CCME

2019 External Quality Review

ALLIANCE HEALTH

Submitted: April 17, 2020

Prepared on behalf of the
North Carolina Department of
Health and Human Services,
Division of Medical Assistance

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EXECUTIVE SUMMARY

The *Balanced Budget Act of 1997* requires State Medicaid Agencies that contract with Prepaid Inpatient Health Plans (PIHPs) to evaluate their compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358 (42 CFR § 438.358)*. This review determines the level of performance demonstrated by the Alliance Health (Alliance). This report contains a description of the process and the results of the 2019 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:

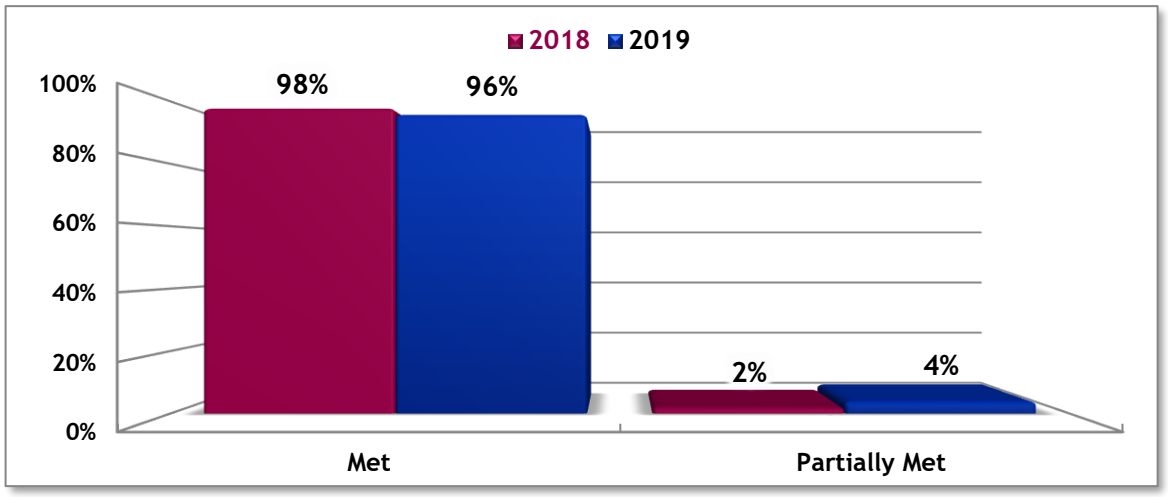
- Determine if Alliance complies with service delivery as mandated by the *NC Medicaid Contract*
- Provide feedback for potential areas of further improvement
- Verify the delivery and determine the quality of contracted health care services

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, a two-day Onsite visit, compliance review, validation of performance improvement projects (PIPs), validation of performance measures (PMs), validation of encounter data, an Information System Capabilities Assessment (ISCA) Audit, and Medicaid program integrity review of the PIHP.

A. Overall Findings

The 2019 Annual EQR reflects that Alliance achieved a “Met” score for 96% of the standards reviewed. As Figure 1 indicates, 4% of the standards were scored as “Partially Met”. The percentage of standards scored as “Not Met” was less than .5% and is not represented in Figure 1. Figure 1 also provides a comparison of Alliance’s 2018 review results to 2019 results.

Figure 1: 2019 Annual EQR Review Results



B. Overall Recommendations

Recommendations addressing each of the review findings are detailed under each respectively labeled section of this report. The following global recommendations were identified for improvement and should be implemented in conjunction with the detailed Recommendations in each section.

Administration

Alliance met 100% of the Administrative standards for this year's EQR. The Administration functions review examined Alliance's policies, procedures, staffing levels, information systems, and how the PIHP handles confidential health information.

In the EQR of Alliance's Administrative functions, all standards were scored a "Met". One Recommendation was issued to address the absence of specific *NC Medicaid Contract* references within Alliance procedures.

Regarding the Information Systems Capabilities Assessment (ISCA), Alliance implemented various processes to address encounter submission denials. Currently, Alliance's encounter data acceptance rate is approximately 99%. Alliance has significantly reduced the backlog of encounter data submissions and addressed the Recommendation from last year. Alliance can capture up to 25 ICD-10 Diagnosis codes for Institutional claims and up to twelve ICD-10 Diagnosis codes for Professional claims on the Provider Web Portal. Alliance can capture up to 29 ICD-10 Diagnosis codes for Institutional claims and up to 12 Diagnosis codes for Professional claims electronically. Alliance can capture the Diagnosis Related Group (DRG) and ICD-10 Procedure codes submitted on an Institutional claim electronically and through the provider web portal. Alliance has addressed the Corrective Action from last year's review and can now submit up to 29 ICD-10 Diagnosis codes on Institutional and up to 12 ICD-10 Diagnosis codes on Professional encounter data files to

NCTracks. Alliance submits DRG and ICD-10 Procedure codes on Institutional encounter data files.

Provider Services

The Provider Services External Quality Review (EQR) is comprised of Credentialing and Recredentialing, and Provider Services, which includes Network Adequacy, Provider Accessibility, Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, and Practitioner Medical Records. In the Credentialing/ Recredentialing section of Provider Services at the last EQR, there were no Corrective Actions and four Recommendations. Alliance addressed the four Recommendations.

At the last EQR, there were no Corrective Action items or Recommendations in the Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, or Practitioner Medical Record sections. There were no Corrective Actions and one Recommendation in the "Adequacy of the Provider Network" area at the last EQR. Alliance addressed the Recommendation.

Alliance met 100% of the Provider Services standards in the current EQR. There are Recommendations in one standard in the Credentialing/Recredentialing area and one standard in the Provider Education section. Details are provided in those sections of this report.

Enrollee Services

The Enrollee Services review focuses on member rights and responsibilities, member program education, behavioral health and chronic disease management education, and the Call Center. Last EQR Alliance had four Corrective Actions which were corrected and maintained over the past year. In the previous EQR, there were three Recommendations, two of which were implemented by Alliance. The third Recommendation was no longer applicable due to internal Alliance changes.

Alliance met 94% of the Enrollee Services standards in the current EQR. There was one standard scored as "Not Met". As a result, one Corrective Action was issued to address notifying enrollees, annually, of their right to request and obtain written materials produced for enrollee use. Four Recommendations were also given. Details are provided in Enrollee Services section of this report.

Quality Improvement

The Quality Improvement (QI) section covers the QI Program, QI Committees, provider participation in QI, the QI Annual Evaluation, performance measures, and Performance Improvement Projects (PIPs). There were no Corrective Actions or Recommendations from last EQR.

Alliance met 94% of the Quality Improvement standards in this EQR. One standard scored a "Partially Met". The standard is Alliance implements significant measures to address quality problems identified through the enrollees' satisfaction survey. CCME issued a Corrective Action and a Recommendation for that standard.

Utilization Management

In this year's EQR, Alliance met 91% of Utilization Management (UM) standards, and CCME has issued four Corrective Actions and two Recommendations. One Corrective Action and two Recommendations are regarding needed enhancements to UM and Care Coordination procedures.

The remaining two Corrective Actions target concerns within the in Mental Health/Substance Use Disorder (MH/SUD), Intellectual/Developmental Disability (I/DD), and Transition to Community Living Initiative (TCLI) Care Coordination files reviewed. For the last two EQRs, Alliance was not able to provide the full record for enrollees participating in MH/SU, I/DD and TCLI Care Coordination from their care management portal Jiva. CCME is requiring Alliance to develop a report that produces the full Care Coordination member record.

CCME also noted inconsistencies in the frequency of contacts, completeness, and quality of documentation within the MH/SU, I/DD and TCLI Care Coordination files. This was a concern highlighted in the previous year's EQR and a Recommendation to enhance the current, internal monitoring of these files was given to Alliance. This year, CCME is requiring Alliance develop, document, and implement a more robust monitoring process to identify and address issues within Care Coordination documentation in Jiva.

Grievances and Appeals

Alliance met 80% of the grievance and appeals standards for this year's EQR.

In this year's grievance EQR, one standard was scored "Partially Met" and one Recommendation was issued. The Corrective Action is aimed at enhancing Alliance's monitoring of the grievance files to ensure all notifications are sent timely. The Recommendation was that Alliance add to a procedure the process by which grievances with quality of care concerns are staffed by Alliance subject matter experts.

In this year's appeals EQR, two standards were scored "Partially Met". This was due to several errors within Alliance's appeals procedure, *Individual and Family Handbook*, the *Provider Operations Manual*, and the appeal files reviewed. Many of the areas addressed in this year's EQR were highlighted in the previous year's EQR, but Recommendations and Corrective Actions from the 2018 EQR were not implemented by Alliance.

Delegation

Alliance met 100% of the Delegation standards for this year's EQR. Alliance currently has an executed Delegation Agreement with three delegates, including Business Associate Agreements with those delegates that have access to Protected Health Information (PHI). Alliance conducted annual monitoring with all delegates. At the last EQR, there were no Corrective Actions and one Recommendation in the Delegation section. During the current EQR review period, Alliance addressed the Recommendation. There are no Corrective Actions or Recommendations for the current EQR.

Program Integrity

Alliance met 98% of the Program Integrity standards for this year's EQR. In the 2018 EQR, three Corrective Actions aimed at improving Alliance procedures were addressed by Alliance. In this year's EQR, Alliance case files were fully compliant and, overall, policies and procedures adequately describe Alliance Program Integrity processes.

One Corrective Action and one Recommendation are issued to further improve Alliance procedures regarding the timeframes for notifying NC Medicaid of changes to FAMS usership and submitting monthly reports to NC Medicaid. Another Recommendation was issued to encourage Alliance staff to maximize the use of the Investigation Report summary form, as several of the Program Integrity files showed the contact information for PIHP staff persons with practical knowledge was missing from this form.

Financial Services

This section includes a review of financial services, including financial statements, audit report, Medicaid monthly reports, and policies and procedures. Alliance had one procedure Recommendation from the prior EQR review regarding length of record retention (10 years) for Medicaid records. Alliance implemented this Recommendation and updated their finance procedure.

In this year's EQR, Alliance met 100% of the Financial Services standards. CCME recommended one procedure revision. This Recommendation involves adding the required due date of monthly Medicaid Financial Reports to NC Medicaid.

Encounter Data Validation

Based on the analysis of Alliance's encounter data, we have concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues still exist with their submission of Institutional encounters and need to be addressed in order to be compliant. Alliance should take Corrective Action to resolve the issues identified with Procedure code and Diagnosis codes, as well as continue to work on improving all up front denials.

METHODOLOGY

The process used for the EQR was based on the CMS protocols for EQR of 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 PIHP was conducted by CCME's subcontractor, IPRO.

On January 28, 2020, 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 19, 2020 and reviewed in the offices of 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, case management, 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 March 18, 2020 and March 19, 2020. 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 Alliance 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 DHHS' NC Medicaid. Strengths, weaknesses, Corrective Action items, and Recommendations are identified where applicable. Areas of review were identified as meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), Not Applicable, or Not Evaluated, and are recorded on the tabular spreadsheet (*Attachment 4*).

A. Administration

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

Policies & Procedures

CCME's EQR of Alliance's policies and procedures demonstrated Alliance has 85 policies and 221 procedures. There was evidence each policy and procedure was reviewed within the past year and that there is an active revision process. Compliance 360 houses the policies, procedures, and facilitates availability to staff.

In Alliance's 2018 EQR, CCME recommended Alliance add the specific *NC Medicaid Contract* references to their procedures. These references would help staff navigate procedures where accrediting bodies (such as URAC and NCQA) requirements differ from Alliance's *NC Medicaid Contract*. This is particularly true in areas such as appeals, Program Integrity, and Finance. Alliance's written response to this Recommendation stated, "Efforts are underway, and are expected to continue for some time, to revise current and draft new policies and procedures for the purpose of Tailored Plan and NCQA readiness. The Alliance contract with DHB will change in July 2021. With our Medicaid contract often being amended, there is a concern that adding specific contract section references would cause unnecessary confusion and the likelihood of incorrect references following comprehensive amendments."

It is understood that Alliance is preparing for NCQA accreditation and that the *NC Medicaid Contract* is often amended. However, Alliance has a revision process in place designed to address the need to revise procedures caused by changes in both internal and external requirements. This process is designed to be nimble and prevent confusion regarding what is required procedurally. CCME again recommends that Alliance add *NC Medicaid Contract* requirements within the narrative of their procedures.

Organizational Staffing/ Management

Alliance has a dedicated Executive Leadership Team and ample staff in place to make sure they can meet the needs of their members. In the last two EQRs, CCME recommended that Alliance delineate the departmental oversight by the medical staff on the *Organizational Chart*. Dr. Mehul Mankad joined Alliance during this past year and the details of his oversight were added to their *Organizational Chart*. During the Onsite discussion, it was explained that additional support is provided by the two Associate Medical Directors, Drs. Middendorf and Kaesemeyer.

Confidentiality

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

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

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

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

Information Systems Capabilities Assessment

As required by its contract with the Carolinas Center for Medical Excellence (CCME), IPRO conducted a review of Alliance's information system capabilities utilizing the Information Systems Capabilities Assessment (ISCA), as specified in the CMS protocol.

Upon receipt of the completed ISCA tool from Alliance and supporting documentation, IPRO reviewed the responses and followed up on areas requiring clarification via Onsite interviews. Additionally, staff presented a member and claims systems review and discussed with the PIHP during the Onsite ISCA session.

Alliance uses the AlphaMCS transactional, a hosted system environment produced by WellSky (formerly known as Mediware). The AlphaMCS system is used to process member enrollment, claims, submit encounters and generate reports. WellSky modifies the user interface and conducts backend programming updates to the system.

Enrollment Systems

Alliance experienced a small decrease in enrollment over the past two years, the year-end enrollment from 2016 to 2018 displayed in Table 1.

Table 1: Enrollment Counts

2016	2017	2018
220,771	223,347	220,968

The ISCA tool and supporting documentation for enrollment systems loading processes clearly define the process for enrollment data updates in the AlphaMCS enrollment system. During the ISCA teleconference review, Alliance provided a demonstration of the AlphaMCS enrollment system. The system maintains a member's enrollment history. The Global Eligibility File (GEF) file is imported daily into the AlphaMCS. The quarterly GEF file is imported quarterly when it is received. The daily and quarterly eligibility files are compared to existing eligibility in the AlphaMCS. The member enrollment records are processed and checked against the existing data in the database. Existing data in the eligibility database is updated and new records are added to the eligibility database.

During the teleconference, Alliance mentioned that the GEF files are validated prior to loading them to AlphaMCS. The GEF files are either loaded in full or not loaded at all. The GEF file load is aborted if any error is encountered. Alliance mentioned that they rarely encounter any errors while processing the GEF files.

Alliance identifies enrollees by the Medicaid identification number received on the GEF. An enrollee retains the same Medicaid ID in case where the enrollee is re-enrolled after a

disenrollment. If the enrollee is assigned a new Medicaid ID, then Alliance's system is able to track the prior Medicaid ID and assign link the historical enrollment records to the new Medicaid ID. Alliance has the capability to track historical claim and encounter data for an enrollee.

In the ISCA discussion, Alliance indicated they rarely see members with multiple IDs, but are able to research and merge the information into one member ID. The historical claims for the member are also merged into one member ID.

Alliance's providers have the capability to confirm a member's eligibility in the AlphaMCS Provider Portal. Member deaths are captured through the GEF file. Alliance is also notified of member deaths directly by providers.

On a monthly basis, Alliance utilizes the 820 Capitation file to record revenue, estimate future enrollment, update membership lag schedule and record receivables. Alliance also utilizes the 820 Capitation file to identify errors in payment such as over or under payments, and incorrect or duplicate Medicaid members.

During the teleconference, staff displayed the enrollment information that is viewable and captured within AlphaMCS. The AlphaMCS system is able to capture demographic data like race, ethnicity and language.

Claims Systems

Alliance's authorizations and claims are processed in the AlphaMCS system. The ISCA tool and supporting documentation for claims processes for receiving, adjudicating, and auditing claims are clearly defined. A demonstration of Alliance's Provider web claims entry portal and the AlphaMCS claims processing system was performed during the teleconference review. Alliance also provided an overview of the processes for receiving, adjudicating and auditing claims.

Alliance receives claims from three methods, 837 electronic file, provider web portal and paper claims. During the teleconference, Alliance mentioned that they accept claims on paper from providers in Hawaii and Emergency Room claims. Table 2 details the percentage of 2018 claims received via the three methods.

Table 2: Claim Method Percentages

Source	HIPAA File	Paper	Provider Web Portal
Institutional	68%	1%	31%
Professional	79%	0%	21%

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

Alliance processes claims within a week to 18 days of receipt of claims submitted on HIPAA files and through the Provider Web Portal. Claims submitted on paper are processed within 10 days of receipt. If a required field is missing from a claim, the provider portal will not allow the claim to be submitted to Alliance. If the claim is being submitted electronically via an electronic 837 file and one or more required fields are missing, the provider will receive a 999 response file advising the provider of the claim submission failure. Alliance's claims processors do not change any information on the claims.

Alliance adjudicates claims on a nightly basis. Approximately 98.02% of Professional claims and 90.53% of Institutional claims are auto-adjudicated. Approximately, 95-99% of all claims are processed and complete within three months of the close of the reporting period.

Alliance conducts audits of claims processed on a weekly basis. Alliance staffs conduct random audits of 2.5% of all claims processed during the previous week. Paper claims are also included in the random sample of 2.5%. Approximately 50% of Inpatient claims that are higher than $5,000 and at least 3% of the Emergency Department (ED) claims are audited on a weekly basis. Alliance staff and managers review 100% of claims examined by new hire claim examiners for approximately two-three weeks. Alliance reviews all denied claims and communicates the errors and resolution required with the providers.

For Institutional claims, Alliance captures up to 25 ICD-10 Diagnosis codes on the Provider Web Portal and up to 29 ICD-10 Diagnosis codes for Institutional claims on the HIPAA 837I file. For Professional claims, the PIHP has the ability to receive and store up to 12 ICD-10 Diagnosis codes on both the provider web portal and HIPAA 837P file. Alliance captures DRG and ICD-10 Procedure codes that are submitted on a claim through the HIPAA 837I file and provider web portal.

As discussed during the teleconference, Alliance has the capability to capture and submit Healthcare Common Procedure Coding System (HCPCS) codes along with required Revenue codes for specific claims regarding lab, drug, or radiology services.

Alliance pends claims that have a billed amount higher than $5,000, ED claims and Professional ED claims with a place of service (POS) for Emergency Room. Alliance also pends claim exceptions that occur when the adjudication process is unable to determine the Patient, Provider or Site ID. The pended claims are manually reviewed and completed on a daily basis.

Reporting

Alliance utilizes the AlphaMCS system, Structured Query Language (SQL) Server database, Alliance Enterprise Data Warehouse, and MicroStrategy reporting environment to generate Performance Measure reports. The SQL Server database is a near real-time replication of the AlphaMCS system. An Extract, Transform, and Load (ETL) process transforms the data in the SQL Server database into data models for the Alliance Enterprise Data Warehouse. Alliance's data reconciliation process verifies the completeness of data in the Enterprise Data Warehouse by comparing the counts to the AlphaMCS. During the teleconference, Alliance mentioned that the Alliance Enterprise Data Warehouse is refreshed by jobs that run multiple times during the day and also by jobs that run on a daily basis. Alliance has automated jobs in place to reconcile the data in the databases and data warehouse. The automated jobs compare the data in the AlphaMCS system to the data in the Enterprise Data Warehouse. The count of providers, provider sites, paid and billed claims and the total patients are compared during the reconciliation process to identify errors.

During the teleconference, Alliance indicated that all enrollment and claims history since 2012 is available in the AlphaMCS system and Enterprise Data Warehouse for reporting. Alliance mentioned that the enrollment and claims data in the Enterprise Data Warehouse are backed up on a nightly and weekly basis.

Alliance utilizes the AlphaMCS database and databases in the Alliance data center for performance measure reporting. Alliance also utilizes MicroStrategy and Microsoft SQL Server to extract data and create reports from the reporting database.

Internal claims reports were provided as supplemental documentation for the ISCA review. A sample claim exception report and the claims lag report indicates Alliance has oversight and monitoring of its claims processes.

Encounter Data Submissions

Alliance has a defined process in place for their encounter data submission, with 837 files submitted to NC Medicaid, and 835 files received back from NC Medicaid through the NCTracks system. Encounters that are approved by Alliance are submitted to NCTracks. Alliance has the ability to track claims from the adjudication process to their encounter submissions status. The 835 file from NCTracks is utilized to review denials. The extraction and submission of encounter data are fully automated. The reconciliation of encounter data is performed manually.

Table 3 provides a breakdown of encounter data acceptance/denial rates provided for the dates of service in 2018 and 2017 year comparison.

Table 3: Volume of Submitted Encounter Data with dates of service in 2017 and 2018

2018	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	80,052	2,398	1,307	83,757
Professional	1,924,817	5,055	1,698	1,931,570
2017	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	71,530	982	514	73,026
Professional	1,666,380	61,497	3,953	1,731,830

Alliance has over 99% acceptance rate for both Professional and Institutional encounters with dates of service in 2018. The encounter data acceptance rate is consistent with last year's audit findings that indicated an acceptance rate of approximately 99%. Alliance indicated that the three top denial reason codes were:

1. Duplicate Claim
2. Timely filing
3. Patient not enrolled

On average, Alliance submits an encounter within four days from the time of adjudication to NCTracks. It takes approximately 17 days to correct and resubmit an encounter to NCTracks. Alliance uses paid and denied reports and a Accounts Receivable (AR) reconciliation system to monitor and track encounters that were submitted to NCTracks. The 835 response file is uploaded into the AR reconciliation system that Alliance's staff access to identify and resolve denials.

Alliance has addressed the Recommendation from last year EQR review and submitted backlog encounters with dates of service in 2017. Alliance exceeds the NC Medicaid standards for encounter data submission.

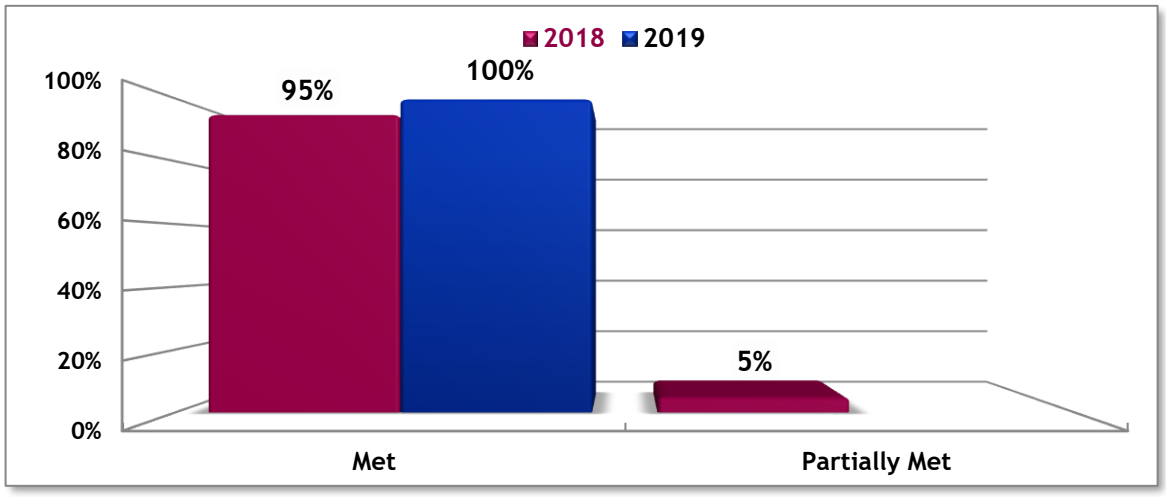
During the teleconference, Alliance advised the number of ICD-10 Diagnosis codes submitted on Institutional and Professional encounters to NC Medicaid. Alliance has updated their system in December 2018 to submit up to 29 ICD-10 Diagnosis codes for Institutional and up to 12 ICD-10 Diagnosis codes for Professional encounters. Though Alliance has the capability to submit up to 29 ICD-10 Diagnosis codes for Institutional

encounters, HMS noted that Institutional encounters submitted to NCTracks only include up to two Diagnosis codes.

Alliance submits the DRG codes submitted by the provider on a claim and the ICD-10 Procedure codes to NCTracks. During the teleconference, Alliance mentioned that they can submit lab, drug, or radiologic services that have Revenue codes along with the HCPCS Procedure code on the encounter data extracts.

The 2019 review shows 100% of the Administrative standards were scored as "Met". Figure 2 provides a comparison of the 2018 scores versus the 2019 scores.

Figure 2: Administration Comparative Findings



Strengths

- Alliance trains new staff on confidentiality on their first day of employment.
- Alliance auto-adjudicates claims; 90.53% of Institutional claims and 98.02% of Professional claims.
- Alliance's current NCTracks encounter data acceptance rate is approximately 99%. The PIHP has made significant improvements in the acceptance rate of encounter data submissions and reduce backlog in encounter data submissions.

Weaknesses

- There are several opportunities within Alliance's procedures to cite specific *NC Medicaid Contract* requirements.

Recommendations

- Add specific references to *NC Medicaid Contract* requirements within Alliance's procedures.

B. Provider Services

The Provider Services External Quality Review (EQR) is composed of Credentialing and Recredentialing, and Network Adequacy, including Provider Accessibility, Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, and Practitioner Medical Records. CCME reviewed relevant policies and procedures, the *Provider Operations Manual*, the *Individual and Family Handbook*, clinical practice guidelines, credentialing and recredentialing files, provider network information, the 2019 *Network Adequacy and Accessibility Analysis* (Gaps Analysis), and the Alliance website. CCME also conducted an Onsite interview with relevant staff.

In the Credentialing/Recredentialing section of Provider Services at the last EQR, there were no items requiring Corrective Action. There were four Recommendations, two of which were the same item in both credentialing and recredentialing. Alliance addressed all four Recommendations.

At the last EQR, there were no Corrective Actions or Recommendations in the Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, or Practitioner Medical Record sections. There were no Corrective Actions and one Recommendation in the "Adequacy of the Provider Network" area at the last EQR. Alliance addressed the Recommendation.

Alliance submitted Procedure 6011, Primary Source Verification, and Procedure 6030, Credentialing Criteria and Enrollment Process for Network Participation, as the *Credentialing Program Description*. Procedure 6030 outlines "criteria for credentialing, re-credentialing and enrollment in the Alliance Closed Network." The procedure provides information about the Credentialing Committee, including defining a quorum ("Quorum is reached when 33% of voting members are present plus the Chairperson"), as well as indicating "The Provider Network Credentialing Committee is chaired by the Chief Medical Officer or an Associate Medical Director in his absence."

Either Dr. Heidi Middendorf, Associate Medical Director (AMD) or Dr. Nadiya Kaesemeyer, AMD, approved "clean" credentialing applications and chaired the Credentialing Committee meetings during this EQR review period. Procedure 6030 states, "The Provider Network Credentialing Committee may meet on a bi-weekly basis or at least monthly to review credentialing files, review any identified quality of care concerns related to an applicant and take actions," and indicates the Credentialing Committee Chair is a "non-voting member except in the event of a tied vote."

A review of the Credentialing Committee Minutes confirmed the committee met at least bimonthly, with 31 Credentialing Committee meetings from February 12, 2019, through January 28, 2020. A quorum was present at all 31 of the meetings.

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

Page 56 of the Gaps Analysis dated September 2018 states, "The Alliance service network meets geographic access and choice expectations for Outpatient, Community/Mobile, Crisis, Inpatient and C-Waiver service categories." The only identified Medicaid-funded location-based services that did not meet geographic access and choice expectations are Child and Adolescent Day Treatment choice in Cumberland County and Opioid Treatment services in Cumberland County and part of Johnston County. Alliance submitted Exception Requests for these services.

The *Network Adequacy and Accessibility Analysis* "serves as the basis for the FY20 Network Access Plan, the final section of the community needs assessment that details specific priorities for addressing identified community needs and gaps." This plan includes "Accomplishments and Updates" on "needs and gaps that were identified as priorities for the FY19 Network Development Plan" and identifies "Priority Areas for FY20."

To address the gap in choice for Medicaid-funded Child and Adolescent Day Treatment in Cumberland County, the report states, "we continue to work with Cumberland schools, stakeholders and providers to evaluate and respond to identified needs for this service." The Gaps Analysis states, "Medicaid-funded choice of Opioid Treatment Program (OTP) providers is limited in Cumberland County and parts of Johnston County. Members have access to Office-Based Opioid Treatment (OBOT) in each county. We will request a waiver of provider choice while we reach out to an existing opioid treatment provider to pursue service expansion in Cumberland county."

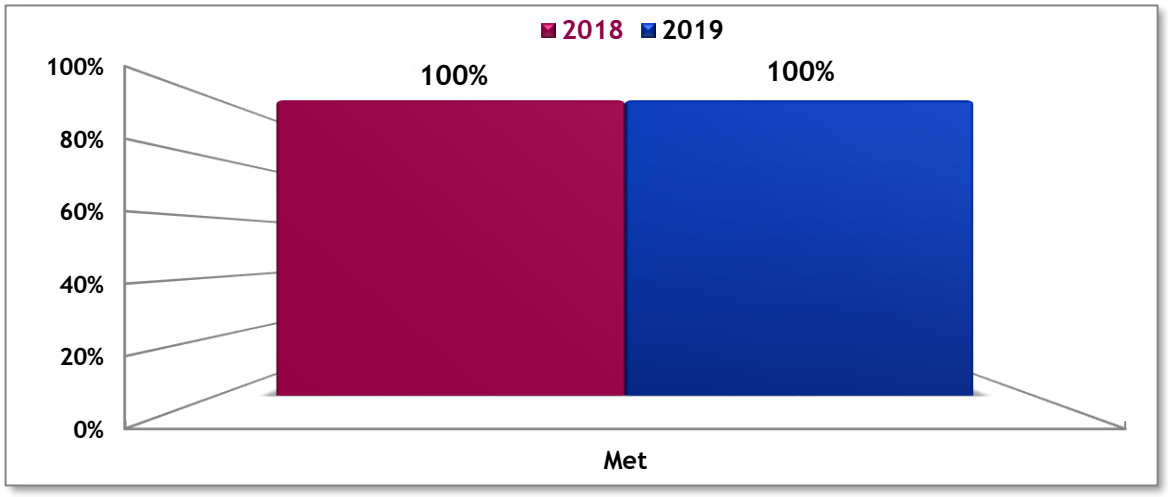
Procedure 6034, Provider Orientation and Education, outlines "orientation and education expectations for providers joining and participating in the Alliance Provider Network." The procedure states, "New Providers receive a Welcome Letter once fully approved to join the Alliance Network. The Welcome Letter includes the name of the Provider's assigned Network Specialist, approved Services and Sites, and a link to the Alliance website that outlines additional key publications and contacts for each functional area." Several links within the procedure are incorrect. Nothing named "Welcome Letter" was submitted with Desk Materials. In the "New Provider Information" Desk Materials, Alliance submitted information including credentialing and recredentialing letters, all of which include some broken links/inaccurate URLs.

Alliance offers Recovery University, an "online training gateway that allows users to register for all Alliance trainings (online and in-person), complete evaluations, view

courses attended and print certificates, plus gain access to a number of additional courses." The program includes a *Recovery Series*, with courses that the website states are "recovery and self-determination orientated" and "encourage self-directed care in a way that impacts the overall health of our communities." However, the Recovery University link is broken in the letters submitted in Folder 27 in Desk Materials.

Figure 3, Provider Services Findings, shows that 100% of the standards in the Provider Services section were scored as "Met" and provides an overview of 2019 scores compared to 2018 scores.

Figure 3: Provider Services Comparative Findings



Strengths

- Credentialing/recredentialing files were well organized and contained appropriate documentation.
- The *Provider Operations Manual* is detailed and provides enough information to help providers navigate the PIHP.
- Recovery University trainings are available via an online portal. Alliance provides additional "in person" trainings as warranted. These training events are posted on the *Events Calendar* and in the *Upcoming Trainings and Events* section of the *For Providers* section of the Alliance website.

Weaknesses

- Procedure 6030, Credentialing Criteria and Enrollment Process for Network Participation, does not accurately reflect membership and the Chair.
- Broken links/incorrect URLs are present in template letters sent to providers upon credentialing and recredentialing approval and in Procedure 6034, Provider Orientation and Education.

Recommendations

- Revise Procedure 6030, the Credentialing Committee meeting minutes template, and any other documents that list Credentialing Committee membership, to accurately reflect membership and Chair. For example, as the Credentialing Manager position no longer exists, delete that position from the documents or revise the position title to reflect the current title. If the Director of Network Operations is not going to attend the meetings, delete that position from the documents. If an AMD is always the Committee Chair, revise the documents to reflect that.
- Correct broken/inaccurate URLs/links in Procedure 6034, Provider Orientation and Education, in the letters to providers, and in other documents in which they may appear. Develop an internal process for ensuring the appropriate department(s) are notified whenever items are moved on, or removed from, the website, so the corresponding link(s)/URL(s) in documents can be revised/changed to the appropriate location.

C. Enrollee Services

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

CCME reviewed Alliances' Member Services, including relevant policies and procedures, the *Individual and Family Handbook*, the *Provider Directory*, Call Center training and orientation materials, new member correspondence and documentation, member and community education offerings, and the PIHP's website. In the previous EQR, Alliance received four Corrective Actions which were addressed and maintained by Alliance. Also offered in the previous EQR were three Recommendations. Only two Recommendations were implemented as the third Recommendation was no longer applicable due to internal changes at Alliance.

Within 14 days of the initial request for services, Alliance provided new members with a *Welcome Letter*. The letter directs members to the Alliance website for written materials including the *Individual and Family Handbook*. Also provided in the mailing with the letter is the *Notice of Privacy Practices (NPP)*, *Enrollee Rights and Responsibilities*, and information about the Alliance Crisis and Assessment Centers. For members without internet access, the Access and Information telephone number is provided in the *Welcome Letter* so they may call to ask questions or request copies of any documentation. The *Welcome Letter* is available in Spanish, as well.

In the previous EQR, it was noted Alliance sent an annual mailing to notify enrollees of their right to request and obtain written materials produced for Enrollee use. The annual notice has been historically sent each year between December and January. However,

Alliance did not send this annual mailing during this EQR period (February 1, 2019- January 31, 2020). During the Onsite interview on March 19, 2020, A NC Medicaid legal representative and an Alliance legal representative sent email correspondences that resulted in a resolution for mailing this notification. The resolution allows Alliance to provide the notification via Alliance's website. *NC Medicaid Contract, Section 6.9.5*, states, "At least once each year, PIHP shall notify all Enrollees of their right to request and obtain a copy of written materials produced for Enrollee use." This resolution was not agreed upon until after the review period and as of March 19, 2020, this member right was not posted on the Alliance website.

Alliance attested that there were no "with cause" provider contract terminations during the review period of February 1, 2019- January 31, 2020. There were four Voluntary contract withdrawals and twenty contract non-renewals. All files submitted for review contain documentation verifying that members were notified within 15 calendar day after the provider notified Alliance of the contract withdrawal. There was a Recommendation at the last EQR to Include the date of the provider's termination from the network in the member communication letters. In this year's EQR, that date was included in all member letters.

Alliance is co-sponsoring member trainings with the National Alliance on Mental Illness (NAMI). In Durham, there is a monthly education meeting with NAMI at the local library and the library promotes materials through their website and provides the meeting space and snacks.

Individual and Family Handbook states, "Alliance provides educational opportunities to our members, families and other community members with helpful information about diagnoses, treatment options and maximizing treatment benefits. More information can be found on our website at AllianceHealthPlan.org or by calling (800) 510-9132." There is very little information on the website about diagnosis, treatment options, and maximizing treatment benefits. CCME Recommends Alliance display easy to find information on the website about diagnoses, treatment options, and maximizing treatment benefits within the "Individuals and Families" section.

Alliance's website has a link for trainings, but the link is hard to find and produced an error message when accessed during the Onsite. The Events Calendar Category filter choices are: Alliance Staff Only, Board of Directors and Board Committees, Meeting and Events, and Trainings. None of the selections indicate they are member trainings. Some of the items in the training category descriptions indicate members can attend. CCME recommends Alliance make member trainings easier to locate on the Events Calendar by indicating which trainings are specifically for members.

Access and Information Center staff ask safety questions at the beginning of each call. Then, they use clinical decision guides to determine if the member needs emergent, urgent, or routine care. If emergent, and its decided that 911 is needed, the clinician will typically manage the process with the support of another clinician. One clinician remains on the phone, and the other calls 911. If less urgent, the member is referred to a crisis center. Alliance will call ahead to the crisis center to make sure they know the member is coming. Alliance contracts with Vaya to answer calls which have been in the phone system for more than 30 seconds. Vaya has 226 calls from Alliance in the queue and answered 195.

Alliance met 94% of the Enrollee EQR standards and did not meet 6% of the standards. Figure 4 shows a comparison of the percentage scores for 2018 and 2019.

Figure 4: Enrollee Services Comparative Findings

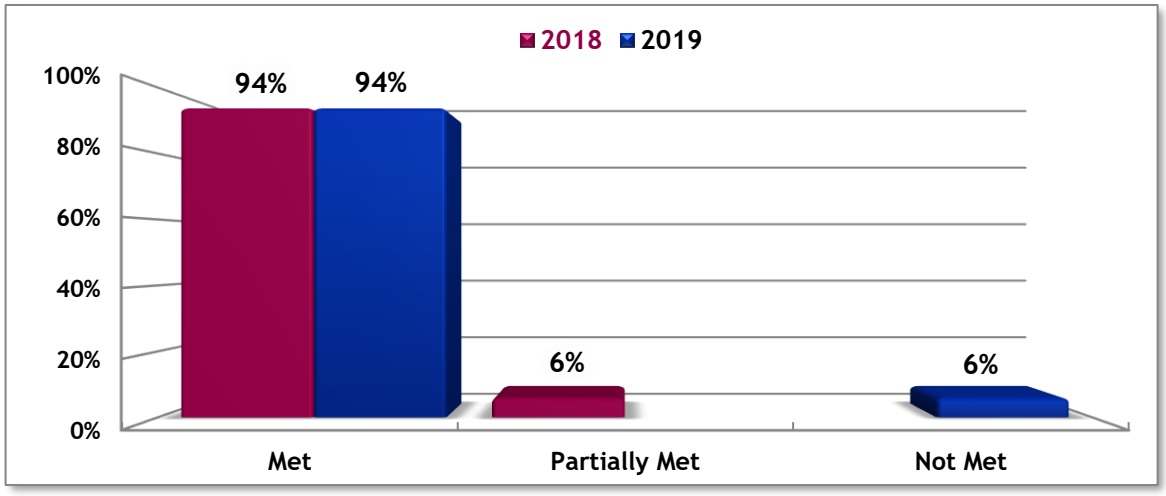


Table 4: Enrollee Services

Section	Standard	2019 Review
Enrollee PIHP Program Education	Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.	Not Met

Strengths

- Alliance is contracting with HealthCrowd, a communications solution for their members. This solution allows for text messaging and email voice response. Alliance has received positive feedback from members who have used it.

- Alliance is working with LogistiCare to provide transportation services to members. The first four appointments include transportation to get members engaged. If members continue to need transportation, Alliance works with that member's needs.

Weaknesses

- The Rights and Responsibilities for members is difficult to find on the Alliance website.
- Alliance did not send the annual mailing to enrollees that notify them of their right to request and obtain written materials produced for Enrollee use, as required *by NC Medicaid Contract, Section 6.9.5*.
- There is very little information on Alliance's website about member's diagnosis, treatment options, and maximizing treatment benefits.
- Alliance's website has a link called Alliance Trainings, but the link to the Events Calendar didn't load during the Onsite discussion and is difficult to find.
- On Alliance's website, none of the Events Calendar Category filter choices indicate which trainings are for members.

Corrective Action

- Revise Procedure 3500, Individual Rights and Responsibilities, to reflect the current process Alliance implements to meet the *NC Medicaid Contract, Section 6.9.5* that requires "At least once each year, PIHP shall notify all Enrollees of their right to request and obtain a copy of written materials produced for Enrollee use." Also, maintain proof of the enrollee notification.

Recommendations

- From the Alliance website home page, provide a direct link to the Individual Rights and Responsibilities.
- On Alliance's website, enhance the educational information about member's diagnoses, treatment options, and maximizing treatment benefits within the "Individuals and Families" section. Ensure this information is easy to access.
- Place the member Events Calendar in a location where members can easily find it.
- Make member trainings easier to locate on the Events Calendar by indicating which trainings are specifically for members.

D. Quality Improvement

The Quality Improvement (QI) EQR covers the QI Program, QI Committees, provider participation in QI, the QI Annual Evaluation, performance measures, and Performance Improvement Projects (PIPs). There were no Corrective Actions or Recommendations from Alliance's last EQR.

Alliance's *FY 2020 Quality Management Program Description* explains the formal Quality Improvement (QI) Program with clearly defined goals, structure, scope, and methodology.

Procedure 7506, Clinical Guidelines, documents the development, approval, dissemination, application (section for provider adherence), and review of clinical guidelines. Alliance documents the monitoring of chosen Clinical Practice Guidelines in a detailed and complete, five-page document, titled *FY20 Adherence to Clinical Practice Guidelines*. This document explains the methodology and projected results of monitoring adherence to the clinical guidelines for antipsychotic medication, schizophrenia, and substance use disorders.

Alliance analyzed the 2018 Adult and Child Experience of Care and Health Outcomes (ECHO®) Survey 3.0 results. This analysis was documented in the *Alliance Health 2019 Network Adequacy & Accessibility Analysis*, the *FY 2019 Quality Management Program Evaluation*, and in the PowerPoint presentation titled *Combined Surveys Final*. Each of these documents has a similar section titled either, "FY 2020 Strategy" or "Takeaways." These sections list a summary of findings, but there is no documentation of interventions implemented by Alliance to improve any of the identified findings. The April 2019 Continuous Quality Improvement (CQI) committee meeting minutes indicate that updates on interventions will be given to CQI quarterly. However, there was no follow-up documented in CQI minutes for these identified areas of the 2018 enrollee surveys throughout the 2019 calendar year. Corrective Action is required of Alliance to submit a plan that will be used routinely and annually. This plan should outline how Alliance will implement measures, if decided on by the appropriate committee, to address quality problems identified through the adult and child ECHO® surveys. This plan should include how Alliance will know when implemented measures have an effect on the ECHO® survey outcomes year-to-year.

The 2019 ECHO® Surveys have been analyzed and shared with CQI in the January 22, 2020 CQI Committee meeting. The PowerPoint presentation titled, *2019 Provider Satisfaction and ECHO Survey Summaries* was uploaded during the Onsite to provide additional information. Slides 9 and 13 document areas of focus for the Adult and Child ECHO® Surveys. In the next EQR, CCME will review to ensure these areas of focus have been discussed within the appropriate QM Committee or Sub-committee, and if committee recommendations and/or input is followed. Currently there is no Alliance document that tracks lower scoring enrollee survey items year-to-year, barriers and interventions for

those items, and an analysis explaining if interventions implemented were successful based on the next year's survey results. CCME recommends Alliance create a document that tracks lower scoring enrollee survey items year-to-year, barriers and interventions for those items, and an analysis explaining if interventions implemented were successful based on the next year's survey results.

The Global Quality Management Committee (GQMC) is comprised of five Board members, two Consumer and Family Advisory Committee members, and two providers. The CQI Committee is comprised of 11 members from Alliance. The CQI subcommittees are: Provider Quality, Utilization Management, Member Experience, Care Management, Social Drivers of Health (meetings started December 2019), and Delegation and Accreditation (started February 2020). All subcommittee membership is 100% Alliance staff except the Provider Quality Subcommittee. CQI, GQMC, and the CQI subcommittees meet at regular intervals and all committee meeting activities are adequately captured through minutes. The Provider Quality subcommittee of CQI meets monthly and minutes show this provider group actively participated in QI activities.

The *FY 2019 Quality Management Program Evaluation* documents a summary and assessment of the QI program effectiveness. This Program Evaluation was approved by the Alliance GQMC on September 5, 2019.

Performance Measure Validation

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

Table 5: (b) Waiver Measures

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

Table 6: (c) Waiver Measures

(c) WAIVER MEASURES	
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals. IW D1 ISP	Percentage of level 2 and 3 incidents reported within required timeframes. IW G2
Proportion of Individual Support Plans that address identified health and safety risk factors. IW D2 ISP	Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required. IW G3
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need. IW D3 ISP	Percentage of medication errors resulting in medical treatment. IW G4
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Percentage of beneficiaries who received appropriate medication. IW G5
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8

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

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

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

(b) Waiver Measures Reported Results

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

Inpatient 7-day follow-up after hospitalization for mental illness improved by over 10%. The 3 and 7-day rates for follow up after detox and facility based crisis (FBC) hospitalizations also improved more than 10%. There were no measures that had a substantial decrease.

The current rate in comparison to last year's rate is presented in the Tables 7 through Table 16.

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

30-day Readmission Rates for Mental Health	FY 2018	FY 2019	Change
Inpatient (Community Hospital Only)	10.1%	12.1%	2.0%
Inpatient (State Hospital Only)	3.5%	4.4%	0.9%
Inpatient (Community and State Hospital Combined)	9.9%	12.0%	2.1%
Facility Based Crisis	5.9%	6.4%	0.5%
Psychiatric Residential Treatment Facility (PRTF)	17.8%	11.3%	-6.5%
Combined (includes cross-overs between services)	13.7%	11.3%	-2.4%

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

30-day Readmission Rates for Substance Abuse	FY 2018	FY 2019	Change
Inpatient (Community Hospital Only)	13.5%	17.6%	4.1%
Inpatient (State Hospital Only)	0.0%	4.5%	4.5%
Inpatient (Community and State Hospital Combined)	13.0%	16.5%	3.5%
Detox/Facility Based Crisis	9.6%	11.3%	1.7%
Combined (includes cross-overs between services)	13.2%	13.0%	-0.2%

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

Follow-up after Hospitalization for Mental Illness	FY 2018	FY 2019	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	45.5%	45.3%	-0.2%
Percent Received Outpatient Visit Within 30 Days	64.7%	63.0%	-1.7%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	54.1%	64.6%	10.5%
Percent Received Outpatient Visit Within 30 Days	65.3%	74.0%	8.7%
PRTF			
Percent Received Outpatient Visit Within 7 Days	37.3%	32.7%	-4.6%
Percent Received Outpatient Visit Within 30 Days	53.0%	51.5%	-1.5%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	45.9%	46.1%	0.2%
Percent Received Outpatient Visit Within 30 Days	64.3%	63.3%	-1.0%

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

Follow-up after Hospitalization for Substance Abuse	FY2018	FY 2019	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	21.3%	24.2%	2.9%
Percent Received Outpatient Visit Within 30 Days	35.3%	40.6%	5.3%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	54.1%	66.0%	11.9%
Percent Received Outpatient Visit Within 7 Days	57.9%	68.6%	10.7%
Percent Received Outpatient Visit Within 30 Days	64.8%	74.3%	9.5%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	48.0%	50.4%	2.4%
Percent Received Outpatient Visit Within 30 Days	56.8%	60.5%	3.7%

**NR = Denominator is equal to zero.*

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2018	FY 2019	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	39.9%	37.7%	-2.2%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	23.9%	22.2%	-1.7%
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	38.7%	36.2%	-2.5%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	18.5%	17.8%	-0.7%
Ages 21–34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	50.6%	48.1%	-2.5%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	39.2%	36.9%	-2.3%
Ages 35–64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	45.8%	45.4%	-0.4%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	34.6%	36.1%	1.5%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	44.4%	44.3%	-0.1%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	29.2%	27.8%	-1.4%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	46.4%	45.2%	-1.2%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	34.2%	34.1%	-0.1%

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

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY 2018	FY 2019	Change	FY 2018	FY 2019	Change
3–12	Male	0.3	0.3	0.0	29.5	24.3	0.2
	Female	0.2	0.3	0.1	23.0	26.5	-5.2
	Total	0.3	0.3	0.0	26.8	25.3	3.5
13–17	Male	1.3	1.3	0.0	48.3	52.5	-1.5
	Female	2.2	2.0	-0.2	33.0	31.1	4.2
	Total	1.7	1.6	-0.1	38.8	39.7	-1.9
18–20	Male	1.7	1.7	0.0	19.3	12.9	0.9
	Female	1.5	1.6	0.1	12.4	13.3	-6.4
	Total	1.6	1.6	0.0	15.9	13.1	0.9
21–34	Male	5.1	5.9	0.8	11.5	10.9	-2.8
	Female	1.2	1.6	0.4	8.6	9.7	-0.6
	Total	2.1	2.6	0.5	10.2	10.4	1.1
35–64	Male	3.2	4.7	1.5	10.8	10.6	0.2
	Female	1.9	2.2	0.3	9.3	9.0	-0.2
	Total	2.3	3.1	0.8	10.0	9.9	-0.3
65+	Male	0.5	0.5	0.0	26.3	33.9	-0.1
	Female	0.4	0.5	0.1	21.7	25.2	7.6
	Total	0.4	0.5	0.1	23.4	28.3	3.5
Unknown	Male	0.0	0.0	0.0	0.0	0.0	4.9
	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	1.4	1.6	0.2	20.9	19.0	0.0
	Female	1.1	1.2	0.1	17.5	16.6	-1.9
	Total	1.2	1.4	0.2	19.2	17.8	-0.9

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

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2018	FY 2019	Change	FY 2018	FY 2019	Change	FY 2018	FY 2019	Change	FY 2018	FY 2019	Change
3-12	Male	13.58%	13.63%	0.05%	0.26%	0.05%	-0.21%	0.51%	0.27%	-0.24%	13.50%	13.60%	0.10%
	Female	9.47%	9.81%	0.34%	0.18%	0.02%	-0.16%	0.23%	0.09%	-0.14%	9.42%	9.80%	0.38%
	Total	11.56%	11.76%	0.20%	0.22%	0.04%	-0.18%	0.37%	0.18%	-0.19%	11.50%	11.74%	0.24%
13-17	Male	16.69%	15.89%	-0.80%	1.30%	0.25%	-1.05%	0.48%	0.29%	-0.19%	16.52%	15.81%	-0.71%
	Female	18.39%	18.64%	0.25%	1.95%	0.24%	-1.71%	0.43%	0.14%	-0.29%	18.12%	18.61%	0.49%
	Total	17.53%	17.25%	-0.28%	1.62%	0.24%	-1.38%	0.46%	0.21%	-0.25%	17.31%	17.19%	-0.12%
18-20	Male	10.38%	10.33%	-0.05%	1.30%	0.13%	-1.17%	0.24%	0.01%	-0.23%	10.15%	10.30%	0.15%
	Female	12.72%	13.05%	0.33%	1.22%	0.20%	-1.02%	0.10%	0.01%	-0.09%	12.44%	13.02%	0.58%
	Total	11.60%	11.74%	0.14%	1.26%	0.17%	-1.09%	0.17%	0.01%	-0.16%	11.35%	11.71%	0.36%
21-34	Male	24.54%	24.93%	0.39%	3.28%	0.81%	-2.47%	0.38%	0.01%	-0.37%	24.29%	24.93%	0.64%
	Female	18.81%	20.16%	1.35%	1.09%	0.22%	-0.87%	0.20%	0.00%	-0.20%	18.67%	20.16%	1.49%
	Total	20.12%	21.29%	1.17%	1.59%	0.36%	-1.23%	0.24%	0.00%	-0.24%	19.95%	21.29%	1.34%
35-64	Male	25.04%	25.51%	0.47%	2.36%	0.71%	-1.65%	0.73%	0.01%	-0.72%	24.69%	25.51%	0.82%
	Female	26.58%	27.66%	1.08%	1.45%	0.34%	-1.11%	0.89%	0.00%	-0.89%	26.35%	27.66%	1.31%
	Total	26.02%	26.87%	0.85%	1.78%	0.48%	-1.30%	0.83%	0.01%	-0.82%	25.75%	26.87%	1.12%
65+	Male	6.03%	6.59%	0.56%	0.30%	0.11%	-0.19%	0.28%	0.00%	-0.28%	5.87%	6.59%	0.72%
	Female	6.01%	6.63%	0.62%	0.23%	0.05%	-0.18%	0.23%	0.00%	-0.23%	5.88%	6.63%	0.75%

	Total	6.02%	6.62%	0.60%	0.25%	0.07%	-0.18%	0.24%	0.00%	-0.24%	5.88%	6.62%	0.74%
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**	**15.95%**	**15.90%**	**-0.05%**	**1.06%**	**0.25%**	**-0.81%**	**0.50%**	**0.18%**	**-0.32%**	**15.78%**	**15.87%**	**0.09%**
	Female	**15.57%**	**16.21%**	**0.64%**	**0.91%**	**0.16%**	**-0.75%**	**0.37%**	**0.05%**	**-0.32%**	**15.42%**	**16.20%**	**0.78%**
	Total	**15.73%**	**16.07%**	**0.34%**	**0.97%**	**0.20%**	**-0.77%**	**0.42%**	**0.11%**	**-0.31%**	**15.58%**	**16.06%**	**0.48%**

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

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2018	FY 2019	Change	FY 2018	FY 2019	Change	FY 2018	FY 2019	Change	FY 2018	FY 2019	Change
3–12	**Male**	0.03%	0.01%	-0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%	0.01%	-0.02%
	Female	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
	Total	0.02%	0.01%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.01%	-0.01%
13–17	**Male**	0.86%	0.79%	-0.07%	0.04%	0.01%	-0.03%	0.14%	0.10%	-0.04%	0.78%	0.72%	-0.06%
	Female	0.55%	0.50%	-0.05%	0.05%	0.01%	-0.04%	0.05%	0.02%	-0.03%	0.48%	0.48%	0.00%
	Total	0.70%	0.65%	-0.05%	0.05%	0.01%	-0.04%	0.09%	0.06%	-0.03%	0.63%	0.60%	-0.03%
18–20	**Male**	1.44%	1.17%	-0.27%	0.10%	0.01%	-0.09%	0.13%	0.06%	-0.07%	1.35%	1.12%	-0.23%
	Female	1.11%	1.05%	-0.06%	0.16%	0.03%	-0.13%	0.06%	0.05%	-0.01%	1.05%	1.04%	-0.01%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2018	FY 2019	Change	FY 2018	FY 2019	Change	FY 2018	FY 2019	Change	FY 2018	FY 2019	Change
	Total	1.26%	1.11%	-0.15%	0.13%	0.02%	-0.11%	0.09%	0.05%	-0.04%	1.19%	1.08%	-0.11%
21–34	Male	5.33%	5.23%	-0.10%	0.75%	0.36%	-0.39%	0.28%	0.54%	0.26%	5.10%	5.13%	0.03%
	Female	5.01%	5.17%	0.16%	0.50%	0.22%	-0.28%	0.59%	0.61%	0.02%	4.81%	5.08%	0.27%
	Total	5.09%	5.18%	0.09%	0.56%	0.25%	-0.31%	0.52%	0.59%	0.07%	4.87%	5.09%	0.22%
35–64	Male	7.95%	8.21%	0.26%	1.74%	0.73%	-1.01%	1.36%	1.25%	-0.11%	7.25%	7.92%	0.67%
	Female	5.12%	5.47%	0.35%	0.56%	0.30%	-0.26%	0.75%	0.83%	0.08%	4.80%	5.21%	0.41%
	Total	6.15%	6.47%	0.32%	0.99%	0.46%	-0.53%	0.97%	0.99%	0.02%	5.69%	6.20%	0.51%
65+	Male	1.08%	1.23%	0.15%	0.28%	0.20%	-0.08%	0.22%	0.19%	-0.03%	0.86%	1.18%	0.32%
	Female	0.20%	0.34%	0.14%	0.02%	0.04%	0.02%	0.03%	0.09%	0.06%	0.17%	0.29%	0.12%
	Total	0.48%	0.63%	0.15%	0.10%	0.09%	-0.01%	0.09%	0.13%	0.04%	0.39%	0.58%	0.19%
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	1.86%	1.86%	0.00%	0.33%	0.14%	-0.19%	0.27%	0.25%	-0.02%	1.71%	1.79%	0.08%
	Female	2.03%	2.10%	0.07%	0.21%	0.10%	-0.11%	0.26%	0.28%	0.02%	1.92%	2.03%	0.11%
	Total	1.96%	2.00%	0.04%	0.27%	0.12%	-0.15%	0.26%	0.27%	0.01%	1.83%	1.92%	0.09%

Table 15: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2018	FY 2019	Change	FY 2018	FY 2019	Change	FY 2018	FY 2019	Change	FY 2018	FY 2019	Change
	3-12			13-17			18-20			21-34		
Cumberland	0.01%	0.02%	0.01%	0.48%	1.14%	0.66%	0.98%	1.31%	0.33%	4.86%	4.67%	-0.19%
Durham	0.02%	0.02%	0.00%	0.70%	1.07%	0.37%	0.77%	1.54%	0.77%	2.60%	4.68%	2.08%
Johnston	0.01%	0.01%	0.00%	0.48%	0.80%	0.32%	0.98%	1.42%	0.44%	4.86%	5.59%	0.73%
Wake	0.02%	0.01%	-0.01%	0.70%	0.86%	0.16%	0.77%	1.21%	0.44%	2.60%	3.43%	0.83%
	35-64			65+			Unknown			Total		
Cumberland	3.96%	5.13%	1.17%	0.30%	0.47%	0.17%	0.00%	0.00%	0.00%	1.48%	2.04%	0.56%
Durham	8.31%	9.16%	0.85%	1.02%	1.22%	0.20%	0.00%	0.00%	0.00%	2.17%	2.50%	0.33%
Johnston	4.38%	5.38%	1.00%	0.49%	0.41%	-0.08%	0.00%	0.00%	0.00%	1.51%	1.85%	0.34%
Wake	4.58%	5.37%	0.79%	0.44%	0.79%	0.35%	0.00%	0.00%	0.00%	1.19%	1.52%	0.33%

Table 16: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	FY2018	FY2019	Change	FY2018	FY2019	Change	FY2018	FY2019	Change	FY2018	FY2019	Change
	3-12			13-17			18-20			21-34		
Cumberland	10.63%	12.13%	1.50%	20.94%	17.84%	-3.10%	10.45%	11.63%	1.18%	13.43%	16.19%	2.76%
Durham	8.87%	9.38%	0.51%	20.98%	17.16%	-3.82%	10.69%	10.47%	-0.22%	14.28%	15.77%	1.49%
Johnston	7.89%	8.95%	1.06%	17.75%	14.65%	-3.10%	9.49%	9.80%	0.31%	13.76%	14.48%	0.72%
Wake	7.68%	7.90%	0.22%	18.85%	14.98%	-3.87%	9.48%	10.11%	0.63%	12.80%	14.07%	1.27%
	35-64			65+			Unknown			Total		
Cumberland	21.72%	21.18%	-0.54%	7.61%	8.04%	0.43%	0.00%	0.00%	0.00%	14.16%	15.08%	0.92%
Durham	24.80%	24.50%	-0.30%	6.56%	6.41%	-0.15%	0.00%	0.00%	0.00%	13.67%	13.79%	0.12%
Johnston	20.41%	20.85%	0.44%	9.15%	11.31%	2.16%	0.00%	0.00%	0.00%	12.13%	12.75%	0.62%
Wake	20.21%	20.44%	0.23%	6.46%	6.34%	-0.12%	0.00%	0.00%	0.00%	11.69%	11.74%	0.05%

(b) Waiver Validation Results

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

Table 17 contains validation scores for each of the 10 (b) Waiver Performance Measures.

Table 17: (b) Waiver Performance Measure Validation Scores

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

For reviews of 2018-2019 (c) Waiver measures, there were changes made to the measures that were validated. Eight new measures were chosen, and two previously validated measures were retained. Documentation was included for all ten (c) Waiver measures. The rates reported by Alliance are displayed in Table 18.

Table 18: (c) Waiver Measures Reported Results 2018-2019

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals. IW D1 ISP	Annual	1841/1841=100%	85%
Proportion of Individual Support Plans that address identified health and safety risk factors. IW D2 ISP	Semi Annually	888/915=97.05%	85%
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need. IW D3 ISP	Annually	1841/1841=100%	85%
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	1841/1841=100%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	1841/1841=100%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	43/47=91.5%	85%
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required. IW G3	Quarterly	1/1=100%	85%
Percentage of medication errors resulting in medical treatment. IW G4	Quarterly	0/0=N/A	15%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	1031/1031=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 file "Innovations Performance Measures FY2019"*

(c) Waiver Validation

Validation scores are "Fully Compliant" with an average validation score of 100% across the ten measures. The validation scores are shown in Table 19, (c) Waiver Performance Measure Validation Scores. Documentation on data sources, data validation, source code, and calculated rate for the ten (c) Waiver measures was provided. Additionally, all rates met or exceeded state performance benchmarks. The validation worksheets offer detailed information on validation and calculation steps for (c) Waiver measure.

Table 19: C Waiver Performance Measures Validation Scores

Measure	Validation Score Received
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals. IW D1 ISP	100%
Proportion of Individual Support Plans that address identified health and safety risk factors. IW D2 ISP	100%
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need. IW D3 ISP	100%
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%
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required. IW G3	100%
Percentage of medication errors resulting in medical treatment. IW G4	100%
Percentage of beneficiaries who received appropriate medication. IW G5	100%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	100%
Average Validation Score & Audit Designation	**100% FULLY COMPLIANT**

Performance Improvement Project (PIP) Validation

The validation of the PIPs was conducted in accordance with the protocol developed by *CMS titled, EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012*. 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 2018, the four active PIPs submitted and validated were Access to Care: Emergent, Access to Care: Routine/Urgent, CC Clinical Contacts, and TCLI Housing Turn Around Time. There were some Recommendations regarding benchmark reporting on two PIPs and those were resolved. For 2019, the PIPs Desk Materials noted two closed PIPs (Access to Care-Emergent and TCLI Housing Timeliness) and four active PIPs (Access to Care-Routine/Urgent, Call Center IDD/TAT, Care Coordination (CC) Clinical Contacts During Hospitalization, and Increase TCLI IPS-SE Referrals). For the CC clinical Contacts PIP, the improvement appears to be related to interventions. The report notes Alliance is still working on census reporting to rectify inconsistencies. For Access to Care, the most recent rates are above baseline, but most recent measurements were not an improvement from previous measurement. For the Call Center PIP, there are three measurements. Improvement has occurred and 85% of the goal has been met and exceeded. The last rate was above 85%. Finally, for the Increase TCLI IPS/SE Referrals PIP, the number referred for employment is improving toward the goal of 33 for the year. Table 20 is a summary of the validation scores for each Project. As shown, all four of the validated projects received a score of “High Confidence in Reported Results.”

Table 20: PIP Summary of Validation Scores

Project Type	Project	2018 Validation Score	2019 Validation Score
Clinical	Care Coordination Clinical Contacts During Hospitalization	78/78= 100% High Confidence in Reported Results	90/90= 100% High Confidence in Reported Results
Non-Clinical	Access to Care Routine: Routine/Urgent Callers (non Clinical)	85/90= 94% High Confidence in Reported Results	89/90= 99% High Confidence in Reported Results
	Call Center IDD/TAT	Not Submitted	90/90=100% High Confidence in Reported Results
	Increase TCLI IPS-SE Referrals	Not Submitted	90/90=100% High Confidence in Reported Results

There is one Recommendation for the Access to Care PIP. There are no Corrective Actions for the current active PIPs.

Table 21 list the specific errors for projects that have Recommendations.

Table 21: Performance Improvement Project Errors and Recommendations

Project	Section	Reason	Recommendation
Access to Care: Routine/Urgent	Was there any documented, quantitative improvement in processes or outcomes of care?	From baseline, both indicators have shown improvement, although both are still well below the goal rate. The most recent remeasurements did not improve.	***Continue interventions related to Patient ID errors, ridesharing, and Open Access issues, as well as other recent interventions to improve rates.***

Figure 5 provides a comparison of the 2018 scores versus the 2019 scores. The 2019 review shows 94% of the standards were scored as "Met", and 6% of the standards were scored as "Partially Met." None of the standards were scored "Not Met."

Figure 5: Quality Improvement Comparative Findings

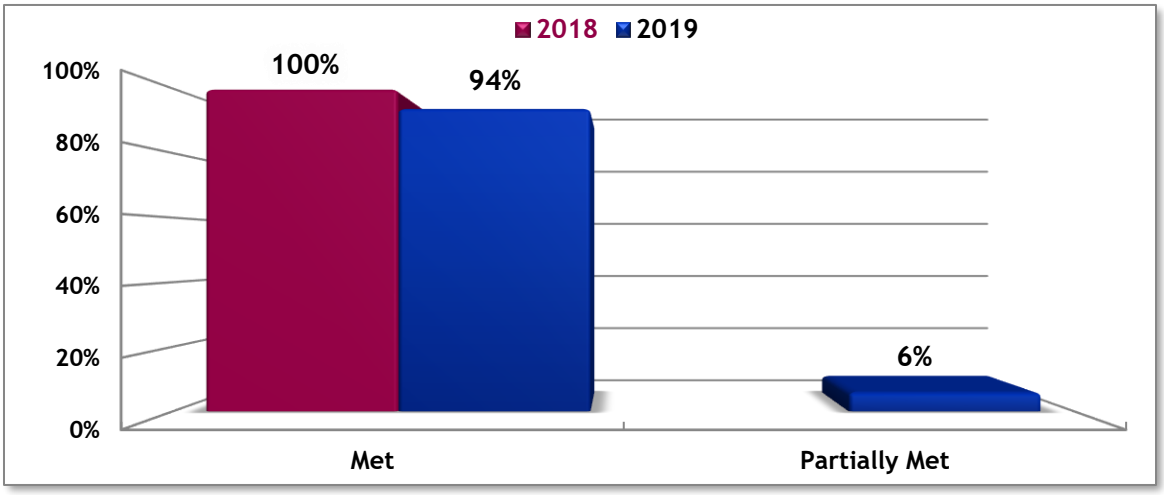


Table 22: Quality Improvement

Section	Standard	2019 Review
The Quality Improvement (QI) Program	The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.	Partially Met

Strengths

- There is evidence of active provider participation on several of Alliance's quality committees.
- Alliance's current Chief Medical Officer, Dr. Mehul Mankad brings to Alliance a background and expertise in quality improvement.

Weaknesses

- The April 2019 CQI meeting minutes indicate that updates on what will be implemented to address identified findings in the 2018 Adult and Child ECHO® Surveys will be given to CQI quarterly. However, there was no follow-up in CQI minutes for these identified areas of the 2018 enrollee surveys throughout the 2019 calendar year.
- Currently, there is no Alliance document that tracks lower scoring enrollee survey items year-to-year, barriers and interventions for those items, and an analysis explaining if interventions implemented were successful based on the next year's survey results.

Corrective Action

- Develop and implement a plan to routinely and annually implement measures, if decided on by the appropriate committee, to address quality problems identified through the Adult and Child Experience of Care and Health Outcomes (ECHO®) Surveys. Include how you will know when implemented measures have an effect on the enrollee survey from year-to-year.

Recommendations

- Create an Alliance document that tracks lower scoring ECHO® survey items year-to-year, barriers and interventions for those items, and an analysis explaining if interventions implemented were successful when compared to the subsequent year's survey results.

E. Utilization Management

The External Quality Review (EQR) of Utilization Management (UM) includes a review of the *Utilization Management Plan* (*UM Plan*), Organizational Chart, UM policies and procedures, and 50 service authorization request (SAR) files. Also included in the EQR of PIHP UM functions is the review of the Care Coordination and Transition to Community Living (TCLI) programs. CCME reviewed relevant policies, procedures, staffing patterns, job descriptions, and 35 files of enrollees participating in mental health/substance use disorder (MH/SUD), Intellectual/Developmental Disability (I/DD), and TCLI Care Coordination. Onsite discussion with staff provided additional information. In this year's EQR, Alliance met 91% of UM standards. CCME has issued four Corrective Actions and two Recommendations to improve upon Alliance's compliance and quality of UM operations.

Procedure 7503, Applying Clinical Criteria to Medical Necessity, details the required assessment tools providers should use to evaluate an enrollee's clinical needs. However, Alliance requires providers to implement the Child and Adolescent Needs and Strengths (CANS) to assess the clinical needs of children ages 3 to 6, and this requirement is not listed in any procedure.

During the Onsite discussion, Alliance stated that communications with providers occur regularly through the Provider Communication portal, as well as by email or phone. Those communications are expected to be captured in the patient notes. Alliance also asserted that not all providers engage in active communications. However, when possible, they do make reasonable efforts to engage with the provider before deciding to deny services. Staff collaboration is evidenced by the decreased number of administrative denials (i.e., denials due to a lack of required documentation).

In the file review, one denied request did contain a Care Manager note stating, "an email was sent to the provider, but no response was received." However, only 8% of the SAR files contained any communications with providers prior to issuing a denial.

Alliance staff also explained that, when a SAR is requested to be expedited by the provider, the Care Manager consults with their supervisor. Care Managers are also expected to reach out to the provider to discuss the justification for requesting an expedited review. Further, when the request does not meet criteria for an expedited SAR, the expectation is that the Care Manager documents this change in the patient note portal and shares this decision with the provider, along with an expected decision date.

The file review found three SARs that were marked as Expedited and the Care Managers determined that the request did not meet the Expedited criteria in two of the three requests. Only one of these files contained notes explaining the reason for changing the timeframe from expedited to standard, and neither of the files showed the change was communicated to the provider.

Given the inconsistencies found in the UM file review, Alliance needs to outline in a procedure the expectations of UM Care Managers around provider communication and the documentation of those communications.

At the last EQR, Alliance was unable to produce the full record for the enrollees participating in MH/SUD, I/DD, and TCLI Care Coordination. Further, when a sample of file was reviewing during the Onsite, data entry errors were noted and inconsistencies in the completeness of records was also observed.

A Recommendation was issued last year to remedy these concerns. CCME encouraged Alliance to develop a report that could pull the full Care Coordination member record, including all assessments and Care Coordination interventions, in chronological order. This report could be used for audits, internal quality improvement interventions, court proceedings, etc.

During this year's Onsite discussion, Alliance reported that as of October 2018, all Care Coordination activities are captured in Jiva and staff are thoroughly trained in documenting activities in Jiva. Staff explained Jiva can produce reports that show the continuous Care Coordination activity.

However, the review of MH/SUD, I/DD, and TCLI Care Coordination files showed that the Recommendation from the last EQR were not fully implemented. Several errors were identified from the documentation produced out of Jiva and submitted for this EQR.

- Progress notes had the incorrect header information
- Only a portion of the progress note was submitted (e.g., the narrative was cut off in 35% of the progress notes submitted)
- Progress notes abruptly ended with no indication the enrollee had discharged from Care Coordination
- Progress notes did not include the date of service, so timeliness of documentation by Care Coordinators could not be assessed

As this is the second EQR where Alliance could not produce complete enrollee files, CCME is requiring Alliance to address this issue.

In the previous EQR, CCME recommended that Alliance enhance the current monitoring processes of Care Coordination documentation in Jiva to ensure documentation is consistently and correct. This Recommendation stemmed from errors noted within the files reviewed prior to Onsite and a live demonstration of Jiva documentation during the Onsite.

During this year's EQR Onsite, Alliance explained that supervision occurs monthly with each Care Coordinator. During supervision, the completeness of tasks and documentation are reviewed within the Jiva platform. Reports derived from Jiva are used during supervision to show the Care Coordinators what their progress is regarding task completion. When asked what the current benchmarks or compliance rate are for Care Coordination task completion such as monitoring, ISP's, and progress notes, Alliance was unable to provide any data.

What could be reviewed in the MH/SUD, I/DD, and TCLI files, revealed inconsistencies in the frequency of contacts, completeness, and quality of documentation. There is evidence of ineffective monitoring to ensure that all tasks are being delivered timely, and that documenting of activities are reflected in the Jiva platform accurately. Specific, examples of these inconsistencies are noted on Attachment 4, Tabular Spreadsheet of this report. CCME is requiring Alliance to develop, document, and implement a data-driven monitoring process to improve the quality and completeness of MH/SUD, I/DD and TCLI Care Coordination documentation in Jiva.

Alliance has Procedure 2027, Monitor Requirements for NC Innovation Participants, in place to ensure that the monitoring of Innovations enrollee services occurs in accordance with *Clinical Coverage Policy 8P*. This procedure does not include the monitoring standards for Home Community Based Services as stated in *Clinical Coverage Policy 8P*, nor does it reference the state required Monitoring Checklist.

Figure 6 shows 91% of the Utilization Management standards were scored as "Met" and compares this score to the 2018 EQR UM score.

Figure 6: Utilization Management Comparative Findings

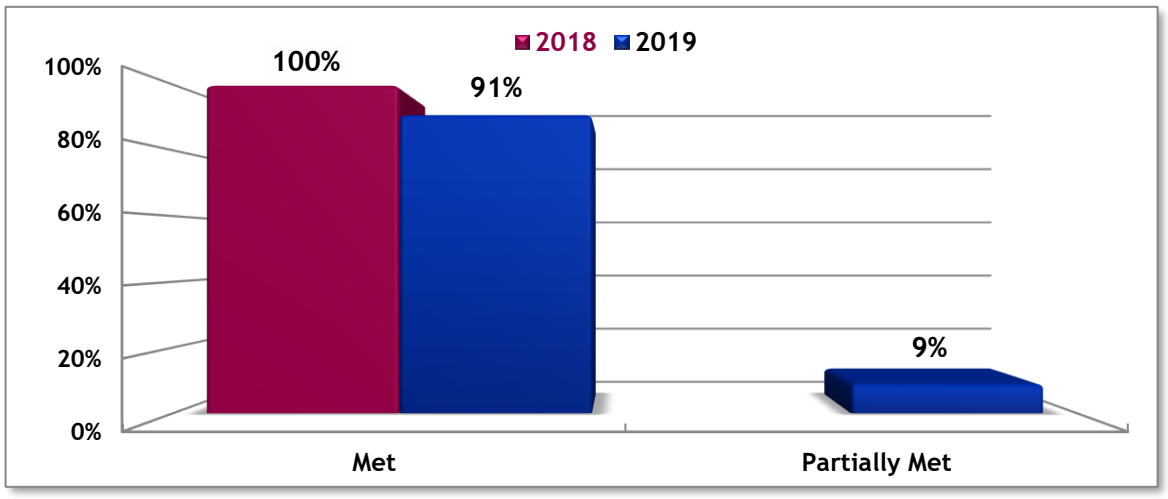


Table 23: Utilization Management

Section	Standard	2019 Review
Denials	A reasonable effort that is not burdensome on the enrollee or the provider is made to obtain all pertinent information prior to making the decisions to deny services	Partially Met
Care Coordination	Quality monitoring and continuous quality improvement;	Partially Met
	The PIHP applies the Care Coordination policies and procedures as formulated.	Partially Met
Transition to Community Living Initiative	A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures and processes, as required by *NC Medicaid*, and developed by the PIHP.	Partially Met

Strengths

- Alliance launched an initiative to increase monitoring of Assertive Community Treatment Team (ACTT) and Community Support Team (CST) for enrollees in the TCLI program. The increased monitoring will also focus on enhancing supported employment services for TCLI enrollees who are interested in obtaining employment.

- Alliance's Care Coordinators helped 45 individuals transition back to their communities from State hospitals, developmental centers, skilled nursing facilities, and intermediate care facilities (ICF).

Weaknesses

- Procedure 7503, Applying Clinical Criteria to Medical Necessity, details the required assessment tools providers should use to evaluate an enrollee's clinical needs. However, Alliance requires providers to implement the Child and Adolescent Needs and Strengths (CANS) to assess the clinical needs of children ages 3 to 6, and this requirement is not listed in any procedure.
- During the Onsite discussion, Alliance stated that communications with providers occur regularly through the Provider Communication portal, as well as, by email or phone. Those communications are expected to be captured in the patient notes, but the files showed little evidence of this practice.
- Alliance was not able to provide the full record for enrollees participating in MH/SUD, I/DD and TCLI Care Coordination.
- What could be reviewed in the MH/SUD, I/DD and TCLI files, revealed inconsistencies in the frequency of contacts, completeness, and quality of documentation.
- Procedure 2027, Monitor Requirements for NC Innovation Participants, does not include the monitoring standards for Home Community Based Services as stated in *Clinical Coverage Policy 8P*, nor does it reference the state required Monitoring Checklist.

Corrective Action

- Add information to a UM procedure that describes the expectations on Care Managers to obtain additional information from providers prior to rendering a denial of a SAR or denial of a request to expedite a SAR decision. Include details regarding the documentation requirements within the SAR portal.
- Develop a report that produces the full Care Coordination member record to include the date of service, all assessments, interventions, and discharges, in chronological order.
- Develop, document, and implement a data-driven monitoring plan that routinely reviews I/DD, MH/SU and TCLI Care Coordination documentation entered into Jiva. The monitoring plan should identify the frequency of monitoring, departmental benchmarks for compliance, and how and when outcomes of monitoring are captured, reviewed, and reported. The monitoring plan should include a routine review of timeliness of activities (e.g., documentation of completed activities, follow up activities, HCBS monitoring, etc.), as well as the quality and completeness of Care Coordinator and TCLI documentation, including cases targeted for discharge.

Recommendations

- Update Procedure 7503, Applying Clinical Criteria to Medical Necessity, to include the requirement of providers to use the Children's Assessment of Needs and Strengths (CANS) to determine the clinical needs of children ages 3 through 6 years.
- Add to Procedure 2027, Monitoring Requirements for NC Innovation Participants, an explanation of Home and Community Based Services and the required use of the required State Monitoring Checklist.

F. Grievances and Appeals

The Grievances and Appeals External Quality Review (EQR) for Alliance included a Desk Review of policies and procedures, 20 grievance, 28 appeal files, the Grievances and Appeals Logs, the *Provider Operations Manual*, the *Individual and Family Handbook,* and information about grievances and appeals available on the Alliance website. An Onsite discussion with Grievance and Appeal staff occurred to further clarify Alliance's documentation and processes.

Grievances

In the previous year's EQR of grievances, Alliance received one Recommendation. This year's review showed Alliance fully implemented and maintained the Recommendation to revise Procedure 6503, Management and Investigation of Grievances, to be consistent with contract requirements around extensions to the grievance resolution timeframe.

The review of 20 grievance files showed the grievance resolution notifications contained a thorough description of the steps taken by staff to resolve the grievance. All grievance resolution notifications were sent within the timeframe required by Alliance procedure and *NC Medicaid Contract, Attachment M, Section C*. There was a pattern of noncompliance, however, in the grievance acknowledgement notifications, eight acknowledgements were sent outside of the five business days required by Alliance's grievance procedure and two files showed no acknowledgment notifications were sent. Staff explained during the Onsite discussion that the grievance program was understaffed during the year in review. While the department is now fully staffed, Alliance still needs to establish a monitoring plan that identifies any early patterns of noncompliance within the grievance process.

During the Onsite discussion, staff clarified that grievances with quality of care concerns are reviewed by the Quality Review Committee. This committee meets biweekly and is attended by clinicians specializing in psychiatry, psychology, pharmacy, etc. However, this formal process is not included in the grievance procedure. CCME is recommending that Alliance provide a description of this process within the grievance procedure. This description should also include the process by which the referral and consultation by the Quality Review Committee is documented within the grievance record.

Appeals

In the 2018 EQR, CCME recommended Alliance revise the appeal procedure to accurately reflect the definition of an appeal and who can file an appeal. In the past year, Alliance corrected the definition of an appeal within their procedure but did not change the procedure to accurately reflect who can file an appeal. *NC Medicaid Contract, Attachment M, Section G.1,* defines an appellant as "the Enrollee, legally responsible person, or a Provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent, may file a PIHP internal appeal."

Three sections in Alliance's appeals procedure define who can file an appeal. On page 7, Alliance's procedure states, "a provider who has the member's written consent" and does not reference other stakeholders. The procedure then states representatives, "can be a provider, friend or family member even if not a guardian", but does not reference the requirement of the enrollee's written consent allowing stakeholders to be appeal representatives.

Under the expedited appeal section within the appeals procedure it's stated, "Any member, the member's legal representative, or the provider (if acting on the member's behalf with the members written permission) may request an expedited LME/MCO Appeal". However, this statement does not reference other stakeholders (not just providers), with written permission, can serve as the enrollee's representative and request an expedited appeal. *NC Medicaid Contract, Attachment M, Section G.1* and *42 CFR § 438.402(c)(2)(ii)* allows appellants to file appeals 60 days from mailing date of the Adverse Benefit Determination notice. This timeframe changed from 30 days to 60 days in 2017 in both the *NC Medicaid Contract* and federal regulations.

In Alliance's 2018 EQR, it was recommended that Alliance, "update any documentation discussing Appeals to reflect the Enrollee has 60 days to file an Appeal." This Recommendation was based on errors within the *Provider Operations Manual* and the *IDD Care Coordination Desk Reference* but was not implemented by Alliance.

The Provider Operations Manual, in several places, states the timeframe to file an appeal is 30 days and the *IDD Care Coordination Desk Reference* states the timeframe to file an appeal is 15 days.

Additionally, it was noted in this year's review that the *Provider Operations Manual* has incorrect information regarding the timeframe for notifying an appellant of the expedited appeal resolution. The manual states Alliance will, "provide verbal notification of the determination within 72 hours of the request followed by written notification about the appeal within three (3) calendar days of the verbal notification." However, the timeframe required by *NC Medicaid Contract, Attachment M, H.5* is 72 hours for either a written or oral notification of the expedited appeal determination.

Lastly, it was noted that the *IDD Care Coordination Desk Reference* states 2nd level appeals must be filed with the Office Of Administrative hearings in 30 days, but this timeframe is 120 days per *NC Medicaid Contract, Attachment M, Section I.1* and *42 CFR § 438.408(f)(2)*.

The appeal file review for Alliance involved a thorough review of 23 first level appeals, 5 second level appeals and Alliance Appeal Log. Five of the 23 first level appeals were requested to be expedited by appellants. Review of the 23 appeal files showed several errors within these files, as well as data errors on the Appeal Log related to the selected files. Every file reviewed for this year's EQR contained some error. Specific examples of errors are detailed on Attachment 4, Tabular Spreadsheet of this report. To a lesser degree, similar issues were identified in last year's appeal file review and it was recommended that Alliance enhance its current appeal monitoring process.

During the Onsite, Alliance explained reorganization of the appeal/grievance Department along with changes and vacancies in the appeal specialist position caused challenges in adequately monitoring the appeals process. Staff also explained that appeals data will soon be moved to the Jiva platform, which will assist in the monitoring of the appeals functions, notification due dates, internal steps, etc.

However, given Alliance's current appeals process is almost entirely manual and the rate of errors across notifications, internal steps, and appeal data continues to rise, an enhanced monitoring plan is needed. This level of monitoring will also ensure appeal data accuracy when Alliance moves its appeals functions to Jiva.

Figure 7 shows 80% of the grievance and appeals standards were scored as "Met" and compares this score to the 2018 EQR score for this section.

Figure 7: Grievances and Appeals Comparative Findings

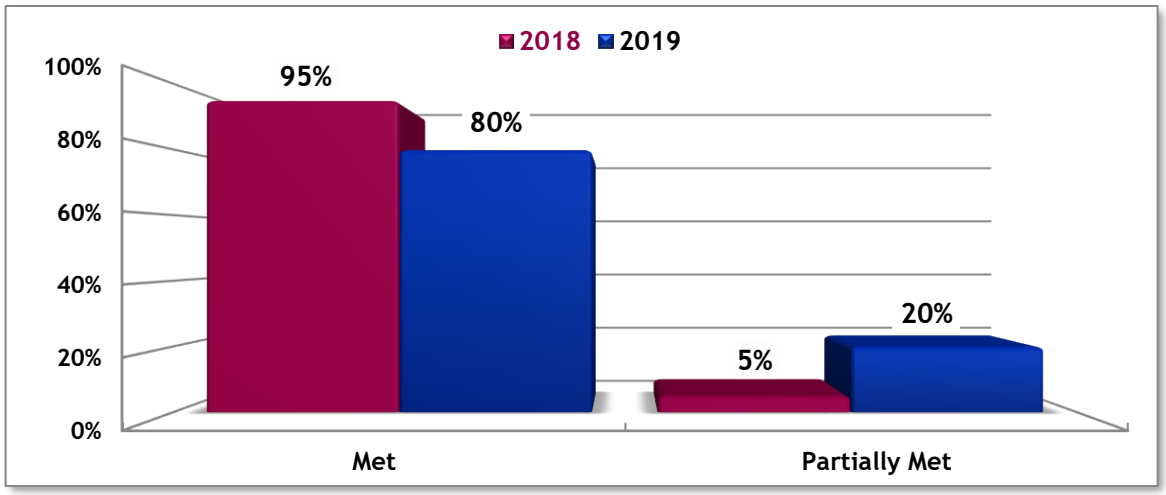


Table 24: Grievances and Appeals

Section	Standard	2019 Review
Grievances	The PIHP applies the grievance policy and procedure as formulated	Partially Met
Appeals	The definitions an appeal and who may file an appeal;	Partially Met
	The procedure for filing an appeal;	Partially Met

Strengths

- The grievance resolution notifications contained a detailed explanation of the internal steps taken by Alliance in resolving the grievance.
- Alliance now has a dedicated Appeals Specialist and additional staff are being cross-trained to assist in supporting the appeals functions.

Weaknesses

- Ten of the 20 grievance files reviewed showed grievance acknowledgment notifications were not compliant with Procedure 6503, Management and Investigation of Grievances.
- Procedure 6503, Management and Investigation of Grievances, does not describe the formal process by which grievances with quality of care concerns are reviewed by the Quality Review Committee.
- Procedure 6505, Due Process/Appeals of Medical Necessity Determination, does provide a clear and consistent definition of who can file an appeal.
- The *Provider Operations Manual* and the *IDD Care Coordination Desk Reference* have errors in explaining the timeframe enrollees and/or their representatives have for filing an appeal.
- The *Provider Operations Manual* incorrectly states that Alliance will "provide verbal notification of the determination within 72 hours of the request followed by written notification about the appeal within three (3) calendar days of the verbal notification."

- *IDD Care Coordination Desk Reference* has the incorrect timeframe enrollees and/or their representatives have to submit a second level appeal at the Office of Administrative Hearings.

- There were numerous errors within the 23 appeal files reviewed, the Appeal Log, and the communication logs within the appeal files.

- Procedure 6505 does not detail the oral notification Alliance is required to provide when Alliance extends an expedited appeal resolution timeframe.

- In one section of the *Individual and Family Handbook* it is implied that Alliance offers appeal rights before the adverse benefit determination is final.

Corrective Action

- Develop, document, and implement a monitoring plan to increase compliance with required grievance notifications. This monitoring plan should include the timeline for implementation, frequency of monitoring, staff that will implement the monitoring, benchmarks, and how and when outcomes of monitoring are captured, reviewed, and reported. The monitoring plan should include monitoring of timeliness of all required written grievance notifications (i.e., grievance acknowledgement notifications and grievance resolution notifications).

- Revise Procedure 6505, Due Process/Appeals of Medical Necessity Determination, to clearly and consistently state "the Enrollee, legally responsible person, or a Provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent, may file a PIHP internal appeal."

- Revise the *Provider Operations Manual* and the *IDD Care Coordination Desk Reference* to clearly and consistently state the timeframe for filing an appeal is 60 calendar days from the mailing date on the adverse benefit determination notice, per *NC Medicaid Contract, Attachment M, Section G.1* and *42 CFR § 438.402(c)(2)(ii)*.

- Revise the Provider Operations Manual to clearly and consistently state the timeframe for providing notification of an expedited appeal determination is 72 hours.

- Revise the *IDD Care Coordination Desk Reference* to clearly and consistently state the timeframe for enrollees to file a second level appeal is 120 days from the mailing date on the Appeal Resolution notifications.

- Develop, document, and implement a monitoring plan to increase compliance with required appeal notifications and internal steps. This monitoring plan should include the timeline for implementation, frequency of monitoring, staff that will implement the monitoring, benchmarks, and how and when outcomes of monitoring are captured, reviewed, and reported. The monitoring plan should include monitoring of:

- Accuracy of all data within the appeal log
- Timeliness of all required written and oral notifications for standard and expedited appeals
- Accuracy and completeness of staff documentation within the Communication Log

Recommendations

- Within Procedure 6503, provide a description of the process by which the referral and consultation by the Quality Review Committee is consulted in grievances with quality of care concerns. Ensure this description includes how this referral, along with outcome of this consultation, is documented within the grievance record.
- Revise Procedure 6505 to include in the expedited section that Alliance will make "reasonable efforts to give the Enrollee prompt oral notice of the delay." Per *NC Medicaid Contract, Attachment M, Section G.6(i)*, and *42 CFR § 438.408l(2)(i)*.
- Revise the *Individual and Family Handbook* to either remove the statement, "Before the adverse benefit determination is final, you will receive a letter explaining how to appeal the adverse benefit determination," or revise it to clarify that notifications are sent to the enrollee after the adverse benefit determination is final.

G. Delegation

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

At the last EQR, there were no Corrective Actions issued. There was one Recommendation, which Alliance addressed.

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

Alliance reported three current delegation agreements, as indicated in Table 25. The delegation agreement with ProtoCall ended in June 2019 and was replaced by a delegation agreement with Vaya effective July 2019. Vaya is URAC accredited, and Alliance conducted a pre-delegation assignment before entering into the agreement.

The delegation agreement with Realon Consulting Services ended in June 2019 and the delegation agreement with AC Ellers, LLC ended in August 2019. Alliance does not delegate any credentialing functions.

Table 25: Delegated Entities

Delegated Entities	Service
ProtoCall Services, Inc. (ended 6/2019)	Overflow call center service for 24/7/365 Alliance ACCESS and information call center
Realon Consulting Services (ended 6/2019)	Perform SIS assessments as needed
AC Ellers, LLC (ended 8/2019)	Perform SIS assessments as needed
Klutz Healthcare Consulting	Perform SIS assessments as needed
Prest & Associates (URAC accredited)	Clinical Peer Review services as needed
Vaya Health (URAC accredited) (beginning July 2019)	Overflow call center service for 24/7/365 Alliance ACCESS and information call center

During the Onsite discussion, Suzie Equez, Supports Intensity Scale® (SIS) Evaluation Supervisor and a SIS Certified Mentor Trainer, confirmed she monitors the SIS Assessment delegate. Monitoring includes quarterly meetings with the evaluators, review of the annual report of Inter-Rater Reliability (IRR) conducted by the assessors, and administration and review of customer satisfaction surveys "to ensure member experience is meeting expectations."

Largely due to the limited call volume, ProtoCall was not meeting call standards, despite intervention efforts from Alliance. Alliance ended the delegation agreement with ProtoCall in June 2019. Effective July 2019, Alliance has a Delegation Agreement and a reciprocal arrangement with Vaya for covering Call Center Overflow (answering calls that the PIHP has not answered within 30 seconds). Vaya submits phone metrics reports, which are reported to the Utilization Management (UM) Committee.

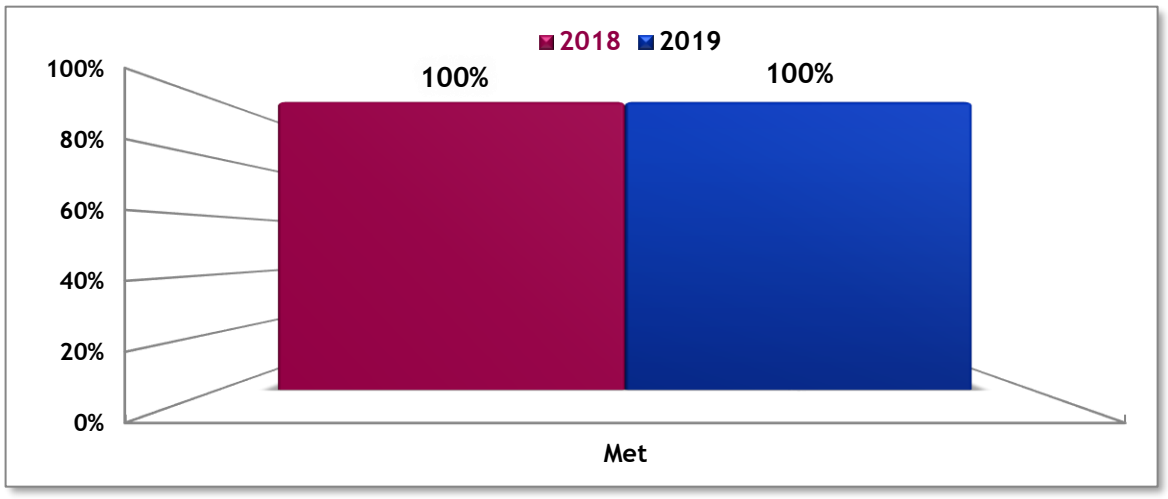
Each month, an Alliance Access and Information Department supervisor monitors between two and four calls answered by Vaya. The *Vaya Health MCO- QM Delegation 2nd level review* submitted in the Desk Materials reported that, for December 2019, three calls were assessed. Two of the three calls were "requesting services and both did not meet assessing for safety." The report indicated Alliance reviewed the calls with Vaya during their monthly meeting, and Vaya followed up with their staff.

During Onsite discussion, CCME raised concerns about the failure to assess for safety in two of three monitored calls. The Alliance staff member who monitors the calls reported the two calls were both third-party calls. One caller was a grandmother calling about an adult grandson, and the other was a mother calling about her son. Alliance reported the information in a document titled *QM Delegation 2nd Level Review*, and, during Onsite discussion, indicated Quality Management has historically taken this information to the Utilization Management (UM) Committee, but now takes it to a new committee, the Member Experience Committee. Alliance staff reported there have been no further instances in which safety was not assessed.

Prest is URAC accredited and conducts their own IRR. April Parker, Licensed Professional Counselor (LPC), Alliance Senior Director of UM, is responsible for receiving, reviewing, and overseeing Prest's IRR reports. The Alliance UM Subcommittee of the Continuous Quality Improvement Committee reviews the Prest reports.

Alliance met the requirements of both Delegation standards. The following chart illustrates a comparison of the percentage scores for 2018 and 2019.

Figure 8: Delegation Comparative Findings



Strengths

- Alliance currently has an executed Delegation Agreement with three delegates, including Business Associate Agreements with those delegates that have access to Protected Health Information (PHI).
- Alliance conducts periodic delegation monitoring and presents results to relevant committees.

H. Program Integrity

The Program Integrity (PI) EQR involves an assessment of Alliance's compliance with federal and state regulations regarding PI functions. A Desk Review of Alliance's documentation was conducted, and included review of Alliance's policies, procedures, training materials, organizational charts, job descriptions, committee meeting minutes and reports, provider agreements, enrollment application, workflows, *Provider Operations Manual*, employee handbook, newsletters, conflict of interest forms and the Compliance Plan. Telepresence Onsite interviews were conducted on March 19, 2019 with the Compliance and Program Integrity Managers to discuss the findings within the Desk Materials and PI files.

A sample of 15 PI files for the period of February 1, 2018 through January 31, 2019 were selected from a universe of files submitted by Alliance. During the review of the PI case files, it was identified that many of the files reviewed were found to not constitute possible fraudulent or abusive behaviors. Review of the files, however, showed all of the elements required by the EQR PI standards could be found within the PI files that were investigating fraud, waste and abuse.

In last year's EQR, it was recommended that Alliance maximize the use of the Investigative Report summary form in cases where an investigation is still open. This form summarizes important information including the provider name, National Provider Identification (NPI) number, Special Investigative Unit (SIU) contact person, and estimated amount exposed (or recoupment amount). There is still room for improvement in completion of this form as contact information for PIHP staff persons with practical knowledge of the working of the relevant programs was missing from these reports. It is again recommended that Alliance ensure staff consistently complete this form.

NC Medicaid Contract, Section 17, requires "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." During the year in review, an Alliance FAMS user left Alliance. This departure was discussed during the Onsite and Alliance provided evidence that this user's access to FAMS was terminated. However, they was not able to confirm that NC Medicaid was notified within 48 hours of the FAMS user's departure. This requirement is also not specified in any Alliance procedure.

Similarly, although monthly PI reports required in *NC Medicaid Contract, Section* 18 were sent timely by Alliance to NC Medicaid, no evidence was found within Alliance policies and procedures that addresses the requirement found in *NC Medicaid Contract, Section 18*, which states the reports, "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)."

CCME is advocating that Alliance add these contract requirements to a fraud, waste, and abuse procedure to ensure compliance by staff with the timeliness of these notifications and report submissions.

Figure 9 shows 98% of the Program Integrity standards were scored as "Met" and compares this score to the 2018 EQR Program Integrity score.

Figure 9: Program Integrity Findings

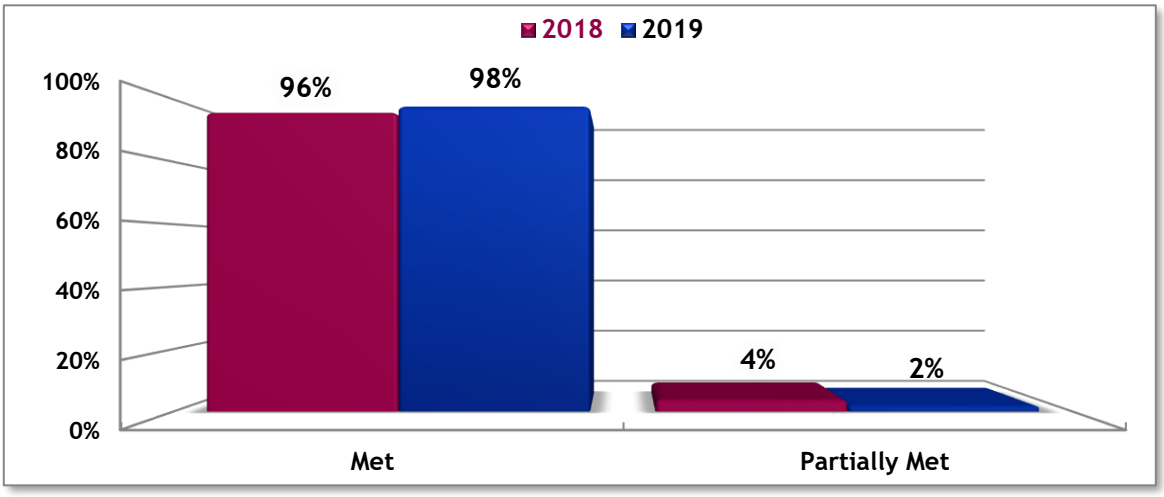


Table 26: Program Integrity

Section	Standard	2019 Review
Fraud and Abuse	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.	Partially Met

Strengths

- Alliance began using the FAMS system during the review period. Since Alliance had previously implemented several successful data mining initiatives that uncovered potential incidents of fraud, waste or abuse, FAMS has been used to strengthen these initiatives.
- Alliance has a training program that engages employees and providers through games, puzzles, and case studies. The adoption of their "quick learning" methodology has proven successful in engaging employees.

Weaknesses

- Procedure wording is not fully compliant with the relevant section of the *NC Medicaid Contract* that requires Alliance to notify the NC Medicaid designated Administrator within forty-eight (48) hours of a FAMS-user changing roles within the organization or termination of employment.
- Two Investigation Report summary forms reviewed during the PI case file review did not contain contact information for PIHP staff persons with practical knowledge of the working of the relevant programs.
- The requirement of timely submission of monthly PI reports to NC Medicaid is not addressed in any Alliance procedure.

Corrective Actions

- Add language to a PI procedure that explains Alliance shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of a FAMS-user changing roles within the organization or termination of employment. This contractual requirement is in *NC Medicaid Contract, Section 14.2.13*.

Recommendation

- Ensure staff maximize the use of the Investigation Report summary form by completing it in its entirety.
- Add language to a PI procedure for the requirement of timely submission of monthly PI reports to NC Medicaid. This contractual requirement is in *NC Medicaid Contract, Section 14.2.14.*

I. Financial Services

In reviewing Alliance's financial operations, CCME implemented a Desk Review of the following documentation:

- Financial policies and procedures
- Audited financial statements, compliance reports, and footnotes dated June 30, 2019
- Balance sheet and income statements dated November 30, 2019 and December 31, 2019
- Medicaid monthly financial reports for November and December 2019
- Claims processing aging reports, as well as claims processing procedures
- Finance Department staffing structure

- Fiscal year budget ordinance for 2019-2020
- Budget to actual expenses report for Medicaid for November and December 2019
- *Administrative Cost Allocation Plan FY 2020*
- Medicaid risk reserve bank statements for November and December 2019

CCME also reviewed deficiencies from prior EQRs to determine if they were corrected.

After reviewing Alliance's desk review materials, a virtual Onsite interview was held. In addition to the standardized desk review inquiries, CCME asked interview questions in the following areas:

- Policies and procedures
- Staffing changes in finance
- Plans for software platform upgrades or changes
- Financial review and monitoring
- Budget variances and development
- Any audit findings/corrective action plans

The 2018 EQR of Alliance's Financial Services identified one procedure enhancement that was needed. The needed revision related to adding language to Procedure 3016, Records Retention and Destruction. The Recommendation was to reflect ten (10) years retention of all Medicaid records. This Recommendation was implemented, and the procedure updated with a revision date of July 22, 2019.

Per the EQR of Alliance's financial records, Alliance demonstrates ongoing financial stability through their audit report, net asset balance, and financial ratios. Alliance's audit report for June 30, 2019 received an overall unqualified audit opinion on financial statements, which indicates that their auditors believe that their audited financial statements present fairly, in all material respects the financial position of Alliance.

Alliance exceeded the contract benchmarks for current ratio and Medical Loss Ratio (MLR). Alliance's Medicaid current ratio is 1.65 total with a total current ratio of 2.11 in November 2019. The Medicaid current ratio is 1.6 total with a total current ratio of 2.03 for December 2019. The benchmark is 1.00. Alliance's year-to-date MLR, including HCQI activities is 89.63% year-to-date as of November 30, 2019, and 89.67% year-to-date as of December 31,2019. The benchmark is 85%. Medicaid total assets as of November 30, 2019

are $140.313.530 and $143,138,703 for December 31, 2019. Alliance's net assets position was $87,974,062 as of June 30, 2019.

Alliance meets the requirement in *42 CFR § 433.32 (a)* for maintaining an appropriate accounting system (Great Plains). Great Plains 2015 modules used are purchasing, general ledger, accounts payable, and fixed assets. Alliance uses Wellsky's AlphaMCS for claims processing. There had been no major financial upgrades or changes, however, they are evaluating alternative accounting system options, as well as using AlphaMCS as a customized system to integrate with any new financial system that is purchased.

Alliance meets the minimum record retention of ten years as required by *NC Medicaid Contract, Section 8.3.2*. Alliance's Procedure, 3016 Records Retention and Destruction, addresses Alliance's plan for record storage, and Alliance stated during the interview that they are following the North Carolina Department of Health and Human Services' (DHHS) records retention schedule. Alliance's Privacy Officer leads the record retention process.

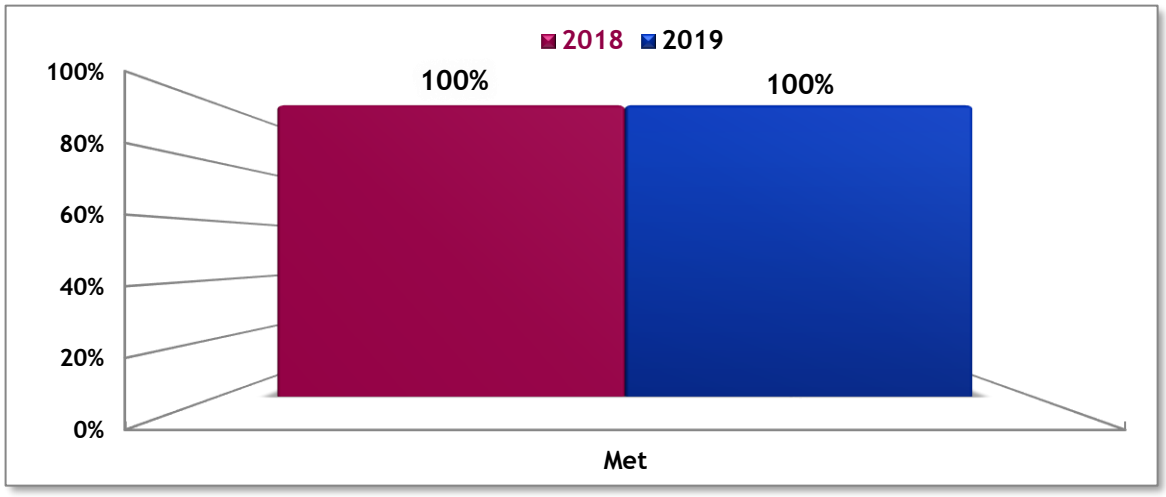
All finance procedures reviewed by CCME had review dates within the past year. Alliance utilizes Compliance 360, which automates the policy and procedure update process and assists in workflow and communication. Staff are notified via email and by communication in meetings if there are procedures which require review.

Alliance's *Cost Allocation Plan* meets the requirements for allocating the administrative costs between Medicaid, non-Medicaid, federal, state, and local entities based on revenue as required by *42 CFR § 433.34*. There were no costs disallowed per the audit report and Onsite interview. Annually, Alliance submits a cost allocation plan to NC Medicaid to determine the percentage to be used monthly for allocation of Medicaid's share of administrative costs. Currently this percentage is 81.91%. The administrative expenses not specific to a funding source are recorded by journal entry on a monthly basis. Alliance's Medicaid funds are properly segregated through the chart of accounts in the general ledger of Great Plains and Alliance's Procedure 2219, Accounting by Funding Source, addresses the segregation of funds by funding source.

Alliance's Medicaid risk reserve account meets the minimum requirement of 2% of the capitation payment per month required by *NC Medicaid Contract, Section 1.9*. Alliance has reached 12.6% of their required percentage of annualized capitation maximum (15%) as of December 31, 2019, with a balance of $56,046,615. Once the capitation payment is received from NC Medicaid, Alliance calculates the risk reserve payment, which is reviewed by the Accounting Manager and paid electronically to Wells Fargo Bank by Finance staff within five business days of the capitation payment. All deposits were timely and there were no unauthorized withdrawals. Alliance provided CCME with bank statements demonstrating the risk reserve balance and deposits, which were made timely. Alliance documents their risk reserve process in Procedure 1506, Risk Reserve Account.

Figure 10 shows 100% of the financial standards were scored as "Met" and compares this score to the 2018 EQR UM score.

Figure 10: Financial Services Comparative Findings



Strengths

- Alliance analyzes their fund balance on a monthly basis to report savings and losses by funding sources to the Board of Directors.
- Alliance is proactively evaluating accounting systems to determine which software will suit them operationally in anticipation of becoming a Tailored Plan.
- Procedure 1537, Medical Loss Ratio, is a very detailed procedure describing processes around Medical Loss Ratio calculation and monitoring.

Weaknesses

- Procedure 1527 does not specify the due date of monthly DHHS NC Medicaid Financial Reports.

Recommendations

- Revise Procedure 1527, DHHS NC Medicaid Financial Reporting, to reflect that monthly Medicaid reporting is due to NC Medicaid by the 20th of the month.

J. Encounter Data Evaluation

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 2018 through December 2018. 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: Procedure Code

The procedure code for Institutional claims should populated 99% of the time. In the encounter data provided, HMS found that the field was populated 45% of the time with valid values; in all other instances the value was null. Valid procedure codes are needed to better understand the services provided and are usually required to adjudicate the claim appropriately. Given the types of services provided, the provider should have provided additional procedure codes in support of the line level revenue code supplied. For example, revenue code 636 indicates an injectable; however, additional detail is needed to determine the type of injection/drug. There were many instances where the revenue code was provided without the appropriate Healthcare Common Procedure Coding System (HCPCS). The same issue was noted in the review of 2017 encounters.

Resolution:

Alliance should ensure that the appropriate data validation checks are in place and that claims submitted through the portal or an 837 should be denied by Alliance without the proper revenue code and procedure code combination. Alliance should review their 837 encounter creation and encounter data extract process to ensure that an invalid procedure code is not transmitted to NC Medicaid, even when the data is invalid based on the provider claim submission. The HCPCS may not be required to adjudicate the claim but it is required to understand the level of services provided.

Issue: Diagnosis Codes

The secondary diagnosis was populated in less than 1% of all institutional claims and only 10% of professional claims. This value is not required by Alliance when adjudicating the claim, therefore, not a requirement of the provider when submitting via Provider Portal or 837.

Resolution:

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

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet
- Attachment 5: Encounter Data Validation Report

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

The Carolinas Center *for* Medical Excellence
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January 28, 2020

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 2019 External Quality Review (EQR) of Alliance Health (Alliance) is being initiated. The review will be conducted by us, The Carolinas Center for Medical Excellence (CCME), and is a contractual requirement. The review will include both a desk review (at CCME) and a two-day Onsite visit at Alliance's office in Morrisville, North Carolina that will address all contractually required services.

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

The CMS EQR protocols can be found at:

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

The CCME EQR review team plans to conduct the Onsite visit at Alliance on **March 18, 2020** through **March 19, 2020**. For your convenience, a tentative agenda for the two-day review is enclosed.

In preparation for the desk review, the items on the enclosed **Desk Materials List** are to be submitted electronically, and are due no later than **February 19, 2020**. As indicated in item 40 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 by the aforementioned deadline.

Further, as indicated on item 42 of the Desk Materials List, Encounter Data Validation (EDV) will also be part of this review. Our subcontractor, Health Management Systems (HMS) will be evaluating this component. Please read the documentation requirements for this section carefully and make note of the submission instructions, as they differ from the other requested materials.

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

The location for the file transfer site is:

https://eqro.thecarolinascenter.org

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

Katherine Niblock, MS, LMFT

Project Manager, External Quality Review

Enclosure(s) – 5

Cc: Monica Hamlin, NC Medicaid Waiver Contract Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager

External Quality Review 2019

MATERIALS REQUESTED FOR DESK REVIEW

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. *(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. Further, please indicate staffing structure for Transitions Community Living Initiative (TCLI) program.

3. Current Medical Director and Medical Staff job descriptions.

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

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

6. A summary of the status of all best practice Recommendations and Corrective Action items from the previous External Quality Review.

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

8. List of new services added to the provider network in the past 12 months (February 2019 through January 2020) by provider.

9. Network turnover rate for the past 12 months (February 2019 through January 2020) including a list of providers that were terminated for cause and list of providers that did not have their contracts renewed. For five providers termed in the last 12 months (February 2019 through January 2020), who were providing service to enrollees at the time of the termination notice, submit the termination letter sent to or from the provider, and the notification (of provider termination) letters sent to three consumers who were seeing the provider at the time of the provider termination notice.

10. List of providers credentialed/recredentialed in the last 12 months (February 2019 through January 2020). Include the date of approval of initial credentialing and the date of approval of recredentialing.

11. A current provider manual and provider directory.

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

13. The Quality Improvement work plans for 2018 and 2019.

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

15. Minutes of committee meetings for the months of February 2019 through January 2020 for all committees reviewing or taking action on enrollee-related activities. For example, quality committees, quality subcommittees, credentialing committees, compliance committee, etc.

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

16. 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.

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

18. Copies of the most recent provider profiling activities conducted to measure contracted provider performance (for example, provider report cards, dashboards, etc.).

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

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

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

22. A copy of the complete Appeal log for the months of February 2019 through January 2020. Please indicate on the log appeal type (standard or expedited), the service appealed, the date the appeal was received, the resolution date, and if the resolution timeframe was extended, who requested the extension. Also include on the log those appeals that were withdrawn or deemed invalid.

23. A copy of the complete Grievances log for the months of February 2019 through January 2020. Please indicate on the log the nature of the grievance, the date received, and the date resolved. If the grievance resolution timeframe was extended, please include who requested the extension.

24. Copies of all letter templates used for Utilization Management, Grievances, and Appeals. This includes all acknowledgement, adverse benefit determination, resolution, extension, invalid, expedited, etc. notifications.

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

26. Clinical Practice Guidelines developed for use by practitioners, including references used in their development, when they were last updated and how they are disseminated. Also, policies and procedures for researching, selecting, adopting, reviewing, updating, and disseminating practice guidelines. Results of the most recent monitoring of provider compliance with Clinical Practices Guidelines.

27. All information supplied at orientation to new providers, including, for example, the Welcome letter and any orientation materials. If the new provider orientation is provided via the PIHP website, provide a link to the location of the orientation materials. Please also provide the location of ongoing provider training materials and/or calendar of training events.

28. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the PIHP, and any reports of activities submitted by the subcontractor to the PIHP. Include pre-delegation assessments conducted for any delegates added/contracted during the timeframe covered by the current EQR.

29. Contracts and relevant amendments for all delegated entities, including Business Associate Agreements for delegates handling PHI.

30. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used. Include annual evaluations, if applicable, and indicate to which committees delegate monitoring is reported.

31. Please provide an excel spreadsheet with a list of enrollees that have been placed in care coordination since April 2016. Please indicate the disability type (MH/SU, I/DD).

32. Please provide an excel spreadsheet with a list of enrollees that have been placed in the TCLI program since April 2016. Please indicate on that list the individuals transitioned to the community, the individuals currently receiving Care Coordination, the individuals connected to services and list the services they are receiving, the individuals choosing to remain in ACH and the services they are receiving.

33. Information regarding the following selected Performance Measures:

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

WAIVER MEASURES	
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 Individual Support Plans in which the services and supports reflect participant assessed needs and life goals
Proportion of beneficiaries reporting they have a choice between providers.	Proportion of Individual Support Plans that address identified health and safety risk factors
Percentage of level 2 and 3 incidents reported within required timeframes.	Percentage of participants reporting that their Individual Support Plan has the services that they need
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.	Percentage of beneficiaries who received appropriate medication.
Percentage of medication errors resulting in medical treatment.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.

Required information includes the following <u>for each measure</u>:

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.

34. 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.)

35. Summary description of quality oversight of the Transition to Community Living Initiative, including monitoring activities, performance metrics, and results.

36. Data, Dashboards and/or reports for the Transition to Community Living Initiative (e.g., numbers of in-reach completed, housing slots filled, completed transitions, numbers of enrollees in supported employment, numbers of enrollees receiving ACT, Supported Employment, Peer Support Services, Community Support Team, Psychosocial Rehabilitation, etc. for the period February 2019 through January 2020.

37. Call performance statistics for the period of February 2019 through January 2020, including average speed of answer, abandoned calls, and average call/handle time for customer service representatives (CSRs).

38. Provide copies of the following files:

    a. Credentialing files for the 12 most recently credentialed practitioners (should include 6 licensed practitioners who work at agencies and 6 Licensed Independent Practitioners; include at least two physicians). Please also include 4 files for network provider agencies and/or hospitals and/or psychiatric facilities, in any combination. 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, the 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.

b. Recredentialing files for the 12 most recently recredentialed practitioners (should include 6 licensed practitioners who work at agencies and 6 Licensed Independent Practitioners, include the files of at least two MDs). Also, please include 4 files of network provider agencies and/or hospitals and/or psychiatric facilities, in any combination.

   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, the 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.

c. Ten MH/SU, ten I/DD and five TCLI files medical necessity approvals made from February 2019 through January 2020, including any medical information and approval criteria used in the decision. Please select MEDICAID ONLY files and submit the entire file.

d. Ten MH/SU, ten I/DD and five TCLI files medical necessity denial files for any denial decisions made from February 2019 through January 2020. Include any medical information and physician review documentations used in making the denial determination. Please include all correspondence or notifications sent to providers and enrollees. Please select MEDICAID ONLY files and submit the entire file.

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

39. Provide the following for Program Integrity:

a. File Review: Please produce a listing of all active files during the review period (February 2019 through January 2020) including:
   i. Date case opened
   ii. Source of referral
   iii. Category of case (enrollee, provider, subcontractor)
   iv. Current status of the case (opened, closed)
b. Program Integrity Plan and/or Compliance Plan.
c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
d. Workflow of process of taking complaint from inception through closure.
e. All 'Attachment Y' reports collected during the review period.
f. 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

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

a. A completed ISCA.

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

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

c. A copy of the IT Disaster Recovery Plan.

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

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

41. Provide the following for Financial Reporting:
    a. Most recent annual audited financial statements.
    b. Most recent annual compliance report
    c. Most recent two months' State-required NC Medicaid financial reports.
    d. Most recent two months' balance sheets and income statements including associated balance sheet and income statement reconciliations.
    e. Most recent months' capitation/revenue reconciliations.
    f. Most recent reconciliation of claims processing system, general ledger, and the reports data warehouse. Provide full year reconciliation if completed.
    g. Most recent incurred but not reported claims medical expense and liability estimation. Include the process, work papers, and any supporting schedules.
    h. Any other most recent month-end financial/operational management reports used by PIHP to monitor its business. Most recent two months' claims aging reports.
    i. Most recent two months' receivable/payable balances by provider. Include a detailed list of all receivables/payables that ties to the two monthly balance sheets.
    j. Any P&Ps for finance that were changed during the review period.
    k. PIHP approved annual budget for fiscal year in review.
    l. P&Ps regarding program integrity (fraud, waste, and abuse) including a copy of PIHP's compliance plan and work plan for the last twelve months.
    m. Copy of the last two program integrity reports sent to NC Medicaid's Program Integrity Department.
    n. An Excel spreadsheet listing all of the internal and external fraud, waste, and abuse referrals, referral agent, case activity, case status, case outcome (such as provider education, termination, recoupment and recoupment amount, recoupment reason) for the last twelve months.
    o. A copy of PIHP's Special Investigation Unit or Program Integrity Unit Organization chart, each staff member's role, and each staff member's credentials.
    p. List of the internal and external program integrity trainings delivered by PIHP in the past year.
    q. Description and procedures used to allocate direct and overhead expenses to Medicaid and State funded programs, if changed during the review period.
    r. Claims still pending after 30 days.
    s. Bank statements for the restricted reserve account for the most recent two months.
    t. A copy of the most recent administrative cost allocation plan.
    u. A copy of the PIHP's accounting manual.
    v. A copy of the PIHP's general ledger chart of accounts.
    w. Any finance Corrective action plan
    x. Detailed medical loss ratio calculation, including the following requirements under *42 CFR § 438.8*:
        i. Total incurred claims
        ii. Expenditures on quality improvement activities
        iii. Expenditures related to PI requirements under §438.608

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

y. A copy of the PIHP's annual MLR report.

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

a. Include all adjudicated claims (paid and denied) from January 1, 2018 – December 31, 2018. 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.

b. Provide a report of all paid claims by service type from January 1, 2018 – December 31, 2018. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

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

B. Attachment 2: Materials Requested for Onsite Revie

External Quality Review 2019

Materials Requested for Onsite Review

1. For the appeal files, please see the accompanying "Supplemental Appeal Onsite Documentation List" which specifies the file information needed. Please create a new subfolder in Folder 22 and label it "Onsite documentation".

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

- Performance Improvement Project Validation Worksheet
    - Access to Care: Routine/Urgent Callers
    - Call Center
    - Care Coordination Clinical Contacts During Hospitalization
    - Increase TCLI IPS/SE Referrals

CCME EQR PM Validation Worksheet

PIHP Name:	**ALLIANCE**
Name of PM:	**READMISSION RATES FOR MENTAL HEALTH**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	03/2020

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N.4 Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N.5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because 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:	7/1/2018-6/30/2019
Review Performed:	03/2020

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because 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:	7/1/2018-6/30/2019
Review Performed:	03/2020

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because 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:	7/1/2018-6/30/2019
Review Performed:	03/2020

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because 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:	7/1/2018-6/30/2019
Review Performed:	03/2020

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because 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 DISCHARGES AND AVERAGE LENGTH OF STAY**
Reporting Year:	7/1/2018-6/30/2019
Review Performed:	03/2020

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because 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:	7/1/2018-6/30/2019
Review Performed:	03/2020

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because 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:	7/1/2018-6/30/2019
Review Performed:	03/2020

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because 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:	7/1/2018-6/30/2019
Review Performed:	03/2020

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because 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:	7/1/2018-6/30/2019
Review Performed:	03/2020

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because 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 Individual Support Plans in which the services and supports reflect participant assessed needs and life goals.
Reporting Year	FY2019
Review Performed	03/2020

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**ALLIANCE**
Name of PM	Proportion of Individual Support Plans that address identified health and safety risk factors
Reporting Year	FY2019
Review Performed	03/2020

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**ALLIANCE**
Name of PM	Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need.
Reporting Year	FY2019
Review Performed	03/2020

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**ALLIANCE**
Name of PM	Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available
Reporting Year	FY2019
Review Performed	03/2020

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**ALLIANCE**
Name of PM	Proportion of beneficiaries reporting they have a choice between providers
Reporting Year	FY2019
Review Performed	03/2020

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**ALLIANCE**
Name of PM	Percentage of level 2 and 3 incidents reported within required timeframes
Reporting Year	FY2019
Review Performed	03/2020

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**ALLIANCE**
Name of PM	Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.
Reporting Year	FY2019
Review Performed	03/2020

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**ALLIANCE**
Name of PM	Percentage of medication errors resulting in medical treatment
Reporting Year	FY2019
Review Performed	03/2020

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**ALLIANCE**
Name of PM	Percentage of beneficiaries who received appropriate medication
Reporting Year	FY2019
Review Performed	03/2020

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures 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
Reporting Year	FY2019
Review Performed	03/2020

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

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

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

VALIDATION SUMMARY

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

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

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

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

AVERAGE VALIDATION PERCENTAGE & AUDIT DESIGNATION
100% FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**ALLIANCE**
Name of PIP:	**ACCESS TO CARE: ROUTINE/URGENT CALLERS (NON-CLINICAL)**
Reporting Year:	**2018-2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Alliance struggled to meet the state benchmarks for timely care.
1.2 Did the PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addressed enrollee access to care and services.
1.3 Did the PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project included all relevant populations.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research questions were stated clearly on page 2 of PIP documentation.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicators were defined and baseline goal was documented. The benchmarks were noted as 82%/62% for Urgent and 75%/63% for Routine.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measured change in processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	All enrollees to whom the study question is relevant were defined.
4.2 If the PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	All relevant enrollees were included in data collection.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not utilized.
5.2 Did the PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not utilized.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not utilized.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were noted in report.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plan was noted in reported quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel were listed in report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions were undertaken to address barriers identified**.**
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to analysis plan (quarterly).
8.2 Did the PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented clearly on page 14 and 15 of PIP Report.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Initial and repeat measurements were documented. Factors that address validity were documented.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data was conducted and is presented in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Methodology did change, but changes were documented and clarified.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	From baseline, both indicators demonstrated improvement; although both were still well below the goal rate. The most recent remeasurements did not improve. ***Recommendation: Continue interventions related to Patient ID errors, ridesharing, and Open Access issues, as well as other recent interventions.***
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvements in rates were linked to interventions that are revised or initiated.

Component / Standard (Total Points)	Score	Comments
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling not used, so statistical testing was not required.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	The most recent remeasurements demonstrated an increase, but sustainment is not available to evaluate at this time.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	**89**
Project Possible Score	**90**
Validation Findings	**99%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**ALLIANCE**
Name of PIP:	**CALL CENTER**
Reporting Year:	**2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Over 35% of calls did not meet standard.
1.2 Did the PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This addressed enrollee population.
1.3 Did the PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	Included member population.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question was documented.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure was clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measured changes in processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Enrollee population was defined.
4.2 If the PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Information collected captured all enrollees of interest to the study,
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling conducted.
5.2 Did the PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling conducted.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling conducted.

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 were documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were admin and call center via AlphaMCS.
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**	Method was systematic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	AlphaMCS was utilized.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis occurred on a bimonthly basis.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff qualifications were included in the report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Barriers and interventions were noted in the qualitative analysis section.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates were reported for every 2-month period.
8.2 Did the PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were presented clearly in Table format
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and 2 remeasurements were reported.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analyses were conducted.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same Methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Changes to selection were documented in report.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate improved from 63% to 72% to 91% at most recent measurement.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement were related to interventions and selection changes.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling was not used so statistical analyses was not required.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Met goal at only one measurement, unable to judge sustainment.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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:	**CARE COORDINATION CLINICAL CONTACTS DURING HOSPITALIZATION**
Reporting Year:	**2017-2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected was clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were noted in report.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plan was noted in report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel were listed in report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions were undertaken to address barriers identified**.**
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to analysis plan (monthly).
8.2 Did the PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were presented clearly on page 11 of PIP Report.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Repeat measurements were noted in report.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of baseline data was documented and follow-up was noted on page 11 of the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Changes to methodology were noted in the report on page 10.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate improved from 35% in Nov to 46% in Dec. 2019.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement was related to interventions. Report notes Alliance is still working on census reporting to rectify inconsistencies.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling not used, so statistical testing was not required.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Goal rate has not been met yet.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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:	**INCREASE TCLI IPS/SE REFERRALS**
Reporting Year:	**2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Alliance did not meet State benchmark for members from the in/at risk population receiving IPS/SE.
1.2 Did the PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This addressed TCLI target population.
1.3 Did the PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	Included member population.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question was documented.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure was clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measured changes in processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Enrollee population was defined.
4.2 If the PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Information collected captured all enrollees of interest to the study,
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling conducted.
5.2 Did the PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling conducted.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling conducted.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collection methods were documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were 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**	Method was systematic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	State tracking log and referral forms.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis occurred on a monthly basis and reported quarterly and annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff qualifications were included in the report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Barriers and interventions were noted in Interventions table.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Numbers were reported for every quarter.
8.2 Did the PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were presented clearly in table and graph format.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and 2 remeasurements were reported.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analyses were conducted.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same Methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Changes to selection were documented in report regarding centralized location for referral forms.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Number improved from 7 to 13 to 22 at most recent measurement.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement was related to interventions and selection changes.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Sampling not used so statistical analyses was not required.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Goal was not met, unable to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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.*

D. Attachment 4: Tabular Spreadsheet

CCME PIHP Data Collection Tool

PIHP Name:	**Alliance Health**
Collection Date:	2019

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A. General Approach to Policies and Procedures						
1. The PIHP has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					In Alliance's 2018 EQR, CCME recommended that Alliance add the specific *NC Medicaid Contract* references to their procedures. These references would help staff navigate procedures where accrediting bodies (such as URAC and NCQA) requirements differ from Alliance's *NC Medicaid Contract*. This is particularly true in areas such as appeals, Program Integrity, and Finance. Alliance's written response to this Recommendation stated, "Efforts are underway, and are expected to continue for some time, to revise current and draft new policies and procedures for the purpose of Tailored Plan and NCQA readiness. The Alliance contract with DHB will change in July 2021. With our Medicaid contract often being amended, there is a concern that adding specific contract section references would cause unnecessary confusion and the likelihood of incorrect references following comprehensive amendments." It is understood Alliance is preparing for NCQA accreditation and that the *NC Medicaid Contract* is often amended. However, Alliance has a revision process in place designed to address the need to revise procedures caused by changes in both internal and external requirements. This process is designed to be nimble and prevent confusion regarding what is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						required procedurally. CCME again recommends that Alliance add *NC Medicaid Contract* requirements within the narrative of their procedures. ***Recommendation: Add specific references to NC Medicaid Contract requirements within Alliance's procedures.***
I. B. Organizational Chart / Staffing						
1. The PIHP's resources are sufficient to ensure that all health care products and services required by the State of North Carolina are provided to enrollees. At a minimum, this includes designated staff performing in the following roles:						
1.1 A full time administrator of day-to-day business activities;	X					Rob Robinson continues in his role as CEO of Alliance and oversees the day-to-day business activities.
1.2 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities.	X					Dr. Mehul Mankad joined Alliance during this past year and the details of his oversight were added to the Organizational Chart.
2. Operational relationships of PIHP staff are clearly delineated.	X					
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all PIHP staff positions, including those that are required by *NC Medicaid Contract*.	X					Alliance's *Organizational Chart* is accompanied by a listing of staff and their education, certification, and licensure information. This list shows staff meet minimum educational and training requirements as required by the *NC Medicaid Contract*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. C. Confidentiality						
1. The PIHP formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					
2. The PIHP provides HIPAA/confidentiality training to new employees and existing staff.	X					Alliance trains new staff on confidentiality on the first day of employment and requires new staff to sign a confidentiality agreement prior to accessing the electronic record system. Alliance conducts annual training for existing staff that includes confidentiality.
I D. Management Information Systems						
1. Enrollment Systems						
1.1 The PIHP capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Alliance has standard processes in place for enrollment data updates. WellSky uploads the daily and quarterly GEF files to the AlphaMCS enrollment system. Alliance utilizes the monthly 820 Capitation file to record revenue, estimate future enrollment, update membership lag schedule and record receivables. Alliance also utilizes the 820 Capitation file to identify errors in payment and incorrect or duplicate Medicaid members.
1.2 The PIHP is able to identify and review any errors identified during or as a result of the State enrollment file load process	X					Demographic data is captured in the AlphaMCS system and patients' IDs are unique to members. Historical enrollment information is captured and maintained for all members.
1.3 The PIHP's enrollment system member screens store and track enrollment and demographic information.	X					Alliance's load process uploads the GEF file completely. If any errors are encountered during the upload then no record in the file is uploaded.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Claims System						
2.1 The PIHP processes provider claims in an accurate and timely fashion.	X					The majority of claims received are electronic or through the provider web portal. Less than 1% of claims that are submitted by providers in Hawaii and Emergency Room claims are received via paper. Approximately, 90.53% of Institutional and 98.02% of Professional claims are auto-adjudicated. Auto-adjudication is performed daily. Emergency Department claims are pended for manual review. Manual review of claims is performed on a daily basis.
2.2 The PIHP has processes and procedures in place to monitor review and audit claims staff.	X					Alliance has processes in place to monitor and audit claims staff.
2.3 The PIHP has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	X					Alliance audits a random sample of at least 2.5% of all claims processed on a weekly basis. Paper claims are included in the random sample of 2.5% and audited weekly. For the first two-three weeks, 100% of claims processed by new-hire claim examiners are audited by experienced staff and Managers.
2.4 The PIHP's claim system screens store and track claim information and claim adjudication/payment information.	X					ICD-10 Procedure codes, Revenue codes and DRG codes are captured in the AlphaMCS system. DRG and ICD-10 Procedure codes can be submitted via the provider web portal. The Revenue codes, DRGs and ICD-10 Procedure codes are also included for encounter data submission reporting. For Institutional claims, up to 25 ICD-10 Diagnosis codes are captured received via the provider web portal and up to 29 ICD-10 Diagnosis codes are captured electronically. For Professional claims, up to 12 ICD-10 Diagnosis codes are captured electronically and via the provider web portal.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Reporting						
3.1 The PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					The enrollment and claims data in the AlphaMCS database from WellSky is mirrored into local databases on a daily basis and also multiple times a day by automated jobs. Alliance utilizes the AlphaMCS system, internal databases, and Enterprise Data Warehouse to generate reports.
3.2 The PIHP has processes in place to back up the enrollment and claims data repositories.	X					Alliance's reporting database and data warehouse contains enrollment and claims data since 2012.
4. Encounter Data Submission						
4.1 The PIHP has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	X					Alliance submits up to 29 ICD-10 Diagnosis codes on Institutional and up to 12 ICD-10 Diagnosis codes on Professional encounters to NCTracks.
4.2 The PIHP has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					Alliance includes DRG codes and ICD-10 Procedure codes on encounter data submissions. Alliance includes Procedure codes and Revenue codes for certain lab, drug or radiology services on encounter data submissions.
4.3 PIHP has policies and procedures in place to reconcile and resubmit encounter data denied by NC Medicaid.	X					Alliance utilizes an internally developed application, Accounts Receivable (AR) reconciliation system, to track and reconcile encounters submitted to NCTracks. The data from the Adam Holtzman's paid and denied reports and the 835 response files are also utilized to identify and reconcile encounter data denials.
4.4 The PIHP has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to NC Medicaid.	X					Alliance has two Claims Analysts that is responsible for working on the denied encounters. The encounter data acceptance rate has been consistent with last year's observations. Alliance has significantly reduced the backlog submissions when compared to last year. Alliance's staff was able to speak to 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 6030, Credentialing Criteria and Enrollment Process for Network Participation, and Procedure 6011, Primary Source Verification, as their Credentialing Plan. Procedure 6011, Primary Source Verification, provides details and guidelines for Primary Source Verification (PSV) during the credentialing and recredentialing processes.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	X					Procedure 6030, Credentialing Criteria and Enrollment Process for Network Participation states, "The Provider Network Credentialing Committee is chaired by the Chief Medical Officer or an Associate Medical Director in his/her absence." The *Credentialing Committee Org Chart 05.14.2019* and the *Credentialing Committee Org Chart 09.27.2019* list Dr. Don Fowls as CMO and Chair of the Credentialing Committee. The *Credentialing Committee Org Chart 11.5.2019* and the *Credentialing Committee Org Chart 2.13.2020* list Dr. Mehul Mankad as CMO and Chair of the Credentialing Committee. During the EQR review period, neither Dr. Fowls nor Dr. Mankad attended any Credentialing Committee meetings. The Associate Medical Directors, Dr. Heidi Middendorf and Dr. Nadiya Kaesemeyer, each chaired some of the Credentialing Committee meetings, with Dr. Middendorf chairing 55% of the meetings, and Dr. Kaesemeyer chairing 45%. The Credentialing Committee has delegated authority to the Chief Medical Officer (CMO) or designee to approve clean credentialing applications. Credentialing Committee Meeting Minutes reflect discussion and votes regarding applications brought to the committee because they have "one or more criteria that may not meet Alliance criteria for participation."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The *Credentialing Committee Organization Chart 2.13.2020* lists 2 Alliance providers and 5 Alliance employee members designated as voting members of the committee. Attendance of voting members ranged from 45% (one member) to 93 % (one member) of the meetings at which they were a member. Procedure 6030 provides details regarding committee membership, including that the Credentialing Manager and the Director of Provider Network Operations are non-voting members. During the EQR review period, the Credentialing Manager accepted a different position at Alliance. The department was reorganized, and the Credentialing Manager position is now a Supervisor position, for which Alliance is recruiting. Though listed in the membership on all Credentialing Committee meetings during the EQR review period, the Director of Provider Network Operations did not attend any of the 31 meetings. ***Recommendations: Revise Procedure 6030, the Credentialing Committee meeting minutes template, and any other documents that list Credentialing Committee membership to accurately reflect membership and Chair. For example, if the Credentialing Manager position no longer exists, delete that position from the documents or revise the title of the position. If the Director of Network Operations is not going to attend the meetings, delete that position from the documents. If an AMD is actually the Committee Chair, revise the documents to reflect that.***
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Credentialing files reviewed were well-organized and contained appropriate information. CCME identified the following issues in the file review:
3.1 Verification of information on the applicant, including:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.1 Insurance requirements;	X					Procedure 6030, Credentialing Criteria and Enrollment Process for Network Participation, and page 33 of the *Provider Operations Manual* 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					
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					Alliance Procedure 6011, Primary Source Verification, states, "For MDs only, Alliance verifies Education via Intellicorp or the Educational Commission for Foreign Medical Graduates certificate or via a Certified (and translated if applicable) copy of Medical School transcripts." During Onsite discussion at the last EQR, Alliance staff confirmed they had not discussed with NC Medicaid the Alliance practice of using Intellicorp as PSV for physician education. NC Medicaid staff present at that Onsite review asked that Alliance send them an email regarding using this source as PSV of physician education. Alliance recently interacted with NC Medicaid about this issue, and NC Medicaid approved the practice of using Intellicorp for education verification for MDs. The physician files reviewed for the current EQR included either Educational Commission For Foreign Medical Graduates (ECFMG) or Primary Source Verification (PSV) of board certification, both of which complete Primary Source Verification of education.
3.1.5 Work History	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					The submitted *Ownership Disclosure* forms were not signed nor dated (there is no space indicated for obtaining signature or date). At the Onsite review, Alliance staff confirmed this is because, for Licensed Independent Practitioners, the *Ownership Disclosure* form is part of the Credentialing Initiation packet, which includes the signed and dated application attestation (which was in the submitted files). For the EQR of Licensed Practitioners joining contracted agencies, Alliance submitted the *Ownership Disclosure* form from the file of the agency.
3.1.16 Criminal background Check	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 were well-organized and contained appropriate information. CCME identified the following issues in the file review:
4.1 Recredentialing every three years;	X					Procedure 6030, Credentialing Criteria and Enrollment Process for Network Participation, states, "All Providers must be re-credentialed a minimum of once every three (3) years." In one of the reviewed files, the recredentialing process was completed within 3 years of the date the previous credentialing was completed (01/27/17), but not within 3 years of the effective date (09/20/16) of the previous credentialing.
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					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.14 Ownership Disclosure is addressed.	X					The submitted *Ownership Disclosure* forms were not signed nor dated (there is no space indicated for obtaining signature or date). At the Onsite review, Alliance staff confirmed this is because, for Licensed Independent Practitioners, the *Ownership Disclosure* form is part of the Credentialing Initiation packet, which includes the signed and dated application attestation (which was in the submitted files). For the EQR of Licensed Practitioners joining contracted agencies, Alliance submitted the *Ownership Disclosure* form from the file of the agency.
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 which includes the *Provider Action Sanctions* document that Alliance generates every month for recredentialing purposes. The *Provider Action Sanctions* list is cumulative, with years of information, but can be filtered for a specific timeframe. The list allows a search by contract name, by practitioner name, or by agency name. Alliance maintains the information electronically as part of the recredentialing file. Credentialing Committee Meeting Minutes reflect committee consideration of issues such as quality of care concerns, issues identified during monitoring, and plans of correction.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Procedure 3043, Provider Sanctions, Administrative Actions, and Suspensions to Ensure Patient Safety, defines "the process for Alliance Health to impose sanctions or administrative actions against Network Providers or to impose an emergency suspension whenever the Chief Medical Officer or Executive VP of Care Management determine that a Network Provider is engaged in activity that may pose a risk to the health, welfare, or safety of any consumer."
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					
II B. Adequacy of the Provider Network						
1. The PIHP maintains a network of providers that is sufficient to meet the health care needs of enrollees and is consistent with contract requirements.	X					Procedure 6012, Provider Network Capacity and Network Development, defines "the process for assessing network capacity and addressing gaps in access to services for members." The procedure indicates "Alliance will conduct an annual Network Adequacy and Accessibility analysis of its Provider Network to determine the appropriate number, mix, and geographic distribution of providers, including an analysis of geographic access of its memberships to practitioners and facilities."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 Enrollees have a Provider location within a 30 – mile distance of 30 minutes' drive time of their residence. Rural areas are 45 miles and 45 minutes. Longer distances as approved by NC Medicaid are allowed for facility based or specialty providers.	X					The *Provider Operations Manual* (*Revised January 2019; effective March 2, 2019*) states "The geographic access standard for services is thirty (30) miles or thirty (30) minutes driving time in urban areas, and forty- five (45) miles or forty-five (45) minutes driving time in rural areas." The *Individual and Family Handbook* states "Most services will be available within 30 miles from your home through in-network providers. However, some specialty providers may be located in another county. Alliance will assist you in locating a provider that can meet your needs as close to your home as possible." The *Network Adequacy and Accessibility Analysis* states, "the Alliance service network meets geographic access and choice expectations for Outpatient, Community/Mobile, Crisis, Inpatient and C-Waiver service categories." As was the case at the last EQR, Alliance identified Child and Adolescent Day Treatment (limited choice in (in Cumberland County), and Opioid Treatment services (limited choice in Cumberland County and part of Johnson County) as Location-based Medicaid-funded services that did not meet geographic access and choice expectations. Alliance submitted Exception Requests for both services. During Onsite discussion, Alliance staff reported they worked with the Cumberland County school system to ensure they were supportive, then added a day treatment provider. Alliance added a provider to address the opioid treatment gap.
1.2 Enrollees have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the enrollee may utilize an out-of-network specialist with no benefit penalty.	X					The *Individual and Family Handbook* provides information about receiving services from an out-of-network provider and addresses medical necessity.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 The sufficiency of the provider network in meeting enrollee demand is formally assessed at least annually.	X					Alliance annually conducts the NC Medicaid-required *Network Adequacy and Accessibility Analysis*.
1.4 Providers are available who can serve enrollees with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					The *Provider Operations Manual* states "Language interpretation services shall be made available by telephone or in-person to ensure that Enrollees are able to communicate with Alliance and Network Providers. Providers and Alliance shall make oral interpretation services available free of charge to each Enrollee. This applies to non-English languages as specified in *42 CFR § 438.10(c)(5)*. TDD (telecommunication devices for the deaf) must also be made available by providers for persons who have impaired hearing or a communication disorder." The "Provider Resources" section of the Alliance website has a link to the "Cultural Competence" section, with links to a variety of websites. The *Alliance Cultural Competency Plan*, effective FY19-Y21 is also on that section of the website. During Onsite discussion, Alliance staff confirmed providers are required to have a Cultural Competency Plan and would have to present the plan, if requested. The *Provider Directory* and the online Provider Search include providers who provide services to enrollees with a visual or hearing impairment, or to enrollees who speak languages other than English. The *Individual and Family Handbook* informs enrollees of the availability of "free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large-print, audio, etc.)." The handbook goes on to state, "Alliance also provides free language services to people whose primary language is not English, such as:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						• Qualified interpreters. • Information written in other languages." Alliance uses Single Case Agreements whenever medically necessary services are not available within the network.
1.5 The PIHP demonstrates significant efforts to increase the provider network when it is identified as not meeting enrollee demand.	X					Per Procedure 6012, Provider Network Capacity and Network Development, "The Network Development and Evaluation Department in collaboration with other Departments will use the results of the analysis to create a Network Access Plan." The Alliance website includes a "Current service needs" webpage. Listings posted at the time of the EQR include "New Medication-Assisted Treatment (MAT: Buprenorphine) Service Definition Modifiers for Medicaid-Funded Outpatient Services", which could address the identified service need for Opioid Treatment. When needed, Requests for Information (RFI), RFPs or Requests for Quotes (RFQs) are posted (including a current Request for Proposal for a provider for School System Embedded Child and Adolescent Day Treatment Program in Durham County).
2. Provider Accessibility						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.1 The PIHP formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Procedure 4017, Service Calls, addresses access standards.
II C. Provider Education						
1. The PIHP formulates and acts within policies and procedures related to initial education of providers.	X					Procedure 6034, Provider Orientation and Education, addresses new provider orientation. Broken links/incorrect URLs are present in template letters sent to providers upon credentialing and recredentialing approval and in Procedure 6034, Provider Orientation and Education. ***Recommendations: Correct broken/inaccurate URLs/links in Procedure 6034, Provider Orientation and Education, in letters to providers, and in other documents in which they may appear.*** ***Develop an internal process for ensuring the appropriate department(s) are notified whenever items are moved on, or removed from, the website, so the corresponding link(s)/URL(s) in documents can be revised/changed to the appropriate location.***
2. Initial provider education includes:						The New Provider Orientation webpage includes a link to the *Provider Operations Manual* and other publications and forms. Links are provided to Provider News as well as information about provider meetings and the Alliance Provider Advisory Council. Relevant information for the following section was located in the *Provider Operations Manual*, *the Individual and Family Handbook*, or on Alliance's website, unless otherwise indicated.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.1 PIHP purpose and mission;	X					
2.2 Clinical Practice Standards;	X					The *Provider Operations Manual* has a link to the Clinical Guidelines posted on the Alliance website.
2.3 Provider responsibilities;	X					
2.4 PIHP closed network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability.	X					
2.5 Access standards related to both appointments and wait times;	X					Access standards are addressed in the *Provider Operations Manual*.
2.6 Authorization, utilization review, and care management requirements;	X					Addressed in Section VI: Clinical Management of the *Provider Operations Manual*.
2.7 Care Coordination and discharge planning requirements;	X					Addressed in Section VI: Clinical Management of the *Provider Operations Manual*.
2.8 PIHP dispute resolution process;	X					Addressed in Section IX: Dispute Resolution Process for Providers of the *Provider Operations Manual*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.9 Complaint investigation and resolution procedures;	X					Addressed in the *Provider Operations Manual*.
2.10 Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements;	X					See *Provider Operations Manual*, Section VII: Claims and Reimbursement.
2.11 Enrollee rights and responsibilities	X					See Section IV: Individual Rights and Empowerment in the *Provider Operations Manual*.
2.12 Provider program integrity requirements that include how to report suspected fraud, waste and abuse, training requirements as outlined in the False Claims Act, and other State and Federal requirements.	X					The *Provider Operations Manual* provides information about fraud, waste, and abuse, including the notation on that "All Providers must monitor for the potential for fraud and abuse and take immediate action to address reports or suspicion", and information about how to report suspected fraud, waste, and abuse. The Home page of the Alliance website has the phone number for the Confidential Fraud and Abuse Line, and a link to the Reporting Provider Fraud and Abuse webpage. The Reporting Provider Fraud and Abuse webpage includes reporting information and provides a link to the "Medicaid fraud and abuse confidential online complaint form DHHS Customer Service website." A link to the U.S. Health and Human Services' Office of Inspector General "Compliance Resource Portal" page is provided, though Alliance has the old name("U.S. Department of Health and Human Services Compliance 101"). A link to the CMS Medicaid Fraud Prevention Toolkit webpage is also provided.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The PIHP provides ongoing education to providers regarding changes and/or additions to its programs, practices, enrollee benefits, standards, policies and procedures.	X					During Onsite discussion, Alliance staff reported they post updates in the Provider section of the Alliance website. For special initiatives, they put a banner on the website, "if there is something that needs to be addressed and we want providers to see quickly". Providers are encouraged to sign up for *Provider News*, and can choose to receive these daily or weekly. Special communications and alerts are sent by the Communications Department, when needed.
II D. Clinical Practice Guidelines for Behavioral Health Management						
1. The PIHP develops clinical practice guidelines for behavioral health management of its enrollees that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Procedure 7506, Clinical Guidelines, indicates the development of clinical guidelines is the responsibility of the Chief Medical Officer, the guidelines are based on scientific evidence and/or consensus of community standards, and may be adopted from nationally recognized professional organizations. The clinical guidelines are approved by the Committee on Provider Quality, which is comprised of practitioners, provider agency medical directors from the Alliance network, the local community of providers, and Alliance clinicians.
2. The PIHP communicates the clinical practice guidelines for behavioral health management and the expectation that they will be followed for PIHP enrollees to providers.	X					The *Provider Operations Manual* informs providers they are "required to follow the clinical guidelines adopted by Alliance in the provision of care and Alliance will measure adherence to these guidelines." A link to the Alliance Clinical Guidelines is provided, and providers are informed they can obtain a hard copy by contacting Alliance.

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

III. ENROLLEE SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III A. Enrollee Rights and Responsibilities						
1. The PIHP formulates policies outlining enrollee rights and procedures for informing enrollees of these rights.	X					
2. Enrollee rights include, but are not limited to, the right:	X					Member rights are outlined in Procedure 3500 and in the *Individual and Family Handbook*. The Alliance Human Rights Committee (HRC) protects the rights of people receiving services. The HRC reviews complaints about violations of member rights, including privacy concerns. HRC meets at least quarterly and reports to the Alliance Board of Directors, the Alliance Continuous Quality Improvement (CQI) Committee, and state authorities. All the sub-standards within this standard were met.
2.1 To be treated with respect and due consideration of dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;						
2.3 To participate in decisions regarding health care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 To refuse treatment;						
2.5 To be free from any form of restraint of seclusion used as a means of coercion, discipline, convenience or retaliation;						
2.6 To request and receive a copy of his or her medical record, except as set forth in *45 CFR § 164.524* and in *NCGS 3(d),* and to request that the medical record be amended or corrected in accordance with *45 CFR § 164*.						
2.7 Of enrollees who live in Adult Care Homes to report any suspected violation of their enrollee rights, to the appropriate regulatory authority as outlined in NCGS§ 131-D21.						
III B. Enrollee PIHP Program Education						
1. Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid waiver managed care program which they are contractually entitled, including:	X					Procedure 3500, Individual Rights and Responsibilities states, "Individuals will be given access to the most recent *Individual and Family Handbook* within fourteen (14) days of enrollment by the Customer Service Department. This handbook contains a list of rights and responsibilities, civil rights and human rights. This handbook must be made available in both English and Spanish." The *Welcome Letter* is sent within 14 business days of enrollment. It directs members to the Access and Information phone number for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						help providing needed information. It also directs members to the AllianceHealthPlan.org website for written materials including the *Individual and Family Handbook*. Also, printed copies of the *Individual and Family Handbook* are available by calling or sending a request in writing. Information in the sub-standards are found in the *Individual and Family Handbook* or other Alliance documentation, unless noted differently. The *Welcome Letter* states "Alliancehealthplan.org, you will find a variety of useful materials and other resources, including the Alliance *Individual and Family Handbook*. This handbook describes how to obtain services and information about your rights and responsibilities as a consumer. A list of those rights and responsibilities is included with this letter."
1.1 A description of the benefits and services provided by the PIHP and of any limitations or exclusions applicable to covered services. These descriptions must have sufficient detail to ensure the Enrollees understand the benefits to which they are entitled and may include a web link to the PIHP Benefit Plan. This includes a descriptions of all Innovations Waiver services and supports;						An explanation of service benefits is in the *Individual and Family Handbook*.
1.2 Benefits include access to a 2nd opinion from a qualified health care professional within the network, or arranges for the enrollees to obtain one outside the network, at no cost to the enrollee;						The right to a second opinion is explained in the *Individual and Family Handbook*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Updates regarding program changes;						Update regarding program changes is explained in the *Individual and Family Handbook* and addressed in Procedure 7528, Significant Change to Healthcare Plan.
1.4 A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;						
1.5 An explanation of the Enrollee's responsibilities and rights and protection as set forth in *42 CFR §438.100.*						The Rights and Responsibilities is difficult to find on the Alliance website. ***Recommendation: From the Alliance website home page, provide a direct link to the Individual Rights and Responsibilities.***
1.6 An explanation of the Enrollee's rights to select and change Network Providers						
1.7 The restrictions, if any, on the enrollee's right to select and change Network Providers						
1.8 The procedure for selecting and changing Network Providers						The process for selecting and changing providers is explained in the *Individual and Family Handbook*.
1.9 Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a						The online provider search allows searching by service, provider, or clinician.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
written list of current Network Providers shall be provided by PIHP to any Enrollee upon request);						
1.10 The non-English languages, if any, spoken by each Network Provider;						Spoken Languages are listed in the online service, provider, and clinician search option on Alliance's website. Languages are listed in the printed *Provider Directory*.
1.11 The extent to which, and how, after-hours and emergency coverage are provided, including:						
1.11.1 What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services in accordance with *42 CFR § 438.114* and EMTALA;						
1.11.2 The fact that prior authorization is not required for emergency services;						
1.11.3 The process and procedures for obtaining Emergency Services, the use of 911 telephone services or the equivalent;						
1.11.4 The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract;						The online provider search has fields for emergency and post stabilization services. The *Individual and Family Handbook* lists 4 locations of emergency and post stabilization services. This was corrected as a result of the last EQR.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.11.5 A statement that, subject to the provisions of the *NC Medicaid Contract*, the Enrollee has a right to use any hospital or other setting for Emergency care;						
1.12 The PIHP's policy on referrals for Specialty Care to include cost sharing, if any, and how to access Medicaid benefits that are not covered under the *NC Medicaid Contract*;						The *Individual and Family Handbook*, states, "For Medicaid services, your local DSS decides Medicaid eligibility and any co-payment or deductibles." The *Individual and Family Handbook* states, "If you are a Medicaid beneficiary, you cannot be charged a co-pay for any of the services managed by Alliance. However, you may be charged a co-pay for services managed by the NC Division of Health Benefits. For example, non-pregnant adults over age 21, may be charged a $3 co-pay for prescriptions. In addition, if you receive non-Medicaid services, your provider can charge a fee based on your income."
1.13 Any limitations that may apply to services obtained from Out-of Network Providers, including disclosures of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of Network Providers, and the procedures for obtaining authorization for such services;						The *Individual and Family Handbook* states, "You may be responsible for payment of services if you go to an out-of-network provider for nonemergency services that have not been pre-authorized by Alliance. The out of network provider will be responsible for contacting Alliance to go through the out of network process and set up the necessary paperwork to receive payment. To receive pre-authorization, call the Alliance Access and Information Center at (800) 510-9132 for more information."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.14 How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost-sharing;						
1.15 Procedures for obtaining out-of-area or out-of-state coverage of services, if special procedures exist;						The *Individual and Family Handbook*, states "Alliance has network providers and out-of-network providers that can be in the Alliance area, out of the Alliance area, or even out of state."
1.16 Information about medically necessary transportation services by the department of Social Services in each county;						Medically necessary transportation is explained in the *Individual and Family Handbook*. Currently, Alliance is contracting with LogistiCare if members need assistance with transportation.
1.17 Identification and explanation of State laws and rules Policies regarding the treatment of minors;						The rights of minors are explained in the *Individual and Family Handbook*.
1.18 The enrollee's right to recommend changes in the PIHP's policies and services;						Procedure 3500, Individual Rights and Responsibilities, states members have, "The right to recommend changes to Alliance policies and services." This was corrected as a result of Alliance's last EQR.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.19 The procedure for recommending changes in the PIHP's policies and services;						The *Individual and Family Handbook* explains that Members have the right to recommend changes to Alliance policies and services. To do so, they may email their recommendations to the Members Engagement Manager or mail them to Alliance (address is provided). This was corrected as a result of last EQR.
1.20 The Enrollee's right to formulate Advance Directives;						The *Individual and Family Handbook* details information about psychiatric advance directives, health care power of attorney, and living wills.
1.21 The Enrollee's right to file a grievance concerning non-actions, and the Enrollee's right to file an appeal if PIHP takes an action against an Enrollee;						
1.22 The accommodations made for non-English speakers, as specified in *42 CFR § 438.10(c)(5);*						The *Individual and Family Handbook* states, "How can I get assistance in languages other than English? Alliance staff can connect you to an interpretation service for languages other than English. This is a free service to you, and available on any call. You may have to wait briefly for the conference call with the interpreter to begin. Free interpretive service is available when working with Alliance providers as well. Alliance can also translate this member handbook, forms and brochures into other languages in addition to English and Spanish. Please call the Access and Information Center at (800) 510-9132 to request translation of materials into other languages."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.23 Written information shall be made available in the non-English languages prevalent in the PIHP's services area;						Many educational materials and brochures are written in Spanish and English. The website has Google Translate available.
1.24 The availability of oral interpretation service for non-English languages and how to access the service;						
1.25 The availability of interpretation of written information in prevalent languages and how to access those services;						Interpreter services are available by calling the Access and Information Center at (800) 510-9132 to request translation of materials into other languages.
1.26 Information on how to report fraud and abuse;						"How can I help prevent fraud and abuse?" is a section within the *Individual and Family Handbook*.
1.27 Upon an Enrollee's request, the PIHP shall provide information on the structure and operation of the agency and any physician incentive plans;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.28 Information on grievance, appeal and fair hearing procedures and information specified in *42 CFR § 438.10 (g).*						
2. Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.			X			In the previous EQR, it was noted Alliance sent an annual mailing to notify enrollees of their right to request and obtain written materials produced for Enrollee use. The annual notice has been historically sent each year between December and January. However, Alliance did not send this annual mailing during this EQR period (February 1, 2019- January 31, 2020). During the Onsite interview on March 19, 2020, A NC Medicaid legal representative and an Alliance legal representative sent email correspondences that resulted in a resolution for mailing this notification. The resolution allows Alliance to provide the notification via Alliance's website. *NC Medicaid Contract, Section 6.9.5*, states, "At least once each year, PIHP shall notify all Enrollees of their right to request and obtain a copy of written materials produced for Enrollee use." This resolution was not agreed upon until after the review period and as of March 19, 2020, this member right was not posted on the Alliance website. ***Corrective Actions: Revise Procedure 3500, Individual Rights and Responsibilities to reflect the current process Alliance implements to meet NC Medicaid Contract 6.9.5., "At least once each year, PIHP shall notify all Enrollees of their right to request and obtain a copy of written materials produced for Enrollee use." Also, maintain proof of the enrollee notification.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in *42 CFR § 438.10 (f) (61)* and *438.10 (g)* at least 30 days before calendar days before the intended effective date of the change; and (2) . termination of their provider within fifteen (15) calendar days after PIHP receives notice that NC Medicaid or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.	X					Alliance attested that there were no "with cause" contract terminations during the review period of February 1, 2019- January 31, 2020. Voluntary contract withdrawals (4) and contract non-renewals (20) were identified and reviewed. All files submitted for review contain documentation verifying that members were notified within 15 calendar day after the provider notified Alliance of the contract withdrawal. There was a Recommendation at the last EQR to Include the date of the provider's termination from the network in the member communication letters. That date was included in all member letters.
4. Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation of prevalent non-English languages as required by the contract.	X					All enrollee materials are written in a clear and understandable manner.
5. The PIHP maintains and informs Enrollees of how to access a toll-free vehicle for 24-hours Enrollee access to coverage information from the PIHP, including the availability of free oral translation services for all languages and care management services such as crisis interventions.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III C. Behavioral Health and Chronic Disease Management Education						
1. The PIHP enables each enrollee to choose a Provider upon enrollment and provides assistance as needed.	X					
2. The PIHP informs enrollees about the behavioral health education services that are available to them and encourages them to utilize these benefits.	X					The *Individual and Family Handbook* states, "Alliance provides educational opportunities to our members, families and other community members with helpful information about diagnoses, treatment options and maximizing treatment benefits. More information can be found on our website at AllianceHealthPlan.org or by calling (800) 510-9132." There is very little information on the website about member's diagnosis, treatment options, and maximizing treatment benefits. ***Recommendations: On Alliance's website, enhance the educational information about member's diagnoses, treatment options, and maximizing treatment benefits within the "Individuals and Families" section. Ensure this information is easy to access.*** Alliance's website has a link for trainings, but the link is hard to find and produced an error message when accessed during the Onsite. The Events Calendar Category filter choices are: Alliance Staff Only, Board of Directors and Board Committees, Meeting and Events, and Trainings. None of the selections indicate they are member trainings. Some of the items in the training category descriptions indicate members can attend. CCME recommends Alliance make member trainings easier to locate on the Events Calendar by indicating which trainings are specifically for members.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Place the member Events Calendar in a location where members can easily find it. The Events Calendar Category filter choices are: Alliance Staff Only, Board of Directors and Board Committees, Meeting and Events, and Trainings. None of the selections indicate they are for members. Some of the item descriptions in the training category indicate members can attend. ***Recommendation: Make member trainings easier to locate on the Events Calendar by indicating which trainings are specifically for members.***
3. The PIHP tracks the participation of enrollees in the behavioral health education services.	X					Alliance has four communication specialists, one in each county. Each specialist keeps a spreadsheet for attendance at events and does outreach to educate groups of free trainings.
III D. Call Center						
1. The PIHP provides customer services that are responsible to the needs of the Enrollees and their families. Services include:	X					
1.1 Respond appropriately to inquiries by enrollees and their family members (including those with limited English proficiency);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 Connect enrollees, family members and stakeholders to crisis services when clinically appropriate;	X					Access and Information Center staff ask safety questions at the beginning of each call. Then, they use clinical decision guides to determine if the member needs emergent, urgent, or routine care. If emergent, and its decided that 911 is needed, the clinician will typically manage the process with another clinician. One clinician stays on the phone, and the other calls 911. If less urgent, the member is referred to a crisis center. Alliance will call ahead to the crisis center to make sure they know the member is coming.
1.3 Provide information to enrollees and their family members on where and how to access behavioral health services;	X					
1.4 Train its staff to recognize third-party insurance issues, recipient appeals, and grievances and to route these issues to the appropriate individual;	X					The Access and Information Center Training Materials include a Desk Reference and Modules 1-23, with a Final Module named “Tying it all together.”
1.5 Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;	X					
1.6 Process referrals twenty-four (24) hours per day, seven (7) days per week; 365 days per year; and	X					The Access and Information Center processes referrals twenty-four (24) hours per day, seven (7) days per week, 365 days per year. When a call is not answered within 30 seconds, the call center delegate, Vaya Health, receives the call.
1.7 Process Call Center linkage and referral requests for services twenty-four (24) hours per day, seven (7) days per week, 365 days per year.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV A. The Quality Improvement (QI) Program						
1. The PIHP formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to enrollees.	X					Alliance's *FY 2020 Quality Management Program Description* explains the formal Quality Improvement (QI) Program with clearly defined goals, structure, scope, and methodology.
2. The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.	X					The *FY 2020 Quality Management Program Description* states, "The QM Department assesses provider compliance with the clinical practice guidelines adopted by Alliance. This process involves: identifying two or more milestone elements in a clinical practice guideline; determining provider compliance via data analysis or record reviews; informing providers of any compliance issues via training and other communications; and identifying outlier providers for focused training." Alliance documents the monitoring of chosen Clinical Practice Guidelines in a detailed and complete, five-page document, titled *FY20 Adherence to Clinical Practice Guidelines*. This document explains the methodology and projected results (for FY20) of monitoring adherence to the clinical guidelines for antipsychotic medication, schizophrenia, and substance use disorder (SUD). Procedure 7506, Clinical Guidelines documents the development, approval, dissemination, application (section for provider adherence), and review of clinical guidelines.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Several reports were submitted for desk material review including monitoring of IIHS, Outpatient, PRTF, ICF/MR, and Inpatient. The Utilization Management (UM) Evaluation provided evidence of monitoring and addressing utilization issues with interventions and program assessments included. The Onsite discussion centered around the new dashboard layout which is still under development and currently undergoing QA testing. Another topic of discussion was the Family Center Treatment model that has shown positive results regarding length of stay outcomes and family engagement prior to PRTF.
4. The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.		X				Alliance analyzed the 2018 Adult and Child Experience of Care and Health Outcomes (ECHO®) Survey 3.0 results. This analysis was documented in the Alliance Health 2019 Network Adequacy & Accessibility Analysis, the FY 2019 Quality Management Program Evaluation, and in the PowerPoint presentation titled Combined Surveys Final. Each of these documents has a similar section titled either, "FY 2020 Strategy" or "Takeaways." These sections list a summary of findings, but there is no documentation of interventions implemented by Alliance to improve any of the identified findings. The April 2019 Continuous Quality Improvement (CQI) committee meeting minutes indicate that updates on interventions will be given to CQI quarterly. However, there was no follow-up documented in CQI minutes for these identified areas of the 2018 enrollee surveys throughout the 2019 calendar year. Corrective Action is required of Alliance to submit a plan that will be used routinely and annually. This plan should outline how Alliance will implement measures, if decided on by the appropriate committee, to address quality problems identified through the adult and child ECHO® surveys. This plan should include how Alliance will know when implemented measures have an effect on the ECHO® survey outcomes year-to-year.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Corrective Actions: Develop and implement a plan to routinely and annually implement measures, if decided on by the appropriate committee, to address quality problems identified through the Adult and Child Experience of Care and Health Outcomes (ECHO®) Surveys. Include how you will know when implemented measures have an effect on the enrollee survey from year-to-year. The 2019 ECHO® Surveys have been analyzed and shared with CQI in the January 22, 2020 CQI Committee meeting. The PowerPoint presentation titled, 2019 Provider Satisfaction and ECHO Survey Summaries was uploaded during the Onsite to provide additional information. Slides 9 and 13 document areas of focus for the Adult and Child ECHO® Surveys. In the next EQR, CCME will review to ensure these areas of focus have been discussed within the appropriate QM Committee or Sub-committee, and if committee recommendations and/or input is followed. Currently there is no Alliance document that tracks lower scoring enrollee survey items year-to-year, barriers and interventions for those items, and an analysis explaining if interventions implemented were successful based on the next year's survey results. CCME recommends Alliance create a document that tracks lower scoring enrollee survey items year-to-year, barriers and interventions for those items, and an analysis explaining if interventions implemented were successful based on the next year's survey results. ***Recommendation: Create an Alliance document that tracks lower scoring ECHO® survey items year-to-year, barriers and interventions for those items, and an analysis explaining if interventions implemented were successful when compared to the subsequent year's survey results.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. The PIHP reports the results of the enrollee satisfaction survey to providers.	X					The enrollee satisfaction results were shared at the April 4, 2019 CQI meeting and at the May 2019 GQMC.
6. The PIHP reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					The 2018 enrollee satisfaction results were shared at the April 4, 2019 CQI meeting. The 2019 ECHO Survey results were shared at the January 2020 CQI meeting.
7. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, time frame for implementation and completion, and the person(s) responsible for the project(s).	X					The *Operations Report-QM* Excel document tracks the QI activities with a Project Status Tracking tab and a Completed tab. This report is discussed and updated monthly.
IV B. Quality Improvement Committee						
1. The PIHP has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					
2. The composition of the QI Committee reflects the membership required by the contract.	X					The Global Quality Management Committee (GQMC) is comprised of five Board members, two Consumer and Family Advisory Committee (CFAC) members, and two providers. The Continuous Quality Improvement (CQI) Committee is comprised of 11 members from Alliance. The CQI subcommittees are Provider Quality, Utilization Management, Member Experience, Care Management, Social Drivers of Health (meetings started 12/19), and Delegation and Accreditation (started 2/20). All subcommittee membership is 100% Alliance staff except the Provider Quality Subcommittee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The QI Committee meets at regular intervals.	X					Provider Quality subcommittee meets monthly. GQMC meets monthly (at least Quarterly is stated in Procedure 6501, Quality Management Program). CQI meets monthly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Meeting minutes are documented and maintained for CQI, GQMC, and the CQI subcommittees.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					(b) and (c) Waiver measures are 100% compliant.
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					There are no Corrective Actions for the PIPs. There is one Recommendation for the Access to Care PIP. That Recommendation is detailed in *Table 21, Performance Improvement Project Errors and Recommendations* of within the Quality section of this report and on the Performance Improvement Project validation worksheet of this project within *Attachment 3* of this report.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV E. Provider Participation in Quality Improvement Activities						
1. The PIHP requires its providers to actively participate in QI activities.	X					Provider Quality subcommittee of CQI meets monthly. Minutes show this provider group actively participated in QI activities. The *FY2019 QM Program Evaluation* states "Reorganizing the CQI structure by function rather than Alliance department will create opportunities for providers to participate in additional CQI subcommittees." During the Onsite interview, Alliance stated they have robust provider participation in collaboratives where providers engage in discussion including feedback and solutions for specific issues. Supported Employment is one of the collaborative topics.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Alliance described during the Onsite interview that data is shared with providers each month on QI projects, including Intensive in-home and quality of services that are family focused and not just patient focused.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					The *FY 2019 Quality Management Program Evaluation* documents a summary and assessment of the QI program effectiveness.
2. The annual report of the QI program is submitted to the QI Committee and to the PIHP Board of Directors.	X					The *FY 2019 Quality Management Program Evaluation* was approved by the Alliance Board of Director's Global Quality Management Committee on 9/5/2019.

V. UTILIZATION MANAGEMENT

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.6 the appeal process, including a mechanism for expedited appeal;	X					Procedure 7518, Service Authorization Review Process, outlines the steps that will be taken by the Care Manager when reviewing SARs that have been requested to be reviewed under the urgent/emergent review timeframes.
1.7 the absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					
1.8 mechanisms to detect underutilization and overutilization of services.	X					Procedure 7509, Detecting Over and Under Utilization, outlines the tracking of over/underutilization of services. Further details regarding the process of monitoring over/underutilization are also listed in the *UM Plan*.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Dr. Mehul Mankad joined Alliance as the Chief Medical Officer (CMO) in October 2019. According to the *UM Plan*, the CMO provides direct supervisory oversight to the UM, Medical Management, and Care Coordination Departments. These duties include the approval of all utilization review criteria and Clinical Guidelines, and the oversight and leadership of the inter-rater reliability process.
3. The UM program design is reevaluated annually, including Provider input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The *UM Plan* is evaluated annually; the last update occurred on November 19, 2019.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Procedure 7503, Applying Clinical Criteria to Medical Necessity, indicates the required tools providers use for evaluating an enrollee's clinical needs. Alliance requires providers to implement the *Child and Adolescent Needs and Strengths* (CANS) for children ages 3 to 6, but this requirement is not listed in any procedure. ***Recommendation Update Procedure 7503, Applying Clinical Criteria to Medical Necessity, to include the requirement of providers to use the Children's Assessment of Needs and Strengths (CANS) to determine the clinical needs of children ages 3 to 6.***
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
4. Utilization management standards/criteria are consistently applied to all enrollees across all reviewers.	X					
5. Emergency and post stabilization care is provided in a manner consistent with contract and federal regulations.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. Utilization management standards/criteria are available for Providers.	X					UM standards and criteria are outlined in several procedures, the *Provider Operations Manual*, and the Alliance website.
7. Utilization management decisions are made by appropriately trained reviewers	X					
8. Initial utilization decisions are made promptly after all necessary information is received	X					All SAR approvals reviewed showed notifications were timely.
9. Denials						
9.1 A reasonable effort that is not burdensome on the enrollee or the provider is made to obtain all pertinent information prior to making the decisions to deny services		X				During the Onsite discussion, Alliance stated that communications with providers occur regularly through the Provider Communication portal, as well as, by email or phone. Those communications are expected to be captured in patient notes. Alliance also asserted that not all providers engage in active communications. However, when possible, they do make reasonable efforts to engage with the provider before deciding to deny services. Staff collaboration is evidenced by the decreased number of administrative denials (i.e., denials due to a lack of required documentation). In the file review, one denied request did contain a Care Manager stating, "an email was sent to the provider, but no response was received." However, only 8% of the SAR files contained any communications with providers prior to issuing a denial. Alliance staff also explained when a SAR is requested to be expedited by the provider, the Care Manager consults with their supervisor. Care Managers are also expected to reach out to the provider to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						discuss the justification for requesting an expedited review. Further, when the request does not meet criteria for an expedited SAR, the expectation is that the Care Manager documents this change in the patient note portal and shares this decision with the provider, along with an expected decision date. The file review found three SARs that were marked as Expedited and the Care Managers determined that the request did not meet the Expedited criteria in two of the three requests. Only one of these files contained notes explaining the reason for changing the timeframe from expedited to standard, and neither of the files showed the change was communicated to the provider. Given the inconsistencies found in the file review, Alliance needs to outline in a procedure the expectations of UM Care Managers around provider communication and the documentation of that communication. ***Corrective Actions: Add information to a UM procedure that describes the expectations on Care Managers to obtain additional information from providers prior to rendering a denial of a SAR or denial of a request to expedite a SAR decision. Include details regarding the documentation requirements within the SAR portal.***
9.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					All UM denial decisions were rendered by appropriate clinicians.
9.3 Denial decisions are promptly communicated to the provider and enrollee and include the basis for the denials of service and the procedure for appeal	X					All SAR denials reviewed showed notifications were timely.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V C. Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					The *Care Coordination Program Description* illustrates the six distinctive functional units in the Care Coordination program. Alliance also has Desk Manuals for I/DD, MH/SUD, and TCLI. The *Care Coordination Program Description* noted that the Complex Integrated Care Team was recently eliminated, and the Multi-Care Management Team was formed.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					Alliance Procedure 2004, Individual Support Plan (ISP), outlines the timely development of the Individual Support Plan (ISP). Procedure 2005, Identification, Referral, and Timely Initiation of MHSUD and IDD Care Coordination Functions, details the protocols for identification/referral and timely initiation of MH/SUD and I/DD Care Coordination. During last year's EQR, it was Recommended that Alliance add to Procedure 2005, Identification, Referral, and Timely Initiation of MHSUD and IDD Care Coordination Functions, more detail regarding the various functions of MH/SUD Care Coordinator. This Recommendation was implemented by Alliance.
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					
2.5 Quality monitoring and continuous quality improvement;		X				At the last EQR, Alliance was unable to produce the full record for the enrollees participating in MH/SUD and I/DD Care Coordination. Further, when a sample of files was reviewing during the Onsite, data entry errors were noted and inconsistencies in the completeness of records was also observed. A Recommendation was issued last year to remedy these concerns. CCME encouraged Alliance to develop a report that could pull the full Care Coordination member record, including all assessments and Care Coordination interventions, in chronological order. This report could be used for audits, internal quality improvement interventions, court proceedings, etc.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						During this year's Onsite discussion, Alliance reported that as of October 2018, all Care Coordination activities are captured in Jiva and staff are thoroughly trained in documenting activities in Jiva. Staff explained Jiva can produce reports that show the continuous Care Coordination activity. However, the review of Care Coordination files showed that the Recommendation from the last EQR were not fully implemented. Several errors were identified from the documentation produced out of Jiva and submitted for this EQR. • Progress notes had the incorrect header information. • Only a portion of the progress note was submitted (i.e., the narrative was cut off) in 35% of the progress notes submitted. • Progress notes abruptly ended with no indication that the enrollee had discharged from Care Coordination. • Progress notes did not include the date of service, so timeliness of documentation by Care Coordinators could not be assessed. As this is the second EQR where Alliance could not produce complete enrollee files, CCME is requiring Alliance to address this issue. ***Corrective Action: Develop a report that produces the full Care Coordination member record to include the date of service, all assessments, interventions, and discharges, in chronological order.***
2.6 Determination of which Behavioral Health Services are medically necessary;	X					

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					
2.10 Ensure privacy for each Enrollee is protected.	X					Onboarding training of new Care Coordinators on confidentiality and client rights is described in Procedure 2007, Training and Monitoring and Supervision of I/DD Care Coordinators.
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					Alliance has Procedure 2027, Monitor Requirements for NC Innovation Participants, in place to ensure that the monitoring of Innovations enrollee services occurs in accordance with *Clinical Coverage Policy 8P*. This procedure does not include the monitoring standards for Home Community Based Services as stated in *Clinical Coverage Policy 8P*, nor does it reference the state required Monitoring Checklist. ***Recommendation: Add to Procedure 2027, Monitoring Requirements for NC Innovation Participants, an explanation of Home and Community Based Services and the required use of the required State Monitoring Checklist.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The PIHP applies the Care Coordination policies and procedures as formulated.		X				In the previous EQR, CCME recommended that Alliance enhance the current monitoring processes of Care Coordination documentation in Jiva to ensure documentation is consistently and correct. This Recommendation stemmed from errors noted within the files reviewed prior to Onsite and a live demonstration of Jiva documentation during the Onsite. During this year's EQR Onsite, Alliance explained that supervision occurs monthly with each Care Coordinator. During supervision, the completeness of tasks and documentation are reviewed within the Jiva platform. Reports derived from Jiva are used during supervision to show the Care Coordinators what their progress is regarding task completion. When asked what the current benchmarks or compliance rate are for Care Coordination task completion such as monitoring, ISP's, and progress notes, Alliance was unable to provide any data. The review of the Care Coordination files revealed general inconsistencies in the frequency of contact and completeness and quality of documentation. The Support Intensity Scale (SIS) Assessment for two different enrollees over the age of 16 had expired up to six months before a new assessment was completed. According to Procedure 2028, Use of the Supports Intensity Scale, re-evaluation occurs every two years for individuals ages 5-15 years of age and every three years for individuals 16 years of age and older. Evidence that the SIS was completed was also not found in the progress notes. The required frequency of monitoring and State Monitoring Checklist for two members receiving HCBS did not meet the requirement outlined in Procedure 2027, Monitor Requirements for NC Innovation Participants. One file had no State Monitoring Checklist completed for the plan year for residential services. Also, progress notes documenting the monitoring were labeled as quarterly, when they

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						should have been monthly. In another enrollee's file, residential monitoring was occurring quarterly, which is not in compliance with the procedure that requires monthly monitoring of residential services. Additionally, Monitoring Checklists did not include dates of completion, had incorrect quarterly review dates and were completed before the end of the quarter. As this is the second EQR where the file review showed inconsistencies and errors in Care Coordination documentation, CCME is requiring Alliance to implement measures to ensure improvement in Care Coordination documentation within Jiva. ***Corrective Actions: Develop, document, and implement a data-driven monitoring plan that routinely reviews Care Coordination documentation.*** ***The monitoring plan should identify the frequency of monitoring, departmental benchmarks for compliance, and how and when outcomes of monitoring are captured, reviewed, and reported.*** ***The monitoring plan should include a routine review of timeliness of activities (e.g., documentation of completed activities, follow up activities, HCBS monitoring, etc.), as well as the quality and completeness of Care Coordinator documentation, including cases targeted for discharge.***
V. D Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					Per the Organizational chart and supplemental credentials list, all TCLI staff are appropriately credentialed.

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					Procedure 2034, In-Reach and Transition Process, outlines the requirement for Person Centered Plans.
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					Procedure 2034, Transition to Community Living Initiative, lists the enhanced services available to enrollees in the TCLI program. During the Onsite, Alliance shared a new monitoring initiative they have developed to use with providers who offer ACTT and CST services. The initiative includes ongoing discussions with providers on how to improve the supported employment component of these services.
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					
2.5 QOL Surveys are administered timely.	X					The review of TCLI files identified six enrollees who had transitioned to housing. Of the six files, three enrollees did not receive the 11-month QOL survey, and one member did not receive the 24-month survey. No QOL surveys were submitted for one enrollee. Instead, a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Screenshot that listed the due date of the survey and the number of days from the date that the survey was provided. Alliance explained that the dates listed on the Screenshot are not the actual date completed, but when it should have occurred for that enrollee. The enrollee would not have completed the 11 months or the 24-month survey because she was separated from housing before the survey was required to have been completed. The review of progress notes confirms that the member was separated from housing in April 2017. During the Onsite, Alliance noted that monitoring occurs to ensure the QOL surveys and In-Reach tool are complete and timely. However, the effects of the TCLI monitoring was not apparent in the files. CCME is requiring the TCLI program to increase their monitoring of the required TCLI activities and documentation through a Corrective Action detailed in TCLI Standard 6.
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					The TCLI Dashboards are submitted quarterly to NC Medicaid and were provided for this EQR review.

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					In last year's EQR, CCME recommended that Alliance design and make available TCLI materials for members with limited English proficiency. This Recommendation was implemented by Alliance in the past year.
6. A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures and processes, as required by NC Medicaid, and developed by the PIHP.		X				In the previous EQR, CCME recommended that Alliance enhance the current monitoring processes of TCLI Care Coordination documentation in Jiva to ensure documentation is consistent and correct. This Recommendation stemmed from errors noted within the TCLI files last year. This year's findings included progress notes that abruptly ended, not capturing the complete episode of care for the review period. Additionally, a large portion of progress notes were cut off, making it difficult to determine if TCLI activities were provided consistently and with appropriate follow-up. What could be reviewed in the I/DD, MH/SUD and TCLI files revealed inconsistencies in the frequency of contacts, completeness, and quality of documentation. There is evidence of ineffective monitoring to ensure that all task are being delivered timely, and that the documenting of activities are reflected in the Jiva platform accurately. As an example, TCLI follow-up/continued monitoring activities of enrollees who could not be located did not follow the process outlined in the TCLI Desk Manual. This manual requires continued monitoring or outreach, every 75 days. The review found that follow-up engagement for these enrollees ranged from 180 to 466 days.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						As this is the second EQR where the file review showed inconsistencies and errors in TCLI documentation, CCME is requiring Alliance to implement measures to ensure improvement in TCLI documentation within Jiva. ***Corrective Actions: Develop a report that produces the full TCLI member record to include the date of service, all assessments, interventions, and discharges, in chronological order.*** ***Develop, document, and implement a data-driven monitoring plan that routinely reviews TCLI Care Coordination documentation.*** ***The monitoring plan should identify the frequency of monitoring, departmental benchmarks for compliance, and how and when outcomes of monitoring are captured, reviewed, and reported.*** ***The monitoring plan should include a routine review of timeliness of TCLI activities (e.g., documentation of completed activities, follow up activities, completion of Quality of Life surveys, etc.), as well as the quality and completeness of TCLI Care Coordinator documentation including cases targeted for discharge.***

VI. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					Procedure 6503, Management and Investigation of Grievances, outlines Alliance's primary procedure for guiding staff through 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					
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					In the previous year's EQR of grievances, Alliance received one Recommendation. This year's review showed Alliance fully implemented and maintained the Recommendation to revise Procedure 6503, Management and Investigation of Grievances, to be consistent with contract requirements around extensions to the grievance resolution timeframe.
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					Procedure 6503, Management and Investigation of Grievances, does not describe the formal process by which grievances with quality of care concerns are reviewed by the Quality Review Committee. ***Recommendations: Within Procedure 6503, provide a description of the process by which the referral and consultation by the Quality Review Committee is consulted in grievances with quality of care concerns. Ensure this description includes how this referral and outcome of this consultation is documented within the grievance record.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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				Ten of the 20 grievance files reviewed showed grievance acknowledgment notifications were not compliant with Procedure 6503, Management and Investigation of Grievances. ***Corrective Actions: Develop, document, and implement a monitoring plan to increase compliance with required grievance notifications. This monitoring plan should include the timeline for implementation, frequency of monitoring, staff that will implement the monitoring, benchmarks, and how and when outcomes of monitoring are captured, reviewed, and reported. The monitoring plan should include monitoring of timeliness of all required written grievance notifications (i.e., grievance acknowledgement notifications and grievance resolution notifications).***
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					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				In the 2018 EQR, CCME recommended Alliance revise the appeal procedure to accurately reflect the definition of an appeal and who can file an appeal. In the past year, Alliance corrected the definition of an appeal within their procedure but did not change the procedure to accurately reflect who can file an appeal. *NC Medicaid Contract, Attachment M, Section G.1,* defines an appellant as "the Enrollee, legally responsible person, or a Provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent, may file a PIHP internal appeal." Three sections in Alliance's appeals procedure define who can file an appeal. On page seven, Alliance's appeal procedure states, "a provider who has the member's written consent" and does not reference other stakeholders. Then the procedure states representatives, "can be a provider, friend or family member even if not a guardian", but does not reference the requirement of the enrollee's written consent allowing stakeholders to be appeal representatives. Under the expedited appeal section within the appeals procedure its stated, "Any member, the member's legal representative, or the provider (if acting on the member's behalf with the members written permission) may request an expedited LME/MCO Appeal".

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						However, this statement does not reference other stakeholders (not just providers), with written permission, can serve as the enrollee's representative and request an expedited appeal. ***Corrective Action: Revise Procedure 6505, Due Process/Appeals of Medical Necessity Determination, to clearly and consistently state "the Enrollee, legally responsible person, or a Provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent, may file a PIHP internal appeal."***
1.2 The procedure for filing an appeal;		X				*NC Medicaid Contract, Attachment M, Section G.1* and *42 CFR § 438.402(c)(2)(ii)* allows appellants to file appeals 60 days from the mailing date of the Adverse Benefit Determination notice. This timeframe changed from 30 days to 60 days in 2017 in both the *NC Medicaid Contract* and federal regulations. In Alliance's 2018 EQR, it was recommended that Alliance, "update any documentation discussing Appeals to reflect the Enrollee has 60 days to file an Appeal." This Recommendation was based on errors within the *Provider Operations Manual* and the *IDD Care Coordination Desk Reference*, but was not implemented by Alliance. The *Provider Operations Manual* states, in multiple places, the timeframe to file an appeal is 30 days and the *IDD Care Coordination Desk Reference* states the timeframe to file an appeal is 15 days. ***Corrective Action: Revise the Provider Operations Manual and the IDD Care Coordination Desk Reference to clearly and consistently state the timeframe for filing an appeal is 60 calendar days from the mailing date on the adverse benefit determination notice, per NC Medicaid Contract, Attachment M, Section G.1 and 42 CFR § 438.402(c)(2)(ii).***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Additionally, it was noted in this year's review that the *Provider Operations Manual* has incorrect information regarding the timeframe for notifying an appellant of the expedited appeal resolution. The manual states Alliance will, "provide verbal notification of the determination within 72 hours of the request followed by written notification about the appeal within three (3) calendar days of the verbal notification." However, the timeframe required by *NC Medicaid Contract, Attachment M, H.5* is 72 hours for either a written or oral notification of an expedited appeal determination. ***Corrective Action: Revise the Provider Operations Manual to clearly and consistently state the timeframe for providing notification of an expedited appeal resolution is 72 hours.*** Lastly, it was also noted this year that *the IDD Care Coordination Desk Reference* states 2nd level appeals must be filed with the Office Of Administrative hearings is 30 days, but this timeframe is 120 days per *NC Medicaid Contract, Attachment M, Section I.1 and 42 CFR § 438.408(f)(2).* ***Corrective Action: Revise the IDD Care Coordination Desk Reference to clearly and consistently state the timeframe for enrollees to file a second level appeal is 120 days from the mailing date on the Appeal Resolution notifications.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					It was recommended in last year's EQR that Alliance add the required notifications when Alliance extends the appeal resolution timeframe the appeals procedure. In the past year, Alliance added information about the required notifications under the standard appeals section. However, under the expedited appeal section, the procedure does not explain the requirement that Alliance shall make "reasonable efforts" to give the Enrollee prompt oral notice of the delay imposed by Alliance. ***Recommendation: Revise Procedure 6505 to include that Alliance will make "reasonable efforts to give the Enrollee prompt oral notice of the delay." Per NC Medicaid Contract, Attachment M, Section G.6(i), and 42 CFR § 438.408l(2)(i).***
1.6 Written notice of the appeal resolution as required by the contract;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.7 Other requirements as specified in the contract.	X					In this year's EQR, it was noted there is an incorrect statement in the *Individual and Family Handbook*. Page 61 states, "Before the adverse benefit determination is final, you will receive a letter explaining how to appeal the adverse benefit determination." This statement was highlighted during the Onsite and now additional clarification could be provided. ***Recommendation: Revise the Individual and Family Handbook to either remove the statement, "Before the adverse benefit determination is final, you will receive a letter explaining how to appeal the adverse benefit determination", or revise it to clarify that notifications are sent to the enrollee after the adverse benefit determination is final.***
2. The PIHP applies the appeal policies and procedures as formulated.		X				The appeal file review for Alliance involved thorough review of 23 first level appeals, 5 second level appeals and Alliance Appeal Log. Five of the 23 first level appeals were requested to be expedited by appellants. Review of the 23 appeal files showed several errors within these files, as well as, data errors on the Appeal Log related to the selected files. Every file reviewed for this year's EQR contained some kind of error. **Files:** 2 of the 18 standard appeals files showed appeal resolution notifications were sent outside of the allowable 30 days. 2 of the 18 standard appeal files showed acknowledgment notifications were mailed outside of the "one business day" required by Alliance's appeal procedure.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						1 acknowledgement notice was not dated and another acknowledgment was sent with the wrong mailing date. 2 of the 5 expedited appeals did not have any evidence of the required oral notifications. 1 of the 5 expedited appeals showed the enrollee was called and informed of the expedited appeal resolution. However, the enrollee was either informed of the wrong outcome, or this notation in the file was for a different appeal. 1 of the 3 invalid appeals provided by Alliance showed the invalid notification was either not sent, or sent outside of the 1 business day required by Alliance's procedure. 13 of the 23 files reviewed showed staff did not call appellants to provide assistance with the appeal process. Alliance's procedure requires staff to call "each appellant" to see "if assistance is needed with understanding the reason for the denial, submitting additional information for the appeal and/or reviewing the clinical information that will be reviewed in the LME/MCO Level appeal". **Appeal Log:** 2 of the 23 appeal files provided by Alliance were not on the Appeals Log. All of the 5 expedited appeal files (accepted and denied expedited requests) were marked not expedited on the Appeal Log. One of the standard appeals provided by Alliance was marked on the Appeal Log as expedited, but there was no evidence that an expedited resolution was requested. One of the standard appeal files reviewed showed the resolution timeframe was extended, but was not marked extended on the Appeal Log.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						One of the files was noted on the log to have an extended resolution timeframe, but there was no evidence in the file that the resolution timeframe was extended or requested to be extended. Overall, review of all of the data within the Appeals Log showed at least 12 of the 125 appeals had incomplete or incorrect data captured on the log (e.g., incorrect/impossible appeal resolution dates, missing data, incorrect Appeal IDs, etc.) **Communication Log:** Alliance uses a Communication Log to capture internal steps by staff, such as required oral notifications provided by staff, required staff consultations with the Chief Medical Officer, providing enrollees assistance with the submission of additional information, etc. It was noted in the previous year's EQR that these logs were often incomplete or contained errors. In the 2018 EQR, CCME recommended Alliance "Train staff on the processes for completing the Communication Log, including which sections within that document are required." This Recommendation was addressed by Alliance, however, in this year's EQR, 19 of the 23 files reviewed, or 83%, had communication logs with missing or incorrect information. During the Onsite, Alliance explained reorganization of the appeal/grievance Department and changes and vacancies in the appeal specialist position caused challenges in adequately monitoring the appeals process. Staff also explained that appeals data will soon be moved to the Jiva platform, which will assist in the monitoring of the appeals functions, notification due dates, internal steps, etc. However, given that Alliance's current appeals process is almost entirely manual, the rate of errors across notifications, internal

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						steps, and appeal data continues to rise, an enhanced monitoring plan is needed. ***Corrective Actions: Develop, document, and implement a monitoring plan to increase compliance with required appeal notifications and internal steps. This monitoring plan should include the timeline for implementation, frequency of monitoring, staff that will implement the monitoring, benchmarks, and how and when outcomes of monitoring are captured, reviewed, and reported. The monitoring plan should include monitoring of:*** • ***Accuracy of all data within the appeal log*** • ***Timeliness of all required written and oral notifications for standard and expedited appeals*** • ***Accuracy and completeness of staff documentation within the Communication Log***
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					It was recommended in last year's EQR that Alliance provide guidance to staff in the appeal procedure regarding the steps taken when releasing the appeal record to enrollee's or their representatives. The Procedure now explains consultation with Alliance's HIPAA Privacy & Security Officer to "ensure that the release occurs appropriately".

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. Delegation						
1. The PIHP has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Alliance currently has an executed Delegation Agreement with three delegates, including Business Associate Agreements with those delegates that have access to Protected Health Information (PHI).
2. The PIHP conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the PIHP if the PIHP were directly performing the delegated functions.	X					Alliance conducts periodic delegation monitoring and presents results to relevant committees.

VIII. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII A. General Requirements						
1. PIHP shall be familiar and comply with *Section 1902(a)(68) of the Social Security Act*, *42 CFR § 438.455* and *1000* through *1008*, as applicable, including proper payments to Providers and methods for detection of fraud and abuse.	X					This requirement is addressed in Procedure 6001, Post Payments Reviews, and in the Alliance *Corporate Compliance Plan FY20*.
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					This requirement is addressed in the Alliance Corporate Compliance Procedure, in Procedure 3007, Guarding Against Fraud and Abuse, and in the Program Integrity Presentation Alliance web site training material.
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					This requirement is addressed in the *Provider Operations Manual*, as well as in Alliance Subcontractor Agreement Contract Templates.
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					This requirement is addressed in the Alliance Corporate Compliance Procedure and in Procedure 3007, Guarding Against Fraud and Abuse.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII 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					This requirement is addressed in the Alliance Corporate Compliance Procedure. Annual submission to NC Medicaid is evidenced by provision of emails dated 05/30/2019 and 12/17/2019.
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					This requirement is addressed in the Alliance Corporate Compliance Procedure. Examples of training include the Program-Integrity-Presentation Alliance web site, Compliance and Ethic Week materials, and SIU newsletters.

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					This requirement is addressed in the *Alliance Corporate Compliance Plan FY20* and in the Procedure 3008, Special Investigations Procedures. Alliance provided a detailed Organizational Chart for the Office of Compliance and associated job descriptions to demonstrate sufficient staffing. Procedure 3053, Coordination of Program Integrity Activity, addresses the point of contact portion of this requirement.
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					This requirement is addressed in Procedure 3053, Coordination of Program Integrity Activity Procedure.
5. PIHP shall send staff to participate in monthly meetings with Division Program Integrity staff, either telephonically or in person at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information.	X					This requirement is addressed in Procedure 3053, Coordination of Program Integrity Activity Procedure.
7. The Division recognizes that the scope of the PIHP's Regulatory Compliance Committee includes issues beyond those related to Program Integrity. 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					Minutes of quarterly and monthly meetings covering the entire review period were provided to evidence their availability. During Onsite discussion, it was confirmed that one such request was made, and it was sent within the required timeframe.
8. PIHP's written Compliance Plan shall, at a minimum include:						
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(66) of the Social Security Act;	X					This requirement is addressed in the Alliance *Corporate Compliance Plan FY20* and Program Integrity Workplan. Alliance provided numerous training materials, including the Compliance orientation training, FWA PowerPoint presentations, Provider training presentation, Alliance Employee training, and Compliance and Ethics Week materials.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing and development of corrective action initiatives;	X					This requirement is addressed in the *Alliance Corporate Compliance Plan FY20*.
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					This requirement is addressed in the *Alliance Corporate Compliance Plan FY20* and in the Compliance & FWA Provider training PowerPoint presentation dated October 2019.
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 promptly 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 Division as provided in Section 13.2 – Monetary Penalties.	X					This requirement is addressed in the *Alliance Corporate Compliance Plan FY20*.
9. In accordance with *42 CFR § 436.606(a)(vii)*, PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under *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*;	X					This requirement is addressed in the *Alliance Corporate Compliance Plan FY20*, in Procedure 1517, Overpayments and in Procedure 3007, Guarding Against Fraud and Abuse. Alliance provided Attachment Y reports for each month during the review period.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					This requirement is addressed in Procedure 3007, Guarding Against Fraud and Abuse.
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse;	X					This requirement is addressed in Procedure 3007, Guarding Against Fraud and Abuse.
10.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure. This process shall include procedures for logging the complaint, determining if the complaint is valid, assigning the complaint, investigating, appeal, recoupment, and closure. The detailed workflow needs to differentiate the steps taken for fraud versus abuse; PIHP shall establish and implement policies for treatment of recoveries of all overpayments from PIHP to Providers and contracted agencies, specifically including retention policies for treatment of recoveries of overpayments due to fraud, waste, or abuse. The retention policies shall include processes, timeframes, and required documentation for payment	X					This requirement is addressed in Procedure 3008, Special Investigations Procedures. Alliance provided numerous documents to guide PI staff and indicated they are readily available in a secure OneNote notebook to all investigators as reference. 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	
of recoveries of overpayments to the State in situations where PIHP is not permitted to retain some or all of the recoveries of overpayments. This provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.						
10.3 In accordance with Attachment Y – Audits/Self-Audits/investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					Alliance provided Attachment Y reports for each month during the review period.
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					This requirement is addressed in Procedure 1517, Overpayments, and Description for Tracking Overpayments and Recoveries.
10.5 Process for handling self-audits and challenge audits;	X					This requirement is addressed in Procedure 3030, Auditing of Claims.
10.6 Process for using data mining to determine leads;	X					
10.7 Process for informing PIHP employees, subcontractors and providers regarding the False Claims Act;	X					Alliance provided copies of the internal SIU newsletter for employees.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.8 If PIHP makes or receives annual payments of at least $5,000,000, PIHP shall establish and maintain written policies for all employees, contractors or agents that detail information about the False Claims Act and other Federal and State laws as described in the Social Security Act 1902(a)(66), including information about rights of employees to be protected as whistleblowers.	X					This requirement is addressed in Procedure 3004, Employee Code of Ethics and Conduct.
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid -standardized elements or a NC Medicaid -approved template;	X					This requirement is addressed in Procedure 3007, Guarding Against Fraud and Abuse.
10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available database or other search mechanism.	X					This requirement is addressed in Procedure 6030, Credentialing Criteria and Enrollment Process for Network Participation, and in Procedure 3007, Guarding Against Fraud and Abuse. Alliance also provided template credentialing and re-credentialing applications, which capture the required information.
11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.	X					This requirement is addressed in Procedure 1517, Overpayments, and in Procedure 3044, Provider Dispute Resolution.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					This requirement is addressed in the *Alliance Corporate Compliance Plan FY20*, and in Procedure 3008, Special Investigations Procedures. This procedure details timely initiation and reporting to NC Medicaid and subsequent electronic storage of records. The Alliance SIU Detailed Workflow demonstrates the forwarding of investigations to NC Medicaid.
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:						All of the PI files reviewed contained evidence that the required information outlined below was submitted to NC Medicaid.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 issues, when available.	X					
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs was found in all of the files reviewed. However, this information was missing from the Investigation Report summary form in two files. ***Recommendation: Ensure staff maximize the use of the Investigation Report summary form by completing it in its entirety.***
13.8 Total Sample Amount of Funds Investigated per Service Type.	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:						
14.1 The Enrollee's name, birth date, and Medicaid number;	X					
14.2 The source of the allegation;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;	X					
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and	X					
14.7 The legal and administrative status of the case.	X					
15. PIHP and 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					There was no indication of new forms, tools, or letters during the review period. This was corroborated during Onsite discussion.
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					Alliance provided FAMS Visualization Report Cards which demonstrate their use of FAMS.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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				This requirement is partially addressed by monthly NCID-FAMS User lists dating from September 2019 to January, 2020, but language pertaining to the notification of the NC Medicaid designated Administrator within forty-eight (48) hours of a FAMS-user changing roles within the organization or termination of employment is not included in any policy or procedure provided by Alliance for review. During Onsite discussion, it was explained that one employee with FAMS access left Alliance on 11/14/2019. Alliance stated this change was communicated to NC Medicaid during a monthly call but not likely within 48 hours. Additional explanation from Alliance indicated that Alliance Human Resources off-boarding process includes notification to the HIPAA Privacy & Security Officer in the Office of Compliance of an employee's last date of employment to ensure that all accounts are deactivated. This process was followed for this employee, but there is no indication that notification was made within 48 hours and this information is not in any PI procedure. ***Corrective Action: Add language to a PI procedure that explains Alliance shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of a FAMS-user changing roles within the organization or termination of employment. This contractual requirement is in NC Medicaid Contract, Section 14.2.13.***

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). Section 9.8 Fraud and Abuse Reports. 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 11:59p.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 monthly report submission requirement is addressed by the monthly Attachment Y and Z Reports provided by Alliance. However, the requirement of timely submission of monthly PI reports to NC Medicaid is not addressed in any Alliance procedure. ***Recommendation: Add language to a PI procedure the requirement of timely submission of monthly PI reports to NC Medicaid. This contractual requirement is in NC Medicaid Contract, Section 9.8.***
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						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 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					
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					Procedure 3053, Coordination of Program Integrity Activity, addressed the suspension of payments as well as the lifting of suspension.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					This requirement is addressed in the *Alliance Corporate Compliance Plan FY20*.
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					This requirement is addressed in Procedure 3053, Coordination of Program Integrity Activity Procedure.
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					This requirement is addressed in Procedure 3043, Provider Sanctions, Administrative Actions, and Suspensions to Ensure Patient Safety.

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					This requirement is address in Procedure 1538, NC DHHS Mandated Recovery of Funds.
7. Recovery Audit Contactors (RACs) for the Medicaid program may audit Providers in the PIHP Network and may work collaboratively with PIHP on identification of overpayments. NC Medicaid shall require RACs to give PIHP prior written notice of such audits and the results of any audits as permitted by law.						
8. The MFCU/MID reserves the right to prosecute or seek civil damages regardless of payments made by the Provider to PIHP. The Parties shall work collaboratively to develop a plan for the disbursement of the share of monies that are recovered and returned to the state by the MFCU/MID for fraudulent claims paid by PIHP. NC Medicaid will examine options to refund returned funds to PIHP and/or to appropriately account for these recoveries in the rate setting process.						

IX. FINANCIAL SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IX. Financial						
1. The PIHP has policies and systems in-place for submitting and reporting financial data.	X					This requirement is addressed in Procedure 1527, DHHS Financial Reporting. ***Recommendation: Revise Procedure 1527 to reflect the due date of the 20th of the month for financial reporting to NC Medicaid.***
2. The PIHP has and adheres to a cost allocation P that meets the requirements of *42 CFR § 433.34*.	X					This requirement is addressed in Procedure 1540, Cost Allocation, under which Item C explains the administrative expense allocation between their funding/revenue sources.
3. PIHP maintains detailed records of the administrative costs and expenses incurred as required by the *NC Medicaid Contract*.	X					This requirement is addressed in Procedure 1540, Cost Allocation. Administrative costs are recorded monthly to their natural expense account and are allocated by journal entries to the respective accounts using the percentages calculated at the beginning of the fiscal year.
4. Maintains an accounting system in accordance with *42 CFR § 433.32 (a).*	X					Alliance uses Microsoft GP Dynamics version 2015. During the interview, they indicated that they are evaluating a software change.
5. The PIHP follows a record retention policy of retaining records for ten years. (*NC Medicaid Contract, Section 8.3.2* and *Amendment 4, Section 31).*	X					This requirement is addressed in Procedure 3016, Records Retention and Destruction.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution in accordance with *NC Medicaid Contract*.	X					Alliance maintains their restricted risk reserve account at Wells Fargo Bank. They provided bank statements for November and December 2019. These balances agree with the November and December 2019 Medicaid reports. The November 2019 deposit was made on 11/7 and the balance was $55,303,771.41. The December 2019 deposit was made on December 6 and the balance was $56,046,614.15.
7. The required minimum balance of the Risk Reserve Account meets the requirements of the *NC Medicaid Contract*.	X					This requirement is addressed *in* Procedure 1506, Risk Reserve Account. Per the interview, the deposits were all made on time, in the correct amounts, and there were no withdrawals.
8. All funds received by PIHP are accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as required by the *NC Medicaid Contract*.	X					This requirement is addressed in Procedure 1500, Accounting by Funding Source. In order to ensure that they are correctly coded, the general ledger accounts are coded in segments by funding source. Alliance provided a copy of their general ledger chart of accounts, as well as a breakdown of the segments of the chart of account segments.
9. The Medical Loss Ratio (MLR) meets the requirements of *42 CFR § 438.8* and the *NC Medicaid Contract*.	X					This requirement is addressed in detail in Procedure 1537, Medical Loss Ratio.

E. Attachment 5: Encounter Data Validation Report

Alliance Behavioral Healthcare

Encounter Data Validation Report

performed on behalf of

North Carolina Department of Health and Human Services, Division of Medical Assistance

April 8, 2020

Prepared By:

hms

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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."

In order 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 2018 through December 2018. All claims paid by Alliance should be submitted and accepted as a 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 2018 encounter data provided as a data extract
- Analysis of Alliance’s 837 encounter files
- 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 LME 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. The 999 response is used to confirm receipt and communicate any compliance or layout errors to the PIHP. The behavioral health encounter claims are then validated by applying a list of edits provided by the state (See Appendix 1) and adjudicated accordingly by MMIS. Utilizing existing Medicaid pricing methodology, using the billing or rendering provider

accordingly, the appropriate Medicaid allowed amount is calculated for each encounter claim in order to shadow price what was paid by the LME.

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 2018, Alliance submitted 2,015,327 unique encounters to the State. To date, less than 1% of all 2018 encounters submitted have not been corrected and accepted by NC Medicaid.

2018	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
Institutional	83,757	80,052	2,398	1,307	1.56%
Professional	1,931,570	1,924,817	5,055	1,698	0.09%
Total	2,015,327	2,004,869	7,453	3,005	0.15%

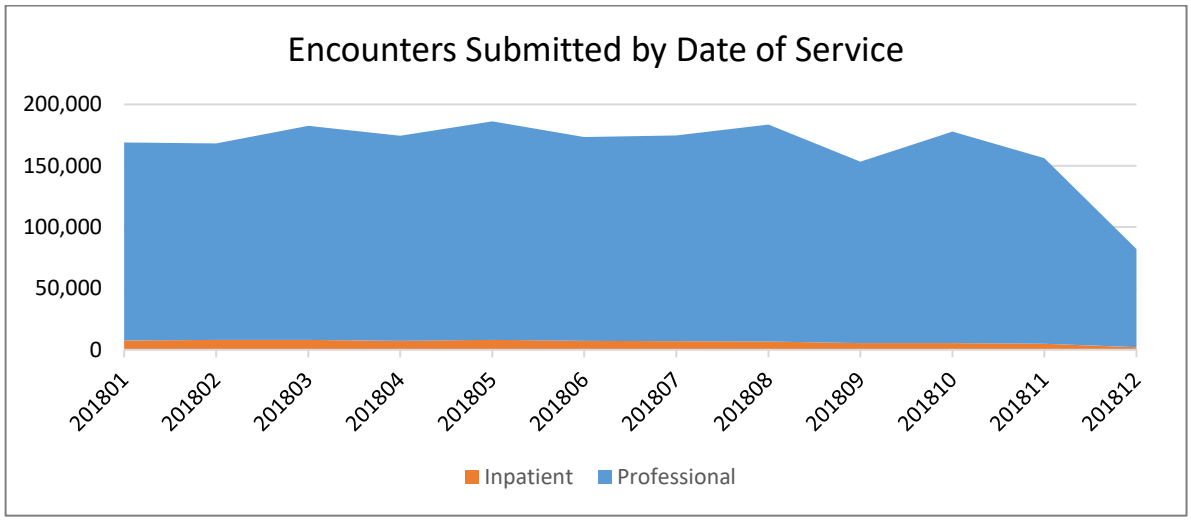
Each year Alliance has made significant improvements to their encounter submission process, increasing their acceptance rate and quality of encounter data year over year. The table below reflects the increase in acceptance rate from 93% to over 99%, well above NC Medicaid's expectations.

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%

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 claim analysts responsible for reviewing and resubmitted denied encounter claims. After a check write cycle, Alliance receives an 835 from NCTracks to review denials. 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. The majority of denials are based on provider setup. 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.

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, 2018 and December 31, 2018. Alliance pulled all claims adjudicated and submitted to NC Medicaid during 2018 and sent to HMS via SFTP. This included more than two million Professional claims and just over ninety-three thousand Institutional claims. Some may have been resubmissions for denials or adjustments, however, there was not an easy way to identify a subsequent adjustment looking at the data elements provided.



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

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Recipient ID	Should be valid ID as found in the State's eligibility file. Can use State's ID unless State also accepts Social Security Number.	100% valid
Recipient Name	Should be captured in such a way that makes separating pieces of	85% present. Lengths should vary, but there should be at least some last names of >8 digits and some first names of < 8 digits,

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
	name easy. Expect data to be present and of good quality	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% non-missing 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 or not the data populated was valid. Although we looked at the complete data set and validated all data values, the fields below are key to properly shadow pricing for the services paid by Alliance.

Table: Evaluation of Key Fields

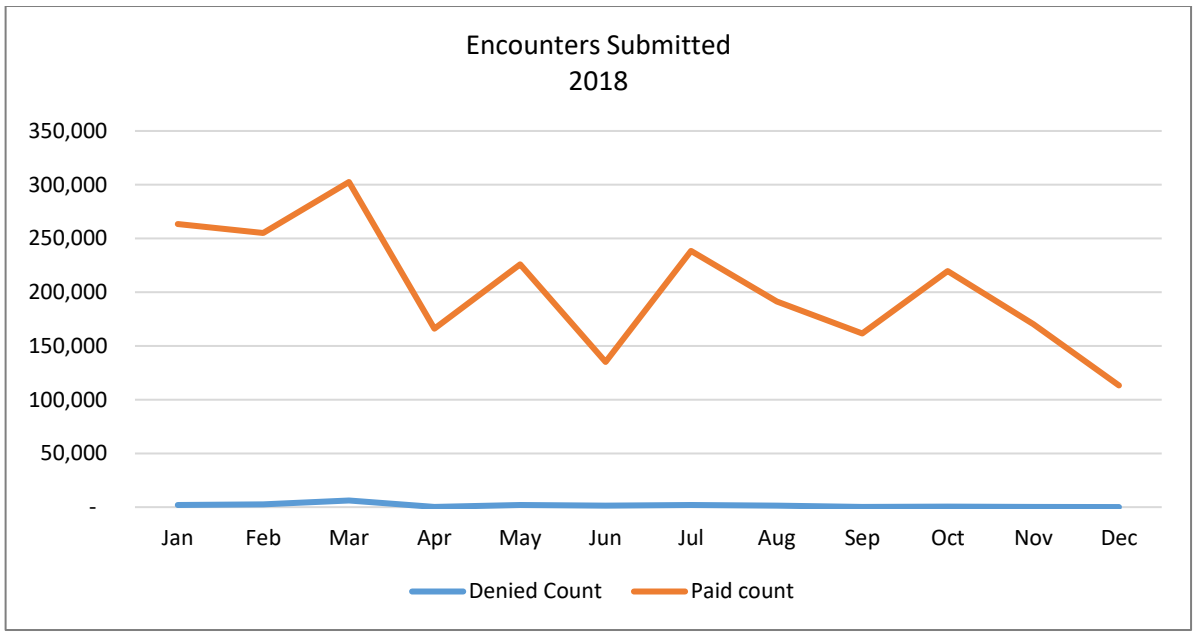
Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	2,139,067	100.00%	2,139,067	100.00%	2,139,067	100.00%	2,139,067	100.00%
Recipient Name	2,139,067	100.00%	2,139,067	100.00%	2,139,067	100.00%	2,139,067	100.00%
Recipient Date of Birth	2,139,067	100.00%	2,139,067	100.00%	2,139,067	100.00%	2,139,067	100.00%
PIHP ID	2,139,067	100.00%	2,139,067	100.00%	2,139,067	100.00%	2,139,067	100.00%
Provider ID	2,138,522	99.97%	2,138,522	99.97%	2,138,522	99.97%	2,138,522	99.97%
Attending/Rendering Provider ID	2,138,522	99.97%	2,138,522	99.97%	2,138,522	99.97%	2,138,522	99.97%
Provider Location	2,139,067	100.00%	2,139,067	100.00%	2,139,067	100.00%	2,139,067	100.00%
Place of Service	2,139,066	100.00%	2,139,066	100.00%	2,139,066	100.00%	2,139,066	100.00%
Specialty Code / Taxonomy - Billing	2,139,067	100.00%	2,139,067	100.00%	2,139,067	100.00%	2,139,067	100.00%
Specialty Code / Taxonomy - Rendering / Attending	2,139,067	100.00%	2,139,067	100.00%	2,139,056	100.00%	2,139,067	100.00%
Principal Diagnosis	2,139,067	100.00%	2,139,067	100.00%	2,139,051	100.00%	2,139,067	100.00%
Other Diagnosis	200,163	9.36%	200,163	9.36%	200,163	9.36%	200,163	9.36%
Dates of Service	2,139,067	100.00%	2,139,067	100.00%	2,139,067	100.00%	2,139,067	100.00%
Unit of Service (Quantity)	2,139,067	100.00%	2,139,067	100.00%	2,139,067	100.00%	2,139,067	100.00%
Procedure Code	2,097,282	98.05%	2,097,270	98.05%	2,097,270	98.05%	2,097,270	98.05%
Procedure Code Modifier	641,021	29.97%	641,021	29.97%	641,021	29.97%	641,021	29.97%
Patient Discharge Status Code Inpatient	93,357	100.00%	93,357	100.00%	93,357	100.00%	93,357	100.00%
Revenue Code	93,357	100.00%	93,357	100.00%	93,357	100.00%	93,357	100.00%

Overall, there were very few inconsistencies in the data. Institutional claims contained complete and valid data in 16 of the 18 key fields (94%) with issues identified with Procedure code and additional Diagnosis codes. The Procedure code was missing or invalid for 41% of the claims. Given the services provided and Revenue codes submitted, the Procedure code should have been more consistently populated with valid values. Additional Diagnosis codes were present in less than 1% of all Institutional claims. The frequency is expected to be higher given the services being provided.

Professional encounter claims submitted contained complete and valid data in 14 of the 15 key Professional fields (93%). The only issue noted for Professional claims that exceeded the thresholds outlined in the Data Quality Standards above was with the consistency of additional Diagnosis codes. A secondary Diagnosis code was present in only 10% of all Professional claims reported.

Encounter Acceptance Report

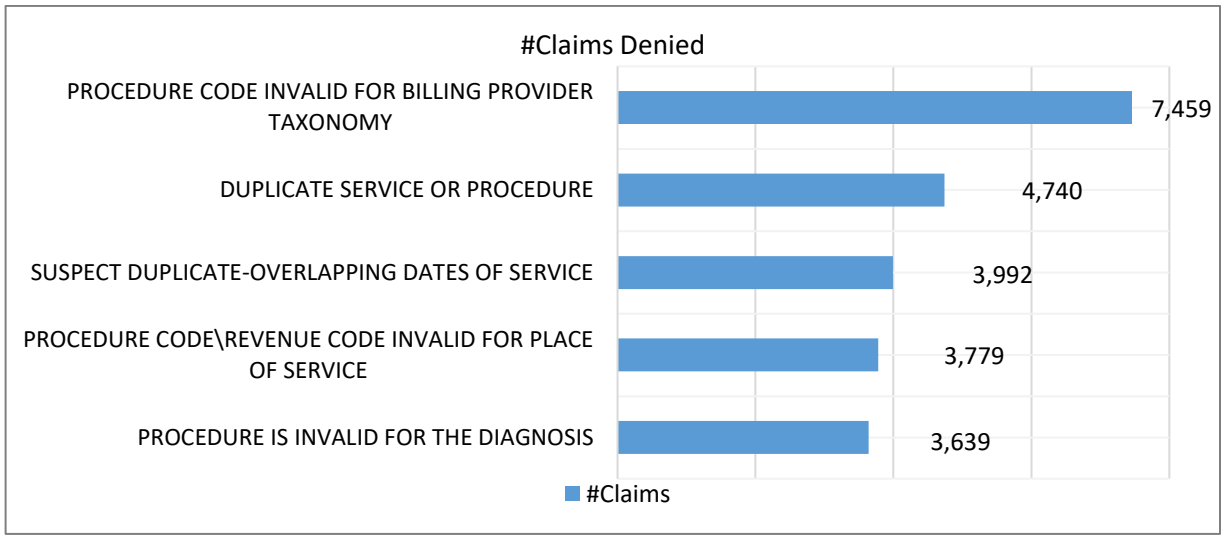
In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write and excludes duplicates or resubmission which made it difficult to tie back to the ISCA response and converted encounter files. Data provided by LME's reports for our review includes all submission and resubmissions during 2018 which may include older dates of service. During the 2018 weekly check write schedule, Alliance submitted a total of 2,442,576 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.



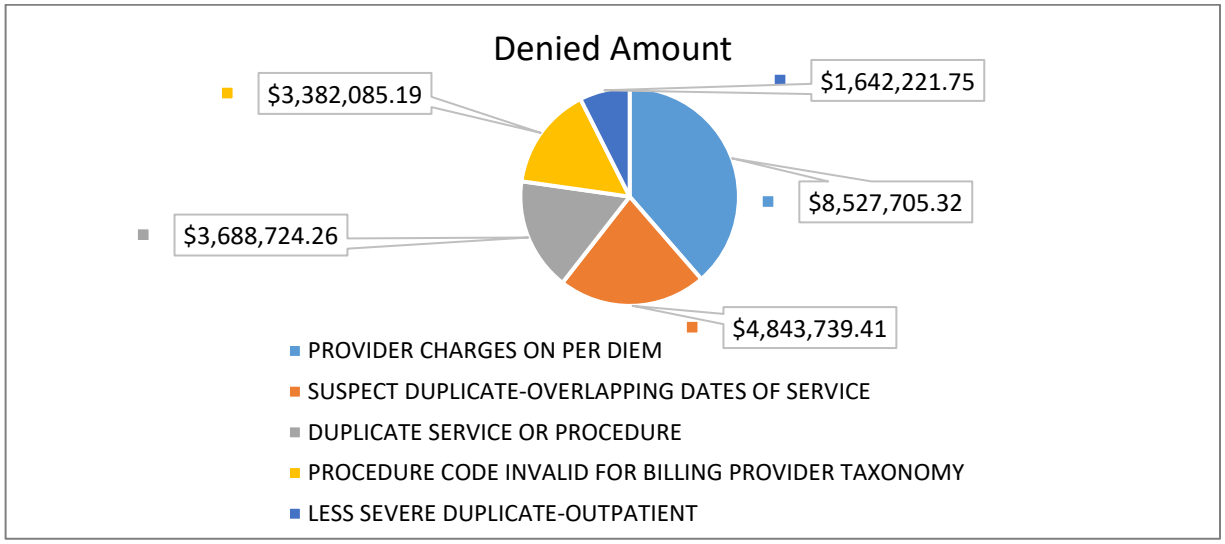
Evaluation of the top denials for Alliance encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis an ISCA review above. Encounters were denied primarily for:

- Procedure Code invalid for billing provider taxonomy
- Duplicate service or procedure
- Suspect duplicate - overlapping dates of service
- Procedure Code/Revenue Code invalid for Place of Service
- Procedure is invalid for the diagnosis

The graph below reflects the top 5 denials by claim volume.



The pie chart below reflects the top 5 denials by claim dollar amount.



Results and Recommendations

Issue: Procedure Code

The Procedure code for Institutional claims should populated 99% of the time. In the encounter data provided, HMS found that the field was populated 45% of the time with valid values; in all other instances the value was null. Valid Procedure codes are needed to better understand the services provided and are usually required to adjudicate the claim appropriately. Given the types of services provided, the provider should have provided additional Procedure codes in support of the line level Revenue code supplied. For example, Revenue code 636 indicates an injectable; however, additional detail is needed to determine the type of injection/drug. There were many instances where the Revenue code was provided without the appropriate Healthcare Common Procedure Coding System (HCPCS). The same issue was noted in the review of 2017 encounters.

Resolution:

Alliance should ensure that the appropriate data validation checks are in place and that claims submitted through the portal or an 837 should be denied by Alliance without the proper Revenue code and Procedure code combination. Alliance should review their 837 encounter creation and encounter data extract process to ensure that an invalid Procedure code is not transmitted to NC Medicaid, even when the data is invalid based on the provider claim submission. The HCPCS may not be required to adjudicate the claim but it is required to understand the level of services provided.

Issue: Diagnosis Codes

The secondary diagnosis was populated in less than 1% of all Institutional claims and only 10% of Professional claims. This value is not required by Alliance when adjudicating the claim, therefore, not a requirement of the provider when submitting via Provider Portal or 837.

Resolution:

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

Conclusion

Based on the analysis of Alliance's encounter data, we have concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues still exist with their submission of Institutional encounters and need to be addressed in order to be compliant. Alliance should take Corrective Action to resolve the issues identified with Procedure code and Diagnosis codes, as well as continue to work on improving all up front denials.

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