00157	VIS FLD EXAM REQ MED JUST	IGNORE
00158	CPT LAB CODE REQ FOR REV CD	IGNORE
00164	IMMUNIZATION REVIEW	IGNORE
00166	INVALID VISUAL PROC CODE	IGNORE
00174	VACCINE FOR AGE 00-18	IGNORE
00175	CPT CODE REQUIRED FOR RC 0391	IGNORE
00176	MULT LINES SAME PROC, SAME TCN	IGNORE
00177	HCPCS CODE REQ W/ RC 0250	IGNORE
00179	MULT LINES SAME PROC, SAME TCN	IGNORE
00180	INVALID DIAGNOSIS FOR LAB CODE	IGNORE
00184	REV CODE NOT ALLOW OUTPAT CLM	IGNORE
00190	DIAGNOSIS NOT VALID	DENY
00192	DIAG INVALID RECIP AGE	IGNORE
00194	DIAG INVLD FOR RECIP SEX	IGNORE
00202	HEALTH CHECK SHADOW BILLING	IGNORE
00205	SPECIAL ANESTHESIA SERVICE	IGNORE
00217	ADMISSION TYPE CODE INVALID	PAY AND REPORT
00250	RECIP NOT ON ELIG DATABASE	DENY
00252	RECIPIENT NAME/NUMBER MISMATCH	PAY AND REPORT
00253	RECIP DECEASED BEFORE HDR TDOS	DENY
00254	PART ELIG FOR HEADER DOS	PAY AND REPORT
00259	TPL SUSPECT	PAY AND REPORT
00260	M/I RECIPIENT ID NUMBER	DENY
00261	RECIP DECEASED BEFORE TDOS	DENY
00262	RECIP NOT ELIG ON DOS	DENY
00263	PART ELIG FOR LINE DOS	PAY AND REPORT
00267	DOS PRIOR TO RECIP BIRTH	DENY
00295	ENC PRV NOT ENRL TAX	IGNORE

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

00800	PROC CODE/TAXON REQ PSYCH DX	PAY AND REPORT
00810	PRICING DTE INVALID	IGNORE
00811	PRICING CODE MOD REC M/I	IGNORE
00812	PRICING FACTOR CODE SEG M/I	IGNORE
00813	PRICING MOD PROC CODE DTE M/I	IGNORE
00814	SEC FACT CDE X & % SEG DTE M/I	IGNORE
00815	SEC FCT CDE Y PSTOP SEG DT M/I	IGNORE
01005	ANTHES PROC REQ ANTHES MODS	IGNORE
01060	ADMISSION HOUR INVALID	IGNORE
01061	ONLY ONE DOS PER CLAIM	IGNORE
01102	PRV TAXON CHCK - RAD PROF SRV	IGNORE
01200	INPAT CLM BILL ACCOM REV CDE	DENY
01201	MCE - ADMIT DTE = DISCH DTE	DENY
01202	M/I ADMIT AND DISCH HRS	DENY
01205	MCE: PAT STAT INVLD FOR TOB	DENY
01207	MCE - INVALID AGE	PAY AND REPORT
01208	MCE - INVALID SEX	PAY AND REPORT
01209	MCE - INVALID PATIENT STATUS	DENY
01705	PA REQD FOR CAPCH/DA/CO RECIP	PAY AND REPORT
01792	DME SUPPLIES INCLD IN PR DIEM	DENY
02101	INVALID MODIFIER COMB	IGNORE
02102	INVALID MODIFIERS	PAY AND REPORT
02104	TAXON NOT ALLOWED WITH MOD	PAY AND REPORT
02105	POST-OP DATES M/I WITH MOD 55	IGNORE
02106	LN W/ MOD 55 MST BE SAME DOS	IGNORE
02107	XOVER CLAIM FOR CAP PROVIDER	IGNORE
02111	MODIFIER CC INTERNAL USE ONLY	IGNORE
02143	CIRCUMCISION REQ MED RECS	IGNORE
03001	REV/HCPCS CD M/I COMBO	IGNORE
03010	M/I MOD FOR PROF XOVER	IGNORE
03012	HOME HLTH RECIP NOT ELG MCARE	IGNORE
03100	CARDIO CODE REQ LC LD LM RC RI	IGNORE
03101	MODIFIER Q7, Q8 OR Q9 REQ	IGNORE
03200	MCE - INVALID ICD-9 CM PROC	DENY
03201	MCE INVLD FOR SEX PRIN PROC	PAY AND REPORT
03224	MCE-PROC INCONSISTENT WITH LOS	PAY AND REPORT
03405	HIST CLM CANNOT BE ADJ/VOIDED	DENY

03406	HIST REC NOT FND FOR ADJ/VOID	DENY
03407	ADJ/VOID - PRV NOT ON HIST REC	DENY
04200	MCE - ADMITTING DIAG MISSING	DENY
04201	MCE - PRIN DIAG CODE MISSING	DENY
04202	MCE DIAG CD - ADMIT DIAG	DENY
04203	MCE DIAG CODE INVLD RECIP SEX	PAY AND REPORT
04206	MCE MANIFEST CODE AS PRIN DIAG	DENY
04207	MCE E-CODE AS PRIN DIAG	DENY
04208	MCE - UNACCEPTABLE PRIN DIAG	DENY
04209	MCE - PRIN DIAG REQ SEC DIAG	PAY AND REPORT
04210	MCE - DUPE OF PRIN DIAG	DENY
04506	PROC INVLD FOR DIAG	IGNORE
04507	PROC INVLD FOR DIAG	IGNORE
04508	PROC INVLD FOR DIAG	IGNORE
04509	PROC INVLD FOR DIAG	IGNORE
04510	PROC INVLD FOR DIAG	IGNORE
04511	PROC INVLD FOR DIAG	IGNORE
07001	TAXON FOR ATTND/REND PROV M/I	DENY
07011	INVLD BILLING PROV TAXON CODE	DENY
07012	INVLD REND PROV TAXONOMY CODE	DENY
07013	INVLD ATTEND PROV TAXON CODE	PAY AND REPORT
07100	ANESTH MUST BILL BY APPR PROV	IGNORE
07101	ASC MODIFIER REQUIREMENTS	IGNORE
13320	DUP-SAME PROV/AMT/DOS/PX	DENY
13420	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
13460	POSSIBLE DUP-SAME PROV/PX/DOS	PAY AND REPORT
13470	LESS SEV DUPLICATE OUTPATIENT	PAY AND REPORT
13480	POSSIBLE DUP SAME PROV/OVRLAP	PAY AND REPORT
13490	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13500	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13510	POSSIBLE DUP/SME PRV/OVRLP DOS	PAY AND REPORT
13580	DUPLICATE SAME PROV/AMT/DOS	PAY AND REPORT
13590	DUPLICATE-SAME PROV/AMT/DOS	PAY AND REPORT
25980	EXACT DUPE. SAME DOS/ADMT/NDC	PAY AND REPORT
34420	EXACT DUP SAME DOS/PX/MOD/AMT	PAY AND REPORT
34460	SEV DUP-SAME PX/PRV/IM/DOS/MOD	DENY
34490	DUP-PX/IM/DOS/MOD/$$/PRV/TCN	PAY AND REPORT
34550	SEV DUP-SAME PX/IM/MOD/DOS/TCN	PAY AND REPORT
39360	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT

39380	EXACT/LESS SEVERE DUPLICATE	PAY AND REPORT
49450	PROCDURE CODE UNIT LIMIT	PAY AND REPORT
53800	Dupe service or procedure	PAY AND REPORT
53810	Dupe service or procedure	PAY AND REPORT
53820	Dupe service or procedure	PAY AND REPORT
53830	Dupe service or procedure	PAY AND REPORT
53840	Limit of one unit per day	PAY AND REPORT
53850	Limit of one unit per day	PAY AND REPORT
53860	Limit of one unit per month	PAY AND REPORT
53870	Limit of one unit per day	PAY AND REPORT
53880	Limit of 24 units per day	DENY
53890	Limit of 96 units per day	DENY
53900	Limit of 96 units per day	DENY