CCME

2020 External Quality Review

ALLIANCE HEALTH

Submitted: June 18, 2021
Revised: July 6, 2021

Prepared on behalf of the
North Carolina Medicaid

Table of Contents

EXECUTIVE SUMMARY

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

This report contains a description of the process and the results of the 2020 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the North Carolina Medicaid (NC Medicaid).

Goals of the review are to:

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

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

Due to the COVID-19 pandemic, the 2020 EQR was delayed and CCME implemented a focused review.

A. Overall Score

The 2020 Annual EQR reflects that Alliance achieved a "Met" score for 98% of the standards reviewed. As Figure 1 indicates, 2% of the standards were scored as "Partially Met". None of the standards were scored as "Not Met".

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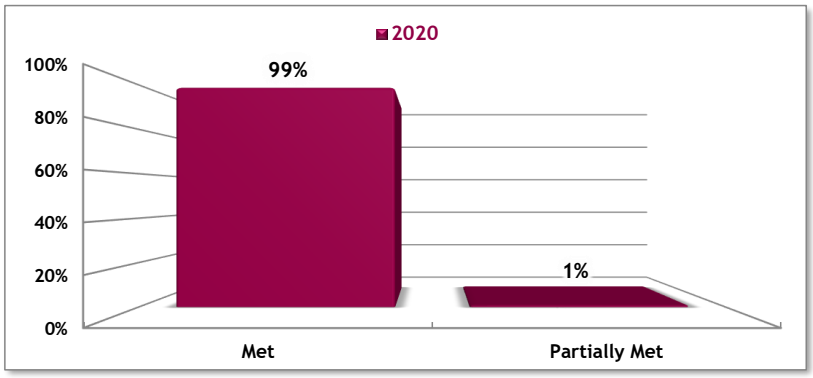
REVISION: On July 2, 2021, the State provided the following information: "Alliance reached out to DHB yesterday regarding their 2020 EQR CAP report. After consulting with DHB Legal it was determined that 3 of the 4 CAPs should be recommendations. This is based on the CAPs not relating to health and safety. Only item #4 (1.5 Timeliness guidelines for resolution of the Appeal as specified in the Contract) should remain as a CAP." This action changed Alliance's overall score from 98% to 99%.

Figure 1: 2020 Annual EQR Review Results



B. Overall Findings

The following provides a global or high-level summary of the status of the Recommendations and Corrective Action items from the 2019 EQR and the findings of the 2020 EQR. Specific Recommendations and Corrective Actions are detailed in each section of this report.

Administration

In the 2020 EQR, Alliance met 92% of the administrative standards. Based on the findings from the 2020 EQR, a Corrective Action has been issued for Alliance to update their encounter data submission process to increase the number of ICD-10 Diagnosis codes submitted on Institutional encounters into NCTracks. Currently 29 ICD Diagnosis codes are being captured and stored, but only a maximum of 12 are being submitted. Since NCTracks can accept up to 25 ICD-10 Diagnosis codes for an Institutional encounter, 25 should be submitted.

REVISION: Per feedback from the State on July 2, 2021, this Corrective Action should be changed to a Recommendation and the score on this standard changed from a "Partially Met" to a "Met".

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Provider Services

In Alliance's 2019 EQR of Credentialing/Recredentialing, there were no items requiring Corrective Action and one Recommendation. Though Alliance partially addressed the Recommendation from the last EQR, some issues persist, resulting in a Recommendation in the current EQR. Additional information is provided in this report and in the Tabular Spreadsheet. In the current EQR, Alliance met 100% of the Provider Services standards.

Quality Improvement

The Quality Improvement (QI) EQR included validation of Performance Measures (PMs) and Performance Improvement Projects (PIPs). In the 2019 EQR, there were no Corrective Actions and one Recommendation given for the Routine Access to Care PIP to revise interventions for rate improvements. This PIP was closed and not evaluated this year.

For the 2020 EQR, the Performance Measure Query was accurate for (b) Waiver Measures, although Follow-Up After Hospitalization for Substance Abuse had substantial declines for two subsets of the rate calculation. It was recommended to continue with current interventions for this (b) Waiver Measure. All (c) Waiver Performance Measures were above State benchmark rates. All PMs were validated at 100%. The seven validated PIPs all scored in the High Confidence range, although four PIPs have Recommendations for improvement. In this 2020 EQR, 100% of the QI standards were met.

Utilization Management

In the 2019 EQR, Alliance met 91% of UM standards. Four Corrective Actions and two Recommendations were issued. One Corrective Action and two Recommendation were issued to address concerns within policies and procedures. One Corrective Action was due to Alliance's inability to produce the full record from their care management platform for members participating in MH/SUD/I/DD/TCLI Care Coordination. The remaining two Corrective Actions targeted concerns within the MH/SUD/I/DD/TCLI file review. Alliance addressed the four Corrective Actions and two Recommendations.

For this 2020 EQR, Alliance has met 92% of UM standards. CCME issued two Corrective Actions and three Recommendations. The two Corrective Actions target inconsistencies in the frequency of contacts for I/DD members receiving residential supports and the timeliness of TCLI documentation. CCME is requiring Alliance to enhance the current monitoring process by incorporating a manual record review to ensure compliance with Alliances' policies and procedures and the *NC Medicaid Contract*. The three Recommendations aim to correct information in Alliance procedures, the *Individual and Family Handbook*, and the *Innovations Individual and Family Handbook* related to the Innovations Waiver and required clinical assessments for children and adolescents.

REVISION: Per feedback from the State on July 2, 2021, these two Corrective Actions should be changed to Recommendations and the scores on the two standards changed from a "Partially Met" to a "Met".

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Grievances and Appeals

In the 2019 EQR, Alliance met 80% of the Grievance and Appeals standards. Six Corrective Actions and three Recommendations were issued to address concerns noted within the Grievance and Appeal procedures, the *Provider Operations Manual*, the *Individual and Family Handbook*, the *Intellectual and Developmental Disabilities Care Coordination*

Desk Reference, and the Grievance and Appeal files reviewed. In the 2020 EQR Alliance met 95% of the Grievance and Appeals standards.

In the 2020 EQR of Alliance's Grievance processes, there are five Recommendations issued. Two Recommendations are related to the inconsistent use of the term "Grievance" in the Procedure 6503 and a Recommendation to include the definition of "Grievant" to Procedure 6503. Two Recommendations have been issued regarding incorrect Grievance information within the *Provider Operations Manual* around the timeframe for resolving Grievances, the required notifications related to extensions to the Grievance resolution timeframe, and the need to use one the term "Grievance" to reflect the Grievance process. Finally, CCME also recommends Alliance ensure the *Provider Operations Manual* consistently uses the term "Grievance" when explaining Alliance's Grievance processes to providers.

In the 2019 EQR of Appeal functions, five Corrective Actions and two Recommendations were issued to address incorrect or missing information in Alliance's Appeals procedure and Appeal files. Alliance addressed and implemented all 2019 Corrective Actions and Recommendations, with one exception. Additional information is still needed in Procedure 6505, Due Process of Medical Necessity Determinations around the notifications required when Alliance extends the Appeal resolution timeframe. As a result, CCME has issued a Corrective Action in this 2020 EQR to include these notifications, required by *42 CFR § 438.408 (c)(2)* and the *NC Medicaid Contract, Attachment M, Section G.6,* into Alliance's Appeals procedure.

Also in the 2020 EQR, CCME issued one Corrective Action to address errors in the *Individual and Family Handbook*. Four Recommendations from this 2020 EQR of Appeals also target missing or incomplete information within the *Individual and Family Handbook*, the *Provider Operations Manual* and the Peer Review Tool for Appeals that Alliance uses to monitor Appeal files for potential compliance issues.

Program Integrity

In this 2020 EQR, there was evidence Alliance addressed the Corrective Actions and Recommendations issued in the 2019 EQR. After a thorough review of all current procedures and Program Integrity files, it was determined that all elements required by Alliance's contract with NC Medicaid were satisfied. Further, Alliance was able to continue their full investigative process during COVID-19 and modified several of its data mining schemes to account for the COVID Flexibilities. In this 2020 EQR, Alliance met 100% of the Program Integrity EQR standards.

Encounter Data Validation

Based on the analysis of Alliance's encounter data, it was concluded the data submitted to NC Medicaid is complete and accurate in accordance with NC Medicaid standards. Alliance took multiple Corrective Actions in 2019 to address issues that were highlighted

in prior reviews. More specifically, Alliance instituted multiple claiming edits and other system changes to address deficiencies in Procedure and Additional Diagnosis codes.

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

METHODOLOGY

The process used for the EQR was based on the CMS protocols for EQR of MCOs and PIHPs. This review focused on the three federally mandated EQR activities: compliance determination, validation of Performance Measures, and validation of Performance Improvement Projects, 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 Program Integrity (PI) review of the PIHP was conducted by CCME's subcontractor, IPRO.

On November 2, 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 Alliance 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 on November 23, 2020 and reviewed by CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. The Desk Review included a review of credentialing, Grievance, program integrity, care coordination, and Appeal files.

The second segment of the EQR is typically a two-day, Onsite review conducted at the PIHP's offices. However, due to COVID-19, this Onsite was conducted through a teleconference platform on May 20, 2021. This Onsite visit focused on areas not covered in the Desk Review, and areas needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's Onsite activities included:

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

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

FINDINGS

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

A. Information Systems Capabilities Assessment (ISCA)

The review of Alliance's system capabilities involves the use of the Information Systems Capabilities Assessment (ISCA) tool and review of supporting documentation such as Alliance's claim audit reports, enrollment workflows and Alliance's Information Technology staffing patterns. This system analysis is completed as specified in the Centers for Medicaid and Medicare Services (CMS) protocol. During the Onsite, staff presented a member and claims systems review. Questions regarding the ISCA tool and encounter denial reason codes were discussed with Alliance staff.

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 Onsite, Alliance provided a demonstration of the Alliance Claims System (ACS) enrollment system that went live May 03, 2021. The system maintains a member's enrollment history. The Global Eligibility File (GEF) file is imported daily into the AlphaMCS by WellSky.

Alliance stores the Medicaid identification number received on the GEF. During the Onsite, Alliance indicated that they rarely see members with multiple IDs, but are able to research and merge the information into one Member ID. The historical claims and authorizations for the member are also merged into one Member ID, the new Member ID.

During the Onsite system demonstration, staff displayed the enrollment information that is viewable and captured within ACS system. The AlphaMCS system is able to capture demographic data like race, ethnicity, language, and coordination of benefit (COB) information.

Table 1 demonstrates Alliance has experienced a small decrease in year-end enrollment numbers over the past three years.

Table 1: Enrollment Counts

2017	2018	2019
223,347	220,968	216,407

Throughout 2019 Alliance's claims and authorizations were processed in the AlphaMCS system. A review of Alliance's processes for collecting, adjudicating, and reporting claims were conducted through a review of its ISCA response and supporting documentation provided. A demonstration of Alliance's current ACS claims processing system was performed during the Onsite and Institutional and Professional screens were reviewed.

Alliance receives claims from three methods, 837 electronic file, provider web portal, and paper claims. Table 2 details the percentage of 2019 claims received via the three methods.

Table 2: Percent of claims with 2019 dates of service that were received via Electronic (HIPAA, Provider Web Portal) or Paper forms.

Source	HIPAA File	Paper	Provider Web Portal
Institutional	70.93%	.17%	28.90%
Professional	81.37%	.09%	18.4%

Alliance auto-adjudicated 92.97% of Institutional and 94.20% of Professional claims received in 2019. Alliance claims are approved, pended, or denied within 18 days of receipt and paid within 30 days of approval. If a required field is missing from a claim, 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 HIPAA 999 response file advising the provider of the claim submission failure. If the claim is submitted, Alliance claims processors do not change any information on the claims. Alliance conducts monthly and quarterly audits of claims processed. Alliance staffs' goal is to randomly sample and audit 2.5% of all claims weekly, with a focused audit of a minimum of 50% of inpatient hospital claims over $5,000 and 3% of Emergency Department claims.

Throughout 2019, all Alliance claims were processed using AlphaMCS' claims adjudication procedure, without pending, except for Emergency Department claims and claims with amounts greater than $5,000. These are pended for manual review.

For Professional claims, Alliance has the ability to receive and store up to 12 ICD-10 Diagnosis codes on both the provider web portal and via HIPAA files. For Institutional

claims, Alliance has the ability to capture up to 29 ICD-10 Diagnosis codes, ICD-10 Procedure codes, and Diagnosis Related Groups (DRGs), if they are submitted on the claim on both provider web portal and via HIPAA files.

Throughout 2019, Alliance retained and maintained all enrollment and claims history in the AlphaMCS' data warehouse and reporting system, with ability to recover older historical enrollment and claims data. Alliance and WellSky have implemented a near real-time replication of the AlphaMCS transactional database to the Enterprise Data Warehouse.

Alliance has a defined process in place for their encounter data submission for approved claims, with 837 files submitted to NC Medicaid, and 999 and 835 response files received back from NC Medicaid through the NCTracks system. Alliance has the ability to track and reconcile claims from the adjudication process to their encounter submissions status. The 835 response file from NCTracks is used to review denials. The encounter data for 837 files are manually pulled from the WellSky's FTP server and submitted weekly to NCTracks.

The breakdown of encounter data acceptance/denial rates by claim service detail counts was provided for encounters submitted in 2019. Table 3 provides a comparison of 2018 and 2019.

Table 3: Volume of 2018 and 2019 Submitted Encounter Data

2019	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	79,301	553	518	80,372
Professional	1,990,578	6,317	2,624	1,999,519
2018	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	84,047	962	318	85,327
Professional	1,965,746	2,078	1,641	1,969,465

Each month, Alliance has approximately 98% to100% acceptance rate for both Professional and Institutional encounters. During the Onsite, Alliance advised the two top denial reason codes for encounters:

- Member enrollment related issues
- Encounters with missing or invalid information

On average, Alliance submits an encounter within an average of four business days from the time of adjudication to NCTracks. It takes Alliance approximately 16 business days to correct and resubmit a denied encounter to NCTracks. Alliance uses the Adam Holtzman's Encounter Summary by MCO Checkwrite and an encounter denial detail report to identify encounters that were denied. Alliance has a dedicated team of two claims analysts reviewing and resubmitting the denied encounters. Alliance's claims team actively reviews and works the denied encounters and resubmits claims as part of their daily responsibilities.

Per Alliance's ISCA response, Alliance is submitting up to 12 ICD-10 Diagnosis codes for Professional and only 12 ICD-10 Diagnosis codes for Institutional encounters to NC Medicaid. Alliance submits any DRG and ICD-10 Procedure codes received from the provider on Institutional encounters to NCTracks.

Figure 2 demonstrates that Alliance met 92% of the standards and partially met all 8% of the Standards in the 2020 ISCA EQR.

REVISION: Per feedback from the State on July 2, 2021, the below Corrective Action should be changed to a Recommendation and the score on this standard changed from a "Partially Met" to a "Met".

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Figure 2: ISCA Findings

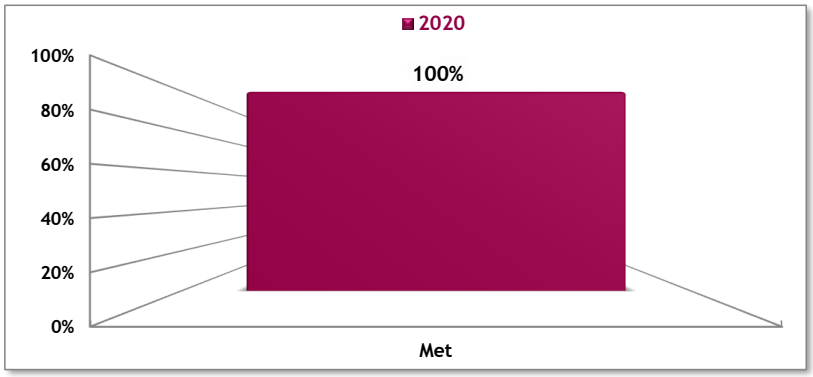

Table 4: Administrative Findings

Section	Standard	2020 Review
Encounter Data Submission	The PIHP has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	Partially Met

Strengths

- Alliance can capture of up to 25 Diagnosis codes on Institutional claims and 12 Diagnosis codes on Professional claims on their Web Portal, 29 Diagnosis codes on Institutional claims and 12 Diagnosis codes on Professional claims on the HIPAA files, and Alliance claim system is able to display all diagnosis codes received on their claim system.
- Alliance has the ability to submit all 12 ICD-10 Diagnosis codes received on a Professional encounter to NCTracks.
- Alliance can capture the DRG and ICD-10 Procedure codes on Institutional claims on the Provider Web Portal and via HIPAA files.
- Alliance has the ability to submit all ICD-10 Procedure codes and DRG codes submitted by the provider on the encounter data extracts to NCTracks.
- Alliance's current NCTracks encounter data acceptance rate is approximately 98% to 100% monthly, for the combined Professional and Institutional extracts.

Weaknesses

- Although Alliance is able to capture and store up to 29 ICD-10 Diagnosis codes for Institutional encounters, Alliance is only submitting up to 12 ICD-10 Diagnosis codes on an Institutional encounter data extract to NCTracks. NCTracks can accept up to 25 ICD-10 Diagnosis codes for Institutional encounters.

Recommendation

- Update Alliance's encounter data submission process to allow submission of up to 25 ICD-10 Diagnosis codes included on Institutional encounters into NCTracks.

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B. Provider Services

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

In Alliance's 2019 EQR of Credentialing/Recredentialing, there were no items requiring Corrective Action and one Recommendation. Though Alliance partially addressed the Recommendation, some issues persist, resulting in a Recommendation in the current EQR. Additional information is provided in this report and in the Tabular Spreadsheet.

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

Procedure 6030 addresses the Provider Network Credentialing Committee (PNCC), noting, "The Network Credentialing Committee is comprised of an interdisciplinary team that includes providers from across disciplines, in order to be able to access peer input when discussing standards of care for providers." The procedure states a "Quorum is reached when 33% of voting members are present plus the Chairperson"), states the committee "may meet at least monthly", and indicates the PNCC is chaired by an Associate Medical Director. Dr. Heidi Middendorf, Associate Medical Director (AMD) and Dr. Nadiya Kaesemeyer (AMD), both of whom are board-certified psychiatrists, are listed on the *Committee Matrix* as Co-Chairs of the PNCC. Dr. Kaesemeyer chaired the committee meetings for which minutes were submitted. Dr. Middendorf was not present at any of those meetings. The sample of Credentialing Committee meeting minutes reviewed for this EQR indicated a quorum was present.

There is conflicting information regarding committee membership and voting status across Procedure 6030, the *Provider Network Credentialing Committee (PNCC) Org Chart 11.12.2020*, and the submitted Credentialing Committee meeting minutes. At the last EQR, there were similar issues, for which Alliance received a Recommendation. In response, Alliance revised Procedure 6030, but issues persist, resulting in a Recommendation in the current EQR. See the Tabular Spreadsheet for details.

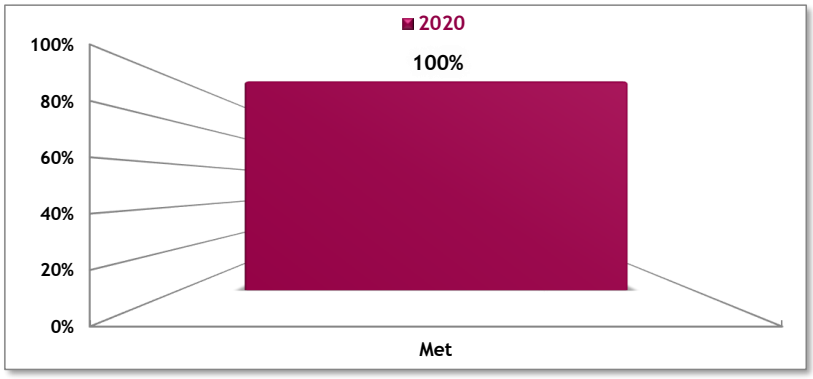
Procedure 6034, Provider Orientation and Education, outlines "orientation and education expectations for providers joining and participating in the Alliance Provider Network." New providers receive a Welcome Letter that includes the name of the provider's assigned Network Specialist and information about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

accessed via the Alliance website. The letter includes a "link to the Alliance website that outlines additional key publications and contacts for each functional area."

Under the COVID-19 flexibilities as outlined in *NC Medicaid Contract, Amendment #9*, the annual *Network Adequacy and Accessibility Analysis* (Gaps Analysis) will be submitted "no later than ninety (90) calendar days after termination of the Amendment." At the last EQR, Alliance identified Child and Adolescent Day Treatment (limited choice 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. At the last Onsite review, Alliance's staff reported they added a provider to address the opioid treatment gap and worked with the Cumberland County school system to confirm support, then added a day treatment provider. During the Onsite review for this EQR, Alliance staff reported they have continued to work with the school system to look at meeting needs in Cumberland County, once face-to-face services can be reinstituted (post pandemic). Alliance has added a second Medicaid funded program to address the opioid treatment gap.

As Figure 3 indicates, 100% of the standards in the Provider Services review were scored as "Met".

Figure 3: Provider Services Findings



Strengths

- Alliance has a Provider Helpdesk to assist providers.
- Recovery University trainings are available via an online portal. Training events are posted on the Events Calendar and in the Upcoming Provider Events section of the For Providers section of the Alliance website.

- During the Onsite, Alliance staff highlighted several actions focused on readying both the PIHP and the provider network for the Tailored Plan. For example, Alliance added a new team focused on helping providers move to more outcome/value-based care, and assisted providers with identifying barriers. Additional efforts include working to get more members with TCLI into competitive employment and using predictive modeling to look at why TCLI members lose housing.
- In response to the COVID-19 pandemic, Alliance took several steps to ensure member access to care, including providing funding to providers to support telehealth, enabling the purchase of smart phones and data plans for members.

Weaknesses

- There is conflicting information regarding committee membership and voting status across Procedure 6030, the *Provider Network Credentialing Committee (PNCC) Org Chart 11.12.2020*, and the Credentialing Committee meeting minutes.

Recommendations

- Revise Procedure 6030, the Credentialing Committee meeting minutes template, and any other documents that list Credentialing Committee membership to accurately reflect membership and voting status. For example, as the Chief Medical Officer (CMO) is a non-voting member of the committee, include the CMO in the list of non-voting members in Procedure 6030. As the CMO and Credentialing Supervisor are non-voting members of the Credentialing Committee, ensure that designation is clear on the Credentialing Committee meeting minutes.

C. Quality Improvement

The 2020 Quality Improvement (QI) EQR included Performance Measures (PMs) and Performance Improvement Projects (PIPs) validation. CCME conducted a Desk Review of the submitted (b) and (c) Waiver Performance Measures and a review of each PIP's *Quality Improvement Project Description Form* for validation, using CMS standard validation protocols. An Onsite discussion occurred to clarify measurement rates for each of the areas.

In the 2019 EQR, there were no Corrective Actions and one Recommendation given for the Routine Access to Care PIP to revise interventions for rate improvements. This PIP was closed and not evaluated this year. There were no Recommendations given in the 2019 EQR for the PMs. The 2019 EQR validation scores for (b) Waiver and (c) Waiver Performance Measures were fully compliant with an average validation score of 100%.

For the 2020 EQR, seven PIPs were validated, and all PIPS scored in the High Confidence range. The 2020 EQR has no Corrective Action items, although four PIPs have one

Recommendation each. The Performance Measure Query was accurate for (b) Waiver Measures and all measures were validated at 100%, Fully Compliant, although Follow-Up After Hospitalization for Substance Abuse had substantial declines for two subsets of the rate calculation. It was recommended to continue with current interventions for this (b) Waiver Measure. The (c) Waiver Measures exceeded State benchmarks and were validated at 100%, Fully Compliant.

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

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

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

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

(b) Waiver Measures Reported Results

These measure rates for FY2019-FY2020 as reported by Alliance are included in the Table below, in addition to the previous year's rate the change in rate is displayed. Follow-Up After Hospitalization for Substance Abuse had substantial declines for two subsets of the

rate calculation. The Detox and Facility Based Crisis (FBC) rate showed a 47% decline for 3-day follow up, a 38.9% decline for 7-day follow up and a 27.8% decline for 30 day follow up. The Combined had a 21% decline for 7-day and 15.5% decline for 30 day follow up. There were no rates with a substantial increase over 10% in the year-to-year trending. The current rate in comparison to last year's rate is presented in the Tables 7 through 16.

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

30-day Readmission Rates for Mental Health	FY 2019	FY 2020	Change
Inpatient (Community Hospital Only)	12.1%	15.0%	2.90%
Inpatient (State Hospital Only)	4.4%	0.0%	-4.40%
Inpatient (Community and State Hospital Combined)	12.0%	14.7%	2.70%
Facility Based Crisis	6.4%	8.9%	2.50%
Psychiatric Residential Treatment Facility (PRTF)	11.3%	11.6%	0.30%
Combined (includes cross-overs between services)	11.3%	14.0%	2.70%

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

30-day Readmission Rates for Substance Abuse	FY 2019	FY 2020	Change
Inpatient (Community Hospital Only)	17.6%	13.2%	-4.40%
Inpatient (State Hospital Only)	4.5%	4.0%	-0.50%
Inpatient (Community and State Hospital Combined)	16.5%	11.3%	-5.20%
Detox/Facility Based Crisis	11.3%	12.2%	0.90%
Combined (includes cross-overs between services)	13.0%	11.7%	-1.30%

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

Follow-up after Hospitalization for Mental Illness	FY 2019	FY 2020	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	45.3%	43.9%	-1.40%
Percent Received Outpatient Visit Within 30 Days	63.0%	61.9%	-1.10%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	64.6%	62.5%	-2.10%
Percent Received Outpatient Visit Within 30 Days	74.0%	78.6%	4.60%
PRTF			
Percent Received Outpatient Visit Within 7 Days	32.7%	38.6%	5.90%
Percent Received Outpatient Visit Within 30 Days	51.5%	61.4%	9.90%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	46.1%	44.5%	-1.60%
Percent Received Outpatient Visit Within 30 Days	63.3%	62.6%	-0.70%

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

Follow-up after Hospitalization for Substance Abuse	FY 2019	FY 2020	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	24.2%	29.6%	5.40%
Percent Received Outpatient Visit Within 30 Days	40.6%	44.6%	4.00%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	66.0%	18.8%	-47.20%
Percent Received Outpatient Visit Within 7 Days	68.6%	29.7%	-38.90%
Percent Received Outpatient Visit Within 30 Days	74.3%	46.5%	-27.80%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	50.4%	29.6%	-20.80%
Percent Received Outpatient Visit Within 30 Days	60.5%	45.0%	-15.50%

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2019	FY 2020	Change
Ages 13-17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	37.7%	40.5%	2.80%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	22.2%	21.6%	-0.60%
Ages 18-20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	36.2%	28.7%	-7.50%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	17.8%	13.5%	-4.30%
Ages 21-34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	48.1%	46.7%	-1.40%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	36.9%	33.9%	-3.00%
Ages 35-64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	45.4%	42.7%	-2.70%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	36.1%	30.6%	-5.50%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	44.3%	35.3%	-9.00%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	27.8%	25.9%	-1.90%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	45.2%	42.7%	-2.50%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	34.1%	29.8%	-4.30%

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 2019	FY 2020	Change	FY 2019	FY 2020	Change
3-12	Male	0.3	0.2	-0.1	24.3	37.9	13.6
	Female	0.3	0.2	-0.1	26.5	32.1	5.6
	Total	0.3	0.2	-0.1	25.3	35.3	10.0
13-17	Male	1.3	1.0	-0.3	52.5	59.0	6.5
	Female	2.0	1.7	-0.3	31.1	28.1	-3.0
	Total	1.6	1.4	-0.2	39.7	39.8	0.1
18-20	Male	1.7	1.5	-0.2	12.9	12.5	-0.4
	Female	1.6	1.8	0.2	13.3	14.9	1.6
	Total	1.6	1.7	0.1	13.1	13.8	0.7
21-34	Male	5.9	5.6	-0.3	10.9	11.6	0.7
	Female	1.6	1.7	0.1	9.7	8.3	-1.4
	Total	2.6	2.6	0.0	10.4	10.0	-0.4
35-64	Male	4.7	4.9	0.2	10.6	10.2	-0.4
	Female	2.2	2.2	0.0	9.0	8.7	-0.3
	Total	3.1	3.2	0.1	9.9	9.5	-0.4
65+	Male	0.5	0.6	0.1	33.9	32.7	-1.2
	Female	0.5	0.3	-0.2	25.2	19.5	-5.7
	Total	0.5	0.4	-0.1	28.3	25.7	-2.6
Unknown	Male	0.0	0.0	0.0	0.0	0.0	0.0
	Female	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0
Total	**Male**	**1.6**	**1.6**	**0.0**	**19.0**	**19.3**	**0.3**
	Female	**1.2**	**1.2**	**0.0**	**16.6**	**15.0**	**-1.6**
	Total	**1.4**	**1.4**	**0.0**	**17.8**	**17.2**	**-0.6**

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 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
3-12	Male	13.63%	12.67%	-0.96%	0.05%	0.04%	-0.01%	0.27%	0.28%	0.01%	13.60%	12.62%	-0.98%
	Female	9.81%	9.18%	-0.63%	0.02%	0.04%	0.02%	0.09%	0.09%	0.00%	9.80%	9.16%	-0.64%
	Total	11.76%	10.96%	-0.80%	0.04%	0.04%	0.00%	0.18%	0.18%	0.00%	11.74%	10.93%	-0.81%
13-17	Male	15.89%	14.80%	-1.09%	0.25%	0.31%	0.06%	0.29%	0.24%	-0.05%	15.81%	14.72%	-1.09%
	Female	18.64%	17.72%	-0.92%	0.24%	0.28%	0.04%	0.14%	0.14%	0.00%	18.61%	17.69%	-0.92%
	Total	17.25%	16.24%	-1.01%	0.24%	0.30%	0.06%	0.21%	0.19%	-0.02%	17.19%	16.19%	-1.00%
18-20	Male	10.33%	9.73%	-0.60%	0.13%	0.07%	-0.06%	0.01%	0.01%	0.00%	10.30%	9.71%	-0.59%
	Female	13.05%	12.83%	-0.22%	0.20%	0.11%	-0.09%	0.01%	0.03%	0.02%	13.02%	12.82%	-0.20%
	Total	11.74%	11.35%	-0.39%	0.17%	0.09%	-0.08%	0.01%	0.02%	0.01%	11.71%	11.34%	-0.37%
21-34	Male	24.93%	24.51%	-0.42%	0.81%	0.44%	-0.37%	0.01%	0.01%	0.00%	24.93%	24.51%	-0.42%
	Female	20.16%	19.32%	-0.84%	0.22%	0.14%	-0.08%	0.00%	0.06%	0.06%	20.16%	19.32%	-0.84%
	Total	21.29%	20.56%	-0.73%	0.36%	0.21%	-0.15%	0.00%	0.05%	0.05%	21.29%	20.55%	-0.74%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
35-64	Male	25.51%	24.46%	-1.05%	0.71%	0.45%	-0.26%	0.01%	0.03%	0.02%	25.51%	24.44%	-1.07%
	Female	27.66%	25.63%	-2.03%	0.34%	0.21%	-0.13%	0.00%	0.04%	0.04%	27.66%	25.61%	-2.05%
	Total	26.87%	25.20%	-1.67%	0.48%	0.30%	-0.18%	0.01%	0.04%	0.03%	26.87%	25.18%	-1.69%
65+	Male	6.59%	5.60%	-0.99%	0.11%	0.02%	-0.09%	0.00%	0.00%	0.00%	6.59%	5.60%	-0.99%
	Female	6.63%	5.98%	-0.65%	0.05%	0.01%	-0.04%	0.00%	0.01%	0.01%	6.63%	5.97%	-0.66%
	Total	6.62%	5.85%	-0.77%	0.07%	0.01%	-0.06%	0.00%	0.01%	0.01%	6.62%	5.85%	-0.77%
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	15.90%	14.98%	-0.92%	0.25%	0.18%	-0.07%	0.18%	0.18%	0.00%	15.87%	14.94%	-0.93%
	Female	16.21%	15.32%	-0.89%	0.16%	0.13%	-0.03%	0.05%	0.07%	0.02%	16.20%	15.31%	-0.89%
	Total	16.07%	15.17%	-0.90%	0.20%	0.15%	-0.05%	0.11%	0.12%	0.01%	16.06%	15.15%	-0.91%

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 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
3–12	Male	0.01%	0.02%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.02%	0.01%
	Female	0.01%	0.00%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.00%	-0.01%
	Total	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
13–17	Male	0.79%	0.70%	-0.09%	0.01%	0.03%	0.02%	0.10%	0.11%	0.01%	0.72%	0.64%	-0.08%
	Female	0.50%	0.56%	0.06%	0.01%	0.02%	0.01%	0.02%	0.02%	0.00%	0.48%	0.54%	0.06%
	Total	0.65%	0.63%	-0.02%	0.01%	0.02%	0.01%	0.06%	0.07%	0.01%	0.60%	0.59%	-0.01%
18–20	Male	1.17%	1.29%	0.12%	0.01%	0.02%	0.01%	0.06%	0.05%	-0.01%	1.12%	1.29%	0.17%
	Female	1.05%	1.40%	0.35%	0.03%	0.00%	-0.03%	0.05%	0.04%	-0.01%	1.04%	1.38%	0.34%
	Total	1.11%	1.35%	0.24%	0.02%	0.01%	-0.01%	0.05%	0.05%	0.00%	1.08%	1.34%	0.26%
21–34	Male	5.23%	5.79%	0.56%	0.36%	0.18%	-0.18%	0.54%	0.49%	-0.05%	5.13%	5.65%	0.52%
	Female	5.17%	5.03%	-0.14%	0.22%	0.10%	-0.12%	0.61%	0.57%	-0.04%	5.08%	4.92%	-0.16%
	Total	5.18%	5.21%	0.03%	0.25%	0.12%	-0.13%	0.59%	0.55%	-0.04%	5.09%	5.10%	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 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
35–64	Male	8.21%	7.84%	-0.37%	0.73%	0.54%	-0.19%	1.25%	1.21%	-0.04%	7.92%	7.60%	-0.32%
	Female	5.47%	5.37%	-0.10%	0.30%	0.13%	-0.17%	0.83%	0.66%	-0.17%	5.21%	5.16%	-0.05%
	Total	6.47%	6.27%	-0.20%	0.46%	0.28%	-0.18%	0.99%	0.86%	-0.13%	6.20%	6.05%	-0.15%
65+	Male	1.23%	1.33%	0.10%	0.20%	0.14%	-0.06%	0.19%	0.17%	-0.02%	1.18%	1.20%	0.02%
	Female	0.34%	0.31%	-0.03%	0.04%	0.02%	-0.02%	0.09%	0.05%	-0.04%	0.29%	0.27%	-0.02%
	Total	0.63%	0.65%	0.02%	0.09%	0.06%	-0.03%	0.13%	0.09%	-0.04%	0.58%	0.58%	0.00%
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%	1.87%	0.01%	0.14%	0.11%	-0.03%	0.25%	0.25%	0.00%	1.79%	1.80%	0.01%
	Female	2.10%	2.10%	0.00%	0.10%	0.05%	-0.05%	0.28%	0.24%	-0.04%	2.03%	2.04%	0.01%
	Total	2.00%	2.00%	0.00%	0.12%	0.07%	-0.05%	0.27%	0.24%	-0.03%	1.92%	1.93%	0.01%

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 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
	3-12			13-17			18-20			21-34		
Cumberland	0.02%	0.03%	0.01%	1.14%	1.01%	-0.13%	1.31%	1.82%	0.51%	4.67%	4.89%	0.22%
Durham	0.02%	0.00%	-0.02%	1.07%	0.70%	-0.37%	1.54%	1.39%	-0.15%	4.68%	4.62%	-0.06%
Johnston	0.01%	0.01%	0.00%	0.80%	0.84%	0.04%	1.42%	1.40%	-0.02%	5.59%	5.30%	-0.29%
Wake	0.01%	0.01%	0.00%	0.86%	0.83%	-0.03%	1.21%	1.49%	0.28%	3.43%	3.37%	-0.06%
	35-64			65+			Unknown			Total		
Cumberland	5.13%	4.72%	-0.41%	0.47%	0.44%	-0.03%	0.00%	0.00%	0.00%	2.04%	2.00%	-0.04%
Durham	9.16%	8.56%	-0.60%	1.22%	1.33%	0.11%	0.00%	0.00%	0.00%	2.50%	2.34%	-0.16%
Johnston	5.38%	5.41%	0.03%	0.41%	0.46%	0.05%	0.00%	0.00%	0.00%	1.85%	1.82%	-0.03%
Wake	5.37%	5.13%	-0.24%	0.79%	0.74%	-0.05%	0.00%	0.00%	0.00%	1.52%	1.51%	-0.01%

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		
	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
	3-12			13-17			18-20			21-34		
Cumberland	12.13%	11.76%	-0.37%	17.84%	17.99%	0.15%	11.63%	11.28%	-0.35%	16.19%	16.47%	0.28%
Durham	9.38%	9.37%	-0.01%	17.16%	16.31%	-0.85%	10.47%	10.12%	-0.35%	15.77%	14.49%	-1.28%
Johnston	8.95%	8.20%	-0.75%	14.65%	14.56%	-0.09%	9.80%	9.69%	-0.11%	14.48%	14.18%	-0.30%
Wake	7.90%	7.40%	-0.50%	14.98%	14.46%	-0.52%	10.11%	9.49%	-0.62%	14.07%	13.81%	-0.26%
	35-64			65+			Unknown			Total		
Cumberland	21.18%	20.28%	-0.90%	8.04%	6.83%	-1.21%	0.00%	0.00%	0.00%	15.08%	14.72%	-0.36%
Durham	24.50%	23.80%	-0.70%	6.41%	6.77%	0.36%	0.00%	0.00%	0.00%	13.79%	13.40%	-0.39%
Johnston	20.85%	20.57%	-0.28%	11.31%	10.51%	-0.80%	0.00%	0.00%	0.00%	12.75%	12.27%	-0.48%
Wake	20.44%	19.86%	-0.58%	6.34%	6.33%	-0.01%	0.00%	0.00%	0.00%	11.74%	11.34%	-0.40%

(b) Waiver Validation Results

All measures received a validation score of 100% and were found Fully Compliant. The stored procedures have been updated to address NC Medicaid's most recent changes to the measures.

Table 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

Five (c) Waiver Measures were chosen for validation. The rates reported by Alliance and the State benchmarks are displayed in Table 18: (c) Waiver Measures Reported Results 2019 - 2020. Documentation on data sources, data validation, source code, and calculated rate for the five measures was provided. Additionally, all rates exceeded the State Performance Benchmarks.

Table 18: (c) Waiver Measures Reported Results 2019-2020

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	1832/1850 = 99.03%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	1832/1850 = 99.03%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	44/50 = 88.0%	85%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	966/966 = 100.0%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	13/14 = 92.86%	85%

(c) Waiver Validation

All (c) Waiver Measures met the validation requirements and were Fully Compliant as shown in Table 19, (c) Waiver Performance Measure Validation Scores. The validation worksheets offer detailed information on validation and calculation steps for (c) Waiver Measures.

Table 19: C Waiver Performance Measures Validation Scores

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

Performance Improvement Project (PIP) Validation

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

- 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 this 2020 EQR, there were seven active PIPs submitted and validated. The PIPs reviewed in 2019 were all noted as closed. This is the first year of validation for all seven active PIPs, thus, Table 20, PIP Summary of Validation Scores, shows the current EQR score only.

Table 20: PIP Summary of Validation Scores

Project Type	Project	2019 Validation Score	2020 Validation Score
Clinical	7-Day Super Measure – Medicaid DHB SUD	NA	79/79 = 100% High Confidence in Reported Results
	7-Day Super Measure – State DMH MH	NA	73/74 = 98.6% High Confidence in Reported Results
	7-Day Super Measure – State DMH SUD	NA	79/79 = 100% High Confidence in Reported Results
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM)	NA	73/74 = 98.6% High Confidence in Reported Results
	HEDIS Antipsychotic Adherence (SAA)	NA	73/74 = 98.6% High Confidence in Reported Results
	Diabetes Screenings for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (HEDIS SSD)	NA	79/79 = 100% High Confidence in Reported Results
Non-Clinical	Transitions to Community Living Initiative (TCLI) Improve In-Reach Contact Rate	NA	73/74 = 98.6% High Confidence in Reported Results

The 2020 PIP documentation contained all necessary elements for validation. There were three Supermeasure PIPs with like interventions across all three PIPs, including value-based incentives, education, open access clinics, provider scorecards, and Peer Bridger programs. The Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), Antipsychotic Adherence (SAA), and Diabetic Screening for Members with Schizophrenia/Bipolar Disorder on Antipsychotics (SSD) PIP included several interventions for member education through the HealthCrowd campaign, provider scorecards, and patient level data analysis for providers. The TCLI In Reach PIP has interventions focused on data tracking, monitoring, assignments for contacts, and warnings for those nearing

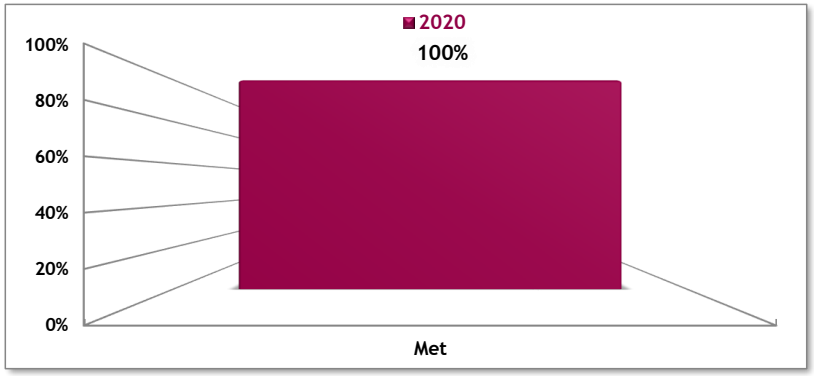
the 80-day no-contact timepoint. There were no Corrective Actions for the validated PIPS. There were Recommendations for four of the seven PIPs regarding the revision of interventions and initiation of additional interventions to improve rates that showed a decline in the most recent remeasurement period. The project, section, reason, and Recommendations are displayed in Table 21 below.

Table 21: Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
7-Day Super Measure - State DMH MH	Was there any documented, quantitative improvement in processes or outcomes of care?	The most recent remeasurement showed a decline in the rate from 39% to 34%.	Continue the current interventions of incentives, education, open access, provider scorecards, and Peer Bridger Programs. Determine if additional interventions should be implemented to improve rate toward the 40% benchmark.
Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM)	Was there any documented, quantitative improvement in processes or outcomes of care?	The most recent remeasurement showed no improvement in the rate. It stayed at 27% for remeasurement 2 and 3.	Continue the current interventions of HealthCrowd campaign, planning for point of care testing, provider scorecards, and patient level data analysis. Determine if additional interventions should be implemented to improve rate toward the 35% benchmark.
HEDIS Antipsychotic Adherence (SAA)	Was there any documented, quantitative improvement in processes or outcomes of care?	The most recent remeasurement showed a decline in the rate from 59% to 58%.	Continue the current interventions of HealthCrowd campaign, provider scorecards, and patient level data analysis. Determine if additional interventions should be implemented to improve rate toward the 60% benchmark.
TCLI Improve In-Reach Contact Rate	Was there any documented, quantitative improvement in processes or outcomes of care?	The most recent remeasurement showed a decline in the rate from 93% to 92%.	Continue the current interventions of data tracking/monitoring, assignments, and 80 day no contact tracking to determine if rate will improve to the goal of 95%.

Details of the validation activities for the PMs and PIPs and specific outcomes related to each activity may be found in *Attachment 3, CCME EQR Validation Worksheets*. As demonstrated in Figure 4, Alliance met all the Quality Improvement standards in the 2020 EQR.

Figure 4: Quality Improvement Findings



Strengths

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

Weaknesses

- The (b) Waiver Performance Measure Follow-Up After Hospitalization for Substance Abuse had substantial declines for two subsets of the rate calculation.
- For the 7-Day Super Measure – State DMH MH PIP, the most recent remeasurement showed a decline in the rate from 39% to 34%.
- For the Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM) PIP, the most recent remeasurement showed no improvement in the rate. It stayed at 27% for remeasurements 2 and 3.
- For the HEDIS Antipsychotic Adherence (SAA) PIP, the most recent remeasurement showed a decline in the rate from 59% to 58%.
- For the TCLI Improve In-Reach Contact Rate PIP, the most recent remeasurement showed a decline in the rate from 93% to 92%.

Recommendations

- Continue current interventions for the (b) Waiver Performance Measure Follow-up After Hospitalization for Substance Abuse.
- For the 7-Day Super Measure, continue the current interventions of incentives, education, open access, provider scorecards, and Peer Bridger Programs. Determine if additional interventions should be implemented to improve rate toward the 40% benchmark.
- For the Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM) PIP, continue the current interventions of HealthCrowd campaign, planning for point of care testing, provider scorecards, and patient level data analysis. Determine if additional interventions should be implemented to improve rate toward the 35% benchmark.
- For the HEDIS Antipsychotic Adherence (SAA) PIP, continue the current interventions of HealthCrowd campaign, provider scorecards, and patient level data analysis. Determine if additional interventions should be implemented to improve the rate toward the 60% benchmark.
- For the TCLI Improve In-Reach Contact Rate PIP, continue the current interventions of data tracking/monitoring, assignments, and 80 day no contact tracking to determine if rate will improve to the goal of 95%.

D. Utilization Management

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

For the 2019 EQR, Alliance met 91% of UM standards. CCME issued four Corrective Actions and two Recommendations. One Corrective Action and one Recommendation were issued to Utilization Review (UR). The Corrective Action addressed the expectation for Care Managers to obtain additional information from providers prior to rendering a denial for service authorization. The Recommendation was to include the requirement for providers to use the Children's Assessment of Needs and Strengths (CANS) to determine the clinical needs of children ages three to six. The Corrective Action and Recommendation were addressed.

Three Corrective Actions and one Recommendation were issued to Care Coordination and TCLI. Findings from the 2019 EQR for Care Coordination and TCLI were similar to the previous year. One Corrective Action was aimed at developing a report that would

produce the complete member record. The remaining two Corrective Actions were to address inconsistencies in the frequency of contacts, completeness, and quality of documentation within the MH/SU, I/DD and TCLI Care Coordination files. The final Recommendation was aimed at adding information to Alliance's policies and procedures regarding Home and Community Based Services (HCBS). The Corrective Actions and Recommendations were addressed.

For the 2020 EQR, Alliance was able to produce the complete member record from its case management platform. However, discrepancies were identified. Alliance lists the tools and age requirements used to determine the appropriate level of service for children and adolescent in the *Individual and Family Handbook*. The tools include the CALOCUS for ages five to seventeen years and the CANS for ages zero to four years. However, this does not align with *NC Medicaid Contract, Section 7.4.2* that states "CALOCUS scores shall be used for medical necessity reviews…except for Children ages three (3) through six (6) and *section 7.4.3*, "For Children ages three (3) through six (6), PIHP shall use one of the following options to determine medical necessity reviews: *b.* The Children and Adolescents Needs and Strengths (CANS)". CCME recommends that Alliance update the *Individual and Family Handbook* to ensure that ages listed for the use of assessments and tools correspond with the *NC Medicaid Contract*.

Alliance's Procedure 2009 ICF-IDD Deinstitutionalization Planning and the *Innovations Individual and Family Handbook*, list the funding cap for members participating in the Innovations waiver at $135,000. However, *NC Medicaid Joint Communication Bulletin #J362* allows members to exceed the funding cap when one of three criteria are met. CCME is recommending that Alliance update Procedure 2009 and the *Innovations Individual and Family Handbook* to include the exemptions to the funding cap as listed in *NC Joint Communication Bulletin #J362*.

Alliance's Procedure 2015, Management of New/Open NC Innovations Slots, addresses the access, screening, and administration of Alliance's Registry of Unmet Needs. The procedure includes the process for when a member or the Legal Responsible Person (LRP) requests a delay or declines to participate in the Innovations waiver. The procedure does not include additional follow-up to confirm the decision to delay or decline the Innovations waiver prior to placing them at the bottom or removing the member from the Registry of Unmet Needs. During the Onsite, Alliance staff described a process that includes a collateral contact that is followed by a letter, to confirm the decision made by the member or LRP. CCME is recommending Alliance update Procedure 2015 to include follow-up activities completed by staff before making changes to the Registry of Unmet Needs.

The review of I/DD files found gaps in Care Coordination monthly contacts with members who receive residential supports. Alliance Procedure 2027, Monitoring Requirements for NC Innovations and NC TBI Waiver Participants, and *NC Medicaid Contract, Section 6.11.3*

(h) require monthly face-to-face monitoring for members who receive residential supports, including Alternative Family Living (AFL) homes. However, in two I/DD files, this did not occur. In one file, 20% of face-to-face Care Coordinator contacts did not occur monthly during the review period. During the Onsite, Alliance staff described a current monitoring process that relies heavily on reports from its case management platform Jiva but does not include a manual record review to ensure compliance with Alliance procedure and *NC Medicaid Contract*. CCME has issued a Corrective Action for Alliance to enhance the current monitoring process by adding a manual record review that will ensure data in Jiva meets compliance standards outlined in Alliance policies and procedures and in the *NC Medicaid Contract*.

For the second year, the review of TCLI files found issues with timely completion of the Quality of Life (QOL) surveys. Alliance Procedure 2032, In-Reach and Transition Process, and *NC Medicaid Contract, Section 15.4* require QOL surveys to be administered 11 months after the member transitions out of the facility. In two qualifying files the review found that the 11-month QOL survey was not completed timely; one survey was more than 19 months late. During the Onsite, Alliance staff acknowledged the lack of the timely completion of the 11th month and the 24 month QOL survey and described a manual review of member records that tracks the due date and completion of QOL surveys. CCME is requiring Alliance to develop, document and implement a monitoring process to improve the timeliness and completeness of the QOL survey.

REVISION: Per feedback from the State on July 2, 2021, these two Corrective Actions should be changed to Recommendations and the scores on the related standards changed from a "Partially Met" to a "Met".

Figure 5 shows 100% of the Utilization Management standards were scored as "Met" and 8% scored as "Partially Met" in the 2020 EQR.

Figure 5: Utilization Management Findings

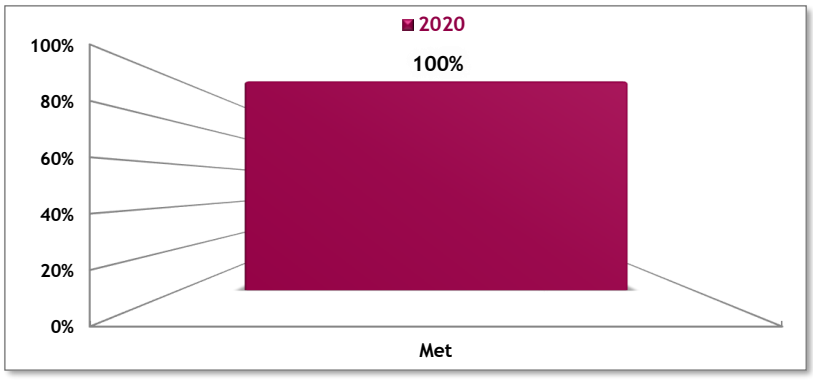


Table 22: Utilization Management

Section	Standard	2020 Review
Care Coordination	The PIHP applies the Care Coordination policies and procedures as formulated.	Partially Met
Transition to Community Living	QOL Surveys are administered timely.	Partially Met

Strengths

- Alliance provided the complete MH/SUD/I/DD/TCLI member records for file review.
- Alliance increased Care Coordination/TCLI contact with members, families, and providers during the Covid-19 Stay at Home Order.
- During the Covid-19 Stay at Home Order, members who were receiving residential supports but wished to return to their family homes were allowed to do so without losing their residential placement.
- Alliance exceeded the number of TCLI transitions set by the state by housing 111 new members and rehousing 21 members.

Weaknesses

- The ages listed in the *Individual and Family Handbook* for the CANS and CALOCUS contradicts *North Carolina Medicaid Contract*, *Sections 7.4.2* and *7.4.3*.
- Procedure 2009 and the *Innovations Individual and Family Handbook* do not include exemptions to the Innovations funding caps listed in NC Joint Communication Bulletin #J362.
- Procedure 2015, Management of New/Open NC Innovations Slots, does not include a follow-up process that ensures the decision made by or on behalf of the member to decline or delay receiving Innovations support is accurate before taking actions to update the Registry of Unmet Needs.
- The review of I/DD files found noncompliance with *NC Medicaid Contract, Section 6.11.3 (h)* and Alliance Procedure 2027, which require monthly face-to-face contact with members receiving residential supports. The current monitoring process does not include a manual record review that would ensure the frequency of contacts made by the Care Coordinator are within contractual requirements.

- For a second year, the review of TCLI files found that the 11-month and 24-month QOL Survey did not meet Alliance Procedure 2032 and *NC Medicaid Contract, Section 15.4.*

Recommendations

- Revise the *Individual and Family Handbook* to reflect the ages to administer the CANS and the CALOCUS to children and adolescents as listed in the *NC Medicaid Contract, Sections 7.4.2.* and *7.4.3.*
- Revise Procedure 2009 and the *Innovations Individual and Family Handbook*, to include exemption to the Innovations funding cap as listed in *NC Joint Communication Bulletin #J362.*
- Include in Procedure 2015, Management of New/Open NC Innovations Slots, a follow-up process that confirms the member or LRP request to delay or decline to participate in the Innovations Waiver.
- Enhance the current monitoring process to include a manual record review that routinely reviews the frequency of Care Coordinator contact with members receiving Innovations services. Ensure that the monitoring process includes the frequency of monitoring, departmental benchmarks for compliance, and how and when outcomes of monitoring are reviewed and reported.
- Develop, document, and implement a comprehensive monitoring plan that will review the timeliness and completeness of QOL Surveys at the required intervals according to Alliance Procedure 2032 and *NC Medicaid Contract, Section 15.4.*

E. Grievances and Appeals

The EQR of Alliance's Grievance and Appeal functions included a Desk Review of policies and procedures, 10 Grievance and 12 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.

In the 2019 EQR, Alliance met 80% of the Grievance and Appeals standards. Six Corrective Actions and three Recommendations were issued to address concerns noted within the Grievance and Appeal procedures, the *Provider Operations Manual*, the *Individual and Family Handbook*, the *Intellectual and Developmental Disabilities Care Coordination Desk Reference*, and the Grievance and Appeal files reviewed in the 2019 EQR.

In the 2020 EQR, Alliance met 95% of the Grievance and Appeals standards.

Grievances

In 2019, Alliance was issued one Recommendation and one Corrective Action in the Grievance EQR. CCME recommended Alliance add within Procedure 6503, Management, and Investigation of Grievances, a description of the process by which the referral and consultation by the Quality Review Committee (QRC) with quality-of-care concerns are reviewed. A Corrective Action was issued for Alliance to develop, document, and implement a monitoring plan to increase compliance with required Grievance notifications. Alliance implemented and maintained both the Recommendation and Corrective Action over the past review year.

In this 2020 EQR of Grievances, CCME has issued five Recommendations. These Recommendations target confusing and incorrect information within Alliance's Grievance procedure and the *Provider Operations Manual*.

The review of Procedure 6503, Management and Investigation of Grievances revealed there are numerous references to the term "complaint", which makes the procedure confusing. The use of one term, "Grievance", within this procedure would provide a clear and concise explanation of Alliance's Grievance processes. Further, there is no definition of the term "Grievant" within this procedure. CCME is recommending Alliance include the definition of "Grievant" to the "Definitions" section, page seven (7) of the procedure.

The review of Alliance's *Provider Operations Manual*, also found there are references to concerns, complainant, and complaint when explaining Grievance processes. There is also no reference to the term "Grievance" or "Grievant". This section creates confusion and misleading information regarding the Grievance process. CCME is recommending Alliance use the terms "Grievance" and "Grievant" to describe Alliance's Grievance process clearly and concisely.

Additionally, the *Provider Operations Manual* states an incorrect timeframe from the completion of a Grievance. On pg. 62, it is stated, "Alliance will seek to resolve Grievances…no later than thirty (30) calendar days from the date Alliance received the Grievance." This timeframe conflicts with the 90-day Grievance resolution timeframe required in Procedure 6503.

Also, in the *Provider Operations Manual*, details about the required notifications when Alliance extends the Grievance resolution timeframe are incorrect. The *Provider Operations Manual* on pg. 62 states, "Any extension granted shall be communicated to the individual within one (1) business day either verbally or in writing. Verbal notifications shall be followed up in writing to the individual." Alliance needs to correct this information to state, Alliance will "make reasonable efforts to give the enrollee prompt oral notice of the delay" and written notice "within 2 calendar days". This correction will bring the *Provider Operations Manual* into compliance with Alliance *Procedure 6503* and *42 CFR § 438.408 (c)(2)(ii)*.

Appeals

In the 2019 EQR of Appeals, five Corrective Actions and two Recommendations were issued. In this 2020 EQR, it was evident Alliance addressed all 2019 Corrective Actions and Recommendations, with one exception. In 2019, CCME recommended Alliance add to Procedure 6505, Due Process Appeals of Medical Necessity, the verbal notification required to be issued when Alliance extends an expedited Appeal resolution timeframe. This verbal notification is required by *42 CFR § 438.408 (c)(2)* and Alliance's *NC Medicaid Contract, Attachment M, Section G.6.* This Recommendation was not implemented by Alliance. It was also noted in this 2020 EQR that the Appeals procedure does not specify the timeframe for the written notice to enrollee's regarding an extension to the Appeal resolution timeframe. In both the standard and expedited sections of this procedure it is stated "Alliance will notify the member in writing before the expiration of the designated timeframe." The required timeframe for written notification to enrollees regarding an extension to the Appeal resolution timeframe is "within 2 calendar days". This requirement is also outlined in *42 CFR § 438.408 (c)(2)* and Alliance's *NC Medicaid Contract, Attachment M, Section G.6.* CCME has issued a Corrective Action to ensure these required verbal and written notifications are captured in Alliance's Appeal procedure, and the required timeframes for issuing the verbal and written notifications are also detailed in this procedure.

In the 2019 EQR, one of the Corrective Actions issued aimed to improve accuracy and compliance within the Appeal Log and Appeal files reviewed. This Corrective Action required the development of an Appeals monitoring process. Alliance implemented a monitoring process that included development of a *Peer Review Tool*. This tool is routinely used to identify incorrect data or compliance issues within the Appeal files. In this 2020 EQR, the Appeal Log and Appeal files showed improvement since last year's EQR. However, to a lesser degree, compliance issues were still noted. There was one data entry error in the Appeal Log and concerns identified in two of the twelve files reviewed. These concerns were discussed and reviewed with staff during the Onsite interview. Further, it was highlighted during the Onsite that the Peer Review Tool does not adequately review identify compliance issues around verbal and written notifications related to invalid, extended, expedited and withdrawn Appeals. CCME recommends Alliance hone the Peer Review Tool to better identify compliance issues within all types of Appeals, such as expedited, invalid, extended, or withdrawn Appeals, and not just standard Appeals.

In this 2020 review, there are four revisions needed in the *Individual and Family Handbook*. As a result, CCME has issued one Corrective Action and two Recommendations related to the *Individual and Family Handbook*. The Corrective Action targets incorrect information on page 64 of the *Individual and Family Handbook*. The handbook states written notice of the resolution of an expedited Appeal will be provided by Alliance within "three business days". Per Alliance's Appeal procedure, written notification of the

resolution of an expedited Appeal must be issued "within 72 hours of the receipt of the LME/MCO Level Appeal request." Also, in the *Individual and Family Handbook* (pg. 64), it is stated that the "60-day" Appeal resolution timeframe can be expedited. However, the timeframe for resolving and providing Appeal resolution notification of Appeals is "30 days". Further, in the *Individual and Family Handbook* (pg. 64) it is stated the written notification to the enrollee of an extension to the Appeal resolution timeframe by Alliance will be provided "within three business days." The timeframe for this written notification, as required by the *42 CFR § 438.408 (c)(2)*, is "2 calendar days". Lastly, there is also no mention in the *Individual and Family Handbook* regarding the requirement that Alliance notify the enrollee of their right to file a Grievance if they disagree with Alliance's decision to extend the Appeal resolution timeframe. This notification is required by *42 CFR § 438.408 (c)(2)(ii)*.

Three additional Recommendations have been issued for this EQR targeting information in the *Provider Operations Manual*. There is no information in the *Provider Operations Manual* regarding the verbal notification Alliance must issue when Alliance extends an expedited Appeal resolution, nor is the timeframe for this verbal and the written notification of extension explained. Also, the Table of Contents in this manual needs to be updated to ensure it correctly directs providers to Appeal information. Lastly, page 64 of the *Provider Operations Manual* has the incorrect timeframe for filing an Appeal.

In this year's EQR, Alliance met 95% of the Grievance and Appeal Standards. One Appeal standard were scored "Partially Met". Figure 6 demonstrates the outcome of the 2020 EQR of Grievance and Appeals standards.

Figure 6: Grievances and Appeals Findings

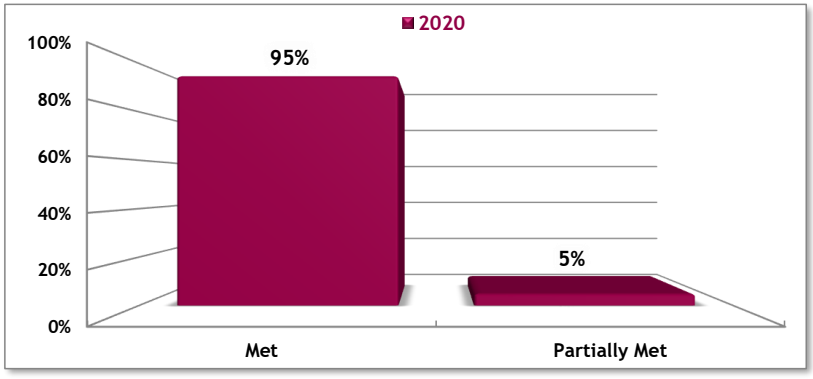


Table 23: Grievances and Appeals

Section	Standard	2020 Review
Appeals	Timeliness guidelines for resolution of the Appeal as specified in the contract	Partially Met

Strengths

- Alliance implemented a Grievance monitoring process that improved the timeliness of Grievance notifications.
- The Appeals monitoring process implemented Alliance in the past year significantly improved the compliance issues noted in the 2020 EQR.

Weaknesses

- *In Procedure 6503, Management, and Investigation of Grievances* there are at least 16 references to the term "complaint" within the procedure which makes the procedure confusing.
- Grievance information within the *Provider Operations Manual* is also confusing and because the terms "concerns", "complainant", and "complaint" are interspersed within the description of Alliance's Grievance processes.
- In *Procedure 6503, Management, and Investigation of Grievances*, there is no definition of the term "Grievant".
- On page 62 of the *Provider Operations Manual*, it is stated the timeframe for Grievance resolution is 30 days, this is incorrect per Alliance's Grievance procedure which states Grievance are resolved in 90 days.
- There is incorrect information in the *Provider Operations Manual* (page 62) regarding the required notification Alliance must provide when Alliance extends the resolution timeframe of a Grievance.
- The *Provider Operations Manual* Table of Contents should ensure it correctly directs providers to Appeal information.
- Page 64 of the *Individual and Family Handbook* has the incorrect timeframe for filing an Appeal.
- There is no information in the Appeal procedure regarding the verbal notification Alliance must issue when Alliance extends an expedited Appeal resolution. There is also no timeframe specified in the Appeal procedure for the issuance of the written notification when Alliance extends a standard or expedited Appeal.

- The *Provider Operations Manual* also does not explain Alliance will verbally notify the enrollee of Alliance's extension to the Appeal resolution timeframe, nor is a timeframe identified for the verbal and written notifications from Alliance regarding an extension.
- There is incorrect or missing Appeals information in the *Individual and Family Handbook*.
- The *Peer Review Tool* used by staff to review Appeals for potential compliance issues does not adequately review for required verbal and/or written notifications related to expedited, invalid, extended, or withdrawn Appeals.

Corrective Action

- Within Procedure 6505, correct the language explaining the required written and verbal notifications from Alliance when Alliance extends the Appeal resolution timeframe. The language within these documents should reflect the language in *42 CFR § 438.408 (c)(2)* and Alliance's *NC Medicaid Contract, Attachment M, Section G.6* and should be added to both the standard Appeals and expedited Appeals sections of the procedure.
- Correct the *Individual and Family Handbook* to state:
  - Written resolution of an expedited Appeal will be provided within 72 hours of the receipt of the Appeal.
  - The 30-day Appeal resolution timeframe can be expedited.
  - Written notification of an extension to the Appeal resolution timeframe by Alliance will provided "within 2 calendar days".
  - Alliance will notify the enrollee of their right to file a Grievance if they disagree with Alliance's decision to extend the Appeal resolution timeframe.

Recommendations

- Revise Procedure 6503, Management, and Investigation of Grievances to consistently use the term "Grievance".
- Revise the *Provider Operations Manual* to ensure Grievance information on pages 62-63 consistently uses the term "Grievance".
- In Procedure 6503, add the definition of "Grievant" to the "Definitions" section.
- Revise the *Provider Operations Manual* (pg. 62) to reflect Grievances are resolved in 90 calendar days, as required by Alliance Procedure 6503 and *42 CFR § 438.408 (c)(2)(ii)*.

- Correct the *Provider Operations* Manual to reflect the verbal and written notifications Alliance issues when Alliance extends the Appeal resolution timeframe. Include the timeframes for these verbal and written notifications, as required by *42 CFR § 438.408 (c)(2)* and *NC Medicaid Contract, Attachment M, Section G.6*.
- Update the *Provider Operations Manual* Table of Contents to reflect the correct pages for Appeal information.
- Revise page 64 of the *Individual and Family Handbook* to reflect enrollees have 60 days from the mailing date of the Adverse Benefit Determination timeframe to file an Appeal.
- Revise the monitoring process and Peer Review Tool to ensure expedited, extended, invalid, and withdrawn Appeals are routinely reviewed for compliance issues. For these Appeals, check to ensure all verbal and/or written notifications are provided in compliance with *NC Medicaid Contract, Attachment M* and *42 CFR § 438.406 and § 408*.

F. 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, PI workflows, *Provider Operations Manual*, conflict of interest forms, and Alliance's *Compliance Plan*. Additionally, 15 PI files were selected from the period of October 1, 2019 through September 30, 2020. The Onsite interviews were conducted on May 20, 2021 to discuss the findings within the Desk Materials and PI files.

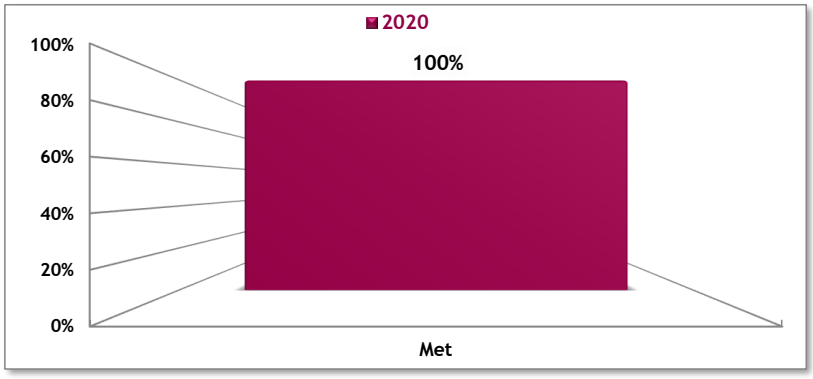
Two Corrective Actions issued in the 2019 EQR involved adding information to a PI procedure. *NC Medicaid Contract, Section 17* requires "PIHP shall notify the DMA designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment." In 2019, 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, Alliance 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 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)." In the 2020 EQR. there was evidence that these two Corrective Actions were addressed and language added to Alliance PI procedures.

Also in the 2019 EQR, one Recommendation was issued to ensure staff maximize the use of the Investigation Report summary form by completing it in it its entirety. It was noted in the 2020 EQR of PI files that this Recommendation was implemented.

Figure 7: Program Integrity Findings



Strengths

- Alliance has policies and procedures in place that address all contractual requirements.
- Alliance demonstrated all required elements in its Program Integrity files.
- Alliance is using its Investigation Report summary to produce a single source of case documentation.

G. Encounter Data Validation

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

The scope of the EQR Encounter Data Validation review, guided by the CMS Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid by Alliance for the period of January 2019 through December 2019. All claims paid by Alliance should be submitted and accepted as a valid encounter to NC Medicaid. Our approach to the review included:

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

Results and Recommendations

Issue: Additional Diagnosis Codes

The secondary diagnosis was populated in more than 53% of all institutional claims but only 12.9% 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. However, all claims should be complete and accurate at all times and these figures suggest that some providers are not as diligent in coding and submitting Additional Diagnosis codes.

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 and as a result we saw noticeable improvements in 2019. In addition, we recommend that Alliance identify providers who never or very rarely submit Additional Diagnosis codes and perform an outreach to remind them of their obligation to ensure that the claims they submit to Alliance are complete and accurate.

Conclusion

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

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

ATTACHMENTS

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

Attachments

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

The Carolinas Center *for* Medical Excellence
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November 2, 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 2020 External Quality Review (EQR) of Alliance Health is being initiated. The review will be conducted by us, The Carolinas Center for Medical Excellence (CCME), and is a contractual requirement. The review will include both a Desk Review (at CCME) and a one-day, virtual Onsite that will address contractually required services.

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

The CMS EQR protocols can be found at:
https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

Due to COVID-19 and the issuance of the contractual flexibilities issued by the State outlined in Contract Amendment #9, the 2020 EQR will be a focused review. The focus of this review will be on the Corrective Actions from the previous EQR and Alliance functions that impact enrollee health and safety. Similarly, for the 2020 EQR, the two day Onsite previously performed at PIHP offices will conducted during a one day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **May 20, 2021**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

In preparation for the Desk Review, the items on the enclosed **Desk Materials List** are to be submitted electronically. **Please note that, to facilitate a timely review, there are three lists on the Desk Materials List (items 9, 10, and 19.a) that should be submitted by no later than November 6, 2020.** The remaining items are due by no later than **November 23, 2020**. Also, as indicated in item 20 of the Desk Materials List, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted with the other Desk Materials on **November 23, 2020**.

Further, as indicated on item 21 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.

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. Additional information and technical assistance will be provided as needed, or upon request.

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 5

Cc: Sara Wilson, Alliance Contract Manager
Monica Hamlin, NC Medicaid Contract Manager
Hope Newsome, NC Medicaid Quality Management Specialist
Deb Goda, NC Medicaid Behavioral Health Unit Manager

ALLIANCE

Focused External Quality Review 2020

MATERIALS REQUESTED FOR DESK REVIEW

****Please note that the lists requested in items 9, 10, and 19.a must be uploaded by no later than November 6, 2020. The remainder of items must be uploaded by no later than November 23, 2020.**

1. Copies of all current policies and procedures, as well as a complete index which includes policy and procedure name, number, and department owner. The date of the addition/review/revision should be identifiable on each policy/procedure. *(Please do not embed files within word documents.)*
2. Organizational Chart of all staff members including names of individuals in each position including their degrees, licensure, and any certifications required for their position. Include any current vacancies. In addition, please include any positions currently filled by outside consultants/vendors.
3. Description of major changes in operations such as expansions, new technology systems implemented, etc. Include any major changes to PIHP functions related to COVID-19.
4. A summary of the status of all Corrective Action items from the previous External Quality Review. Please include evidence of Corrective Action implementation.
5. List of providers credentialed/recredentialed in the last 12 months (October 2019 through September 2020). Include the date of approval of initial credentialing and the date of approval of recredentialing.
6. A description of the Quality Improvement, Utilization Management, and Care Coordination Programs. Include a Credentialing Program Description and/or Plan, if applicable.
7. Minutes of committee meetings for the following committees:
    a. Credentialing (for the three, most recent committee meetings)
    b. UM (for the three, most recent committee meetings)
    c. Any clinical committee meeting minutes showing discussion of Clinical Practice Guidelines impacted by COVID-19.
8. Membership lists and a committee matrix for all committees, including the professional specialty of any non-staff members. Please indicate which members are voting members. Include the required quorum for each committee.
9. By November 6, 2020, submit a copy of the complete Appeal log for the months of October 2019 through September 2020. Please indicate on the log: the Appeal type (standard, expedited, extended, withdrawn, or invalid), the service Appealed, the date the Appeal was received, and the date of Appeal resolution.

10. By November 6, 2020, submit a copy of the complete Grievances log for the months of October 2019 through September 2020. Please indicate on the log: the nature of the Grievance, the date received, and the date of Grievance resolution.
11. Copies of all Appeal notification templates used for expedited, invalid, extended, and withdrawn Appeals.
12. For Appeals and Grievances, please submit a description of your monitoring process that reviews compliance of oral and written notifications, completeness of documentation within the Appeal and Grievance records, accuracy of Appeal and Grievance logs, etc. Provide details regarding frequency of monitoring and any benchmarks, performance metrics, and reporting of monitoring outcomes.
13. Please submit a summary of new provider orientation processes and include a list of materials and training provided to new providers.
14. For MH/SU, I/DD, and TCLI Care Coordination, please submit a description of your monitoring plan that reviews compliance of Care Coordinator documentation. Include in the description the elements reviewed (timeliness of progress notes, timeliness of Innovations monitoring, timeliness of Quality of Life surveys, review of quality, completeness of discharge notes, accuracy of documentation, etc.). Provide details regarding frequency of monitoring, and any benchmarks, performance metrics, and reporting of monitoring outcomes.
15. For Care Coordination enrollees files, please provide:
    a. three MH/SU Care Coordination enrollee files (two active since 2018 and one recently discharged)
    b. three I/DD Care Coordination enrollee files (two active since 2018 and one recently discharged)
    c. four TCLI Care Coordination enrollee files (one active since 2018, one who received In-Reach, one who transitioned to the community and one recently discharged).

    NOTE: Care Coordination enrollee files should include all progress/contact notes, monitoring tools, Quality of Life surveys, and any notifications sent to or received from the enrollees.
16. Information regarding the following selected Performance Measures:

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

A.4. Follow-up After Hospitalization for Substance Abuse	D.4. Substance Abuse Penetration Rate
B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	D.5. Mental Health Penetration Rate
C WAIVER MEASURES	
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	
Proportion of beneficiaries reporting they have a choice between providers.	
Percentage of level 2 and 3 incidents reported within required timeframes.	
Percentage of beneficiaries who received appropriate medication.	
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.	

Required information includes the following for each measure:

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

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

c. Reporting frequency and format;

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

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

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

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

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

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

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

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

18. Provide copies of the following Credentialing/Recredentialing files:
    a. Credentialing files for the five most recently credentialed practitioners/agency (as listed below)
        i. One licensed practitioner who is joining an already contracted agency
        ii. One non-MD, Licensed Independent Practitioner (i.e., clinician who will have their own contract)
        iii. One physician
        iv. One practitioner with an associate licensure (e.g., LCSW-A, LMFT-A, etc.)
        v. One file for a network provider agency

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

    A. Insurance:
        1. Proof of all required insurance, or a signed and dated statement/waiver/attestation from the practitioner/agency indicating why specific insurance coverage is not required
        2. For practitioners joining already-contracted agencies, include copies of the proof of insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.

    B. Other:
        1. 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).

2. Ownership disclosure information/form (For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file).

b. Recredentialing files for the five most recently recredentialed practitioners/agency (as listed below)

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

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

A. Insurance:

1. Proof of all required insurance, or a signed and dated statement/waiver/attestation from the practitioner/agency indicating why specific insurance coverage is not required.
2. For practitioners joining already-contracted agencies, include copies of the proof of insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.

B. Other:

1. 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).
2. 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).
3. Site visit/assessment reports if the provider has had a quality issue or a change of address.
4. Ownership disclosure information/form (For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file).

19. a. By November 6, 2020, submit a copy of the complete listing of Program Integrity case files active during October 2019 through September 2020. On this list, provide the following for each case file:

i. Date case opened
ii. Source of referral
iii. Category of case (enrollee, provider, subcontractor)

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

b. Program Integrity Plan and/or Compliance Plan.
c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
d. Workflow of process of taking complaint from inception through closure.
e. All 'Attachment Y' reports collected during the review period.
f. All 'Attachment Z' reports collected during the review period.
g. Provider Manual and Provider Application.
h. Enrollee Handbook
i. Subcontractor Agreement/Contract Template.
j. Training and educational materials for the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
k. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse.
l. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors, and employees.
m. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other State or Federal agency.
n. Code of Ethics and Business Conduct.
o. Internal and/or external monitoring and auditing materials.
p. Materials pertaining to how the PIHP captures and tracks complaints.
q. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
    i. NC Medicaid approved reporting templates.
r. Sample Data Mining Reports.
s. NC Medicaid Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
t. Monthly reports of NCID holders/FAMS-users in PIHP.
u. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
v. Corrective action plans including any relevant follow-up documentation.
w. Policies/Procedures for:
    i. Program Integrity
    ii. HIPAA and Compliance
    iii. Internal and external monitoring and auditing
    iv. Annual ownership and financial disclosures
    v. Investigative Process
    vi. Detecting and preventing fraud
    vii. Employee Training
    viii. Collecting overpayments
    ix. Corrective Actions
    x. Reporting Requirements
    xi. Credentialing and Recredentialing Policies

xii. Disciplinary Guidelines

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

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

    c. A copy of the IT Disaster Recovery Plan.
    d. A copy of the most recent disaster recovery or business continuity plan test results.
    e. An organizational chart for the IT/IS staff and a corporate organizational chart that shows the location of the IT organization within the corporation.

21. Provide the following for Encounter Data Validation (EDV):
    a. Include all adjudicated claims (paid and denied) from January 1, 2019 – December 31, 2019. 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, 2019 – December 31, 2019. 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 Kyung Lee of HMS at (978) 902-0031.

B. Attachment 2: Materials Requested for Onsite Review

ALLIANCE

External Quality Review 2020

Please note: If any of the documentation requested on this list or any supplemental list does not currently exist, please submit into the indicated folders a statement to that effect.

MATERIALS REQUESTED FOR ONSITE REVIEW

Please upload the following into folder #9:

1. The invalid Appeal processed from September 2020 to February 2021.
2. The most recently completed Peer Review Tool (Appeal). This is a tool that is completed monthly and measures compliance with Appeal processes and notifications.
3. Quality Review Committee minutes for March and May of 2020.

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

Attachments

- **Performance Improvement Project Validation Worksheet**
  - 7-Day Super Measure – Medicaid DHB SUD
  - 7-Day Super Measure – State DMH MH
  - 7-Day Super Measure – State DMH SUD
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM)
  - HEDIS Antipsychotic Adherence (SAA)
  - Diabetes Screenings for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (HEDIS SSD)
  - Transitions to Community Living Initiative (TCLI) Improve In-Reach Contact Rate

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Readmission Rates for Mental Health**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Readmission Rates for Substance Abuse**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Follow-up After Hospitalization for Mental Illness**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Follow-up After Hospitalization for Substance Abuse**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Mental Health Utilization- Inpatient Discharged and Average Length of Stay**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Mental Health Utilization**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Identification of Alcohol and Other Drug Services**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Substance Abuse Penetration Rate**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	**Mental Health Penetration Rate**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	Proportion of beneficiaries reporting they have a choice between providers. IW D10
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	Percentage of level 2 and 3 incidents reported within required timeframes. IW G2
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	Percentage of beneficiaries who received appropriate medication. IW G5
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Alliance**
Name of PM:	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8
Reporting Year:	**2019/2020**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Alliance**
Name of PIP:	**7 DAY DHB SUD- SUPERMEASURE**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis were documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates were reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates were presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by month.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers were reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate increased from 24% to 31% to 46% with a goal of 40%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appeared to be result of interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Alliance**
Name of PIP:	**7 DAY DMH MH- SUPERMEASURE**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis were documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates were reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates were presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by month.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers were reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Rate was 27% at baseline; 39% at remeasurement 1; 34% at remeasurement 2. The goal is 40%. ***Recommendation: Continue the current interventions of incentives, education, open access, provider scorecards, and Peer Bridger Programs. Determine if additional interventions should be implemented to improve rate toward the 40% benchmark.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Alliance**
Name of PIP:	**7 DAY DMH SUD- SUPERMEASURE**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis were documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates were reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates were presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by month.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers were reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate was 37% at baseline; 28% at remeasurement 1; 38% at remeasurement 2. The goal is 40%.
9.2 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to the interventions which are similar to the other PIPs, including incentives, education, Open Access clinics, Provider Scorecards, and the Peer Bridger program.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Alliance**
Name of PIP:	**METABOLIC MONITORING FOR CHILDREN AND ADOLESCENTS ON ANTI-SPYCHOTICS (APM)**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis were documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates were reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates were presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by month.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers were reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Rate was 29% at baseline; 28% at remeasurement 1; 27% at remeasurement 2; 27% at remeasurement 3. The goal is 35%. ***Recommendations: Continue the current interventions of HealthCrowd campaign, planning for point of care testing, provider scorecards, and patient level data analysis. Determine if additional interventions should be implemented to improve rate toward the 35% benchmark.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Alliance**
Name of PIP:	**ANTI-PSYCHOTIC ADHERENCE (SAA)**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis were documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates were reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates were presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by month.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers were reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Rate was 59% at baseline; 58% at remeasurement 1; 59% at remeasurement 2; 58% at remeasurement 3. The goal is 60%. ***Recommendations: Continue the current interventions of HealthCrowd campaign, provider scorecards, and patient level data analysis. Determine if additional interventions should be implemented to improve rate toward the 60% benchmark.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Alliance**
Name of PIP:	**DIABETES SCREENING FOR PEOPLE WITH SCHIZOPHRENIA OR BIPLOAR DISORDER WHO ARE USING ANYTIPSYCHOTIC MEDICATIONS (SSD)**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis were documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates were reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates were presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by month.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers were reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate was 69% at baseline; 68% at remeasurement 1; 67% at remeasurement 2; 68% at remeasurement 3. The goal is 81%. The most recent remeasurement showed improvement.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appeared to be related to the interventions in place including the HealthCrowd campaign, pilot POC testing, provider scorecards, and patient level data monitoring.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	79
Project Possible Score	79
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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:	**TRANSITIONS TO COMMUNITY LIVING INITIATIVE (TCLI) IMPROVE IN-REACH CONTACT RATE**
Reporting Year:	2020
Review Performed:	2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis were documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Rates were reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates were presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation by month.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers were reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Rate was 93% at baseline; 93% at remeasurement 1; 92% at remeasurement 2. The goal is 95%. ***Recommendations: Continue the current interventions of data tracking/monitoring, assignments, and 80 day no contact tracking to determine if rate will improve to the goal of 95%.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

D. Attachment 4: Tabular Spreadsheet

CCME PIHP Data Collection Tool

PIHP Name:	Alliance Health
Collection Date:	2021

I. Information Systems Capabilities Assessment (ISCA)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I A. Management Information Systems						
1. Enrollment Systems						
1.1 The 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 and the monthly 834 files. Alliance uses the monthly 820 capitation file to reconcile the payment received every month to determine the categories of aid for which payments were received. 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.
1.2 The PIHP is able to identify and review any errors identified during, or as a result, of the State enrollment file load process.	X					Alliance produces an enrollment exception report to verify the completeness of the GEF load.
1.3 The PIHP's enrollment system member screens store and track enrollment and demographic information.	X					During the Onsite discussion, Alliance demonstrated the ACS enrollment screens and their capability to store the demographic information. All historical data, including claims and authorizations, for members is stored and merged under one member ID.

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					For 2019, approximately 92.9% of the Institutional and 94.20% of Professional claims are auto-adjudicated. Alliance claims are approved, pended, or denied within 18 days of receipt and paid within 30 days of approval. If a required field is missing from a claim, 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 HIPAA 999 response file advising the provider of the claim submission failure. Alliance claims processors do not change any information on the claims. All Alliance claims are processed through AlphaMCS' claims adjudication procedure, without pending, except for Emergency Department claims and claims with amounts greater than $5,000. These are pended for manual review
2.2 The PIHP has processes and procedures in place to monitor review and audit claims staff.	X					Alliance conducts Random weekly audits of 2.5% of all claims adjudicated during the previous week and focused studies of 50% of the inpatient hospital claims over $5,000 and 3% of Emergency Department claims.
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 indicated in their ISCA response that 25 Institutional ICD-10 Diagnosis codes and 12 ICD-10 Diagnosis codes are captured for Professional on the provider web portal, 29 Institutional ICD-10 Diagnosis codes, and 12 ICD-10 Diagnosis codes are captured for Professional on a HIPAA file and the claim screens capture all Diagnosis codes. ICD-10 Procedure codes and DRG codes received from the provider are captured.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 The PIHP's claim system screens store and track claim information and claim adjudication/payment information.	X					Onsite review of the claims system screens identified the capture of adjudication/payment information for the claims.
3. Reporting						
3.1 The PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Alliance captures all necessary data elements required for enrollment and claims reporting. All historical enrollment and behavioral health claims data are stored and available in the reporting system.
3.2 The PIHP has processes in place to back up the enrollment and claims data repositories.	X					WellSky is responsible for the backup and archive of data in the cloud environment. Alliance and WellSky have implemented a near real-time replication of the AlphaMCS transactional database to the Enterprise Data Warehouse.
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					Although Alliance is able to capture and store up to 29 ICD-10 Diagnosis codes for Institutional encounters, Alliance is only submitting up to 12 ICD-10 Diagnosis codes on an Institutional encounter data extract to NCTracks. NCTracks can accept up to 25 ICD-10 Diagnosis codes for Institutional encounters. *REVISION: Per feedback from the State on July 2, 2021, this Corrective Action should be changed to a Recommendation and the score on this standard changed from a "Partially Met" to a "Met".*

Commented [KN6]:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Update Alliance's encounter data submission process to allow submission of up to 25 ICD-10 Diagnosis codes included on Institutional encounters into NCTracks.
4.2 The PIHP has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					Alliance's vendor WellSky updates and maintains details on encounters that are submitted for encounter data submission on the 837 files and the details on the 999 and 835 response files.
4.3 PIHP has policies and procedures in place to reconcile and resubmit encounter data denied by NC Medicaid.	X					AlphaMCS compiles weekly encounter files based on approved claims. Files are submitted to NCTracks weekly via the NCTracks portal. Upon receipt at NCTracks, Alliance receives a 999-acknowledgement file. When Alliance receives the 835 from NCTracks, Alliance reconciles the data with the 837 encounter file submitted to NCTracks in the Alliance reconciliation(AR) system.
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 a dedicated team of two claims analysts reviewing and resubmitting the denied encounters. Alliance's claims team actively reviews and works the denied encounters and resubmits claims as part of their daily responsibilities. Alliance has a high monthly acceptance rate of encounter data submission to NCTracks. Alliance's current NCTracks encounter data acceptance rate is approximately 98% to 100% for the combined Professional and Institutional extracts.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II A. Credentialing and Recredentialing						
1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					Alliance identifies Procedure 6011 Primary Source Verification, Procedure 6030 Credentialing Criteria and Enrollment Process for Network Participation, and Procedure 6036 Re-Credentialing Criteria and Enrollment Process for Network Participation as their *Credentialing Program Description*.
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 provides information regarding the Provider Network Credentialing Committee, including that the committee is "chaired by an Associate Medical Director as designated by the Chief Medical Officer." Nadiya Kaesemeyer, MD and Heidi Middendorf, MD, Associate Medical Directors, are listed on the *Provider Network Credentialing Committee (PNCC) Org Chart 11.12.2020* as Co-Chairs of the Credentialing Committee. Dr. Kaesemeyer chaired the Credentialing Committee meetings for which minutes were submitted for this EQR. Dr. Middendorf was not present at any of the meetings. The procedure stipulates that a quorum is reached when 33% of voting members are present plus the Chairperson, noting, "The Credentialing Committee Chair is a non-voting member, unless the vote is required to break a tie." Procedure 6030 defines "clean" applications, and states, "The Associate Medical Director as designated by the Chief Medical Officer can review and approve all Clean Credentialing Applications." The Credentialing Committee meeting minutes include lists of "clean" applications approved by Dr. Kaesemeyer or Dr. Middendorf, and reflect consideration of, 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	
						There is conflicting information regarding committee membership and voting status across Procedure 6030, the *PNCC*, and the Credentialing Committee meeting minutes. Procedure 6030 lists six Alliance staff positions (including the Credentialing Supervisor and Credentialing Specialist) as non-voting members of the committee and states, "All other members, Alliance employees and provider representatives are voting members." The CMO is not listed as a non-voting member, so, based on procedure language, would be a voting member. However, Alliance indicated the CMO is a non-voting member. On the *PNCC Org Chart*, 2 providers and 5 Alliance employees are designated as voting members. Two Alliance staff members (the CMO and the Credentialing Specialist) who are listed as members on the Credentialing Committee meeting minutes do not appear on the *PNCC Org Chart*. The legend on the Credentialing Committee meeting minutes states, "MEMBERS * indicates non-voting member(s)." On the submitted meeting minutes, there is no asterisk by the name of the Credentialing Supervisor nor the name of the CMO, which would indicate they are both voting members, but Alliance confirmed they are both non-voting members. ***Recommendation: Revise Procedure 6030, the Credentialing Committee meeting minutes template, and any other documents that list Credentialing Committee membership to accurately reflect membership and voting status. For example, as the CMO is a non-voting member of the committee, include the CMO in the list of non-voting members in Procedure 6030. As the CMO and Credentialing Supervisor are non-voting members of the Credentialing Committee, ensure that designation is clear on the Credentialing Committee meeting minutes.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Credentialing files reviewed for the EQR were organized and contained appropriate information. CCME identified the following issues in the file review:
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					Procedure 6030, Credentialing Criteria and Enrollment Process for Network Participation 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					
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					One submitted file did not have an *Ownership Disclosure* form, and the *Credentialing Initiation Form* was incomplete. Upon CCME's request on the Missing Desk Materials list, Alliance submitted the Ownership Disclosure from the file of the agency the Licensed Practitioner (LP) is joining.
3.1.16 Criminal background Check	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files reviewed for the EQR were organized and contained appropriate information. CCME identified the following issues in the file review:
4.1 Recredentialing every three years;	X					Procedure 6030 Credentialing Criteria and Enrollment Process for Network Participation states, "Re-credentialing needs to be completed within the 3 years based on the month of the previous credentialing."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Procedure 6036 Re-Credentialing Criteria and Enrollment Process for Network Participation states, "All providers must be re-credentialed a minimum of once every 36 months." In two of the reviewed files, the recredentialing process was approved after 3 years of the effective date of the previous credentialing. Based on the effective date, recredentialing was overdue/late. This (overdue recredentialing, based on effective versus approval date) was an issue in one file at the last EQR. As this only affected one file at the last EQR, it did not result in a Corrective Action item, but was discussed at the Onsite Review, and was mentioned in the Tabular Spreadsheet of the 2019 EQR report. In response to COVID-19, Alliance is "allowing an additional 90 days from the standard to recredential providers within 36 months." Therefore, in the current EQR, CCME is not issuing a Recommendation related to recredentialing within three years. However, after the end of the COVID flexibilities, "Re-credentialing needs to be completed within the 3 years based on the month of the previous credentialing", to comply with Alliance Procedure 6036.
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					One LP file did not include evidence of Workers' Comp/Employers Liability insurance (WC/EL). Upon CCME's request, Alliance submitted the Certificate of Insurance showing WC/EL coverage held by the agency with which the LP was associated.
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.3 Valid DEA certificate; and/or CDS certificate	X					
4.2.4 Board certification if claimed by the applicant;	X					
4.2.5 Malpractice claims since the previous credentialing event;	X					
4.2.6 Practitioner attestation statement;	X					
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event; 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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.11 Requery of the Social Security Administration's Death Master File	X					
4.2.12 Requery of the NPPES;	X					
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					
4.2.14 Ownership Disclosure is addressed.	X					
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					Recredentialing files include a "Provider Profiling" section with supporting materials. Credentialing Committee meeting minutes reflect committee consideration of issues such as, quality of care concerns, issues identified during monitoring, and plans of correction.
5. The PIHP formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the PIHP for serious quality of care or service issues.	X					Addressed in Procedure 3043, Provider Sanctions, Administrative Actions, and Suspensions to Ensure Patient Safety.
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					

III. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III. Quality Improvement						
III. A Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					There was one area of substantial decline in the (b) Waiver Measures from FY2019 to FY2020. Follow-Up After Hospitalization for Substance Abuse had substantial declines for two subsets of the rate calculation. All (c) Waiver Measures were above the State benchmark rates. The overall validation scores for all Performance Measures were in the Fully Compliant range, with an average validation score of 100% across the ten (b) Waiver Measures and the five (c) Waiver Measures. ***Recommendation: Continue current interventions for the (b) Waiver Performance Measure Follow-up After Hospitalization for Substance Abuse.***
III. B Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					Alliance submitted seven projects for this 2020 EQR. All seven were validated: • 7-Day Super Measure – Medicaid DHB SUD • 7-Day Super Measure – State DMH MH • 7-Day Super Measure – State DMH SUD • Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM) • HEDIS Antipsychotic Adherence (SAA) • Diabetes Screenings for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (HEDIS SSD) • Transitions to Community Living Initiative (TCLI) Improve In-Reach Contact Rate

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					All seven validated PIPs scored in the High Confidence range, although four PIPs had one error each. See Recommendations below. For the 7-Day Super Measure – State DMH MH PIP, the most recent remeasurement showed a decline in the rate from 39% to 34%. ***Recommendation: Continue the current interventions of incentives, education, open access, provider scorecards, and Peer Bridger Programs. Determine if additional interventions should be implemented to improve rate toward the 40% benchmark.*** For the Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM) PIP, the most recent remeasurement showed no improvement in the rate. It stayed at 27% for remeasurement 2 and 3. ***Recommendation: Continue the current interventions of HealthCrowd campaign, planning for point of care testing, provider scorecards, and patient level data analysis. Determine if additional interventions should be implemented to improve rate toward the 35% benchmark.*** For the HEDIS Antipsychotic Adherence (SAA) PIP, the most recent remeasurement showed a decline in the rate from 59% to 58%. ***Recommendation: Continue the current interventions of HealthCrowd campaign, provider scorecards, and patient level data analysis. Determine if additional interventions should be implemented to improve the rate toward the 60% benchmark.*** For the TCLI Improve In-Reach Contact Rate PIP, the most recent remeasurement showed a decline in the rate from 93% to 92%. ***Recommendation: Continue the current interventions of data tracking/monitoring, assignments, and 80-day no contact tracking to determine if rate will improve to the goal of 95%.***

IV. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. A Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					The *Care Coordination Program Description* defines the roles and responsibilities of the four units that encompass Care Coordination.
2. The case coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					The *Individual and Family Handbook* lists the tools and age requirements for assessments used to determine medical necessity and service needs. The assessments include the CALOCUS for children and adolescents ages 5 - 17 years and CANS for children ages 0 – 4 years. However, *NC Medicaid Contract, Section 7.4.2* states that "PIHP shall use …CALOCUS scores for medical necessity reviews for mental health services and ASAM for substance abuse services, except for Children ages three (3) through six (6)." *Section 7.4.3* continues by stating that, "For Children ages three (3) through six (6), PIHP shall use one of the following options to determine medical necessity reviews: a. The Early Childhood Services Intensity Instrument (ECSII) for Infants, Toddlers and Pre-Schoolers;

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						b. The Children and Adolescents Needs and Strengths (CANS); or c. Another validated assessment tool for ages 3 to 6, with prior written approval from the Division of Medical Assistance." ***Recommendation: Revise the Individual and Family Handbook to reflect the ages to administer the CANS and the CALOCUS to children and adolescents as listed in the NC Medicaid Contract Sections 7.4.2. and 7.4.3.***
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					
2.5 Quality monitoring and continuous quality improvement;	X					
2.6 Determination of which Behavioral Health Services are medically necessary;	X					Procedure 2009, ICF-IDD Deinstitutionalization Planning, states that, "Through the use of Alliance's 1915b/c waiver, funding is available to support a person in their home community once they leave institutional care. This funding will be capped at $135,000 annually." Likewise, the *Innovations Individual and Family Handbook* states, "The [Innovations] individual budget cannot total more than the Innovations Waiver cost limit of $135,000 per year." However, *NC Medicaid Joint Communications Bulletin #J362* allows the members to exceed the Innovations funding cap when: • The individual lives independently • The individual receives Supported Living Level III, and • The individual requires 24-hour support. ***Recommendation: Revise Procedure 2009 and the Innovations Individual and Family Handbook to include the exemption to the waiver cost limits/funding cap as listed in NC Joint Communication Bulletin #J362.***

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					Alliance's Procedure 2015, Management of New/Open North Carolina Innovations Slots, includes steps taken when a member or LRP declines Innovations supports or requests a delay in receiving Innovations supports. A decline would result in the member being removed from the Registry of Unmet Needs. A request to delay would place the member at the bottom of the Registry of Unmet Needs. The procedure does not include additional follow-up provided by staff to ensure that the decision is final. However, during the Onsite, staff described a process that included reasonable efforts taken to confirm the decision. ***Recommendation: Include in Procedure 2015, Management of New/Open NC Innovations Slots, a follow-up process that confirms the member or LRP requests to delay or decline to participate in the Innovations Waiver.***
2.10 Ensure privacy for each Enrollee is protected.	X					
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					During the 2019 EQR, it was recommended that Alliance add to Procedure 2027, Monitoring Requirements for NC Innovations Participants, an explanation of Home and Community Based Services (HCBS) and the use of the required State Monitoring Checklist. The Recommendation was addressed.

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					The review of the 2019 EQR found inconsistencies in the frequency of contact made by the Care Coordinator and in the completeness and quality of documentation. Additionally, the review revealed non-compliance with Alliance Procedure 2028, Use of the Supports Intensity Scale, and in Procedure 2027, Monitor Requirements for NC Innovations Participants. This was the second EQR where the file review showed inconsistencies and errors in Care Coordination documentation. CCME issued a Corrective Action for Alliance to develop and implement a data-driven monitoring plan that routinely reviews Care Coordination documentation. The Corrective Action was addressed. For this EQR, the review found gaps in Care Coordination contacts with two (2) I/DD members receiving residential supports. In one I/DD file, 20% of face-to-face Care Coordinator contacts did not occur monthly during the review period. The missed face-to-face contacts were prior to the Covid-19 flexibilities. Procedure 2027, Monitoring Requirements for NC Innovations and NC TBI Waiver Participants, and *NC Medicaid Contract, Section 6.11.3 (h)* require a monthly face-to-face monitoring for members who live in residential placements, including Alternative Family Living (AFL) homes. During the Onsite, Alliance staff described a current monitoring process that relies heavily on reports from its case management platform Jiva. Individual supervision is also based on contact intervals inputted by the Care Coordinator into Jiva. A traditional case review is not conducted by the Supervisor or Manager to ensure contact intervals correspond with the frequency of contacts identified in the treatment plan and the *NC Medicaid Contract*. The review of MH/SU files found Alliance is compliant with their policies and procedures and the *NC Medicaid Contract*.

Commented [KN7]:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						REVISION: Per feedback from the State on July 2, 2021, this Corrective Action should be changed to a Recommendation and the score on this standard changed from a "Partially Met" to a "Met". ***Recommendation: Enhance the current monitoring process to include a manual record review that routinely reviews the frequency of Care Coordinator contact with members receiving residential support.*** ***Ensure that the monitoring process includes the frequency of monitoring, departmental benchmarks for compliance, and how and when outcomes of monitoring are reviewed and reported.***
IV. Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					
2.1 Care Coordination activities occur, as required.	X					
2.2 Person Centered Plans are developed as required.	X					
2.3 Assertive Community Treatment, Peer Support, Supported Employment, Community Support Team, Psychosocial Rehabilitation, and other services	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
as set forth in the DOJ Settlement are included in the individual's transition, if applicable.						
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 QOL Surveys found in two of three qualifying files, that the 11-month QOL surveys were completed outside of the required timeframe. In one TCLI file, the QOL 11-month survey was more than 19 months late. This is the second year Alliance has had issues with ensuring the timeliness of QOL surveys. Alliance Procedure 2032, In-Reach and Transition Process, requires QOL surveys to be completed with the member at least two weeks prior to transition. Additionally, QOL Surveys will be administered to members at eleven (11) months and twenty-four (24) months post-transition. This corresponds with QOL intervals listed in *NC Medicaid Contract, Section 15.4.* During the Onsite, Alliance staff acknowledged the downward trend for completing the 11-month and 24-month QOL Survey at the required timeframes. A monitoring process is currently under review to determine the effectiveness of the intervention. *REVISION: Per feedback from the State on July 2, 2021, this Corrective Action should be changed to a Recommendation and the score on this standard changed from a "Partially Met" to a "Met".* ***Recommendation: Develop, document, and implement a comprehensive monitoring plan that will review the timeliness and completeness of Quality of Life Surveys at the required timeframes.***

Commented [KN8]:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					
6. A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	X					Findings from the 2019 EQR included progress notes that abruptly ended and did not capture the complete episode of care for the review period. What could be reviewed revealed inconsistencies in the frequency of contacts, completeness, and quality of documentation. Additionally, there was evidence of ineffective monitoring to ensure that all tasks were being delivered timely, and that the documenting of activities are reflected in the Jiva platform accurately. Alliance was issued a Corrective Action to develop a report that would produce the full TCLI member record to include the date of service, all assessments, interventions, and discharges, in chronological order. Moreover, the Corrective Action also required Alliance to develop, document, and implement a data-driven monitoring plan that would routinely review TCLI Care Coordination documentation to ensure monitoring frequencies and departmental

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						benchmarks for compliance were being met. The Corrective Action was addressed. The review of TCLI files found that Alliance is compliant with Care Coordination policies and procedures and the *NC Medicaid Contract*.

VI. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee Grievances in a manner consistent with contract requirements, including, but not limited to:	X					The primary procedure guiding Alliance Grievance processed is Procedure 6503, Management and Investigation of Grievances. In this procedure there are at least 16 references to the term "Complaint". The use of "Complaint" within the Grievance process creates confusion in the procedure. ***Recommendations: Revise Procedure 6503, Management, and Investigation of Grievances to consistently use the term "Grievance".*** The review of Alliance's *Provider Operations Manual*, also found there are references to concerns, complainant, and complaint when explaining Grievance processes. There is also no reference to the term "Grievance" or "Grievant". This section creates confusion and misleading information regarding the Grievance process. ***Recommendation: Within the Provider Operations Manual in the For Medicaid Related Grievances section, on pages 62-63, use***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						one the term "Grievance" or "Grievant" to reflect the Grievance process.
1.1 Definition of a Grievance and who may file a Grievance;	X					There is no definition of the term "Grievant" within Alliance's Grievance procedure. ***Recommendations: Within Procedure 6503, Management, and Investigation of Grievances, include the definition of "Grievant" in the "Definitions" section.***
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					The Desk Review of the *Provider Operations Manual* identified incorrect timeframes for a Grievance resolution. On pg. 62 of the manual, it is stated, "1. Alliance will seek to resolve Grievances…no later than thirty (30) calendar days from the date Alliance received the Grievance." The timeframe for Grievance resolution, per Alliance's Grievance procedure, is 90 days. ***Recommendation: Revise the Provider Operations Manual (pg. 62) to reflect that Grievances are resolved in 90 days, as required by Alliance Procedure 6503.*** Also, in the *Provider Operations Manual*, there is incorrect information on page 62 *regarding the required notification Alliance must provide when* Alliance extends the resolution timeframe of a Grievance. The manual states, "Any extension granted shall be communicated to the individual within one (1) business day either verbally or in writing. Verbal notifications shall be followed up in writing to the individual." Alliance needs to correct this information to state, Alliance will "make reasonable efforts to give the enrollee

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						prompt oral notice of the delay" and written notice "within 2 calendar days". ***Recommendations: Revise the Provider Operations Manual (pg.62) to include; Alliance will "make reasonable efforts to give the enrollee prompt oral notice of the delay" and written notice "within 2 calendar days" when Alliance extends the Grievance Resolution timeframe as required by Alliance Procedure 9603,*** *42 CFR § 438.408 (c)(2)(ii),* ***and Attachment M of Alliance' NC Medicaid Contract.***
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					In the 2019 EQR. a Recommendation was made to add within Procedure 6503 a description of the process by which the referral and consultation by the *Quality Review Committee (QRC)* with quality-of-care concerns are reviewed. The referral, consultation and review process were included within *Procedure 6503 by Alliance in the past year*. During the Onsite interview, an overview that included positive outcomes from the process was provided by staff.
1.5 Maintenance of a Grievance log for oral Grievances and retention of this log and written records of disposition for the period specified in the contract.	X					
2. The PIHP applies the Grievance policy and procedure as formulated.	X					In the 2019 EQR, A Corrective Action was issued that required Alliance to develop, document, and implement a monitoring plan to increase compliance with required Grievance notifications. This Grievance monitoring process was implemented and included within *Procedure 6503*. During the Onsite discussion, staff provided an overview and discussed the positive outcomes of the Alliance Grievance monitoring process. The positive outcome of this monitoring process was also evident in the ten Grievance files reviewed in this 2020 EQR. All Grievance acknowledgement notifications and Grievance resolution notifications were compliant with Alliance Grievance procedures and the *NC Medicaid Contract*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The Grievance resolution notifications also included detailed steps taken by staff in resolving the Grievance.
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					
V. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider Appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					Alliance's procedure governing the processing of Appeals is Procedure 6505, Due Process of Medical Necessity Determinations.
1.1 The definitions an Appeal and who may file an Appeal;	X					In the 2019 EQR, a Corrective Action was issued to ensure Procedure 6505 consistently and clearly defined who can file an Appeal congruent with *NC Medicaid Contract, Attachment M, Section G.1.* Alliance addressed this Corrective Action, and the procedure now consistently defines who can file an Appeal.
1.2 The procedure for filing an Appeal;	X					In the 2019 EQR, three Corrective Actions were issued to correct Appeal information within Alliance's *Provider Operations Manual* and *IDD Care Coordination Desk Reference*. Both documents had incorrect information regarding the timeframe for resolving expedited Appeals and filing first level and second level Appeals. Alliance addressed and implemented these Corrective Actions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						However, other issues were noted within these documents. The *Provider Operations Manual* Table of Contents needs to be updated to ensure it correctly directs providers to Appeal information. ***Recommendation: Update the Provider Operations Manual Table of Contents to reflect the correct pages for Appeal information.*** The *Individual and Family Handbook* has the incorrect timeframe for filing an Appeal on page 64. ***Recommendation: Revise page 64 of the Individual and Family Handbook to reflect enrollees have sixty days from the mailing date of the Adverse Benefit Determination timeframe to file an Appeal.***
1.3 Review of any Appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited Appeal where the life or health of the enrollee would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the Appeal as specified in the Contract;		X				In the 2019 EQR of Appeals, five Corrective Actions and two Recommendations were issued. In this 2020 EQR, it was evident Alliance addressed all 2019 Corrective Actions and Recommendations, with one exception. In 2019, CCME recommended Alliance add to Procedure 6505, Due Process Appeals of Medical Necessity, the verbal notification required to be issued when Alliance extends an expedited Appeal resolution timeframe. This verbal notification is required by *42 CFR § 438.408 (c)(2)* and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Alliance's *NC Medicaid Contract, Attachment M, Section G.6.* This Recommendation was not implemented by Alliance. It was also noted in this 2020 EQR that the Appeals procedure does not specify the timeframe for the written notice to enrollee's regarding an extension to the Appeal resolution timeframe. In both the standard and expedited sections of this procedure it is stated "Alliance will notify the member in writing before the expiration of the designated timeframe." The required timeframe for written notification to enrollees regarding an extension to the Appeal resolution timeframe is "within 2 calendar days". This requirement is also outlined in 42 *CFR § 438.408 (c)(2)* and *Alliance's NC Medicaid Contract, Attachment M, Section G.6.* ***Corrective Action: Within Procedure 6505, correct the language explaining the required written and verbal notifications from Alliance when Alliance extends the Appeal resolution timeframe. The language within these documents should reflect the language in 42 CFR § 438.408 (c)(2) and Alliance's NC Medicaid Contract, Attachment M, Section G.6 and should be added to both the standard Appeals and expedited Appeals sections of the procedure.*** The *Provider Operations Manual* also does not explain Alliance will verbally notify the enrollee of Alliance's extension to the Appeal resolution timeframe, nor is a timeframe identified for the verbal and written notifications from Alliance regarding an extension. ***Recommendation: Correct the Provider Operations Manual to reflect the verbal and written notifications Alliance issues when Alliance extends the Appeal resolution timeframe. Include the timeframes for these verbal and written notifications, as required by 42 CFR § 438.408 (c)(2) and NC Medicaid Contract, Attachment M, Section G.6.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Other Issues were also noted in the *Individual and Family Handbook*. On page 64 of handbook, it is stated written notice of the resolution of an expedited Appeal will be provided by Alliance within "three business days". Per *NC Medicaid Contract, Attachment M, Section G.6*, this written notification should be sent "within 2 calendar days." However, Alliance's Appeal procedure states written notification of the resolution of an expedited Appeal will be issued "within 72 hours of the receipt of the LME/MCO Level Appeal request." Also, in the *Individual and Family Handbook* (pg. 64), states "60-day" Appeal resolution timeframe can be expedited. However, the timeframe for resolving and providing notice of Appeals should be "30 days". Lastly, in the *Individual and Family Handbook* (pg. 64) states written notice of an extension to the Appeal resolution timeframe by Alliance will be provided "within three business days." The timeframe required by the *42 CFR § 438.408 (c)(2)* is "2 calendar days". There is also no mention in the handbook that Alliance will notify the enrollee of their right to file a Grievance if they disagree with Alliance's decision to extend the Appeal resolution timeframe. This notification is required by *42 CFR § 438.408 (c)(2)(ii)*. ***Corrective Action: Correct the Individual and Family Handbook to state:*** ○ ***Written resolution of an expedited Appeal will be provided within 72 hours of the receipt of the Appeal (See Alliance's Procedure 6505, III. Medicaid Appeals, Section C.8)*** ○ ***The 30-day Appeal resolution timeframe can be expedited (See 42 CFR § 438.408, Section (b) 2, NC Medicaid Contract, Attachment M, Section G.4 and Procedure 6505, III. Medicaid Appeals, Section B.1.g)***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						○ ***Written notification of an extension to the Appeal resolution timeframe by Alliance will provided "within 2 calendar days" (See 42 CFR § 438.408 (c)(2), NC Medicaid Contract, Attachment M, Section G.6 (ii).*** ○ ***Alliance will notify the enrollee of their right to file a Grievance if they disagree with Alliance's decision to extend the Appeal resolution timeframe. (See 42 CFR § 438.408 (c)(2)(ii), NC Medicaid Contract, Attachment M, Section G.6.ii and Alliance's Procedure 6505, III. Medicaid Appeals, Sections B.1.g and C.5.***
1.6 Written notice of the Appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					In the 2019 EQR, CCME recommended that Alliance 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. In the 2020 EQR of the Appeal information it was noted that this sentence was removed from the *Individual and Family Handbook*.
2. The PIHP applies the Appeal policies and procedures as formulated.	X					In the 2019 EQR, a Corrective Action was issued to improve compliance within the Appeal log and Appeal files reviewed. This Corrective Action required the development of a monitoring process that included compliance review of verbal and written notifications and accuracy of all data within the Appeals Log. Alliance implemented this Corrective Action and the Appeal files and log showed improvement in this year's EQR. To a lesser degree, however, compliance issues were still noted in the 2020 Appeal Log and in two of the twelve files reviewed in this EQR:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						• One Appeal file reviewed revealed the date of the Appeal resolution was incorrect on the Appeal Log. • One standard Appeal file showed Alliance deemed this Appeal of an Administrative denial of a service authorization as an "invalid" Appeal. No efforts to obtain the missing required documentation from the I/DD Care Coordinator that resulted in the Administrative denial were documented, including any contacts with the I/DD Care Coordinator who submitted the service authorization request for Assistive Technology. This Appeal also showed no Acknowledgement or resolution notification was issued by Alliance (See *42 CFR § 438.408 (b)(2)* and *42 CFR § 438.406 (b)(1)*, *NC Medicaid Contract, Attachment M, Section A.1.b* and *G.4*, and Procedure 6505, III. Medicaid Appeals, Section B.1.c. and g). Furthermore, review of the monthly monitoring process Alliance implemented showed the *Peer Review Tool* for Appeals does not adequately review for compliance with verbal and written notifications related to expedited Appeals, nor does it encompass review of required elements within invalid, extended, or withdrawn Appeals. ***Recommendation: Revise the monitoring process and Peer Review Tool to ensure expedited, extended, invalid, and withdrawn Appeals are routinely reviewed for compliance issues. For these Appeals, check to ensure all verbal and written notifications are provided in compliance with NC Medicaid Contract, Attachment M and 42 CFR § 438.406 and § 408.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					

VI. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					General requirements are found in Post Payments Reviews Procedure 6001 and in the Alliance *Corporate Compliance Plan FY21.*
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					Guidance is found in the Alliance *Provider Operations Manual*, in Procedure 3007 Guarding Against Fraud and Abuse, and in several provider training materials provided for review.
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					Program Integrity requirements were addressed in the *Provider Operations Manual*, as well as in Alliance's 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					Investigative process in the Alliance *Corporate Compliance Plan FY21*, in Procedure 3007 Guarding Against Fraud and Abuse, and in several SIU workflow and procedure documents provided for review.

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					PIHP provided the Alliance *Corporate Compliance Plan FY21*, and in Procedure C-1 Corporate Compliance Plan. Annual submission to NC Medicaid is evidenced by provision of emails dated 12/17/2020, 06/18/2020, and 05/22/2020.
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					The compliance officer designation requirement is addressed in the Alliance *Corporate Compliance Plan FY21*, in Procedure 3000 Corporate Compliance Plan, in the Alliance Compliance Organizational Chart and accompanying job description documents, and in training materials provided for review.

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					The investigation process and point of contact was found in the Alliance *Corporate Compliance Plan FY21* and 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					Participation in meetings is addressed in Procedure 3053 Coordination of Program Integrity Activity.
5. PIHP shall send staff to participate in monthly meetings with NC Medicaid Program Integrity staff either telephonically or in person, at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.	X					

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					Alliance addressed the designation of appropriate staff in Procedure 3053 Coordination of Program Integrity Activity and provided internal minutes for monthly minutes.
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					Providing minutes on request is addressed in Procedure 3053 Coordination of Program Integrity Activity. Minutes of quarterly and monthly meetings covering the entire review period were provided to evidence their availability. During the Onsite discussion, it was confirmed that Alliance has provided all requested reports timely and completely.
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					Training is addressed in the Alliance *Corporate Compliance Plan FY21*, in the Program Integrity Workplan, and in training materials provided for review.

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					Prompt responses are covered in the Alliance *Corporate Compliance Plan FY21*, and in Procedure 3008 Special Investigations Procedures.
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					Disciplinary actions are covered in the Alliance *Corporate Compliance Plan FY21*, in the Alliance *Provider Operations Manual*, in the Program Integrity (PI) for Network Provider training PowerPoint from the Alliance website, and in the Compliance & FWA Provider training PowerPoint presentation dated October 2019. The disciplinary guidelines are outlined in the Alliance Actions document dated 01/18/2019.
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					Cooperation with investigation is addressed in the Alliance *Corporate Compliance Plan FY21*, in Procedure 3053 Coordination of Program Integrity Activity, and in the Alliance *Provider Operations Manual*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9. In accordance with *42 CFR § 438.608 (a)(vii)*, PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under NC Medicaid Contract, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under *NC Medicaid Contract*; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month. PIHP shall be penalized One Hundred Dollars ($100) for each overpayment that is not specified in an Attachment Y Report within the applicable month. In addition, PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					Implementation of systems, monitoring and reporting are all addressed in the Alliance *Corporate Compliance Plan FY21*, in Procedure 3008 Special Investigations Procedures and in Procedure 3007 Guarding Against Fraud and Abuse. Alliance provided Attachment Y reports for each month during the review period.
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					Policies and procedures are addressed in Procedure 3007 Guarding Against Fraud and Abuse.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse;	X					Detecting Fraud Waste and Abuse 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 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.	X					Alliance provided the workflow of complaint to closure in Procedure 3008 Special Investigations Procedures and in the Alliance SIU Detailed Workflow, Investigation Chronology, and Investigation Resources Redacted. Recovery of repayments is addressed in Procedure 1517 Overpayments, and Description for Tracking Overpayments and Recoveries.
10.3 In accordance with Attachment Y – Audits/Self-Audits/Investigations PIHP shall establish and implement a	X					Reporting overpayments is addressed in Procedure 1517 Overpayments, and Description for Tracking Overpayments and Recoveries. Alliance provided

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						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					Tracking overpayments is addressed in Procedure 1517 Overpayments, and Description for Tracking Overpayments and Recoveries. Alliance provided Attachment Y reports for each month during the review period.
10.5 Process for handling self-audits and challenge audits;	X					Audits are addressed in Procedure 3030 Auditing of Claims.
10.6 Process for using data mining to determine leads;	X					Alliance provided sample data mining reports and the process was detailed in Procedure 3030 Auditing of Claims.
10.7 Process for informing PIHP employees, subcontractors and providers regarding the False Claims Act;	X					Notification is addressed in Procedure 3026 False Claims.

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					False claims and whistleblower protection are covered in Procedure 3004 Employee Code of Ethics and Conduct and in Procedure 3026 False Claims.
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					Use of EOB to verify services 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					Obtaining financial information is addressed in Procedure 6030 Initial Credentialing Criteria and Enrollment Process for Network. Alliance also provided template Credentialing Checklists, which capture the required information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Overpayment dispute is addressed in Procedure 1517 Overpayments. The Overpayments Procedure references the Alliance Provider Dispute Resolution Procedure – Procedure 3044 Provider Dispute Resolution outlines this process.
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					Investigation timeframes are found in the Alliance *Corporate Compliance Plan FY21*, and in Procedure 3008 Special Investigations Procedures. This procedure details the timely initiation, reporting, to NC Medicaid, and subsequent electronic storage of records. The Alliance SIU Detailed Workflow demonstrates the forwarding of investigations to NC Medicaid.
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:						File Review Results: 15 of the 15 files contained the required information.
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.2 Source/origin of complaint;	X					
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					
13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations or policies violated; and dates of suspected intentional misconduct;	X					
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					
13.6 All communications between PIHP and the Provider concerning the conduct at issues, when available.	X					There was no documentation provided for one of the files referred to NC Medicaid. However, during the Onsite interview it was explained that the provider was not immediately engaged due to the nature of the complaint and the evidence available. Communication responsibility was left to the department.
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					In the 2019 EQR, it was recommended that Alliance ensure staff maximize the use of the Investigation Report summary by completing it in its entirety. There was evidence in the files reviewed in this 2020 EQR that Alliance implemented this 2019 Recommendations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.8 Total Sample Amount of Funds Investigated per Service Type.	X					
13.8.1 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					
13.8.2 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					
13.8.3 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					
13.8.4 Information on Biller/Owner;	X					
13.8.5 Additional Provider Locations that are related to the allegations;	X					
13.8.6 Legal and Administrative Status of Case.	X					
14. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						No cases of Enrollee Fraud were provided for this review period. However, relevant procedures were reviewed and showed contractual requirements are captured within Alliance's PI procedures.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.1 The Enrollee's name, birth date, and Medicaid number;	X					
14.2 The source of the allegation;	X					
14.3 The nature of the allegation, including the timeframe of the allegation in question;	X					
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.
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					Evidence of FAMS use and data mining efforts was demonstrated through submission of FAMS User and data mining reports and was addressed in Procedure 3008 Special Investigations.
17. If PIHP uses FAMS, PIHP shall work with the NC Medicaid designated Administrator to submit appropriate claims data to load into the NC Medicaid Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	X					Two Corrective Actions issued in the 2019 EQR for this standard were addressed by Alliance.

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					2019 EQR Corrective Actions addressed in section C. (Ad Hoc Coordination and Reporting) of Procedure 3053 Coordination of Program Integrity Activity. Language included in the procedure addresses this requirement. Additionally, Alliance provided monthly NCID-FAMS User lists covering the review period. The monthly report submission requirement is address by the monthly Attachment Y and Z Reports provided for review.

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Alliance provided Procedure 3043 Provider Sanctions, Administrative Actions, and Suspensions to Ensure Patient Safety addresses payment suspension as a potential sanction for allegations of fraud but does not address the lifting of suspensions. Procedure 3053 Coordination of Program Integrity Activity addresses the suspension of payments as well as the lifting of suspension.
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					Alliance provided Procedure 3043 Provider Sanctions, Administrative Actions, and Suspensions to Ensure Patient Safety addresses payment suspension as a potential sanction for allegations of fraud but does not address the lifting of suspensions. Procedure 3053 Coordination of Program Integrity Activity addresses the suspension of payments as well as the lifting of suspension.
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					Support of NC Medicaid in defense of an investigation is addressed in Procedure 3053 Coordination of Program Integrity Activity.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid Program Integrity due to allegations of suspected fraud without prior written approval from NC Medicaid Program Integrity or the MFCU/MID. If PIHP takes administrative action, including issuing a Notice of Overpayment based on such fraud that precedes the submission date of a Division referral, the State will adjust the PIHP capitated payment in the amount of the original overpayment identified or One Thousand Dollars ($1,000) per case, whichever amount is greater.	X					Written authorization for sanctions is addressed in 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	X					Authority to execute sanctions is addressed in Procedure 3043 Provider Actions and Suspensions to Ensure Member Safety.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
Enrollee access to care or with any such ongoing investigation being conducted by NC Medicaid, MFCU/MID or other oversight agency.						
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.	X					Collection of overpayments is addressed in Procedure BO-6, which, "The Chief Executive Officer shall develop procedures to implement this policy." Procedure 1519 Payment Plan Review. Additionally, Alliance provided for review a Description for Tracking Overpayments and Recoveries, and related Tracking document templates.

E. Attachment 5: Encounter Data Validation Report

Alliance Health

Encounter Data Validation Report

performed on behalf of

North Carolina Medicaid

June 2, 2021

Prepared By:

hms

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

Table of Contents

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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 use 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 2019 through December 2019. 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 2019 encounter data elements
- A review of NC Medicaid 's encounter data acceptance report

Review of Alliance's ISCA response

The review of Alliance's ISCA response was focused on section V. Encounter Data Submission. NC Medicaid requires each PIHP to submit their encounter data for all paid claims on a weekly basis via 837 Institutional and Professional transactions. The companion guides follow the standard ASC X12 transaction set with a few modifications to some segments. For example, the 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 to confirm receipt and any compliance errors. The behavioral health encounter claims are then validated by applying a list of edits provided by the state (See Appendix 1) and adjudicated accordingly by MMIS. Utilizing existing Medicaid pricing methodology, using the billing or rendering provider accordingly, the appropriate Medicaid allowed amount is calculated for each encounter claim in order to shadow price what was paid by the PIHP.

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

Looking at claims with dates of service in 2019, Alliance submitted 2,027,891 unique encounters to the State. To date, less than 1% of all 2019 encounters submitted have not been corrected and accepted by NC Medicaid.

2019	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
Institutional	80,372	79,301	553	518	0.64%
Professional	1,999,519	1,990,578	6,317	2,624	0.13%
Total	2,079,891	2,069,879	6,870	3,142	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.

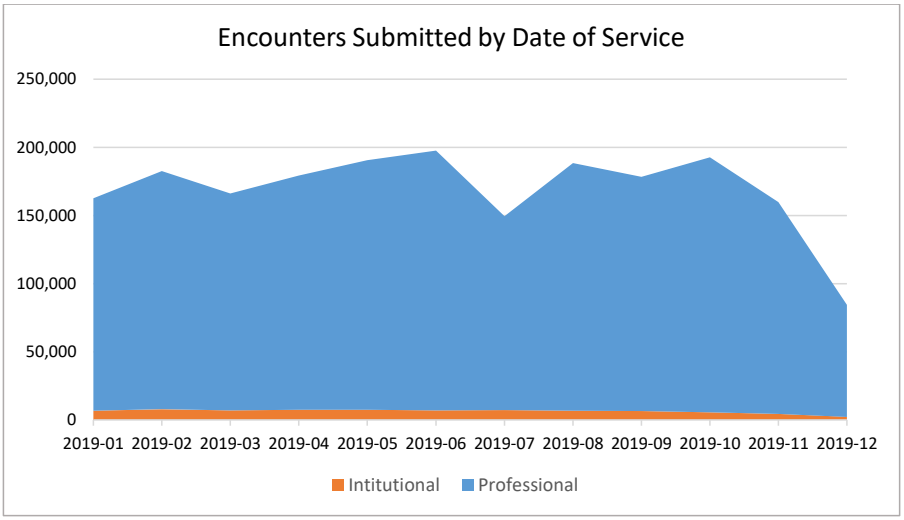
Year of Service	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
2016	2,465,320	1,694,361	595,136	175,823	7.13%
2017	2,464,787	2,299,082	126,488	39,217	1.59%
2018	2,015,327	2,004,869	7,453	3,005	0.15%
2019	2,079,891	2,069,879	6,870	3,142	0.15%

The LME 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 response file from NCTracks. Those results are posted to Alliance's internal system so that encounter submission results as well as their acceptance status is visible to its staff for each claim. Additionally, Alliance has reports and work queue that focus on the denials so that the staff can efficiently review, research, and resolve the issue(s) that caused the denial.

To do this, the team relies on the remark codes to narrow down the true denial reasons and make corrections. Alliance works closely with the providers to communicate issues, make them aware of corrections, and even educate the provider on how to avoid future encounter denials. 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. Lastly, Alliance maintains a tool that allows its senior staff to modify its claiming edits. This allows Alliance to quickly update its edits if the review of denials reveals any issues that can be addressed by applying tighter edits to incoming claims.

Analysis of Encounters

The analysis of encounter data evaluated whether Alliance submitted complete, accurate, and valid data to NC Medicaid for all claims paid between January 1, 2019 and December 31, 2019. Alliance pulled all claims adjudicated and submitted to NC Medicaid during 2019 and sent to HMS via SFTP. This included more than two million professional claims and nearly ninety 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 processed and combined all batch encounter files, and loaded them to a consolidated database. After data onboarding was completed, HMS applied proprietary, internally designed data analysis logic within SAS to review each data element, focusing on the data elements defined as required. Our logic evaluates the presence of data in each field within a record as well as whether the value for the field is within accepted standards. Results of these checks were compared with general expectations for each data field and to the CMS standards adopted for encounter data. The table below depicts the specific data expectations and validity criteria applied.

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Recipient ID	Should be valid ID as found in the State's eligibility file. Can use State's ID unless State also accepts Social Security Number.	100% valid
Recipient Name	Should be captured in such a way that makes separating pieces of name easy. Expect data to be present and of good quality	85% present. Lengths should vary, but there should be at least some last names of >8 digits and some first names of < 8 digits, validating that fields have not been truncated. Also, a high percentage of names should have at least a middle initial.
Recipient Date of Birth	Should not be missing and should be a valid date.	< 2% missing or invalid
MCO/PIHP ID	Critical Data Element	100% valid
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	95% valid
Attending Provider ID	Should be an enrolled provider listed in the provider enrollment file (will accept the MD license number if it is listed in the provider enrollment file).	> 85% match with provider file using either provider ID or MD license number
Provider Location	Minimal requirement is county code, but zip code is strongly advised.	> 95% with valid county code > 95% with valid zip code (if available)
Place of Service	Should be routinely coded, especially for physicians.	> 95% valid for physicians > 80% valid across all providers
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% 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

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
		Revision, Clinical Modification [ICD-9-CM] lookup tables) for practitioner providers (not including transportation, lab, and other ancillary providers)
Other Diagnosis	This is not expected to be coded on all claims even with applicable provider types, but should be coded with a 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

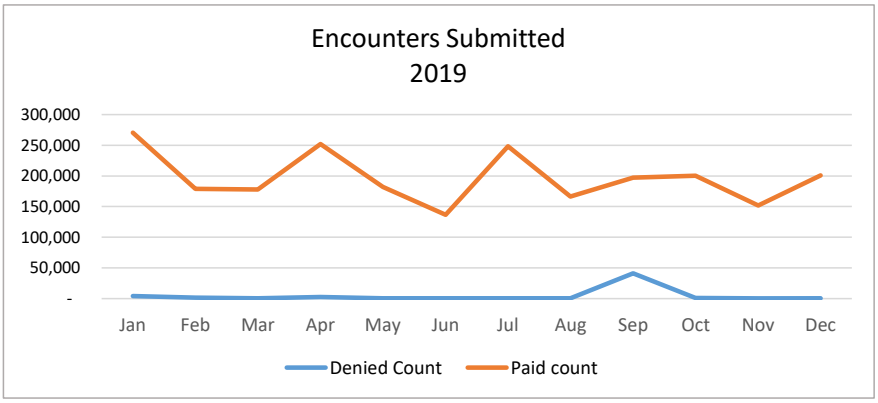
Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	2,280,787	100.00%	2,280,787	100.00%	2,280,787	100.00%	2,280,787	100.00%
Recipient Name	2,280,787	100.00%	2,280,787	100.00%	2,280,787	100.00%	2,280,787	100.00%
Recipient Date of Birth	2,280,787	100.00%	2,280,787	100.00%	2,280,787	100.00%	2,280,787	100.00%
MCO/PIHP ID	2,280,787	100.00%	2,280,787	100.00%	2,280,787	100.00%	2,280,787	100.00%
Provider ID	2,280,203	99.97%	2,280,203	99.97%	2,280,203	99.97%	2,280,203	99.97%
Attending/Rendering Provider ID	2,280,203	99.97%	2,280,203	99.97%	2,280,203	99.97%	2,280,203	99.97%
Provider Location	2,280,787	100.00%	2,280,787	100.00%	2,280,787	100.00%	2,280,787	100.00%
Place of Service	2,280,787	100.00%	2,280,787	100.00%	2,280,771	100.00%	2,280,787	100.00%
Specialty Code / Taxonomy - Billing	2,280,787	100.00%	2,280,787	100.00%	2,280,787	100.00%	2,280,787	100.00%
Specialty Code / Taxonomy - Rendering / Attending	2,280,787	100.00%	2,280,787	100.00%	2,280,776	100.00%	2,280,787	100.00%
Principal Diagnosis	2,280,787	100.00%	2,280,787	100.00%	2,280,771	100.00%	2,280,787	100.00%
Other Diagnosis	330,484	14.49%	330,484	14.49%	330,484	14.49%	330,484	14.49%
Dates of Service	2,280,787	100.00%	2,280,787	100.00%	2,280,787	100.00%	2,280,787	100.00%
Unit of Service (Quantity)	2,280,787	100.00%	2,280,787	100.00%	2,280,787	100.00%	2,280,787	100.00%
Procedure Code	2,271,601	99.60%	2,271,601	99.60%	2,271,601	99.60%	2,271,601	99.60%
Procedure Code Modifier	898,869	39.41%	898,869	39.41%	898,869	39.41%	898,869	39.41%
Patient Discharge Status Code Inpatient	89,028	100.00%	89,028	100.00%	89,028	100.00%	89,028	100.00%
Revenue Code	89,028	100.00%	89,028	100.00%	89,028	100.00%	89,028	100.00%

Overall, there were very few inconsistencies in the data. Institutional claims contained complete and valid data in 17 of the 18 key fields (94%). Significant improvements were seen in Procedure codes and additional Diagnosis codes. In 2018, less than 1% of all institutional claim lines contained additional Diagnosis codes. That figure increased to more than 54%. Similarly, almost 90% of all institutional claim lines in 2019 had a valid Procedure code where one is expected, representing a notable improvement compared to 2018. However, there is still room for further improvement with the Procedure codes to ensure it is populated at least 99% of the time. In 2019, Alliance implemented additional edits to deny line times that are missing a valid Procedure code when one is expected. Additionally, Alliance implemented additional changes to ensure Procedure code field does not populate with Revenue code when the former is missing. We expect these changes to have positive effect on future encounter submissions.

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 less than 17% of all professional claims reported. This is an improvement over 2018, but we continue to see room for improvement.

Encounter Acceptance Report

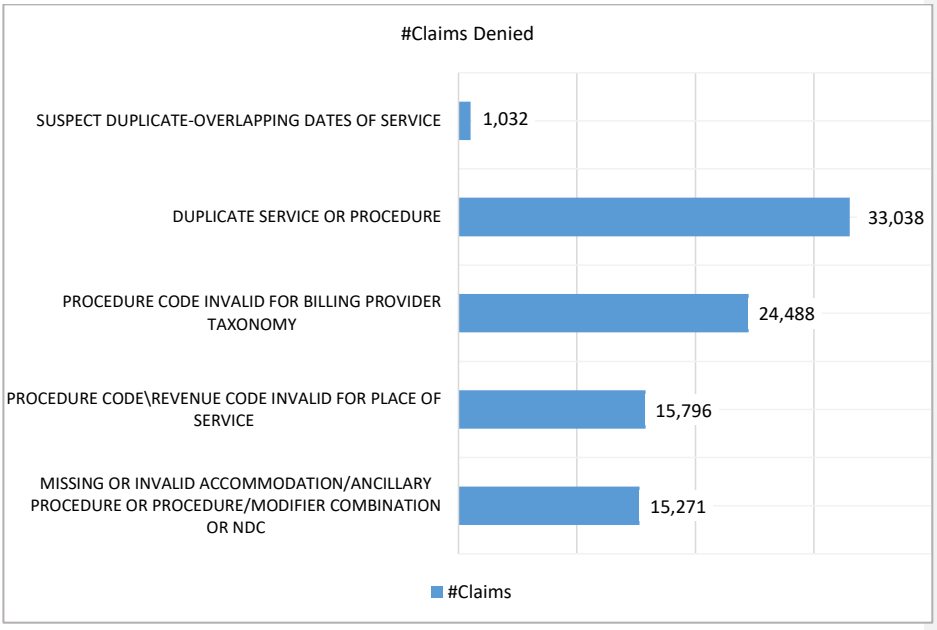
In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write and excludes duplicates 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 2019 which may include older dates of service. During the 2019 weekly check write schedule, Alliance submitted a total of 2,280,787 encounters to NC Medicaid. Approximately less than 1% of claims denied are still outstanding -- the rest have been reviewed, resubmitted, and accepted by NC Medicaid.



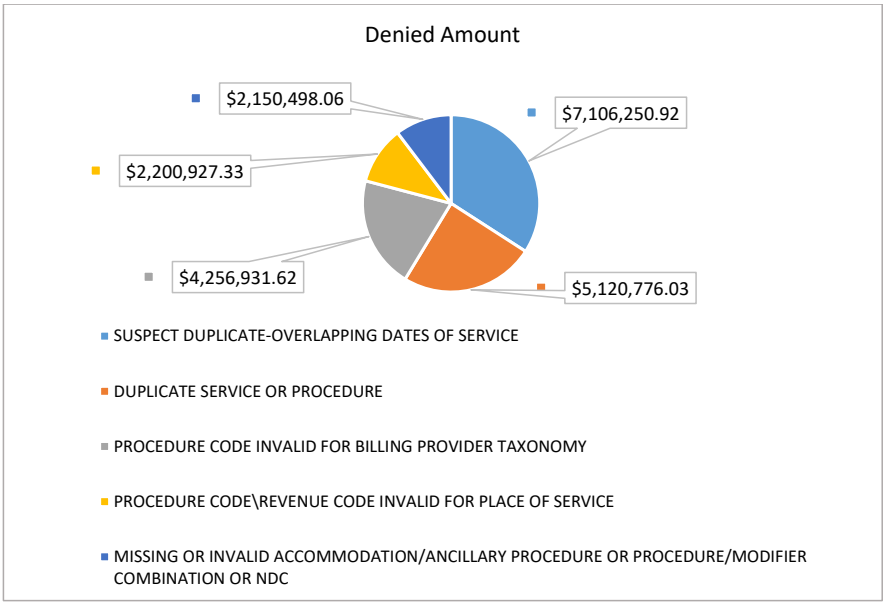
Evaluation of the top denials for Alliance encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis an ISCA review above. Encounters were denied primarily for:

- Suspect duplicate - overlapping dates of service
- Duplicate service or procedure
- Procedure Code invalid for billing Provider Taxonomy
- Procedure Code/Revenue Code invalid for Place of Service
- Missing or invalid accommodation/ancillary procedure or procedure/modifier combination

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: Additional Diagnosis Codes

The secondary diagnosis was populated in more than 53% of all institutional claims but only 12.9% 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. However, all claims should be complete and accurate at all times and these figures suggest that some providers are not as diligent in coding and submitting additional Diagnosis codes.

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 and as a result we saw noticeable improvements in 2019. In addition, we recommend that Alliance identify providers who never or very rarely submit additional Diagnosis codes and perform an outreach to remind them of their obligation to ensure that the claims they submit to Alliance are complete and accurate.

Conclusion

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

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

Appendix 1

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

00117	ONLY ONE DOS ALLOWED/LINE	PAY AND REPORT
00126	TOOTH SURFACE MISSING/INVALID	IGNORE
00127	QUAD CODE MISSING/INVALID	IGNORE
00128	PROC CDE DOESNT MATCH TOOTH #	IGNORE
00132	HCPCS CODE REQ FOR REV CODE	IGNORE
00133	HCPCS CODE REQ BILLING RC 0636	IGNORE
00135	INVL POS INDEP MENT HLTH PROV	PAY AND REPORT
00136	INVLD POS FOR IDTF PROV	PAY AND REPORT
00140	BILL TYPE/ADMIT DATE/FDOS	DENY
00141	MEDICAID DAYS CONFLICT	IGNORE
00142	UNITS NOT EQUAL TO DOS	PAY AND REPORT
00143	REVIEW FOR MEDICAL NECESSITY	IGNORE
00144	FDOS AND TDOS MUST BE THE SAME	IGNORE
00146	PROC INVLD - BILL PROV TAXON	PAY AND REPORT
00148	PROC\REV CODE INVLD FOR POS	PAY AND REPORT
00149	PROC\REV CD INVLD FOR AGE	IGNORE
00150	PROC CODE INVLD FOR RECIP SEX	IGNORE
00151	PROC CD/RATE INVALID FOR DOS	PAY AND REPORT
00152	M/I ACC/ANC PROC CD	PAY AND REPORT
00153	PROC INVLD FOR DIAG	PAY AND REPORT
00154	REIMB RATE NOT ON FILE	PAY AND REPORT
00157	VIS FLD EXAM REQ MED JUST	IGNORE
00158	CPT LAB CODE REQ FOR REV CD	IGNORE
00164	IMMUNIZATION REVIEW	IGNORE
00166	INVALID VISUAL PROC CODE	IGNORE
00174	VACCINE FOR AGE 00-18	IGNORE

00175	CPT CODE REQUIRED FOR RC 0391	IGNORE
00176	MULT LINES SAME PROC, SAME TCN	IGNORE
00177	HCPCS CODE REQ W/ RC 0250	IGNORE
00179	MULT LINES SAME PROC, SAME TCN	IGNORE
00180	INVALID DIAGNOSIS FOR LAB CODE	IGNORE
00184	REV CODE NOT ALLOW OUTPAT CLM	IGNORE
00190	DIAGNOSIS NOT VALID	DENY
00192	DIAG INVALID RECIP AGE	IGNORE
00194	DIAG INVLD FOR RECIP SEX	IGNORE
00202	HEALTH CHECK SHADOW BILLING	IGNORE
00205	SPECIAL ANESTHESIA SERVICE	IGNORE
00217	ADMISSION TYPE CODE INVALID	PAY AND REPORT
00250	RECIP NOT ON ELIG DATABASE	DENY
00252	RECIPIENT NAME/NUMBER MISMATCH	PAY AND REPORT
00253	RECIP DECEASED BEFORE HDR TDOS	DENY
00254	PART ELIG FOR HEADER DOS	PAY AND REPORT
00259	TPL SUSPECT	PAY AND REPORT
00260	M/I RECIPIENT ID NUMBER	DENY
00261	RECIP DECEASED BEFORE TDOS	DENY
00262	RECIP NOT ELIG ON DOS	DENY
00263	PART ELIG FOR LINE DOS	PAY AND REPORT
00267	DOS PRIOR TO RECIP BIRTH	DENY
00295	ENC PRV NOT ENRL TAX	IGNORE
00296	ENC PRV INV FOR DOS	IGNORE
00297	ENC PRV NOT ON FILE	IGNORE
00298	RECIP NOT ENRL W/ THIS ENC PRV	IGNORE

00299	ENCOUNTER HMO ENROLLMENT CHECK	PAY AND REPORT
00300	BILL PROV INVALID/ NOT ON FILE	DENY
00301	ATTEND PROV M/I	PAY AND REPORT
00308	BILLING PROV INVALID FOR DOS	DENY
00313	M/I TYPE BILL	PAY AND REPORT
00320	VENT CARE NO PAY TO PRV TAXON	IGNORE
00322	REND PROV NUM CHECK	IGNORE
00326	REND PROV NUM CHECK	PAY AND REPORT
00328	PEND PER DHB REQ FOR FIN REV	IGNORE
00334	ENCOUNTER TAXON M/I	PAY AND REPORT
00335	ENCOUNTER PROV NUM MISSING	DENY
00337	ENC PROC CODE NOT ON FILE	PAY AND REPORT
00339	PRCNG REC NOT FND FOR ENC CLM	PAY AND REPORT
00349	SERV DENIED FOR BEHAV HLTH LM	IGNORE
00353	NO FEE ON FILE	PAY AND REPORT
00355	MANUAL PRICING REQUIRED	PAY AND REPORT
00358	FACTOR CD IND PROC NON-CVRD	PAY AND REPORT
00359	PROV CHRGS ON PER DIEM	PAY AND REPORT
00361	NO CHARGES BILLED	DENY
00365	DRG - DIAG CANT BE PRIN DIAG	DENY
00366	DRG - DOES NOT MEET MCE CRIT.	PAY AND REPORT
00370	DRG - ILLOGICAL PRIN DIAG	PAY AND REPORT
00371	DRG - INVLD ICD-9-CM PRIN DIAG	DENY
00374	DRG PAY ON FIRST ACCOM LINE	DENY
00375	DRG CODE NOT ON PRICING FILE	PAY AND REPORT
00378	DRG RCC CODE NOT ON FILE DOS	PAY AND REPORT

00439	PROC\REV CD INVLD FOR AGE	IGNORE
00441	PROC INVLD FOR DIAG	IGNORE
00442	PROC INVLD FOR DIAG	IGNORE
00613	PRIM DIAG MISSING	DENY
00628	BILLING PROV ID REQUIRED	IGNORE
00686	ADJ/VOID REPLC TCN INVALID	DENY
00689	UNDEFINED CLAIM TYPE	IGNORE
00701	MISSING BILL PROV TAXON CODE	DENY
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