Quality Management and Improvement Plan FY2023

State Approved 6/2/2022

QMC Approved 11/3/2022

Contents

Executive Summary

Alliance Health (Alliance) is a Managed Care Organization (MCO) operating one of North Carolina's Behavioral Health and Intellectual/Developmental Disabilities (BH I/DD) Tailored Plans. Alliance has managed publicly funded behavioral health services since 2013, and currently serves people who are insured by Medicaid or are uninsured in the following counties:

- Cumberland
- Durham
- Johnston
- Mecklenburg
- Orange
- Wake

Alliance has earned full Medicaid Managed Behavioral Health Organization (MBHO) Accreditation with a Long-Term Services and Supports (LTSS) distinction from the National Committee for Quality Assurance (NCQA). Full Accreditation is granted for a period of three years to those plans that have excellent programs for continuous quality improvement and meeting NCQA's rigorous standards.

Alliance's Quality Management and Improvement Program (QMIP) is dedicated to improving Members' experiences with their healthcare, managing the cost of publicly funded medical and behavioral health services, supporting positive outcomes for population health, and supporting Providers and Practitioners in the Alliance network. The following QMIP describes Alliance's commitment to continuous quality improvement and how the resources dedicated to this process support organizational and state-wide initiatives to improve healthcare and health outcomes in North Carolina.

Section 1: Alliance's QM Philosophy & Scope

1.1 Description of Alliance

Alliance Health (Alliance) is a public-sector Local Management Entity/Managed Care Organization (LME/MCO) administering behavioral health services for the North Carolina counties of Cumberland, Durham, Johnston, Mecklenburg, Orange, and Wake. Alliance authorizes Medicaid and State funds for members in the Alliance region who need services for intellectual/developmental disabilities (I/DD), traumatic brain injuries (TBI), and mental health/substance use disorders (MHSUD). As a Tailored Plan, Alliance is responsible for authorizing Medicaid and State funds related to physical health and pharmacy benefits, in addition to, the behavioral health services.

The North Carolina MH/DD/SAS Health Plan is a prepaid inpatient health plan (PIHP) funded by Medicaid and approved by the Centers for Medicare and Medicaid (CMS). The Health Plan combines two types of waivers: a 1915(b) waiver generally known as a Managed Care/Freedom of Choice waiver, and two 1915(c) waivers generally known as Home and Community-Based Servicers (HCBS) waivers. Alliance implements this plan for the catchment area served.

The NC Innovations Waiver is a 1915(c) Home and Community Based Services waiver. This is a waiver of institutional care. Funds that are typically used to serve a person with intellectual and/or developmental disabilities in an Intermediate Care Facility (ICF) through this waiver may be used to support the participant outside of the ICF setting.

The Traumatic Brain Injury (TBI) waiver is another 1915(c) waiver that provides an array of Home and Community-Based Services. The waiver is designed to provide an alternative to nursing facility care or specialty rehabilitation hospital care for eligible individuals with a traumatic brain injury.

Alliance manages a variety of county-funded programs, including but not limited to crisis and assessment centers and outpatient walk-in clinics.

In this QMIP, Alliance describes our QM program's governance, scope, goals, objectives, structure, and responsibilities. Alliance is committed to serving our communities through good stewardship of public resources to produce positive health outcomes.

1.2 Alliance's Mission

To improve the health and well-being of the people we serve by ensuring highly effective, community-based support and care.

1.3 Alliance's Vision

To be a leader in transforming the delivery of whole person care in the public sector.

1.4 Alliance's Values

Accountability and Integrity: We keep the commitments we make to our stakeholders and to each other. We ensure high-quality services at a sustainable cost.

Collaboration: We actively seek meaningful and diverse partnerships to improve services and systems for the people we serve. We value communication and cooperation between team members and departments to ensure that people receive needed services and supports.

Compassion: Our work is driven by dedication to the people we serve and an understanding of the importance of community in each of our lives.

Dignity and Respect: We value differences and seek diverse input. We strive to be inclusive and honor the culture and history of our communities and the people we serve.

Innovation: We challenge the way it's always been done. We learn from experience to shape a better future.

Section 2: Purpose of the Alliance Quality Program

Alliance's Quality Management Program supports the State's Quality Management Strategy by supporting Alliance to provide whole-person managed care using population health strategies and care management to get Members to the right services at the right time. Alliance must meet a variety of Quality Management requirements. These are set by Alliance's contracts with North Carolina's Department of Health and Human Services (NCDHHS); by the federal government's Medicaid waiver process; and by accreditation requirements.

Quality Management (QM) plays a major role in ensuring Alliance has well-established and evaluated processes for the timely identification, response, reporting, and follow-up to member incidents and stakeholder complaints about service access and quality.

Alliance also must ensure that its employees and providers are fully compliant with critical incident and death reporting laws, regulations, and policies, as well as event reporting requirements of national accreditation organizations. QM, along with the Medical Director and/or designees, shall review, investigate, and analyze trends in critical incidents, deaths, and take preventive action to minimize their occurrence with the goals of improving the behavioral healthcare system, behavioral healthcare access, and member and provider outcomes.

The purpose of the Alliance Quality Management Plan is to provide a systematic method for continuously improving the quality, efficiency and effectiveness of the services managed by Alliance for enrollees served. The plan also encompasses internal quality and effectiveness of all Tailored Plan processes.

Section 3: Purpose and Development of the Quality Management Plan

The Quality Management Plan describes governance, scope, goals, outcomes, structure, and responsibilities of quality program. The plan describes the process by which the organization monitors, evaluates, and improves organizational performance to ensure quality and efficient health outcomes for members served. It also describes how administrative and clinical functions are integrated into the overall scope and purpose of the Quality Management Department.

The QMIP is updated annually by Alliance staff, led by the Chief Medical Officer and Senior Vice President of Quality Management. The Board Quality Management Committee (QMC), a subcommittee of the Board of Directors, reviews, edits, and approves the QMIP annually. QMC also reviews and approves the Quality Assurance and Performance Improvement Plan (QAPI)[1] and Performance Improvement Projects (PIPs). Progress toward performance improvement goals are evaluated in the annual Quality Program Evaluation, which is also reviewed and approved by the QMC subcommittee of the Board of Directors.

Section 4: Goals and Objectives of the Quality Program

The Quality Program plays a major role in ensuring Alliance is successful at meeting performance outcomes and contract requirements. The broad goals listed below provide a focus for staff and organization-wide quality activities:

- Ensure individual members receive services that are appropriate and timely
- Use evidence-based treatments that result in measurable clinical outcomes
- Ensure Alliance focuses on health and safety of members, protection of rights, and monitoring and continually improving the provider network
- Empower members and families to set their own priorities, take reasonable risks, participate in system management, and to shape the system through their choices of services and providers
- Build local partnerships with individuals who depend on the system for services and supports, with community stakeholders, and with the providers of service
- Demonstrate an interactive, mutually supportive, and collaborative partnership between the State agencies and Alliance in the implementation of public policy at the local level, and realization of the State's goals of healthcare change

[1] Formerly known as the Quality Management Workplan

Specifically, the priority performance goals for FY2023 are outlined in the quality workplan and summarized in the table below:

Quality Effort	Summary of Measure	TP Target	Med Direct Target
Follow-Up afterMental Health Discharges (FUH) *Population(s)* • TP Medicaid • Medicaid Direct	The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health that received a follow-upvisit with a behavioral health practitioner within 1-7 days of discharge.	26.2%	TBD
	The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health that received a follow-upvisit with a behavioral health practitioner within 30 days of discharge.	45.1%	TBD
Follow-Up after Discharge from Community Hospitals, State Psychiatric Hospitals, and Facility-based Crisis Services for Mental Health Treatment *Population(s)* • State Funded	The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health that received a follow-upvisit with a behavioral health practitioner within 1-7 days of discharge.	40%	NA
	The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health that received a follow-upvisit with a behavioral health practitioner within 30 days of discharge.	Watch	NA
Follow-Up after Discharge from Community Hospitals, State Psychiatric Hospitals, State ADATCs, and Detox/Facility Based Crisis Services for Substance Use Disorder (SUD) Treatment *Population(s)* • State Funded	The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health that received a follow-upvisit with a behavioral health practitioner within 1-7 days of discharge.	40%	NA
	The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health that received a follow-upvisit with a behavioral health practitioner within 30 days of discharge.	Watch	NA

Quality Effort	Summary of Measure	TP Target	Med Direct Target
Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC) *Population(s)* • TP Medicaid • Medicaid Direct	The percentage of adults 18-75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control (9.0%).[2]	101.3%[3]	TBD
TCL Primary Care Visits *Population(s)* • TP Medicaid • Medicaid Direct • State Funded	To increase the rate of confirmed primary care provider appointments with members in the TCL housing transition and residency cohort.	80%	80%

Section 5: Principles and Strategies of the QMIP

Alliance's QMIP is based on the principles of Continuous Quality Improvement (CQI).

5.1 Continuous Quality Improvement

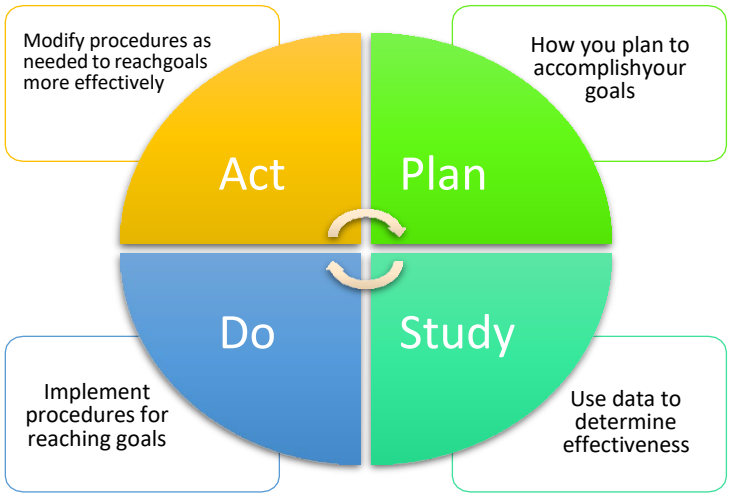
Alliance's Quality Program begins with Quality Assurance (QA), a major activity of Alliance's Quality Management Department. QA involves ongoing activities that ensure compliance with rules, regulations, and requirements. Examples of the QA activities conducted by Alliance include, internal reviews, performance measurement, provider monitoring, and member satisfaction surveys.

QA allows Alliance to identify opportunities for Quality Improvement (QI), which involves continuously monitoring, analyzing, and improving of systems and procedures throughout the agency.

[2] Lower rates signify better performance

[3] Target is pulled from "2021 Tailored Plan Quality Measure Performance and 2023 Targets" sent via email 8/12/2022 from DHB. This rate appears to be incorrect as it exceeds 100% and is higher than FY2021. Lower rates indicate better performance for this HEDIS Measure.

Alliance has implemented a Plan/Do/Study/Act model for CQI.



A goal of the CQI process is ensuring quality care for members. This is achieved by:

- Evaluating evidence-based practices
- Ensuring equal/easy access to services
- Maintaining client rights
- Obtaining member feedback
- Aligning agency policies and procedures with Federal, State, contract, and accreditation expectations
- Using outcomes data to gauge clinical outcomes and administrative success

5.2 Accreditation

Alliance demonstrates its commitment to Continuous Quality Improvement via accreditation. Alliance is accredited as a Managed Behavioral Healthcare Organization with Long-Term Services and Supports distinction by the National Committee for Quality Assurance. As a Tailored Plan, Alliance operates in compliance with the NCQA Health Plan Accreditation Standards. Alliance will undergo Health Plan Accreditation survey in 2023.

Section 6: Quality Program Structure and Resources

All employees at Alliance are responsible for the pursuit of Continuous Quality Improvement. The departments and staff summarized below are central to Alliance's efforts at Continuous Quality Improvement.

6.1 Chief Medical Officer

The Alliance Health Chief Medical Officer (CMO) serves as the designated physician and behavioral healthcare practitioner overseeing the operations of the Quality Management Program. The CMO or Designee is the chair of the CQI Committee, providing guidance and oversight for all major quality

efforts. The entire medical team provides clinical oversight, guidance, and consultation for all MCO functions including Utilization Management, Care Management, Population Health Management, Call Center, Network Management, and Quality Improvement.

6.2 Quality Management

The Alliance QM Department is led by the Senior Vice President of QM and supported by the Chief Medical Officer. The QM Department is divided into two functional areas: Quality Assurance and Quality Improvement.

Quality Assurance is dedicated to continued monitoring and reporting of member experience and clinical outcomes, and reports to the SVP of Quality Management. This team is led by the Director of Quality Assurance and consists of two teams:

- Grievance, Incidents, and Appeals: This team promotes quality assurance within Alliance and the Alliance provider network; develops reports for Alliance management, committees, and the State; investigates and resolves incidents and complaints reported by members, providers, Alliance staff and others. This team is also responsible processing appeal requests from members.
- Quality Management Data: This team is responsible for meeting the data needs of internal and external stakeholders working on quality projects by providing guidance on utilizing data for quality tracking and improvement efforts, completion of external quality reporting, and the implementation and interpretation of surveys.

Quality Improvement supports improved operational performance and clinical outcomes, and reports to the SVP of Quality Management. This team is led by the Director of Quality Improvement and consists of three teams:

- Quality Improvement: This team oversees Performance Improvement Projects and other quality improvement related activities; performs quality reviews to identify opportunities for improvement; conducts in-depth analyses of internal processes and programs.
- Accreditation: This function links quality efforts across the organization to accreditation standards and monitors to ensure on-going compliance.
- Data Science and Analytical Research: This team focuses on using advanced and predictive analytics to identify issues, target solutions, and efficiently improve the health outcomes of our members.

6.3 Provider Network Development and Evaluation

Provider Network Development and Evaluation Team is responsible for the promotion of high-quality and evidence-based services and supports. It provides continuous review and evaluation of the provider network for quality of services, adherence to contract requirements, and standards of care and performance, while ensuring that a full array of providers are available to meet the needs of those in need of services. This team works to:

- Develop and maintain the provider network with a sufficient number, mix and geographic distribution of providers, to ensure availability of easy access, quality care and cost-effective services for members.

- Host a variety of provider collaboratives aimed at sharing best practices within service-specific groups.
- Support the Credentialing Committee to ensure that all providers and practitioners meet requirements to participate in the Alliance provider network.

6.4 Practice Transformation

The Practice Transformation Team is responsible for engaging with providers to promote and encourage transformation to value-based contracting. Practice Transformation Specialists (PTS) provide 1:1 coaching with practices who are becoming Care Management Agencies (CMA)/Advanced Medical Home Plus (AMH+) to ensure their success at managing the lives covered, and 1:1 coaching with providers on specific performance measures and improvement. Specific goals of this team include:

- Development of educational tools for providers to successfully become certified CMAs and AMH+.
- Hosting a Care Management collaborative for all agencies who have applied or are interested in care management within the Tailored Plan.
- Supporting providers by doing gaps analysis to determine where they are now to what is needed for value-based contracting.

6.5 Population Health and Care Management

Population Health and Care Management are led by the SVP of Population Health and Care Management, under the direction of the CMO. Population Health supports population level interventions, including, prevention programs and special population programs. QMIP supports the Population Health initiatives through participating in the annual assessment of PHM Strategy and its ability to meet the characteristics and needs of our population; the QMIP does this through population assessments and resource/program assessments. QMIP also supports population stratification efforts. The current and planned population health programs address:

- Opioid Misuse
- Tobacco Cessation
- Pregnancy Intendedness*
- Early Childhood Interventions*
- Diabetes Prevention*
- Hypertension*
- Asthma*[4]

[4]indicates programs currently planned and in development for Tailored Plan. Programs will be implemented by Tailored Plan go-live

Care Management links individuals and families with special health care needs to services and supports, to maximize potential outcomes, decrease the unnecessary use of emergency services and ensure quality care. It also uses a population health management approach that is designed to intervene at the system level, with providers, and members to address unmet social needs, decrease health disparities, and support members' positive health outcomes. Strategies address prevention, modifiable risk factors, and self-management of chronic conditions. The team provides the following activities

- Manages Complex Case Management and Long-Term Services and Supports programs.
- Support inpatient and crisis providers with connections to treatment and other resources in the community.
- Monitors member's wellbeing to ensure that care is delivered in a safe and effective manner that respects the member's rights.
- Coordinates physical, behavioral, and pharmacy needs across the system of care.

6.6 Utilization Management

Utilization Management ensures that services are medically necessary and monitors member treatment to ensure that services are delivered based on member need and established clinical guidelines.

6.7 Community Health and Well Being

Community Health and Well Being is focused on promoting quality partnerships and collaborative change, and redesigning systems of care to improve health outcomes and promote healthy communities. Community Health and Well Being (CHWB) works to improve quality of life for all the people served, by helping them understand their health care better, and giving them tools and resources to actively engage in their care. As part of Community Health and Well-Being the Community and Member Engagement team works to ensure that the voices of individuals and families are heard and integrated at all levels at Alliance, seeking to empower them through education and exposure to resources. The department is staffed entirely by people with lived experience. This team provides the following activities:

- Champions Health Literacy efforts aimed and ensuring that members and their families can understand and direct their treatment.
- Supports the Consumer Family Advisory Councils (CFAC) in advising the Alliance administration and Board of Directors.
- Leverages partnerships to increase access to permanent and temporary housing for the people served.
- Leads stigma reduction and Mental Health First Aid campaigns, in the Alliance communities.

6.8 Access and Information

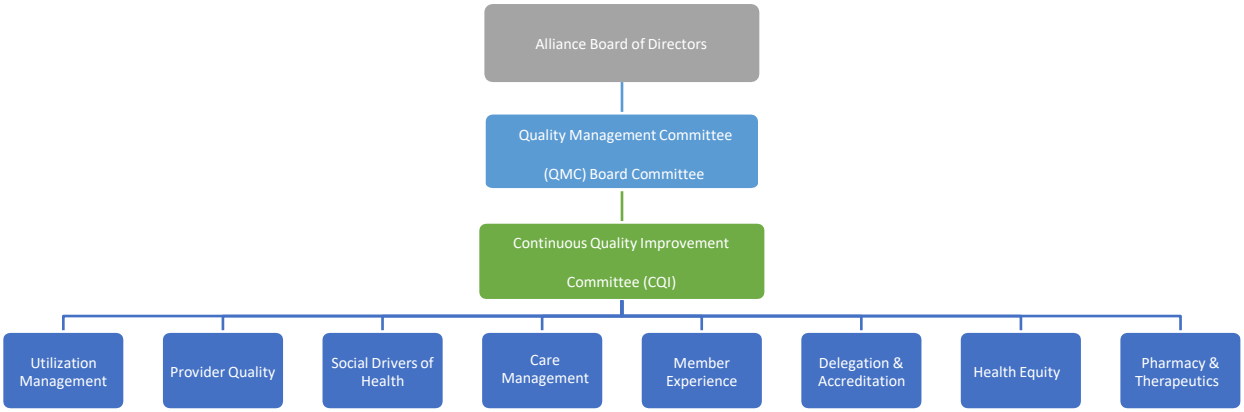
Alliance maintains a 24/7 Access and Information Line to ensure that individuals receive timely access to needed mental health, intellectual and developmental disability, and substance abuse services. It provides information about services and resources available within the community and assistance to anyone requesting information about Alliance.

6.9 Office of Compliance and Risk Management

The Compliance and Risk Management division works to prevent, detect, and correct instances of legal and ethical violations, including fraud, waste and abuse, internally, with delegated vendors, and network providers. It develops and implements Alliance's corporate compliance program, fraud prevention plan, internal audit plan, coordinates the delegation oversight program, and manages the enterprise-wide risk management program.

Section 7: Quality Committee Structure

The Alliance Quality Committee Structure is headed by the full Board of Directors, which has directed the Quality Management Committee (QMC) to provide guidance for the quality program. A visual of the committee structure is below:



7.1 Quality Management Committee (QMC)

The Alliance Quality Management Committee serves as the authority for approving the annual Quality Plan and conducts an evaluation of the Quality Program each fiscal year. QMC has the sole authority to open and close formal Performance Improvement Projects (PIPs)and receives regular status updates for all active PIPs. This group identifies actions that are needed to improve quality and ensures that follow-up occurs to realize the planned improvement. QMC reviews statistical data and provider monitoring reports to make recommendations to the Board of Directors and other Board committees regarding policy decisions. The goal of the QMC is to ensure quality and effectiveness of services, and to identify and address opportunities to improve Alliance operations and local service system, with input from members, providers, family members, and other stakeholders.

Membership for this committee includes board members, consumers or their family members, and two non-voting provider representatives.

7.1.1 Continuous Quality Improvement Committee (CQI)

Purpose	The CQI Committee is responsible for the implementation of the Alliance QMIP and Quality Assessment and Performance Improvement (QAPI) plan, monitoring of quality improvement goals and activities, and identifying opportunities for improvement within the provider network and Alliance operations. The committee reviews organizational performance to prioritize solutions and make recommendations to the Quality Management Committee, of the Board, for additional review, feedback, recommendations and approval. To complete these tasks, eight cross functional subcommittees support these efforts. The subcommittees are described in sections below.
Responsibilities	• The implementation of the Alliance QMIP • Monitoring of quality improvement goals and activities • Identifying opportunities for improvement within the provider network and Alliance operations • Monitor performance regarding key quality indicators of Alliance internal and external functional areas including over/under utilization, member outcomes, network performance,etc.
Reports To	Quality Management Committee, of the Board
Committee Chair	• Chief Medical Officer or Designee (co-chair) • Senior Vice President of Quality Management (co-chair)
Committee Composition	**Operations:** • Chief Operating Officer • Senior Vice President- Community Health and Well Being • Senior Vice President – Population Health and Care Management **Subcommittee Chairs:** • Care Management Subcommittee • Utilization Management Subcommittee • Member Experience Subcommittee • Provider Quality Subcommittee • Social Determinates of Health Subcommittee • Delegation and Accreditation Oversight Subcommittee • Health Equity Subcommittee
Committee Meetings	The committee shall meet as often as its members deem necessary to perform the committee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

7.1.1.1 Utilization Management – CQI Subcommittee

Purpose	The purpose of the Utilization Management Subcommittee is to ensure that consumers have appropriate access to and utilization of behavioral health services. This subcommittee evaluates the utilization of services with the goal of ensuring that each enrollee receives the correct services, in the right amount and in the most appropriate time frames to achieve the best outcomes. This is a collaborative, dynamic process, by which, over or underutilization of services can be detected, monitored and corrected. The subcommittee serves as a vehicle to communicate and coordinate quality improvement efforts to and with CQI.
Responsibilities	• Monitoring for over/under utilization of services • Identify utilization drivers and trends • Address inappropriate utilization patterns • Review and make recommendations to improve basic processes
Reports To	CQI
Subcommittee Chair	• Chief Medical Officer (co-chair) • Senior Director of Utilization Management (co-chair)
Subcommittee Composition	• Finance • Provider Networks • Care Management • Quality Management
Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than fourtimes per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

7.1.1.2 Provider Quality – CQI Subcommittee

Purpose	The purpose of the Provider Quality Subcommittee is threefold: • To engage Alliance providers in developing, evaluating and approving guidelines for clinical practice across the network • To engage Alliance providers in the systematic monitoring and evaluation of provider performance measures, required by NCDHHS and included in Alliance provider contracts • To provide a forum for bidirectional communication between Clinical and Medical leadership in the provider network and Alliance.

	It also provides a mechanism for provider input, feedback, and recommendations. The Provider Quality Subcommittee will draw upon published research, national guidelines, and local expertise to develop guidelines to support clinical decision-making by providers across the network. Furthermore, through identifying and monitoring performance measures, the committee will identify areas of opportunity to improve processes, identify interventions, and improve member outcomes.
Responsibilities	• Help develop, review, and approve clinical guidelines • Review data and other relevant information related to the provider network and make recommendations for improvement • Review and address industry and local trends and issues • Identify solutions to fill clinical and network needs and gaps • Identify and measure quality metrics that support evaluation of health and functional outcomes for members, access to mental health and substance use services, and effectiveness of mental health and substance services delivered by Alliance providers • Provide ongoing monitoring of identified performance measures to be compared against established benchmarks
Reports To	CQI
Subcommittee Chair	• Director of Network Evaluation (co-chair) • Chief Medical Officer or designee (co-chair)
Subcommittee Composition	• Ten Clinical subject matter experts (from MH/SUD and I/DD) • Alliance pharmacist *Membership on this subcommittee, outside of the chairs, is entirely made up of providers representatives and network clinicians. Providers on this subcommittee represent a cross section of different service types, settings, and geographic locations within Alliance's catchment area.
Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than fourtimes per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

7.1.1.3 Social Drivers of Health – CQI Subcommittee

Purpose	The purpose of the Social Drivers of Health Subcommittee is to ensure the environmental conditions impacting members are addressed, and to make recommendations about aligning Social Determinates of Health (SDOH) efforts with care management and network providers. This subcommittee reviewed SDOH assessments and interventions to align efforts across the system, so they can be most effective.
Responsibilities	• Assessing the social determinates of health needs of our members • Aligning resources and efforts within Alliance and across the provider network to help meet the Social Determinates of Health needs of our members • Determining impact of Social Determinates of Health interventions on the overall health and wellbeing of members
Reports To	CQI
Subcommittee Chair	• Senior Director of Clinical Innovation (Chair)
Subcommittee Composition	• Community Health and Wellbeing • Care Management • Quality Management • Medical Management
Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than fourtimes per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

7.1.1.4 Care Management – CQI Subcommittee

Purpose	The purpose of the Care Management Subcommittee is to align care management resources to improve the efficacy of the care delivery network and optimize member outcomes. This subcommittee assists in defining and monitoring the quality of care management services being delivered.
Responsibilities	• Monitor impact and effectiveness of Care Management efforts and identify improvement opportunities • Create framework for evaluating outcomes and functions of internal and external Care Management efforts including Care Management Agencies (CMA) and Advance Medical Home + (AMH+). • Monitor the relationship between Care Management and service providers to ensure members receive the care they need in a timely and appropriate manner
Reports To	CQI
Subcommittee Chair	• Senior Vice President of Population Health and Care Management (Chair)
Subcommittee Composition	• Senior Vice President of Population Health and Care Management (Chair) • Senior Director of Care Management Operations • Director of Physical Healthcare Management • Provider Networks • Care Management • Medical Management • Pharmacy • Quality Management
Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

7.1.1.5 Member Experience – CQI Subcommittee

Purpose	The purpose of the Member Experience Subcommittee is to monitor data related to the member experience of care, identify trends, and suggest any necessary remediation steps, when necessary. Member satisfaction surveys, grievances, appeals, critical incidents, and other member experience data are all reviewed by this subcommittee.
Responsibilities	• Review grievances, critical incidents, appeals, member surveys, mystery shopper experiences, executive walkthrough findings, etc. • Make recommendations about efforts related to improving the experience of our members with Alliance and with network providers • Ensures that member experience is considered central to the definition of quality at Alliance • Direct QIPs that have been assigned to this subcommittee by the full CQI committee
Reports To	CQI
Subcommittee Chair	• Quality Management Specialist (Chair)
Subcommittee Composition	• Senior Director of Access • Provider Networks • Quality Management • Care Management • Community Health and Wellbeing • Medical Management • Member Representative • Provider Representative
Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

7.1.1.6 Delegation & Accreditation Oversight – CQI Subcommittee

Purpose	The purpose of the Delegation and Accreditation Oversight Subcommittee is to ensure that accreditation and any delegated functions are completed successfully. This subcommittee provides a central body that monitors adherence to accreditation standards and ensures that any delegated functions receive appropriate oversight and monitoring.

Responsibilities	• Centralized monitoring of accreditation efforts • Ensure that any delegated functions are done according to requirements • Evaluate impact of delegated functions on providers and members
Reports To	CQI
Subcommittee Chair	• Chief Compliance Officer
Subcommittee Composition	• Corporate Compliance • Quality Management • Provider Networks • Access Call Center • Utilization Management
Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

7.1.1.7 Health Equity – CQI Subcommittee

Purpose	The Health Equity Subcommittee is a centralized place to promote the elimination of health disparities, and the achievement of health equity for all members and recipients, by monitoring outcome gaps between populations, and ensuring that potential improvement efforts do not exacerbate disparities.
Responsibilities	The Health Equity Subcommittee will aide in aligning resources and efforts within Alliance and across the provider network to help meet the health equity needs of our members by: • Assessing the health equity needs of our members • Determining impact of interventions on the overall health and wellbeing of members • Directing QIPs that have been assigned to this subcommittee by the full CQI committee • Monitoring Provider Culturally Competent Plan
Reports To	CQI
Subcommittee Chair	• Quality Improvement Specialist, Quality Management (Chair)
Subcommittee Composition	• Quality Management • Community Health and Wellbeing • Organizational Effectiveness • Provider Networks • Medical Management • Provider Representative • Member Representative (1-2 Members)

Subcommittee Meeting	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

7.1.1.8 Pharmacy & Therapeutics – CQI Subcommittee

Purpose	The Pharmacy and Therapeutics (P&T) Subcommittee's mission is to uniformly, consistently, and equitably provide appropriate drug therapy to meet the clinical needs of Alliance Health Tailored Plan beneficiaries in an effective, efficient, and fiscally responsible manner.
Responsibilities	• Plan and implement pharmacy benefit management programs in partnership with the contracted Pharmacy Benefit Manager (PBM) that promote the safety, effectiveness, and affordability of medications • Develop Drug Utilization Review (DUR) reports and measures that are used to evaluate the effectiveness of pharmacy benefit utilization management programs • Monitor selected DUR reports and metrics to ensure that Alliance Health Plan members are receiving appropriate, safe, and medically necessary prescription, and develop a plan of action to correct deficiencies • Partner with participating network pharmacies willing to provide enhanced services to ensure access to medications for beneficiaries with unmet psychosocial needs • Approve communications with selected prescribers and pharmacists who have been targeted for educational intervention on optimal prescribing, dispensing, or pharmacy care practices • Review pharmacy benefit related grievances and appeals, and recommend actions to address both member and provider concerns • Consider the impact of periodic NC Medicaid Preferred Drug List (PDL) updates on members, collect feedback concerning PDL changes from providers, and make recommendations to the NC Medicaid P&T Committee • Suggest updates to clinical drug coverage policies to the NC Medicaid P&T Committee, in response to recent FDA approved labeling changes, new safety concerns, or current market conditions
Reports To	CQI

Subcommittee Chair	• Deputy Chief Medical Officer (co-chair)
Subcommittee Composition	Subcommittee members include, Alliance Health Plan Medical Management Team staff, and at least one practicing physician and one practicing pharmacist from Alliance's provider network. Members are appointed annually by the Deputy Chief Medical Officer who serves as the P&T Chairperson. The Alliance Pharmacy Director serves as the meeting organizer.
Subcommittee Meeting	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

Section 8: Quality Activities

8.1 Ensuring Adequate Services for a Diverse Membership

Cultural and linguistic competency and the delivery of such services should be integrated into the overall fabric of service delivery, linked to quality of care, and emphasized in policy, practice, procedures, and resources. In FY2021, Alliance completed a Diversity, Equity, and Inclusion Assessment, with the Barthwell Group, to better understand the organization and develop an action plan to achieve the organizational goal of cultural competence.

Alliance recognizes that becoming culturally competent is an ongoing process in which we gain knowledge about one another and use that knowledge to build trust, break down barriers and improve the quality of care throughout the Network. To that end, providers are required to develop Cultural Competency Plans outlining their work to meet those objectives.

Alliance encourages staff and providers to recognize that culture makes us who we are. Culture not only determines how individuals see the world and each other, but greatly impacts how they experience physical and mental illness. It also shapes the recovery process, affects the types of services that are utilized, impacts diagnosis, influences treatment, and the organization and financing of services. Alliance envisions that the Network includes providers who recognize that there is variation in behaviors, beliefs, and values, as they assess an individual's wellness or illness, and incorporate that awareness in treatment planning with competence and sensitivity.

Language interpretation services are available by telephone or in-person to ensure that Enrollees can communicate with Alliance and Network Providers. Providers and Alliance shall make oral interpretation services available free of charge to each Enrollee. This applies to non-English languages as specified in 42

C.F.R. § 438.10(c)(5). Telecommunication Devices for the Deaf (TDD) must also be made available by providers for persons who have impaired hearing or a communication disorder.

Each year, Alliance surveys members to ask about their experience of care including the cultural competence and sensitivity of the provider network. That data is combined with population-level cultural, ethnic, racial, and linguistic data in the annual Network Adequacy and Accessibility Analysis. This report prioritizes interventions within the context of that information.

If there are issues identified related to the cultural competence of providers from any of our member surveys, the Member Experience and the Health Equity subcommittees, of the Continuous Quality Improvement Committee, collaborate with operational leaders, to draft a plan addressing those issues, and reports quarterly to the full CQI committee on the progress of those interventions.

Further, Alliance is committed to understanding disparities through stratifying data by age groups, race, ethnicity, gender, primary language, LTSS needs status, disability status, Transition to Community Living (TCL) involvement, geography, and service region. This allows Alliance to identify disparities in these areas and adjust service delivery to promote equity.

8.2 Member Grievance Response

A grievance is an expression of dissatisfaction about any matter other than decisions regarding requests for Medicaid services. Alliance's goal is to use a fair, impartial and consistent process for receiving, investigating, resolving and managing grievances filed by members or their legal guardians/representatives concerning Alliance staff or Network Providers.

Examples of a grievance may include but are not limited to, grievances about quality of care, failure of the provider or Alliance to follow Client Rights Rules; failure of providers to provide services in the member's Personal Care Plan (PCP) or Individual Support Plan (ISP) , including emergency services noted in the crisis plan, and interpersonal issues, such as, being treated rudely. Members, or a network provider authorized in writing to act on behalf of a member, may file a grievance.

The QM Department's Grievance Team is responsible for processing grievances submitted from within and outside Alliance. Grievances first are designated as Medicaid-related or non-Medicaid- related, depending on member eligibility.

Medicaid: QM staff will notify, in writing, by U.S. mail, the complainant within five (5) working days of receiving the grievance to acknowledge receipt of the grievance and communicate whether the grievance will be initially addressed informally or by conducting an investigation. Alliance's initial response to a grievance shall be to attempt to resolve the issue through informal dialogue and to reach agreement between the parties.

Alliance will seek to resolve grievances expeditiously and provide written notice, by U.S. mail, to all affected parties no later than thirty (30) calendar days of the date Alliance received the grievance.

Alliance may extend the timeframe by up to fourteen (14) calendar days, if the client requests extension or there is a need for additional information and the delay is in the best interest of the client.

Non-Medicaid: QM staff will notify, in writing, by U.S. mail, the complainant within five (5) working days of receiving the grievance regarding whether the grievance will be initially addressed informally or by

conducting an investigation. Alliance's initial response to a grievance shall be to attempt to resolve the issue through informal dialogue and to reach agreement between the parties. Alliance will seek to resolve grievances expeditiously and provide written notice, by U.S. mail, to all affected parties no later than fifteen (15) calendar days of the date Alliance received the grievance. If the grievance is not resolved within fifteen (15) calendar days, then QM staff will send a letter to the complainant updating progress on the grievance resolution and the anticipated resolution date.

8.3 Management of Critical Incidents

Providers must implement procedures that ensure the review, investigation, and follow up for each incident that occurs through the providers' internal quality management process. This includes:

- A review of all incidents on an ongoing basis to monitor for trends and patterns
- Strategies aimed at the reduction/elimination of trends/patterns
- Documentation of the efforts toward improvement, as well as an evaluation of ongoing progress
- Internal root cause analyses on any deaths that occur
- Mandatory reporting requirements are followed
- Entering Level II and III incidents into the State's Incident Response Improvement System (IRIS)

An incident is an event at a facility or in a service/support that is likely to lead to adverse effects upon a member. Incidents are classified into several categories according to the severity of the incident. All Category A and B Providers, serving members in the Alliance catchment area, are required to report Level II or Level III incidents in the State's web-based Incident Response Improvement System (IRIS) within seventy-two (72) hours of the incident. All crisis providers are required to report incidents that occur during the provision of crisis services.

The QM Department's Incidents Team is responsible for tracking incident reporting by network providers. The goal is a uniform and consistent approach for the monitoring of and response to incidents which are not consistent with the routine operations of a facility or service, or the routine care of a client enrolled in the Alliance network.

Upon receipt via IRIS, QM staff reviews all incidents for completeness, appropriateness of interventions and achievement of short and long term follow up both for the individual member, as well as the provider's service system. If questions/concerns are noted when reviewing the incident report, QM staff will work with the provider to resolve these.

If concerns are raised related to member's care, services, or the provider's response to an incident, a referral to Provider Network Evaluation for an onsite review of the provider may be arranged. If deficiencies are found during the review process, the provider will be required to submit and implement a plan of correction. QM staff will provide technical assistance, as needed, and appropriate to assist the provider to address the areas of deficiency and implement the plan.

8.4 Provider Monitoring

Alliance is required under its state contract to routinely monitor its providers to assure compliance with State and Federal regulations, and patient rights requirements. The QM Department works closely with Provider Monitoring. Most importantly, the QM Department is responsible for recommending a special provider monitoring when QM has found a series of grievances or incidents that raise issues of provider performance or member safety.

8.5 Monitoring Over/Under Utilization

Service over/under utilization may indicate poor quality and potentially inefficient care. To ensure the appropriate provision of services, Alliance implements a program that monitors a broad range of data to determine variations in the use of service across providers and levels of care. The Utility Management Committee, a CQI subcommittee, and Clinical operations leadership are responsible for detecting over and under- utilization, analyze claims (encounter) data, and authorization data to determine utilization patterns. Data analysis will identify the potential need for further review.

The Utilization Management Committee will choose utilization data to monitor for under, over and misutilization, annually. The Committee with follow the steps below to obtain, analyze, and report on the data collected:

- Data will be obtained using medical claims/encounter data, pharmacy data, HEDIS's results or other, as appropriate
- Data will be examined for possible explanation for those areas not meeting the threshold
- The analyzed data not within the threshold will be reviewed by appropriate medical group or practice
- Action will be taken to address the identified problem areas and measure the effectiveness of its interventions

In the event that data analyses identify questionable patterns, Alliance may contact providers to review their medical records in order to identify the reasons particular practice patterns are different from the norm. Although this could be a function of the provider's case mix severity, it could also indicate potential problems that need to be resolved.

Clinical Operations leadership may refer to the Director of Network Evaluation for a focused review or may refer cases to the Office of Compliance and Risk Management for further review. Responses to validated utilization issues include, training and technical assistance, increased monitoring or referral to the Special Investigations unit, if the over-utilization appears to be driven by wasteful practice of fraudulent billing. Alliance also may initiate internal action plans to ensure more appropriate service management by the Clinical Operations Department, if utilization issues are related to poor oversight and care coordination.

8.6 Training and Technical Assistance

Alliance provides timely and reasonable training and technical assistance to providers on a regular basis in the areas of State mandates and initiatives, or as a result of monitoring activities related to services for which the provider has a contract with Alliance. A wide variety of links to web-based resources of

potential interest to the Provider Network can be found on the Alliance website at: https://www.alliancehealthplan.org/providers/provider-learning-presentations/

Training of both internal and external stakeholders is an essential part of Alliance's Quality Program. In particular, the QM, Provider Networks, and Practice Transformation Departments play a significant role in developing training to inform stakeholders and staff of quality processes in general, and processes actively subject to quality improvement activities. Practice transformation provides focused support and training in efforts to prepare providers for value-based contracting.

8.7 Value-Based Contracting (VBC)

Alliance supports value-based contracts (VBC). VBC at Alliance supports quality improvement through incentivizing high performing, high quality providers and practitioners. Alliance has implemented a multitude of value-based contracts that are aligned with the Health Care Payment-Learning Action Network (HCP-LAN) alternative payment model framework. Our VBCs cover inpatient, community-based, and residential services. Partnering with our network providers to align payment to provider performance and member outcomes is essential to improving quality of care. This work is assisting both Alliance and providers to be prepared to operate under a system that prioritizes measurement-based care where enhanced reimbursements are tied to successfully meeting quality and performance benchmarks.

Appendix A: FY2022 QM EVALUATION

FY 2022 Quality Management Program Evaluation

QMC Approved: 11/3/2022

Contents

Introduction

Alliance is committed to providing quality and effective care to individuals in Wake, Durham, Cumberland and Johnston Counties. Alliance uses a data-driven continuous quality improvement approach to support internal efforts and the efforts of the Department of Health and Human Resources (DHHR) to improve member outcomes.

The purpose of this Quality Management Evaluation Report is to review Alliance Health's progress at implementing the quality management activities specified within the annual Quality Program Description and Annual Workplan for FY2022 (7/1/2021-6/30/2022). This report also identifies opportunities for improvement and informs future quality management strategies.

The Quality Management (QM) Program Evaluation which includes the following elements:

- Description of QM Program and Structure
- Description of Continuous Quality Improvement (CQI) Committee and Subcommittees
- QM Program Goals and Objectives
- Major Program Accomplishments
- Summary of Quality Improvement Activities including:
    - Goal of activity
    - Interventions/Actions taken
    - Measures trended over time
    - Quantitative and qualitative analyses including barrier analysis
    - Recommendations to continue or discontinue
- Additional Quality Improvement Efforts
- Conclusion that includes a summary of effectiveness addressing:
    - Adequacy of program resources
    - Quality Committee and Subcommittee structure
    - Practitioner participation and leadership involvement
    - Recommendations regarding structure or changes necessary to improve performance

Section 1. QM Program and Structure

The Alliance quality program involves all the agency's stakeholders. Leadership is provided by the Alliance Board of Directors and its Quality Management Committee (QMC). Within Alliance, the Continuous Quality Improvement Committee and its six subcommittees are responsible for quality. Provider and member representatives participate at the board, agency, and project level. Finally, all Alliance staff are responsible for continuous quality improvement.

1.1 QM Department

As of June 30, 2022, the Alliance QM Department consisted of the Senior Vice President of Quality Management who oversaw five teams:

- **Grievance, Incidents, and Appeals**: This team promotes quality assurance within Alliance and the Alliance provider network; develops reports for Alliance management, committees and the State; investigates and resolves incidents and complaints reported by members, providers, Alliance staff and others. In the last year this team has also taken on the responsibility of processing appeal requests from members. Staffing consists of a Grievance, Incidents, and Appeals Manager and five staff.

- **Quality Improvement:** This team oversees Quality Improvement Projects (QIPs) and other quality improvement related activities; performs quality reviews to identify opportunities for improvement; conducts in-depth analyses of internal processes and programs. Staffing includes the Quality Improvement Manager, and four staff to manage QIPs.

- **Quality Management Data**: This team was created to focus on the data needs of internal and external stakeholders working on quality projects. This team is responsible for providing guidance on utilizing data for quality tracking and improvement efforts, completion of external quality reporting, and the implementation and interpretation of surveys. Staffing includes the QM Data Manager, and three staff.

- **Accreditation:** This function oversees the pursuit and maintenance of national accreditation and links quality efforts across the organization to accreditation standards and monitors to ensure on-going compliance.

- **Data Science:** This team focuses on using advanced and predictive analytics to identify issues, target solutions, and efficiently improve the health outcomes of our members.

1.2 Additional Internal Resources

All employees at Alliance are responsible for the pursuit of continuous quality improvement. The departments and staff summarized below are central to Alliance's efforts at continuous quality improvement.

1.2.1 Chief Medical Officer

The Alliance Health Chief Medical Officer (CMO) serves as the designated healthcare practitioner overseeing the operations of the Quality Management Program. The CMO

or designee is the Chair of the CQI Committee, providing guidance and oversight for all major quality efforts. The entire Medical Team provides clinical oversight, guidance and consultation for all Managed Care Organization (MCO) functions including: Utilization Management, Care Coordination, Call Center, Network Management and Quality Improvement.

1.2.2 Provider Network Development and Evaluation Department

The Provider Network Development and Evaluation Team is responsible for the promotion of high-quality and evidence-based services and supports. The team provides continuous review and evaluation of the provider network for quality of services, adherence to contract requirements, and standards of care and performance, while ensuring that a full array of providers are available to meet the needs of those in need of services. This team also works to:

- Develop and maintain the provider network with a sufficient number, mix and geographic distribution of providers to ensure availability of easy access, quality care and cost-effective services for consumers
- Host a variety of provider collaboratives aimed at sharing best practices within service-specific groups
- Support the Credentialing Committee to ensure that all providers and practitioners meet requirements to participate in the Alliance provider network

1.2.3 Care Management Department

The Care Management Team links individuals and families with special health care needs to services and supports in an effort to maximize potential outcomes, decrease the unnecessary use of emergency services and ensure quality care. This team:

- Manages Complex Case Management and Long-Term Services and Supports (LTSS) programs
- Supports inpatient and crisis providers with connections to treatment and other resources in the community
- Monitors member's wellbeing to ensure that care is delivered in a safe and effective manner that respects the member's rights

1.2.4 Utilization Management Department

The Utilization Management Team ensures that services are medically necessary and monitors consumer treatment to ensure that services are delivered based on consumer need and established clinical guidelines.

1.2.5 Community Health and Well Being Department

The Community Health and Well Being Team focuses on promoting quality partnerships and collaborative change, and redesigning systems of care to improve health outcomes and promote healthy communities. The team works to improve quality of life for all the people we serve by helping them understand their health care better and giving them tools and resources to actively engage in their care.

As part of Community Health and Well-being Team, the Community and Member Engagement Team works to ensure that the voices of individuals and families are heard

and integrated at all levels at Alliance, seeking to empower them through education and exposure to resources.

This department is staffed entirely by people with lived experience. This team:

- Champions health literacy efforts aimed and ensuring that members and their families can understand and direct their treatment
- Supports the Consumer Family Advisory Councils (CFAC) in advising the Alliance administration and Board of Directors
- Leverages partnerships to increase access to permanent and temporary housing for the people we serve
- Leads stigma reduction and mental health first aid campaigns in our communities

1.2.6 Access and Information Department

The Access and Information Team maintains the 24/7 Access and Information Line to ensure that individuals receive timely access to needed mental health (MH), intellectual and developmental disability (I/DD), and substance abuse services (SAS). The team provides information about services and resources available within the community and assistance to anyone requesting information about Alliance.

1.2.7 Compliance and Risk Management Department

The Compliance and Risk Management Team, at Alliance, assists the organization in making appropriate business decisions that comply with the law, working to prevent, detect and correct instances of legal and ethical violations and mitigate risk throughout the organization. The team provides compliance training to Alliance employees and members of the Provider Network, oversees policies and procedures and the code of ethics and conduct, conducts internal audits and investigations, and oversees program integrity activities such as fraud and abuse investigations.

Section 2: Quality Committee and Subcommittees

The Alliance Quality Committee structure is headed by the full Board of Directors, which has directed the Quality Management Committee to provide guidance for the quality program. A visual of the committee structure is below:

2.1 Quality Management Committee (QMC)

The Alliance Quality Management Committee (QMC) serves as the authority for approving the annual Quality Management Plan and conducts an evaluation of the Quality Management Program each fiscal year. QMC has the sole authority to open and close formal Quality Improvement Projects (QIPs) and receives regular status updates for all active QIPs. This group identifies actions that are needed to improve quality and ensures that follow-up occurs to realize the planned improvement. QMC reviews statistical data and provider monitoring reports to make recommendations to the Board of Directors and other Board Committees regarding policy decisions. The goal of the QMC is to ensure quality and effectiveness of services and to identify and address opportunities to improve Alliance operations and local service system with input from members, providers, family members, and other stakeholders.

Membership for this committee includes board members, two consumers or their family members, and two non-voting provider representatives.

2.1.2 Continuous Quality Improvement Committee (CQI)

Purpose	The CQI Committee is responsible for the implementation the Alliance Quality Program and Work Plan, monitoring of quality improvement goals and activities and identifying opportunities for improvement within the provider network and Alliance operations. The committee reviews organizational performance in order to prioritize solutions and make recommendations to the Quality Management Committee, of the Board, for additional review, feedback, recommendations and approval. In order to complete these tasks, six cross functional subcommittees exist to support these efforts. The subcommittees are described in tables below.
Responsibilities	• Implementing the Alliance Quality Plan • Monitoring of quality improvement goals and activities • Identifying opportunities for improvement within the provider network and Alliance operations • Monitoring performance regarding key quality indicators of Alliance internal and external functional areas including over/under utilization, member outcomes, network performance, etc.
Reports to	Quality Management Committee, of the Board
Committee Chair	• Chief Medical Officer (co-chair) • Senior Vice President of Quality Management (co-chair)
Committee Composition	Operations: • Chief Operating Officer • Senior VP- Community Health and Well Being • Senior Vice President – Population Health and Care Management

	Subcommittee Chairs: • Care Management Subcommittee • Utilization Management Subcommittee • Member Experience Subcommittee • Provider Quality Subcommittee • Social Determinates of Health Subcommittee • Delegation and Accreditation Oversight Subcommittee • Health Equity Subcommittee
Committee Meetings	The committee shall meet as often as its members deem necessary to perform the committee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

2.1.1.1 Utilization Management – CQI Subcommittee

Purpose	The purpose of the Utilization Management Subcommittee is to ensure that consumers have appropriate access to and utilization of behavioral health services. This subcommittee evaluates the utilization of services with the goal of ensuring that each enrollee receives the correct services, in the right amount and in the most appropriate time frames to achieve the best outcomes. This is a collaborative, dynamic process, by which, over or under utilization of services can be detected, monitored and corrected. The subcommittee serves as a vehicle to communicate and coordinate quality improvement efforts to and with CQI.
Responsibilities	• Monitoring for over/under utilization of services • Identify utilization drivers and trends • Address inappropriate utilization patterns • Review and make recommendations to improve basic processes
Reports To	CQI
Subcommittee Chair	• Chief Medical Officer (co-chair) • Senior Director of Utilization Management (co-chair)
Subcommittee Composition	• Finance • Provider Networks • Care Management • Quality Management

Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than fourtimes per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

2.1.1.2 Provider Quality – CQI Subcommittee

Purpose	The purpose of the Provider Quality Subcommittee is threefold: • To engage Alliance providers in developing, evaluating and approving guidelines for clinical practice across the network • To engage Alliance providers in the systematic monitoring and evaluation of provider performance measures, required by NCDHHS and included in Alliance provider contracts • To provide a forum for bi-directional communication between Clinical and Medical leadership in the provider network and Alliance It also provides a mechanism for provider input, feedback, and recommendations. The Provider Quality Subcommittee will draw upon published research, national guidelines, and local expertise to develop guidelines to support clinical decision-making by providers across the network. Furthermore, through identifying and monitoring performance measures, the committee will identify areas of opportunity to improve processes, identify interventions, and improve member outcomes.
Responsibilities	• Help develop, review, and approve clinical guidelines • Review data and other relevant information related to the provider network and make recommendations for improvement • Review and address industry and local trends and issues • Identify solutions to fill clinical and network needs and gaps • Identify and measure quality metrics that support evaluation of health and functional outcomes for members, access to mental health and substance use services, and effectiveness of mental health and substance services delivered by Alliance providers • Provide ongoing monitoring of identified performance measures to be compared against established benchmarks
Reports To	CQI
Subcommittee Chair	• Director of Network Evaluation (co-chair) • Chief Medical Officer or designee (co-chair)

Subcommittee Composition	• Ten Clinical subject matter experts from Mental Health (MH)/Substance Use Disorder (SUD) and Intellectual/Developmental Disability (I/DD) • Alliance pharmacist *Membership on this subcommittee, outside of the chairs, is entirely made up of providers representatives and network clinicians. Providers on this subcommittee represent a cross section of different service types, settings, and geographic locations within Alliance's catchment area.
Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than fourtimes per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

2.1.1.3 Social Drivers of Health – CQI Subcommittee

Purpose	The purpose of the Social Drivers of Health Subcommittee is to ensure the environmental conditions impacting members are addressed, and to make recommendations about aligning Social Determinates of Health (SDOH) efforts with care management and network providers. This subcommittee reviewed SDOH assessments and interventions to align efforts across the system, so they can be most effective.
Responsibilities	• Assessing the social determinates of health needs of our members • Aligning resources and efforts within Alliance and across the provider network to help meet the Social Determinates of Health needs of our members • Determining impact of Social Determinates of Health interventions on the overall health and wellbeing of members
Reports To	CQI
Subcommittee Chair	• Senior Director of Clinical Innovation (Chair)
Subcommittee Composition	• Community Health and Wellbeing • Care Management • Quality Management • Medical Management
Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than fourtimes per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

2.1.1.4 Care Management – CQI Subcommittee

Purpose	The purpose of the Care Management Subcommittee is to align care management resources to improve the efficacy of the care delivery network and optimize member outcomes. This subcommittee assists in defining and monitoring the quality of care management services being delivered.
Responsibilities	• Monitor impact and effectiveness of Care Management efforts and identify improvement opportunities • Create framework for evaluating outcomes and functions of internal and external Care Management efforts including Care Management Agencies (CMA) and Advance Medical Home + (AMH+). • Monitor the relationship between Care Management and service providers to ensure members receive the care they need in a timely and appropriate manner
Reports To	CQI
Subcommittee Chair	• Senior Vice President of Population Health and Care Management (Chair)
Subcommittee Composition	• Senior Vice President of Population Health and Care Management (Chair) • Senior Director of Care Management Operations • Director of Physical Healthcare Management • Provider Networks • Care Management • Medical Management • Pharmacy • Quality Management
Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

2.1.1.5 Member Experience – CQI Subcommittee

Purpose	The purpose of the Member Experience Subcommittee is to monitor data related to the member experience of care, identify trends, and suggest any necessary remediation steps, when necessary. Member satisfaction surveys, grievances, appeals, critical incidents, and other member experience data are all reviewed by this subcommittee.

Responsibilities	• Review grievances, critical incidents, appeals, member surveys, mystery shopper experiences, executive walkthrough findings, etc. • Make recommendations about efforts related to improving the experience of our members with Alliance and with network providers • Ensures that member experience is considered central to the definition of quality at Alliance • Direct QIPs that have been assigned to this subcommittee by the full CQI committee
Reports To	CQI
Subcommittee Chair	• Quality Management Specialist (Chair)
Subcommittee Composition	• Senior Director of Access • Provider Networks • Quality Management • Care Management • Community Health and Wellbeing • Medical Management • Member Representative • Provider Representative
Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

2.1.1.6 Delegation & Accreditation Oversight – CQI Subcommittee

Purpose	The purpose of the Delegation and Accreditation Oversight Subcommittee is to ensure that accreditation and any delegated functions are completed successfully. This subcommittee provides a central body that monitors adherence to accreditation standards and ensures that any delegated functions receive appropriate oversight and monitoring.
Responsibilities	• Centralized monitoring of accreditation efforts • Ensure that any delegated functions are done according to requirements • Evaluate impact of delegated functions on providers and members
Reports To	CQI
Subcommittee Chair	• Chief Compliance Officer
Subcommittee Composition	• Corporate Compliance • Quality Management • Provider Networks • Access Call Center • Utilization Management
Subcommittee Meetings	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

2.1.1.7 Health Equity – CQI Subcommittee

Purpose	The Health Equity Subcommittee is a centralized place to promote the elimination of health disparities, and the achievement of health equity for all members and recipients, by monitoring outcome gaps between populations, and ensuring that potential improvement efforts do not exacerbate disparities.
Responsibilities	The Health Equity Subcommittee will aide in aligning resources and efforts within Alliance and across the provider network to help meet the health equity needs of our members by: • Assessing the health equity needs of our members • Determining impact of interventions on the overall health and wellbeing of members • Directing QIPs that have been assigned to this subcommittee by the full CQI committee • Monitoring Provider Culturally Competent Plan

Reports To	CQI
Subcommittee Chair	• Quality Improvement Specialist, Quality Management (Chair)
Subcommittee Composition	• Quality Management • Community Health and Wellbeing • Organizational Effectiveness • Provider Networks • Medical Management • Provider Representative • Member Representative (1-2 Members)
Subcommittee Meeting	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

2.1.1.8 Pharmacy & Therapeutics – CQI Subcommittee

Purpose	The Pharmacy and Therapeutics (P&T) Subcommittee's mission is to uniformly, consistently, and equitably provide appropriate drug therapy to meet the clinical needs of Alliance Health Tailored Plan beneficiaries in an effective, efficient, and fiscally responsible manner.
Responsibilities	• Plan and implement pharmacy benefit management programs in partnership with the contracted Pharmacy Benefit Manager (PBM) that promote the safety, effectiveness, and affordability of medications • Develop Drug Utilization Review (DUR) reports and measures that are used to evaluate the effectiveness of pharmacy benefit utilization management programs • Monitor selected DUR reports and metrics to ensure that Alliance Health Plan members are receiving appropriate, safe, and medically necessary prescription, and develop a plan of action to correct deficiencies • Partner with participating network pharmacies willing to provide enhanced services to ensure access to medications for beneficiaries with unmet psychosocial needs • Approve communications with selected prescribers and pharmacists who have been targeted for educational intervention on optimal prescribing, dispensing, or pharmacy care practices

	• Review pharmacy benefit related grievances and appeals, and recommend actions to address both member and provider concerns • Consider the impact of periodic NC Medicaid Preferred Drug List (PDL) updates on members, collect feedback concerning PDL changes from providers, and make recommendations to the NC Medicaid P&T Committee • Suggest updates to clinical drug coverage policies to the NC Medicaid P&T Committee, in response to recent FDA approved labeling changes, new safety concerns, or current market conditions
Reports To	CQI
Subcommittee Chair	• Deputy Chief Medical Officer (co-chair)
Subcommittee Composition	Subcommittee members include, Alliance Health Plan Medical Management Team staff, and at least one practicing physician and one practicing pharmacist from Alliance's provider network. Members are appointed annually by the Deputy Chief Medical Officer who serves as the P&T Chairperson. The Alliance Pharmacy Director serves as the meeting organizer.
Subcommittee Meeting	The Chair of the subcommittee will establish the agenda for each subcommittee meeting. The subcommittee shall meet as often as its members deem necessary to perform the subcommittee's responsibilities, but no less frequently than four times per year, and such meetings may be by telephone or video conference. A majority (over 50%) of members represents a voting quorum.

Section 3: QM Program Goals and Objectives

The Quality Management Program plays a major role in ensuring Alliance is successful at meeting performance outcomes and contract requirements. The broad goals listed below are of particular focus to the QM staff and organization-wide QM activities:

- Ensure individual members receive services that are appropriate and timely
- Use evidence-based treatments that result in measurable clinical outcomes
- Ensure Alliance focuses on health and safety of members, protection of rights, and to monitor and continually improve the provider network

- Empower members and families to set their own priorities, take reasonable risks and participate in system management, and to shape the system through their choices of services and providers
- Build local partnerships with individual who depend on the system for services and supports, with community stakeholders, and with the providers of services
- Demonstrate an interactive, mutually supportive, and collaborative partnership between the State agencies and Alliance in the implementation of public policy at the local level and realization of the State's goals of healthcare change.

Specifically, the priority performance goals for FY2022 are summarized below:

Quality Effort	Summary of Measure	Target
Follow-Up after Mental Health Discharges (Uninsured)	The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.	40%
Follow-Up after Substance Use Discharges (Uninsured)	The percentage of discharges for individuals ages 3 through 64 who were admitted for substance use disorder treatment that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.	40%
Follow-Up after Substance Use Discharges (Medicaid)	The percentage of discharges for individuals ages 3 through 64 who were admitted for substance use disorder treatment that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.	40%
Diabetes Screening for People Using Antipsychotic Medications	The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	77%
Metabolic Monitoring for Youth on Antipsychotics	The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.	31%
Transition to Community Living Initiative (TCLI) Primary Care Visits	To increase the rate of confirmed primary care provider appointments with members in the TCLI housing transition and residency cohort.	80%
Expand CQI Subcommittee	To establish a Health Equity and a Pharmacy and Therapeutics committee to oversee quality and prepare for Tailored Plan.	By 1/1/2022

Healthcare Effectiveness Data and Information Set (HEDIS) Vendor	To engage in a contractual relationship with an NCQA-Certified HEDIS Vendor to allow access to reliable and validated data.	1/1/2022
Add New Counties	To add Mecklenburg and Orange County members, practitioners, and providers to Alliance while maintaining access and adequacy.	6/30/2022
Tailored Plan Preparation Efforts	To meet all stages of Tailored Plan readiness while maintaining the same standards throughout FY2022.	6/30/2022
National Committee for Quality Assurance (NCQA) Health Plan Accreditation	To successfully implement Tailored Plan meeting NCQA Health Plan Accreditation standards.	6/30/2022

Section 4: Major Organizational Quality and Performance Accomplishments

4.1 Began Serving Mecklenburg & Orange Counties

December 1, 2021, Alliance Health began serving members and recipients in Mecklenburg and Orange counties. This increased membership by approximately 50%. Leading up to this transition, Alliance increased our provider network, internal work force across organization, and increased member and provider education efforts. While this timeline was significantly shorter than initially anticipated, the transition occurred relatively smoothly for members and providers. Alliance has increased physical presence and county relationships in these counties as well, to ascertain and address gaps.

4.2 Tailored Plan (TP) Readiness

Alliance has successfully been awarded a Tailored Plan contract. Alliance has implemented a TP readiness project plan to successfully meet the post-contract deliverables contractually required. We are currently on target to meet these goals and go live as a Tailored Plan and support the Medicaid Direct population 12/1/2022.

4.3 Additional CQI Subcommittees

Alliance established two new CQI Subcommittees – Pharmacy & Therapeutics and Health Equity Council. These committees fill a gap in our quality reviews as we prepare to address whole person care including physical and pharmaceutical services for our members and recipients.

4.4 External Quality Review

All of Alliance's Quality Improvement Projects scored at the "high confidence" range during our annual External Quality Review (EQR). Alliance passed EQR with a score of 100%.

4.5 Innovations and Traumatic Brain Injury (TBI) Waiver Measures

Alliance continues to exceed all State required performance measures for the Innovations Waiver. Alliance also exceeded the performance measure for 6 out of 7 applicable performance measures for the TBI Waiver.

4.6 Expanded Value-Based Contracts (VBCs)

Alliance expanded the types and number of providers reimbursed under value-based contracts. We also added variety of value-based contracts offered to support additional quality initiatives in preparation for Tailored Plan.

Section 5: Quality Improvement Activities

Each of the Quality Improvement Activities below is a high-level summary of the full project which is detailed extensively in the full Quality Improvement Activity Report.

5.1 Follow-Up after Mental Health Discharges (Uninsured)

5.1.1 Activity Goal

Increase percentage of uninsured member discharges for individuals ages 3 through 64, who were admitted for mental health treatment in a community-based hospital, state psychiatric hospital, or facility-based crisis service that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge to at least 40%.

5.1.2 Activity Interventions and Barriers

Intervention	Barrier(s)
Provider Education ❖ Reorganization of the Provider Network Development (PND) Team to approach various areas of the Provider Network (PN) operation (PN Operations, PN Relations, and PN Development). ❖ An assessment of provider capacity communications by the Care Management Team is in the process of review by the Provider Networks Team. ❖ PND Team is exploring the interventions and action items which would effectively apply towards the expansion into Mecklenburg and Orange Counties. ❖ On May 2nd hospital liaisons transitioned to onsite duties which will assist with bridging communications and services with providers and with members.	❖ Provider's lack of awareness of performance towards measures. ❖ Inconsistency in accurate, timely, and actionable personal data documented at the point of individual intake and discharge.
Social Drivers of Health ❖ Care Management reorganization (with a focus on the Administrative Care Coordinators contacting members discharged, assisting with barriers, and improving timely member aftercare appointments) continues to serve as an effective campaign. ❖ With the deployment of various action items over the launch period of the QIP, a measure of effectiveness is in	❖ Telehealth challenges faced by members who do not have access to equipment that will allow follow-up care through telephonic or computer/internet accessibility. ❖ COVID-19 related open-access limitations and/or suspensions of providers services.

Intervention	Barrier(s)
progress to determine the future approach towards the QIP deliverables. ❖ More information concerning the individuals that we serve in Mecklenburg and Orange Counties is expected soon.	
Value Based Incentives/Assertive Engagement ❖ Value-based incentives are reviewed in quarterly increments. The second measurement period is to confirm progress of the campaign and to determine monetary payments for performance was completed. ❖ Meetings between Duke and Freedom House held to further strengthen communications and to further streamline the Peer Bridger Program. ❖ One Care Cumberland claims process was reviewed to determine discrepancies with claims submissions. ❖ Communications concerning the extension of the Tailored Plan launch may affect the provider Scope of Work (SOW) updates and momentum of additional value-based initiatives.	❖ Lack of significant provider incentives to ensure appropriate member post-discharge follow-up. ❖ Lack of scheduling flexibilities or methods for referring individuals to alternate providers are used to prioritize individuals receiving timely follow-up.

5.1.3 Activity Measure

Measures trended over time[5]

Goal	J	A	S	O	N	D	J	F	M	A	M	J
40%	34.6%	38.1%	37.2%	**41.0%**	37.6%	24.4%	*	*	*	*	*	*

*Data collection for this project includes a delay to account for claims lag, some months do not yet have final data. Red indicates goal not met.

5.1.4 Activity Quantitative and Qualitative Analyses

- Alliance has validated data for Q1 and Q2 at this time.
- During the month of December 2021, there was a marked decrease in performance. This is a 14.3 point decrease in performance. It is important to note that Alliance began serving Mecklenburg and Orange Counties in December 2021. Prior to this

[5] Data from Super Measures Dashboard – July 2022

transition, these counties were served by an MCO with scores lower than Alliance historically.

- The number of members in the population increased from November (n=186) to December (n=225) 2021. This is due to the additional population associated with the merge of Mecklenburg and Orange Counties into our catchment area.
- Alliance exceeded the target of 40% in the month of October 2021.
- Alliance implemented new Care Management processes and additional provider value-based contracting in Q4 of FY2021. These efforts appear to have kicked off an upward trend through October 2022.

5.1.5 Activity Recommendations

Our recommendation is to continue this project and to monitor existing interventions for impact in the upcoming reported data and to refine the interventions as needed to ensure progress towards the goal. Alliance will continue to monitor for impact of Tailored Plan go-live and adjust interventions as appropriate.

5.2 Follow-Up after Substance Use Discharges (Uninsured)

5.2.1 Activity Goal

Increase the percentage of Medicaid member discharges for individuals ages 3 through 64, who were admitted for substance use disorder treatment in a community-based hospital, state psychiatric hospital,state Alcohol and Drug Abuse Treatment Center (ADATC), or detox/facility-based crisis service, that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge to at least 40%.

5.2.2 Activity Interventions and Barriers

Intervention	Barrier(s)
Provider Education ❖ Reorganization of the PND Team to approach various areas of the PN operation (PN Operations, PN Relations, and PN Development). ❖ An assessment of provider capacity communications by the Care Management Team is in the process of review by the Provider Networks Team. ❖ The PND Team is exploring the interventions and action items which would effectively apply towards the expansion into Mecklenburg and Orange Counties. ❖ On May 2nd hospital liaisons transitioned to onsite duties which will assist with bridging communications	❖ Provider's lack of awareness of performance towards measures. ❖ Inconsistency in accurate, timely, and actionable personal data documented at the point of individual intake and discharge.

Intervention	Barrier(s)
and services with providers and with members.	
Social Drivers of Health ❖ Care Management reorganization (with a focus on the Administrative Care Coordinators contacting members discharged, assisting with barriers, and improving timely member aftercare appointments) continues to serve as an effective campaign. ❖ With the deployment of various action items over the launch period of the QIP, a measure of effectiveness is in progress to determine the future approach towards the QIP deliverables. ❖ More information concerning the individuals that we serve in Mecklenburg and Orange Counties is expected soon.	❖ Telehealth challenges faced by members who do not have access to equipment that will allow follow-up care through telephonic or computer/internet accessibility. ❖ COVID-19 related open-access limitations and/or suspensions of providers services.
Value Based Incentives/Assertive Engagement ❖ Value-based incentives that are reviewed in quarterly increments second measurement period to (confirm progress of the campaign and to determine monetary payments for performance) was completed. ❖ Meetings between Duke and Freedom House held to further strengthen communications and to further streamline the Peer Bridger Program. ❖ One Care Cumberland claims process was reviewed to determine discrepancies with claims submissions. ❖ Communications concerning the extension of the Tailored Plan launch may affect the provider SOW updates and momentum of additional value-based initiatives.	❖ Lack of significant provider incentives to ensure appropriate member post-discharge follow-up. ❖ Lack of scheduling flexibilities or methods for referring individuals to alternate providers are used to prioritize individuals receiving timely follow-up.

5.2.3 Activity Measures

Measures trended over time[6]

Goal	J	A	S	O	N	D	J	F	M	A	M	J
40%	38.8%	39.3%	33.6%	32.7%	27.1%	21.5%	*	*	*	*	*	*

*Data collection for this project includes a delay to account for claims lag, some months do not yet have final data. Red indicates goal not met.

5.2.4 Activity Quantitative and Qualitative Analyses

- Alliance has validated data for Q1 and Q2 at this time.
- During the month of December 2021, there was a marked decrease in performance. This is a 5.6 point decrease in performance. It is important to note that Alliance began serving Mecklenburg and Orange Counties in December 2021. Prior to this transition, these counties were served by an MCO with scores lower than Alliance historically.
- The number of members in the population increased from November (n=129) to December (n=144) 2021. This is due to the additional population associated with the merge of Mecklenburg and Orange Counties into our catchment area.
- Alliance has not met or exceeded the goal of 40% during the months in which we have validated data.
- Alliance implemented new Care Management processes and additional provider value-based contracting in Q4 of FY2021. These efforts appear to have kicked off an upward trend through August 2022.

5.2.5 Activity Recommendations

Our recommendation is to continue this project and to monitor existing interventions for impact in the upcoming reported data and to refine the interventions as needed to ensure progress towards the goal. Alliance will continue to monitor for impact of Tailored Plan go-live and adjust interventions as appropriate.

5.3 Follow-Up after Substance Use Discharges (Medicaid)

5.3.1 Activity Goal

Increase the percentage of Medicaid member discharges for individuals ages 3 through 64, who were admitted for substance use disorder treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility-based crisis service, that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge to at least 40%.

[6] Performance Standards Dashboard – July 2022

5.3.2 Activity Interventions and Barriers

Intervention	Barrier(s)
Provider Education ❖ Reorganization of the PND Team to approach various areas of the Provider Network (PN) operation (PN Operations, PN Relations, and PN Development). ❖ An assessment of provider capacity communications by the Care Management Team is in the process of review by the Provider Networks Team. ❖ The team is exploring the interventions and action items which would effectively apply towards the expansion into Mecklenburg and Orange Counties. ❖ On May 2nd hospital liaisons transitioned to onsite duties which will assist with bridging communications and services with providers and with members.	❖ Provider's lack of awareness of performance towards measures. ❖ Inconsistency in accurate, timely, and actionable personal data documented at the point of individual intake and discharge.
Social Drivers of Health ❖ Care Management reorganization (with a focus on the Administrative Care Coordinators contacting members discharged, assisting with barriers, and improving timely member aftercare appointments) continues to serve as an effective campaign. ❖ With the deployment of various action items over the launch period of the QIP, a measure of effectiveness is in progress to determine the future approach towards the QIP deliverables ❖ More information concerning the individuals that we serve in Mecklenburg and Orange Counties is expected soon.	❖ Telehealth challenges faced by members who do not have access to equipment that will allow follow-up care through telephonic or computer/internet accessibility. ❖ COVID-19 related open-access limitations and/or suspensions of providers services.
Value Based Incentives/Assertive Engagement ❖ Value-based incentives that are reviewed in quarterly increments second measurement period to	❖ Lack of significant provider incentives to ensure appropriate member post-discharge follow-up.

Intervention	Barrier(s)
(confirm progress of the campaign and to determine monetary payments for performance) was completed. ❖ Meetings between Duke and Freedom House held to further strengthen communications and to further streamline the Peer Bridger Program. ❖ One Care Cumberland claims process was reviewed to determine discrepancies with claims submissions. ❖ Communications concerning the extension of the Tailored Plan launch may affect the Provider SOW updates and momentum of additional value-based initiatives.	❖ Lack of scheduling flexibilities or methods for referring individuals to alternate providers are used to prioritize individuals receiving timely follow-up.

5.3.3 Activity Measures

Measures trended over time[7]

Goal	J	A	S	O	N	D	J	F	M	A	M	J
40%	**50%**	**43.9%**	31.9%	36.1%	*	*	*	*	*	*	*	*

*Data collection for this project includes a delay to account for claims lag, some months do not yet have final data. Red indicates goal not met.

5.3.4 Activity Quantitative and Qualitative Analyses

- Alliance has validated data for Q1 and partial data for Q2.
- During the month of September 2021, there was a marked decrease in performance indicated by a decrease of 12 points. October saw an increase in eligible population compared to previous months. Previous quarter averaged 43 members/month. October reflects 61 members.
- Alliance exceeded the goal in July and August 2021.

5.3.5 Activity Recommendations

Our recommendation is to discontinue the formalized QIP but continue to track and trend these outcomes. Discontinuation is in efforts to prioritize Tailored Plan required Performance Improvement Projects (PIPs). The project will be reopened if data continues to support the need for a formalized PIP.

[7] Performance Standards Dashboard – July 2022

5.4 Diabetes Screening for People Using Antipsychotic Medications (SSD)

5.4.1 Activity Goal

Increase the percentage of adult members, 18–64 years of age with Schizophrenia or Bipolar Disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year to at least 77%.

5.4.2 Activity Interventions and Barriers

Intervention	Barrier(s)
Member and Provider Education ❖ The mPulse Mobile project is currently in the implementation phase. An analysis will be conducted in August to assess whether the messages resulted in a metabolic test being conducted. ❖ Clinical Recommendation-This project was initiated in January of 2021. Over the course of the project, the intervention showed steady increases in the percentage of Service Authorization Requests (SARs) that included the appropriate clinical recommendation for metabolic monitoring. The latest results indicated a significant decrease compared to the previous period. There is a continued effort to determine the root cause of this issue.	❖ Members and providers unaware of the need for testing.
Provider Data Sharing ❖ 29 provider HEDIS reports were developed and distributed to providers in the Practice Transformation Cohort in July. ❖ Analysis of the Provider Scorecard Project continues to show minimal percent change in closing the gap in care. Since last July, the percentage for closing the gap continues to range from **3-6** percent for SSD. ❖ Providers are also receiving baseline trend data to assess how well they are progressing towards the measurement goal. ❖ Provider Data Reports – Initial round of reports went through iteration process to increase actionability by providers. Focus	❖ Providers unsure of which members need and/or have received testing.

Intervention	Barrier(s)
is on recent data and members with existing and projected gaps in care.	
Point of Care Testing ❖ Practice transformation staff continue to work with providers regarding the Point of Care (POC) intervention. ❖ Practice transformation staff are working with providers to ensure all expired test strips used for the point of care monitoring devices are replaced/updated.	❖ Members have to go to a separate site for testing instead of being able to do all required functions at the behavioral health provider's office.

5.4.3 Activity Measures

Measures trended over time[8]

Goal	J	A	S	O	N	D	J	F	M	A	M	J
77%	72%	75%	75%	74%	74%	74%	75%	75%	75%	75%	*	*

* Data collection for this project includes a delay to account for claims lag, some months do not yet have final data. Red indicates goal not met.

5.4.4 Activity Quantitative and Qualitative Analyses

- Performance through March 2022 showed a trend of increase of about 2%.
- Discontinued participation from Hope Services. Agency indicated concerns about the high level of efforts in using the POC testing strips and the low level of reimbursements for them.
- 2 of 9 pilot providers have provided claims for the POC testing intervention.
- A few providers have indicated they are continuing to provide telehealth services to members, which limits the opportunity for POC testing.

5.4.5 Activity Recommendations

State benchmarking has not been provided for SSD at this time, so it is unclear if Alliance is currently meeting the benchmarks. Alliance is reprioritizing this QIP to focus resources on State-required Tailored Plan Performance Improvement Projects. It is recommended that the measure continue to be monitored to determine if Tailored Plan implementation improves rates as well.

[8] Performance Standards Dashboard – July 2022

5.5 Metabolic Monitoring for Youth on Antipsychotics (APM)

5.5.1 Activity Goal

Increase the percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year to at least 31%.

5.5.2 Activity Interventions and Barriers

Intervention	Barrier(s)
Member and Provider Education ❖ Continued exploration of assessing how to better bridge the gap in care for members within the APM cohort who are in Department of Social Services (DSS) custody. ❖ The mPulse Mobile Project is currently in the implementation phase. An analysis will be conducted in August to assess whether the messages resulted in a metabolic test being conducted. ❖ Clinical Recommendation- This project was initiated in January of 2021. Over the course of the project, the intervention showed steady increases in the percentage of SARs that included the appropriate clinical recommendation for metabolic monitoring. The latest results indicated a slight decrease from the previous month.	❖ Members and providers unaware of the need for testing.
Provider Data Sharing ❖ 29 provider HEDIS reports were developed and distributed to providers in the Practice Transformation Cohort in July. ❖ Analysis of the Provider Scorecard Project continues to show minimal percent change in closing the gap in care. Since last July, the percentage for closing the gap continues to range from **1-2** percent for APM. ❖ Providers are also receiving baseline trend data to assess how well they are progressing towards the measurement goal. ❖ Provider Data Reports – Initial round of reports went through the iteration process to increase actionability by providers. Focus is on recent data and members with existing and projected gaps in care.	❖ Providers unsure of which members need and/or have received testing.

Intervention	Barrier(s)
Point of Care Testing ❖ Practice transformation staff continue to work with providers regarding the POC intervention. ❖ Practice transformation staff are working with providers to ensure all expired test strips used for the point of care monitoring devices are replaced/updated.	❖ Barriers to going to a separate site for testing instead being able to do all required functions at the behavioral health provider's office.

5.5.3 Activity Measures

Measures trended over time[9]

Goal	J	A	S	O	N	D	J	F	M	A	M	J
32%	31%	33%	34%	34%	34%	33%	33%	33%	33%	33%	*	*

*Data collection for this project includes a delay to account for claims lag, some months do not yet have final data. Red indicates goal not met.

5.5.4 Activity Quantitative and Qualitative Analyses

- Performance has met the goal 11 out of 12 months this fiscal year. July 2021 was the only month where performance goal was not met – July missed the target by 1 percentage point.
- Discontinued participation from Hope Services. Agency indicated concerns about the high level of efforts in using the POC testing strips and the low level of reimbursements for them.
- 2 of 9 pilot providers have provided claims for the POC testing intervention.
- A few providers have indicated they are continuing to provide telehealth services to members, which limits the opportunity for POC testing.

5.5.5 Activity Recommendations

Our recommendation is to close this QIP as the targets have been met. While this QIP will be closed, it will continue to be monitored to ensure progress is not lost.

5.6 Transition to Community Living (TCL) Primary Care Provider (PCP) Visits

5.6.1 Activity Goal

Increase the percentage of confirmed PCP visits for individuals who received a housing slot and/or who have transitioned to housing within 90 days of the measurement period to 80%.

[9] Performance Standards Dashboard – July 2022

5.6.2 Activity Interventions and Barriers

Intervention	Barrier(s)
Member and Provider Bridge: ❖ Members who have transitioned from Mecklenburg catchment area represented nineteen percent of the Tailored Plan eligible members of the assessment. All were reported as not receiving a PCP visit in the measurement period. The measurement, with the exclusion of Mecklenburg County, was seventy seven percent. ❖ Member and provider outreach performed by the Transition to Community Living (TCL) nursing staff (within a period after monthly analysis), to raise awareness towards the need for and importance of a PCP visit, assist with any questions that they may have, as well as to bridge members with a provider. ❖ TCL nursing staff is in attendance of the member transition meeting to further assess member needs. ❖ Alliance staff will document and escalate member concerns, barriers, and engagement. For members who initially refuse PCP consideration, the staff will systematically schedule follow-up contacts to continue to engage and assist them.	❖ Members who experience disparities where a PCP visit is not their primary focus (ex. temporary housing, food, etc.) ❖ Members who do not answer or return outreach calls ❖ Members who are not interested in a PCP visit ❖ Members who are not familiar with phone numbers from Alliance ❖ Members who prefer to use Emergency Department (ED) services as any physical health concerns surface ❖ Members who are hesitant to receive a PCP visit (ex. additional diagnosis, comfort with new physicians, etc.) ❖ Multiple Alliance teams performing communications with members ❖ Physical Health (PH) Provider availability in areas ❖ Member challenges to receive a PCP visit ❖ Covid -19 presence and protocols in relation to member hesitancies ❖ Members in the TCL process that were slotted for housing; but are not engaged in the housing process ❖ Members alternating plans of care ❖ Hesitancy due to the current state of insurance coverage ❖ Member potential inability to meet co-pay requirements for visits
Alliance Staff Awareness: ❖ Adjustments to the Member Assessment approach to further understand consumer PCP contact earlier in the TCL housing process. Implementation of adding PCP information on the Housing Slot Assessment performed by the In-	❖ Integrated care awareness ❖ Standard work for identifying PCP visit needs ❖ Execution of tasks and role clarity of member bridging with PH Providers ❖ Communications, approach, and documentation of PCP information

Intervention	Barrier(s)
Reach, Out-Reach, and Transition Coordinator staff. ❖ Team brainstorming towards the approach to review the potential hypothesis of the presence of barriers (due to dual coverage, no physical health coverage, service reporting and the ability to view/capture information).	❖ Behavioral Health (BH) Provider engagement with bridging members with PH Provider ❖ PCP updates for further member assessments
Provider Communications ❖ Creation of a staff PCP talking point document to assist with the standardization of the approach towards consumers and PCP linkage. ❖ Creation of a nurse outreach tracking tool to document member contact/ non-contact, and findings. ❖ Monthly communication of the PCP confirmation analysis and nurses' findings to staff to further brainstorm approach towards member.	❖ Bridge of gaps between BH and PH Providers ❖ Provider awareness of the importance of PCP visits ❖ Establishing expectations and guidelines towards holistic care before the launch of Tailored Plan. ❖ Provider data base launch to house TCL members' (in housing) information as well as members' doctor visit occurrences.

5.6.3 Activity Measures

Measures trended over time[10]

Goal	J	A	S	O	N	D	J	F	M	A	M	J
80%	NA	71%	83%	84%	78%	76%	62%	64%	61%	73%	78%	79%

* Red indicates goal not met.

5.6.4 Activity Quantitative and Qualitative Analyses

It is important to note that Alliance took on Mecklenburg and Orange Counties in December 2021. In January 2022, there was a distinct decline in performance which appears to be related to the addition of Mecklenburg and Orange County. It is anticipated that rates will start to increase again with the implementation of the TCL

[10] Performance Standards Dashboard – July 2022

Complex Care Management Program and launch of Tailored Plan Care Management as there is a focus on physical health.

5.6.5 Activity Recommendations

It is our recommendation to continue this project into FY2023. It is anticipated that Tailored Plan launch will improve success rates of ensuring members are linked to PCPs.

Section 6: Additional Quality Improvement and Performance Efforts

6.1 Performance Measures[11]

The charts below list performances for all of the Alliance performance measures with State benchmarks. Any measure that does not meet the State benchmark will be highlighted in red and noted as out of compliance. Any measure out of compliance will have a footnote at the end of this section explaining the gap in performance and interventions being taken to address the performance gap. See Appendix A for measure definitions.

[11] Performance Standards Dashboard – July 2022

6.1.1 Call Center Performance

Metric	Goal	J	A	S	O	N	D	J	F	M	A	M	J
Call Abandonment Rate	<5%	1.6%	2.3%	1.6%	2.3%	1.9%	2.0%	1.9%	1.6%	1.2%	1.0%	1.4%	1.4%
Live Answer within 30 seconds	95%	97.6%	96.6%	97.6%	96.9%	97.3%	96.9%	97.2%	97.7%	98.1%	98.2%	98.1%	98.0%

6.1.2 Contract Super Measures[12]

Metric	Goal	J	A	S	O	N	D	J	F	M	A	M	J
Medicaid - Mental Health 7-Day Follow-up	40%	39.4%	48.0%	49.7%	43.3%	35.9%	*	*	*	*	*	*	*
Medicaid - Substance Use 7-Day Follow-up	40%	32.7%	50.0%	43.9%	31.9%	36.1%	*	*	*	*	*	*	*
Medicaid - Innovations Waiver Primary Care	90%	94.0%	93.8%	95.0%	95.0%	95.1%	*	*	*	*	*	*	*
Non-Medicaid - Mental Health 7-Day Follow-up	40%	39.4%	48.0%	49.7%	43.3%	35.9%	*	*	*	*	*	*	*
Non-Medicaid - Substance Use 7-Day Follow-up	40%	34.6%	38.1%	37.2%	41.0%	37.6%	24.4%	*	*	*	*	*	*

*Measure has not yet been reported.

6.1.3 Medicaid Performance Measures[13]

Metric	Goal	J	A	S	O	N	D	J	F	M	A	M	J
Care Coordination Assignment[14]	85%	96.2%	100.0%	90.9%	80.6%	90.0%	92.0%	92.3%	88.4%	80.4%	87.1%	87.5%	88.4%
Authorizations Processed within Timeframes	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Claims Proceed within 30 Days	90%	95.1%	95.3%	95.1%	95.7%	96.9%	95.7%	92.6%	90.7%	88.8%	94.8%	95.0%	96.5%
Resolution of Grievances within 30 Days	90%	90.0%	100.0%	100.0%	100.0%	94.1%	94.7%	92.9%	82.4%	96.6%	94.1%	94.1%	88.9%
Access to Care - Emergent	97%	99%			97%			98%			96%		
Access to Care - Urgent	82%	29%			38%			36%			34%		
Access to Care - Routine	75%	24%			30%			32%			28%		

[12] Performance Standards Dashboard – July 2022

[13] Performance Standards Dashboard – July 2022

[14] Percentage of readmits assigned to Care Coordination – This measure was not met in September (83%) and October (83%). Delays in care coordination were caused by an inpatient hospital's record system being down.

6.1.4 Innovations Waiver Measures[15]

Metric	Goal	FY21 Q3	FY21 Q4	FY22 Q1	FY22 Q2
Members receiving services within 45 days of individual support plan (ISP)[16].	85%	64.3%	81.8%	87.5%	75.0%
Percent of actions taken to protect the beneficiary.	85%	97.6%	92.3%	95.6%	90.0%
Incidents reported within timeframes[17]	85%	79.6%	86.7%	92.2%	85.2%
Percentage of deaths where required Local Management Entity (LME)/Prepaid Inpatient Health Plan (PIHP) follow-up interventions were completed as required.	85%	100.0%	100.0%	100.0%	100.0%
Medication errors resulting in medical treatment.	<15%	0.0%	0.0%	0.0%	0.0%
Beneficiaries who received appropriate medication.	85%	100.0%	100.0%	99.9%	100.0%
Incidents where required LME/PIHP follow-up interventions were completed.	85%	100.0%	100.0%	100.0%	100.0%
Percentage of incidents referred to the Department of Social Services (DSS) or Department of Health Service Regulation (DHSR).	85%	100.0%	100.0%	100.0%	100.0%
Percentage of restrictive interventions resulting in medical treatment.	<15%	0.0%	0.0%	0.0%	0.0%
Level of Care evaluations completed at least annually for enrolled beneficiaries.	85%	99.5%		100.0%	
Level of Care evaluations completed using approved processes and instrument.	85%	99.5%		100.0%	
New Level of Care evaluations completed using approved processes and instrument.	85%	100.0%		91.7%	
Individual Support Plans that address identified health and safety risk factors.	85%	100.0%		100.0%	

[15] Performance Standards Dashboard – July 2022

[16] Proportion of Innovations beneficiaries receiving services within 45 days – This measure was not met for four quarters (63%, 79%, 82%, 79%). Seven members experienced delays due to a lack of direct care staff. Seven members delayed or chose to pursue alternative services. One member did not meet the measure due to a retro ISP start date, however, they received services within 45 days of the indicator entry date.

[17] Percentage of level 2 and 3 incidents reported within require timeframes for Innovations beneficiaries – This measure was not met for Q3 (67%). The majority of late submissions were related to the same provider (same member). During investigation into an unrelated matter, it was discovered that the provider failed to submit incident reports for qualifying events over a several month span. Upon learning of this, the provider immediately addressed the issue, to include submission of incident reports for all identified events; however, these were all submitted outside of the required 72-hour timeframe. The provider also took additional corrective measures, to include termination of all involved staff, and retrained all current staff on incident reporting requirements. Concerns were identified and addressed by Alliance through both incident reporting and grievance processes. The provider agencies responsible for these late reports received a written notification and/or plan of correction in accordance with Alliance Health's actions for late submissions.

Metric	Goal	FY21 Q3	FY21 Q4	FY22 Q1	FY22 Q2
Person Center Plans (PCPs) that are completed in accordance with Division of Medical Assistance (DMA) requirements.	85%	97.2%		98.4%	
New enrollees who have a Level of Care (LOC) prior to receipt of services.	85%	100%			
New licensed providers that meet licensure, certification, and/or other standards.	85%	100.0%			
Providers reviewed according to PIHP monitoring schedule[18].	85%	100.0%			
Providers for whom appropriate remediation has taken place.	85%	100.0%			
Providers that successfully implemented an approved corrective action plan.	85%	100.0%			
Monitored providers wherein all staff completed all mandated training.	85%	90.9%			
ISPs in which the services and supports reflect participant assessed needs and life goals.	85%	100.0%			
Beneficiaries reporting that their ISP has the services that they need.	85%	99.6%			
Individuals for whom an annual plan and/or needed update took place.	85%	100.0%			
Beneficiaries who are receiving services as specified in the ISP[19].	85%	37.5%			
Records that contain a signed Freedom of Choice statement.	85%	99.2%			
Beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	85%	99.6%			
Beneficiaries reporting they have a choice between providers.	85%	99.6%			
Beneficiaries age 21 and older who had a primary care visit during year.	85%	95.6%			

[18] Proportion of providers reviewed according to PIHP monitoring schedule – For the time period 7/1/2019 to 6/30/2020, Alliance Health was scheduled to conduct routine monitoring for 29 Innovations providers. Alliance completed 23 of those having to halt monitoring on March 20, 2020 after the NC DHHS contacted all LME/MCOs asking them to "pause all state and Medicaid audits, settlements and other oversight functions that do not impact consumer health and safety" due to COVID-19. Due to that order, Alliance had to pause six previously scheduled/ongoing monitoring.

[19] Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the Individual Support Plan – 33 new waiver beneficiaries were reviewed for the time period 7/1/2019 to 6/30/2020, and 16 beneficiaries were found to have not received services in the type, scope and frequency listed in the ISP. 27 of the beneficiaries' ISPs started after 1/1/2020 and overall service delivery was likely impacted by COVID-19 precautions, either in refusal of staff, difficulty in recruiting and maintaining staff, or delays in transitions of care.

Metric	Goal	FY21 Q3	FY21 Q4	FY22 Q1	FY22 Q2
Claims paid by the PIHP for Innovations Wavier services authorized in the service plan.	85%	96.9%			

6.1.5 TBI Waiver Measures[20]

Metric	Goal	FY21 Q3	FY21 Q4	FY22 Q1	FY22 Q2
Members receiving services within 45 days of ISP[21].	85%	100%	100%	60%	43%
Percent of actions taken to protect the beneficiary.	85%	100%	100%	N/A	100%
Percentage of incidents referred to DSS or DHSR, as required.	85%	N/A	N/A	N/A	100%
Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.	85%	N/A	N/A	N/A	100%
Medication errors resulting in medical treatment.	<15%	N/A	N/A	N/A	N/A
Beneficiaries who received appropriate medication.	85%	100%	100%	100%	100%
Incidents reported within timeframes.	85%	50%	100%	N/A	100%
Incidents where required LME/PIHP follow-up interventions were completed.	85%	N/A	N/A	N/A	100%
Percentage of restrictive interventions resulting in medical treatment.	<15%	N/A	N/A	N/A	N/A
Percentage of restrictive interventions used after all other possibilities.	85%	N/A	N/A	N/A	N/A
Percentage of restrictive interventions used by trained staff.	85%	N/A	N/A	N/A	N/A
Percentage of restrictive interventions documented according to State policy.	85%	N/A	N/A	N/A	N/A
Level of Care evaluations completed at least annually for enrolled beneficiaries.	85%	100%		100%	
Level of Care evaluations completed using approved processes and instrument.	85%	100%		100%	

[20] Performance Standards Dashboard – July 2022

[21] Proportion of TBI beneficiaries receiving services within 45 days – This measure was not met for three quarters (75%, 63%, 0%). Seven members did not receive services within 45 days of ISP effective date. Three of the six did not meet the measure due to a retro ISP start date. The other four members had extenuating circumstances that our care coordination team was aware of and managing.

Metric	Goal	FY21 Q3	FY21 Q4	FY22 Q1	FY22 Q2
New Level of Care evaluations completed using approved processes and instrument.	85%	100%		100%	
Individual Support Plans that address identified health and safety risk factors.	85%	100%		100%	
PCPs that are completed in accordance with DMA requirements.	85%	100%		100%	
New enrollees who have a LOC prior to receipt of services	85%	100%			
New licensed providers that meet licensure, certification, and/or other standards.	85%	100%			
Providers reviewed according to PIHP monitoring schedule.	85%	100%			
Providers for whom appropriate remediation has taken place.	85%	100%			
Providers that successfully implemented an approved corrective action plan.	85%	N/A			
Monitored providers wherein all staff completed all mandated training.	85%	100%			
ISPs in which the services and supports reflect participant assessed needs and life goals.	85%	100%			
Beneficiaries reporting that their ISP has the services that they need.	85%	100%			
Proportion of PCPs that are completed in accordance with State Medicaid Agency's requirements[22].	85%	94%			
Beneficiaries who are receiving services as specified in the ISP[23].	85%	49%			

[22] Proportion of PCPs that are completed in accordance with State Medicaid Agency's requirements – This measure was not met (79%) because six of twenty-nine beneficiaries either did not have a hand-written care coordinator signature or did not have an annual risk assessment documented in the record per waiver guidelines. Care Coordination made corrections to ensure a physical or electronic signature that meets the documentation standards is entered on each ISP for those identified. Care Coordination moved away from the use of the HRST assessment which can only be produced after the individual is entered into the HRST system (which may occur after ISP development) to the Functional Assessment of Support Needs developed by Alliance and DMH staff to inform ISPs.

[23] Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the Individual Support Plan – This item was not met due to just 13 of 27 members (48%) having received services in type, scope, amount, and frequency as specified. For members on the TBI waiver, Residential Supports were provided at the expected frequency. The members not utilizing supports in the type, scope, amount, and frequency as specified received supports in a private setting. 12 of the 14 were reported to have difficulty finding and maintaining staff and 5 of those were reported to have at least periodic refusal of services. The end of the waiver year also coincided with the COVID-19 pandemic during which 6 of the 14 reduced service utilization due to health precautions. Care Coordinators continue to monitor service provision and support providers to identify and resolve barriers to service provision. Care Coordinators offer provider choice to individuals and families if an authorized provider is unable to provide the services as outlined in the ISP.

Metric	Goal	FY21 Q3	FY21 Q4	FY22 Q1	FY22 Q2
Records that contain a signed Freedom of Choice statement.	85%	100%			
Beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	85%	100%			
Beneficiaries reporting they have a choice between providers.	85%	100%			
Beneficiaries age 21 and older who had a primary care visit during year.	85%	98%			
Claims paid by the PIHP for TBI Wavier services authorized in the service plan.	85%	99%			

6.2 Grievances and Complaints

Any individual receiving services, legally responsible person and/or network provider authorized in writing to act on behalf of an individual receiving services, is encouraged to contact Alliance if they feel that services being provided are unsatisfactory or if the individual's emotional or physical well-being is being endangered by such services. Alliance staff will assist any individual receiving services, legally responsible person and/or network provider authorized in writing to act on behalf of an individual in filing a grievance as needed.

6.2.1 Activity Goal

Alliance assists individuals that feel the care they received was unsatisfactory to resolve the cause of the complaint whenever possible by working with members, providers, and other state agencies.

6.2.2 Activity Performance

The following table shows the aggregate grievance total and rate per 1,000 members for the past two years:

Grievance Category	FY2020	FY2021	FY2022	Change per 1,000	Goal Grievances/1,000 Members	Met
Quality of Care	142/0.65	231/1.05	158/1.76	⇧	10/1,000	Met
Access	88/0.4	63/0.29	213/0.76	⇧	10/1,000	Met
Attitude/Service	20/0.09	17/0.08	147/0.53	⇧	10/1,000	Met
Billing/Financial	51/0.22	30/0.14	141/0.51	⇧	10/1,000	Met
Quality of Practitioner Office Site	0/0	0/0	0/0	N/A	10/1,000	Met

6.2.3 Activity Analysis

During FY2022, Alliance received an increase in the number of grievances received in each category. However, it is important to note that during this time, Alliance had

significant population changes. In July 2021, Alliance's population shifted as Standard Plans went live in North Carolina. Our population served was reduced. In December, our population shifted once again through the addition of Mecklenburg and Orange Counties. It was expected that the number of grievances would increase during that transition period while our total population decreased from FY2021. This resulted in the overall number of grievances per 1,000 members increasing. While the numbers did increase, Alliance was still well under the target of no more than 10 grievances per 1,000 members.

6.2.4 Activity Next Steps

- Continue to address the concerns of each complainant to ensure excellent care is delivered to our members
- Minimize appeals of grievance resolutions with clear communication
- Monitor for on-going changes in patterns of how and when members are filing grievances due to the pandemic.

6.3 Adverse Incident Reports

Alliance tracks the submission of level 2 and 3 critical incidents reported by providers.

6.3.1 Activity Goal

Ensure that all critical incidents are appropriately addressed to ensure member safety.

6.3.2 Activity Performance[24]

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Level 2 Critical Incident Reports	173	172	197	185	183	299	256	297	372	385	315	323
Level 3 Critical Incident Reports	21	26	25	35	31	50	44	41	44	55	52	45

Source: Alliance Monitoring Reports

6.3.3 Activity Analysis

The volume of incident submissions remained consistent with rates from the previous year until November 2021. Mecklenburg and Orange Counties joined Alliance in December 2021. As expected, there was an increase in the total number of incidents reported. However, the volume reported appears to coincide with the population increase.

6.4.4 Activity Next Steps

- Continue to work with providers, members and other state agencies to ensure that all critical incidents are addressed appropriately to ensure member safety
- Continue to monitor changes in patterns related to Tailored Plan implementation and evolving membership.

[24] Level 2 and Level 3 incident reports received through Incident Report Improvement System (IRIS).

6.5 Member Authorization Appeals

Alliance tracks appeal rates to ensure that members receive appropriate care and Alliance's utilization functions are performed well.

6.5.1 Activity Goal

Ensure that appeals are appropriately addressed to ensure that members receive the care they need.

6.5.2 Activity Performance

The following Table shows the aggregate appeals data total and rate per 1,000 members for the past two years:

Appeal Category	FY2020	FY2021	FY2021	Change per 1,000	Goal Grievances/1,000 Members	Met
Quality of Care	0/0	0/0	0/0	No change	10/1,000	Met
Access	139/6.32	39/0.16	77/0.28	↑ 0.12	10/1,000	Met
Attitude/Service	0/0	0/0	0/0	No change	10/1,000	Met
Billing/Financial	0/0	0/0	0/0	No change	10/1,000	Met
Quality of Practitioner Office Site	0/0	0/0	0/0	No change	10/1,000	Met

6.5.3 Activity Analysis

Alliance had low appeal rates and low rates of authorizations being overturned upon appeal. This demonstrates that the Alliance utilization management function is responding to service requests in a manner consistent with clinical coverage policies. Much of the reduction in appeals is due to the impact of the COVID pandemic flexibilities issued by the North Carolina Department of Health and Human Services (NC DHHS) which negated the need for appeals by removing prior authorization requirements. This continued until the end of the COVID flexibilities put in place by NC DHHS until the end of the state of emergency.

6.5.4 Activity Next Steps

- Continue to process appeals and provide feedback to the Utilization Management Department as appropriate.
- Continue to monitor changes in patterns related to the discontinuation of COVID flexibilities.
- Monitor for changes in patterns related to Tailored Plan implementation as Alliance assumes responsibility for physical health and pharmacy benefits.

6.6 Provider Satisfaction Survey[25]

The 2021 DHHS Provider Satisfaction Survey was conducted by the Carolina Centers for Medical Excellence (CCME) under contract with DHHS. A brief summary of the survey results are included below, for full results visit our website: www.alliancehealthplan.org

6.6.1 Activity Goal

Alliance works with DHHS to administer the Provider Satisfaction Surveys to gather information about LME/MCO functioning from the perspective of participating network providers and practitioners.

6.6.2 Activity Performance

- Overall satisfaction with LME/MCO saw a two-percentage point increase from 2020 to 2021.
- For the past 5 years, Alliance scored significantly above State average for referring consumers whose needs match the agency
- Alliance performed significantly lower than the State average in the area of "credentialing/recredentialing process occurs in a timely manner".
- Improvements from 2020-2021:
    - Agency satisfaction with appeals process for denial, reduction, or suspension of service(s)
    - LME/MCO requests for corrective action plans and other supporting materials are fair and reasonable. It is important to note this was a focal point for FY2022 and resulted in a marked improvement.
    - The LME/MCO staff conduct fair and thorough investigations.
- Clinical Coverage Policies remains the most requested training topic – since 2016

6.6.3 Activity Next Steps

- Credentialing/recredentialing will be provided at the State level. Alliance will monitor contracting processes to ensure timely enrollment.
- Continue provider education and practice transformation supports.
- Expand Provider Helpdesk capacity

6.7 Perception of Care Survey

The North Carolina Mental Health and Substance Abuse Consumer Perception of Care Survey is conducted annually by the NC DHHS. The survey assesses individual and family perceptions of the quality of care, provider service and LME/MCO performance. A brief summary of the survey results are included below, for full results of the visit our website: www.alliancehealthplan.org

Alliance's responsibilities included: identifying providers of MH and Substance Abuse (SA) services to English and Spanish-speaking individuals; calculating the number adults, youth and children seen by each provider; distributing survey forms to providers; and following up with providers to assure that surveys were completed and returned to DHHS.

[25] 2021 Provider Satisfaction Survey Results

6.7.1 Activity Goal

Alliance works with providers to administer the Perception of Care Surveys to gather information about network performance from the perspective of an individual receiving care.

6.7.2 Activity Performance

Alliance supported the distribution and administration of the Perception of Care Survey for FY2021. The *2021 Mental Health and Substance Use Services Client Perceptions of Care* was published July 2022. As of date of this report, the Alliance-specific data has not been received.

6.7.3 Activity Next Steps

All member satisfaction survey results are reported to the Member Experience CQI Subcommittee where they are evaluated for follow-up and a plan is developed to address prioritized items. The evaluation includes data from all surveys, as well as performance data.

6.8 Experience of Care and Health Outcomes (ECHO) Survey

Carolinas Center for Medical Excellence (CCME), was contracted to conduct a satisfaction survey of the members participating in the 1915(b)(c) Medicaid Waiver program. This survey utilized the Consumer Assessment of Healthcare Providers and Systems (CAHPS) adult and child versions of the Experience of Care and Health Outcomes (ECHO®) Survey for Managed Behavioral Healthcare Organizations. The purpose of the survey was to assess member perceptions of the LME/MCOs in North Carolina. A brief summary of the survey results are included below, for full results of the visit our website: www.alliancehealthplan.org

6.8.1 Activity Goal

Alliance works with CCME to administer the ECHO Survey in order to gather information about Alliance and network performance from the perspective of an individual receiving care.

6.8.2 Activity Performance

Adult Survey Findings[26]:

- At or above State average:
  - Getting treatment and information
  - Perceived improvement
  - Information about treatment options
- Below State average:
  - Getting treatment quickly
  - How well Clinicians communicate
- Improvements from 2020 to 2021:
  - Delays in treatment while waiting for plan approval were not a problem

[26] 2021 Adult Medicaid ECHO Report

- Care Coordinator usually or always responds to calls in a timely manner
- Talked (informed) about including family and friends in treatment
- Usually or always involved as much as you (member) wanted in treatment
- Told about different treatments that are available

Child Survey Findings[27]:

- At or above State average:
  - Overall satisfaction
  - Getting treatment quickly
  - Getting treatment and Information from the Plan
- Below State average:
  - How well Clinicians communicate
  - Perceived improvement
- Improvements from 2020 to 2021:
  - Getting help from customer service was not a problem
  - Rating of counseling or treatment
  - Much better or a little better able to accomplish things compared to 1 year ago (member)
  - Usually or always got help by telephone

6.8.3 Next Steps

The Member Experience Committee reviews all survey data, grievances/complaints, appeals, and other markers of member satisfaction to develop prioritized targets for interventions.

Section 7: Value-Based Contracting (VBC)

Alliance launched several value-based payment programs targeting improvement on the 7-day follow-up measures. Alliance entered a value-based contract with outpatient providers to:

- Implement VBC with Cumberland One and expand to other counties in FY2023.
- Support a Peer Bridger program aimed to improve follow-up from University of North Carolina's (UNC) Non-Hospital Detoxification program.
- Support a Peer Bridger program focusing on improving both MH and SUD 7-day follow-up performance for individuals leaving Duke inpatient units.
- Incentivize four providers of State-funded outpatient and enhanced services with incentive payments for improvement in State and Medicaid Funded SUD 7-day follow-up rate, and State-funded MH follow-up rates.

Alliance continues to collect data on the efficacy of these programs to improve member outcomes and adjust as needed. These programs have proven to be successful in engaging

[27] 2021 Child Medicaid ECHO Report

providers. This program is being expanded to include other kinds of providers to target additional process and outcome measures.

Section 8: Practice Transformation

Alliance launched the Practice Transformation Program to support Care Management Agencies (CMAs) and Advanced Medical Homes + (AMH+) through Tailored Plan readiness. This program supports CMAs/AMH+ in developing internal processes and procedures around Tailored Care Management, understanding and improving HEDIS outcome measures, quality improvement programming, and the CMA certification process through partnering with leadership to complete self-assessments and gap analyses.

Alliance continues to collect data on the efficacy of this program and adjusts as needed. Additional data is required before a full evaluation of these programs can be offered. The larger evaluation is expected next year.

Conclusion and Recommendations

In Alliance Health's current state and based on the assessment above, the QM program, CQI and its subcommittees are not sufficient for Tailored Plan implementation. Over the next fiscal year Alliance will continue to experience significant changes. On December 1st, 2022, Alliance will go live as a Tailored Plan and add coverage for physical health, pharmacy, and a host of other benefits beyond the existing behavioral health benefits that are currently covered. At that same time, Alliance will also add a Medicaid Direct contract to cover behavioral health services for a specific population of Medicaid members. This will increase the number of covered lives.

While practitioner involvement and leadership in the QM Program has been adequate over the previous year, Alliance recognizes the need to increase physical health and pharmacy knowledge within its QM Program. Alliance has increased personnel over FY2022 and will be including a more diverse group of leadership on CQI and its subcommittees to ensure whole person health is represented.

While the Quality Management Department at Alliance is a strong team with a wealth of knowledge and experience, there are distinct gaps in physical health and pharmaceutical knowledge. QM Department structure and staffing will be assessed to ensure sufficient knowledge and skills are represented to support whole-person care.

The following specific recommendations are being made for the following year:

- Finalize implementation of certified HEDIS vendor and incorporate those metrics into organizational functions (i.e. Population Health, Value-Based Contracting, internal, etc)
- Increase physical health and pharmaceutical expertise within QM Department and across CQI Committee/Sub-Committees

- Implement quality workplan to include Tailored Plan, State-funded, and Medicaid Direct contract requirements
- Implement Performance Improvement Projects (PIPs) as specified by the Department
- Assess and update charters and membership of CQI and Subcommittees to increase physical health and pharmacy representation
- Prepare to meet all of the Tailored Plan quality requirements for performance and reporting by building upon our existing quality infrastructure.
- Expand workforce across the organization to meet the volume-based demands of serving additional members and covering new benefits.
- Update State reporting to reflect updated State-mandated templates and reporting schedule.

Appendix A: Measure Definitions

	Metric	Definition
Call Center	Call Abandonment Rate	Abandonment occurs when the caller dials directly into the organization's Member Services Call Center or selects the Member Services option, is placed in the call queue and hangs up the phone, disconnecting from the call center before being answered.
	Answer within 30 seconds	The number of calls answered by a live voice within 30 seconds.
Contract Super Measures	Medicaid - Mental Health 7-Day Follow-up	The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health treatment in a community-based hospital, state psychiatric hospital, or facility-based crisis service that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.
	Medicaid - Substance Use 7-Day Follow-up	The percentage of discharges for individuals ages 3 through 64 who were admitted for substance use disorder treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility based crisis service that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.
	Medicaid - Innovations Waiver Primary Care	The percentage of continuously enrolled Medicaid enrollees under the 1915(c) Innovations Waiver (ages 3 and older) who received at least one service under the Innovations Waiver during the measurement period who also received a primary care or preventive health service.
	Non-Medicaid - Mental Health 7-Day Follow-up	The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.
	Non-Medicaid - Substance Use 7-Day Follow-up	The percentage of discharges for individuals ages 3 through 64 who were admitted for substance use disorder treatment that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.
	TCLI - Housing	This measure provides the number and percentage of the LME/MCO's annual allotted TCLI housing slots for whom eligible individuals transition to supportive housing.
Medicaid Performance Measures	Care Coordination Assignment	Of all readmits (MH or SA) during the month, indicate the number that were assigned to a Care Coordinator upon readmission.
	Authorizations Processed within Timeframes	Number of standard authorization requests that were processed within 14 calendar days. Number of expedited and inpatient authorization requests that were processed within 3 calendar days.
	Claims Proceed within 30 Days	Number of clean claims that were received during the reporting month that were paid or denied within 30 days of receipt. This number is a subset of the # Paid + # Denied. It should not have to be updated, as the report due date is >30 days after the end of the month being reported.
	Resolution of Grievances within 30 Days	Number of complaints being reported in this report period, that were either resolved in 30 days or referred to other entities for investigation within 30 days. Reference 10A NCAC 27G.0607
	Access to Care - Emergent	Number of calls requesting MH/IDD/SU services determined to need emergent care for which care was provided within 2 hours 15 minutes of request.

	Metric	Definition
	Access to Care - Urgent	Number calls requesting MH/IDD/SU services determined to need urgent care for which a service was provided within 2 calendar days of request.
	Access to Care - Routine	Number calls requesting MH/IDD/SU services determined to need routine care for which a service was provided within 14 calendar days of request.
	Adherence to antipsychotic medications for individuals with Schizophrenia.	The percentage of members 18 years of age and older during the measurement year with Schizophrenia or Schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.
	Diabetes screening for people with Schizophrenia or Bipolar Disorder who are using antipsychotic medications.	The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
	Metabolic monitoring for children and adolescents on antipsychotics.	The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.
Innovations Waiver Measures	Members receiving services within 45 days of ISP.	Proportion of new waiver beneficiaries who are receiving services according to their ISP within 45 days of ISP approval.
	Percent of actions taken to protect the beneficiary.	Number and percent of actions taken to protect the beneficiary, where indicated (include: consumer injury, consumer behavior-abuse, sexual acts, AWOL, illegal acts). Also, were appropriate agencies notified.
	Incidents reported within timeframes.	Percentage of Level 2 and 3 incidents reported within required timeframes.
	Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.	Number and percentage of deaths where required LME/PIHP follow-up interventions were completed as required.
	Medication errors resulting in medical treatment.	Percentage of medication errors resulting in medical treatment.
	Beneficiaries who received appropriate medication.	Percentage of beneficiaries who received appropriate medication.
	Incidents where required LME/PIHP follow-up interventions were completed.	Number and percentage of Level 2 or 3 incidents where required LME/PIHP follow-up interventions were completed, as required.
	Percentage of incidents referred to the DSS or DHSR.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.
	Percentage of restrictive interventions resulting in medical treatment.	Percentage of restrictive interventions resulting in medical treatment.
	Level of Care evaluations completed at least annually for enrolled beneficiaries.	Proportion of Level of Care evaluations completed at least annually for enrolled beneficiaries.
	Level of Care evaluations completed using approved processes and instrument.	Proportion of Level of Care evaluations completed using approved processes and instrument.

	Metric	Definition
	New Level of Care evaluations completed using approved processes and instrument.	Proportion of New Level of Care evaluations completed using approved processes and instrument.
	Individual Support Plans that address identified health and safety risk factors.	Proportion of Individual Support Plans that address identified health and safety risk factors.
	PCPs that are completed in accordance with DMA requirements.	Proportion of PCPs that are completed in accordance with DMA requirements.
	New enrollees who have a LOC prior to receipt of services.	Number and percent of new waiver enrollees who have a LOC prior to receipt of services.
	New licensed providers that meet licensure, certification, and/or other standards.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing waiver services.
	Providers reviewed according to PIHP monitoring schedule.	Proportion of providers reviewed according to PIHP monitoring schedule to determine continuing compliance with licensing, certification, contract and waiver standards.
	Providers for whom appropriate remediation has taken place.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place.
	Providers that successfully implemented an approved corrective action plan.	Proportion of monitored non-licensed/non-certified providers that successfully implemented an approved corrective action plan.
	Monitored providers wherein all staff completed all mandated training.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.
	ISPs in which the services and supports reflect participant assessed needs and life goals.	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals.
	Beneficiaries reporting that their ISP has the services that they need.	Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need.
	Individuals for whom an annual plan and/or needed update took place.	Proportion of individuals for whom an annual plan and/or needed update took place.
	Beneficiaries who are receiving services as specified in the ISP.	Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the Individual Support Plan.
	Records that contain a signed Freedom of Choice statement.	Proportion of records that contain a signed Freedom of Choice statement.
	Beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.

	Metric	Definition
	Beneficiaries reporting they have a choice between providers.	Proportion of beneficiaries reporting they have a choice between providers.
	Beneficiaries age 21 and older who had a primary care visit during year.	The percentage of waiver beneficiaries age 21 and older who had a primary care or preventative care visit during the waiver year.
	Claims paid by the PIHP for Innovations wavier services authorized in the service plan.	The proportion of claims paid by the PIHP for Innovations Wavier services that have been authorized in the service plan.
TBI Waiver Measures	Beneficiaries receiving services in the type, scope, amount, frequency in ISP.	Proportion of new waiver beneficiaries who are receiving services according to their ISP within 45 days of ISP approval.
	Actions taken to protect the beneficiary, where indicated.	Number and percent of actions taken to protect the beneficiary, where indicated (Deaths will be excluded here).
	Incidents referred to DSS or DHHS, as required.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.
	Deaths where required LME/PIHP follow-up interventions were completed.	Number and percentage of deaths where required LME/PIHP follow-up interventions were completed, as required.
	Medication errors resulting in medical treatment.	Percentage of medication errors resulting in medical treatment.
	Beneficiaries who received appropriate medication.	Percentage of beneficiaries who received appropriate medication.
	Incidents reported within required timeframes.	Percentage of Level 2 and 3 incidents reported within required timeframes.
	Incidents where required LME/PIHP follow-up interventions were completed.	Percentage of Level 2 or 3 incidents where required LME/PIHP follow-up interventions were completed, as required.
	Restrictive interventions resulting in medical treatment.	Percentage of restrictive interventions resulting in medical treatment.
	Restrictive interventions used in an emergency after exhausting all other possibilities.	Percent of restrictive interventions used in an emergency after exhausting all other possibilities.
	Restrictive interventions used by a trained staff member.	Percent of restrictive interventions used by a trained staff member.
	Restrictive interventions that are documented according to State policy.	Percent of restrictive interventions that are documented according to State policy.
	Level of Care evaluations completed at least annually for enrolled beneficiaries.	Proportion of Level of Care evaluations completed at least annually for enrolled beneficiaries.

	Metric	Definition
	Level of Care evaluations completed using approved processes and instrument.	Proportion of Level of Care evaluations completed using approved processes and instrument.
	New licensed providers that meet licensure, certification, and/or other standards prior to furnishing waiver services.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing waiver services.
	Individual Support Plans that address identified health and safety risk factors.	Proportion of Individual Support Plans that address identified health and safety risk factors.
	Individuals for whom an annual plan and/or needed update took place.	Proportion of individuals for whom an annual plan and/or needed update took place.

Appendix B: FY2023 QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI)

FY23 Alliance Health Quality Assessment & Performance Improvement (QAPI) Plan

QMC Approved: 11/3/2022

The Quality Assessment Performance Improvement (QAPI) Plan is the foundation for quality improvement activities at Alliance Health. The work plan is developed based on current program effectiveness, analyzed utilization, contraction requirements, HEDIS, and other quality datasets.

Area of Focus[28]	Project/Performance Area	Summary	Target/ Frequency	Primary CQI Subcommittee	Responsible Party	Contract	Start Date	Anticipated Completion Date
Quality of Clinical Care	PIP: Comprehensive Diabetes Care HbA1c (>90%) Poor Control (Tailored Plan)	The percentage of patients 18–75 years of age with diabetes (type 1 and 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year	101.3%[29]	CQI Leadership	CMO	Tailored Plan	10/1/2022	6/30/2023
Quality of Clinical Care	PIP: Comprehensive Diabetes Care HbA1c (>90%) Poor Control (Medicaid Direct)	The percentage of patients 18–75 years of age with diabetes (type 1 and 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year	105% NC Baseline Rate[30]	CQI Leadership	CMO	Medicaid Direct	10/1/2022	6/30/2023

[28] Per NCQA HPA, areas of Focus include Quality of Clinical Care, Safety of Clinical Care, Quality of Service, and Member Experience.

[29] Target is pulled from "2021 Tailored Plan Quality Measure Performance and 2023 Targets" sent via email 8/12/2022 from DHB. This rate appears to be incorrect as it exceeds 100% and is higher than FY2021. Lower rates indicate better performance for this HEDIS Measure.

[30] Benchmark data as not yet been released

Area of Focus[28]	Project/Performance Area	Summary	Target/ Frequency	Primary CQI Subcommittee	Responsible Party	Contract	Start Date	Anticipated Completion Date
Member Experience Quality of Service	PIP: Follow up after hospitalization for Mental Health (7 & 30 Day) (Tailored Plan)	The percentage of discharges for patients six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: • The percentage of discharges for which the patient received follow-up within 30 days of discharge. • The percentage of discharges for which the patient received follow-up within 7 days of discharge.	26.2%[31]	CQI Leadership	SVP CM/Pop Health	Tailored Plan	10/1/2022	6/30/2023
Member Experience Quality of Service	PIP: Follow up after hospitalization for Mental Health (7 & 30 Day) (Medicaid Direct)	The percentage of discharges for patients six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: • The percentage of discharges for which the patient received follow-up within 30 days of discharge. • The percentage of discharges for which the patient received follow-up within 7 days of discharge.	105% NC Baseline Rate[32]	CQI Leadership	SVP CM/Pop Health	Medicaid Direct	10/1/2022	6/30/2023
Member Experience	PIP: Follow up after hospitalization for	The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health	40%[33]	CQI Leadership	SVP CM/Pop Health	State-Funded	10/1/2022	6/30/2023

[31] Target is pulled from "2021 Tailored Plan Quality Measure Performance and 2023 Targets" sent via email 8/12/2022 from DHB.
[32] Benchmark data as not yet been released
[33] Per TP Contract, Section VII, Attachment P. Table 5: Metrics, SLAs, and Liquidated Damages for State-Funded Services.

Area of Focus[28]	Project/Performance Area	Summary	Target/ Frequency	Primary CQI Subcommittee	Responsible Party	Contract	Start Date	Anticipated Completion Date
Quality of Service	Mental Health (7 & 30 Day) (State Funded)	treatment in a community-based hospital, state psychiatric hospital, or facility-based crisis service that received a follow-up visit with a behavioral health practitioner within one to seven and one to thirty days of discharge.						
Quality of Clinical Care	PIP: Follow-up After Discharge from Community Hospitals, State Psychiatric Hospitals, State ADATCs, and Detox/Facility Based Crisis Services for substance use disorder (SUD) Treatment (7 days and 30 days) (State Funded)	The percentage of discharges for individuals ages 3 through 64 who were admitted for substance use disorder treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility-based crisis service and received a follow-up visit with a behavioral health practitioner within one to seven days and one to thirty of discharge.	40%[34]	CQI Leadership	SVP CM/Pop Health	State-Funded	10/1/2022	6/30/2023
Quality of Clinical Care	TCL Primary Care Visits	To increase the rate of confirmed primary care provider appointments with members in the TCL housing transition and residency cohort.	80%	CQI Leadership	SVP CM/Pop Health	Tailored Plan State-Funded Medicaid Direct	7/1/2022	6/30/2023
Quality of Clinical Care	Post Closure Reviews	Complete Post Closure Reviews on previously closed QIPs from FY22: • APM	Once	CQI Leadership	SVP of QM	DHB Contract	5/1/2023	6/30/2023

[34] Per TP Contract, Section VII, Attachment P. Table 5: Metrics, SLAs, and Liquidated Damages for State-Funded Services.

Area of Focus[28]	Project/Performance Area	Summary	Target/ Frequency	Primary CQI Subcommittee	Responsible Party	Contract	Start Date	Anticipated Completion Date
		• SSD						
Quality of Service	Monitoring Over/Under Utilization (annually)	The Utilization Management Committee will choose utilization data to monitor for under, over and misutilization, annually. 1. Data will be obtained using medical claims/encounter data, pharmacy data, HEDIS's results or other, as appropriate. 2. Data will be examined for possible explanation for those areas not meeting the threshold. 3. The analyzed data not within the threshold will be reviewed by appropriate medical group or practice. 4. Action will be taken to address the identified problem areas and measure the effectiveness of its interventions. Committee will monitor for over/under utilization of[35]: • Use of congregate setting • Use of ED for physical health and behavioral	Annually	UM	Sr. Dir. UM	Tailored Plan State-Funded Medicaid Direct	12/1/2022	6/30/2023

[35] While monitored in UM Committee, may be referred to CQI leadership or other subcommittees as appropriate

Area of Focus[28]	Project/Performance Area	Summary	Target/ Frequency	Primary CQI Subcommittee	Responsible Party	Contract	Start Date	Anticipated Completion Date
		health crisis (including LOS) • Out of home placement greater than 30 miles/30 minutes[36] from member's home • Time to service initiation from request of service or determination of service need by a provider and LOS in inappropriate settings while awaiting access • Use of community/home-based services for youth residing in foster care setting who have BH dx • 30/60/180 day readmissions to congregate care settings and ED Settings following discharge from congregate settings.						
Quality of Clinical Care	SDoH CQI Subcommittee to implement and monitor organization-wide SDoH Strategy	Alliance has developed a CQI Subcommittee focused on SDoH. This Committee has developed a strategy that includes reviewing data collected as part of the SDoH assessments completed with all new members, tracking referrals through NC CARES 360 and Jiva, and claims data.	Annually	SDoH	Sr. Dir. Of Clinical Innovations	Tailored Plan State-Funded Medicaid Direct	12/1/2022	6/30/2023

[36] All counties served by Alliance are deemed Urban.

Area of Focus[28]	Project/Performance Area	Summary	Target/ Frequency	Primary CQI Subcommittee	Responsible Party	Contract	Start Date	Anticipated Completion Date
Member Experience Quality of Clinical Care	Monitoring and assessing for health disparities.	Alliance has developed Health Equity Council – a subcommittee of CQI. This committee will monitor and assess the selected measures outlined in the State's Quality Strategy Appendix A based on age, race, ethnicity, sex, primary language, county, and disability status where feasible. Using this data and data from the EQRO-developed annual health equity report, the committee will identify disparities and recommend quality improvement activities as indicated.	Annually	Health Equity	Sr. Dir. Of Population Health	Tailored Plan State-Funded Medicaid Direct	12/1/2022	6/30/2023
Member Experience Quality of Service Safety of Clinical Care Quality of Clinical Care	Population Health Management Impact Evaluation	Annually, Alliance evaluates the effectiveness of Population Health initiatives. Evaluation includes one clinical measure (process or outcome based), one cost/UM measure, and member experience data from at least two programs. Evaluation will include quantitative and qualitative analyses of results. This information will be used to identify opportunities for improvement.	Annually	Care Management	Sr. Dir. Of Population Health	Tailored Plan State-Funded Medicaid Direct	12/1/2022	6/30/2023
Member Experience Quality of Service	LTSS Program Effectiveness Report	Alliance monitors TBI and Innovations Performance measures, outcome targets, and information related to transitions of care. These measures are reported out through the Care Management Subcommittee. This	Annually	Care Management	SVP of Population Health and Care Management	Tailored Plan	12/1/2022	6/30/2023

Area of Focus[28]	Project/Performance Area	Summary	Target/ Frequency	Primary CQI Subcommittee	Responsible Party	Contract	Start Date	Anticipated Completion Date
Quality of Clinical Care		data is used to assess for quality and appropriateness of care provided to beneficiaries needing LTSS. Data includes assessment of transitions of care and a comparison between services received and those set forth in the members treatment/service plan. The Care Management subcommittee reviews effectiveness report for opportunities for improvement.						
Safety of Clinical Care Member Experience	Prevention, Detection, and Remediation of Critical Incidents	Alliance Incidents Team provides reporting as prescribed in the Contract.	Per contract reporting requirements	Member Experience	SVP QM	Tailored Plan State-Funded Medicaid Direct	12/1/2022	Ongoing
Member Experience Quality of Service Quality of Clinical Care Safety of Clinical Care	Consumer and Family Advisory Committee (CFAC)	QM partners with CFAC to obtain feedback regarding QMIP, member experience, and member processes. This feedback will be gathered through monthly CFAC meetings. The Director of Community and Member Engagement will liaise with CFAC and CQI as an active member on each committee. Feedback will also be gathered via annual member satisfaction surveys. Information gathered is communicated to the appropriate	Monthly Meetings and Annual Surveys	CQI Leadership	Director of Community and Member Engagement	Tailored Plan State-Funded Medicaid Direct	12/1/2022	Ongoing

Area of Focus[28]	Project/Performance Area	Summary	Target/ Frequency	Primary CQI Subcommittee	Responsible Party	Contract	Start Date	Anticipated Completion Date
		CQI Committees and used to identify opportunities for improvements and develop interventions/actions/programs as appropriate. Alliance will submit rosters if/when updates are made.						
	Monthly Quality Management Director Forum (QMDF)	SVP of QM or a selected delegate will attend monthly QMDF meetings.	Monthly		SVP of QM	Tailored Plan State-Funded Medicaid Direct	7/1/2022	Ongoing
	EQR Participation	Alliance will comply with annual external quality review. Timeline will be defined by EQRO and Department.	Annually	CQI Leadership	Project Management	Tailored Plan Medicaid Direct	TBD	TBD
Member Experience Quality of Service Quality of Clinical Care	Survey Administration	Alliance will participate and support survey process as required by the Department. Timeline to be determined by Department Surveys include: • Consumer Assessment of Healthcare Providers and System Plan Survey (CAHPS) • Provider Survey • Consumer Perceptions of Care	Annually	Member Experience	SVP of QM	Tailored Plan State-Funded Medicaid Direct	TBD	TBD

Area of Focus[28]	Project/Performance Area	Summary	Target/ Frequency	Primary CQI Subcommittee	Responsible Party	Contract	Start Date	Anticipated Completion Date
		• National Core Indicators (NCI) • Other Surveys, ad hoc						
	Provider Supports	Alliance implements a provider support plan inclusive of practice transformation and provider supports. See attached Provider Support Plan addendum for additional details.	Annually	Provider Quality	Senior Director of Network Evaluation Senior Director of Practice and Payor Transformation	Tailored Plan State-Funded Medicaid Direct	7/1/2022	6/30/2022
	QAPI Report	Quarterly QAPI Update on Activities outlined in the QAPI.	Quarterly	CQI Leadership	SVP of QM	Tailored Plan State-Funded Medicaid Direct	10/1/2022	6/30/2023
	PIP Progress Report	Quarterly PIP Update on activities outlined in the PIP	Quarterly	CQI Leadership	SVP of QM	Tailored Plan State-Funded Medicaid Direct	10/1/2022	6/30/2023
	Member Appeals and Grievances Report	Quarterly report on the appeals and grievances received and processed by the PIHP including the total number of appeal and grievance requests filed with the	Quarterly	Member Experience	Manager of Grievances, Appeals, and Incidents	Tailored Plan State-Funded	7/1/2022	6/30/2022

Area of Focus[28]	Project/Performance Area	Summary	Target/ Frequency	Primary CQI Subcommittee	Responsible Party	Contract	Start Date	Anticipated Completion Date
		PIHP, the basis for each appeal or grievance, the status of pending requests, and the disposition of any requests that have been resolved.				Medicaid Direct		
Member Experience Quality of Service Safety of Clinical Care Quality of Clinical Care	Quality Measures Report (Annual)	Report of quality calculated measures using state-provided template stratified per contract requirements submitted annually.	100%	CQI Leadership	SVP QM	Tailored Plan State-Funded Medicaid Direct	12/1/2022	6/30/2023
Member Experience Quality of Service Safety of Clinical Care Quality of Clinical Care	Quality Management Program Evaluation	Annual evaluation of: • QMIP • QM Goals and Objectives • QM Workplan • Major Program Accomplishments • Progress of PIPs • Progress of Quality Improvement Efforts • Assessment of adequacy of resources, structure, and physician involvement • Identification of opportunities and	Annual	CQI Leadership QMC	SVP-QM	Tailored Plan State-Funded Medicaid Direct	4/1/2023	8/31/2023

Area of Focus[28]	Project/Performance Area	Summary	Target/ Frequency	Primary CQI Subcommittee	Responsible Party	Contract	Start Date	Anticipated Completion Date
		recommendations for change						

Appendix C: BH I/DD Tailored Plan Quality Metrics for Medicaid

Section VII. First Revised and Restated Attachment E.1. Table 1: Survey Measures and General Measures: Pediatric			
Ref #	**NQF #**	**Measure Name**	**Steward**
1.	NA	Child and Adolescent Well-Care Visit	NCQA
2.	NA	Percentage of eligibles who received preventive Dental Services (PDENT-CH)	CMS
3.	0038	Childhood Immunization Status (Combo 10)	NCQA
4.	0108	Follow-up for Children Prescribed ADHD Medication	NCQA
5.	Reserved	N/A	N/A
6.	1407	Immunizations for Adolescents	NCQA
7.	2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA
8.	NA	Well-Child Visits in the First 30 Months of Life	NCQA
9.	2801	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA

Section VII. First Revised and Restated Attachment E.1. Table 1: Survey Measures and General Measures: Pediatric			
Ref #	**NQF #**	**Measure Name**	**Steward**
10.	NA	Total eligibles receiving at least one Initial or Periodic Screen (Federal Fiscal Year)	NC DHHS

Section VII. First Revised and Restated Attachment E.1. Table 2: Survey Measures and General Measures: Adult			
Ref #	**NQF #**	**Measure Name**	**Steward**
1.	0105	Antidepressant Medication Management	NCQA
2.	0032	Cervical Cancer Screening	NCQA
3.	0033	Chlamydia Screening in Women	NCQA
4.	0059	HbA1c Poor Control (>9.0%)[37]	NCQA
5.	3389	Concurrent use of Prescription Opioids and Benzodiazepines	PQA
6.	3175	Continuation of Pharmacotherapy for Opioid Use Disorder	USC
7.	0018	Controlling High Blood Pressure	NCQA
8.	1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	NCQA
9.	0039	Flu Vaccinations for Adults	NCQA
10.	0576	Follow-up After Hospitalization for Mental Illness	NCQA
11.	0027	Medical Assistance with Smoking and Tobacco Use Cessation	NCQA
12.	1768	Plan All Cause Readmissions	NCQA

[37] Pending additional information regarding the collection of clinical data

Section VII. First Revised and Restated Attachment E.1. Table 2: Survey Measures and General Measures: Adult			
Ref #	**NQF #**	**Measure Name**	**Steward**
13.	0418/ 0418e	Screening for Depression and Follow-up Plan[38]	NCQA
14.	2940	Use of Opioids at High Dosage in-Persons Without Cancer	PQA
15.	2950	Use of Opioids from Multiple Providers in-Persons Without Cancer	PQA
16.	NA	Rate of Screening for Unmet Resource Needs	NC DHHS
17.	NA	Total Cost of Care	IBM Watson Health Cost of Care Model

Section VII. First Revised and Restated Attachment E.1. Table 3: Survey Measures and General Measures: Maternal					
Ref #	**NQF #**	**Measure Name**	**Steward**	**Frequency**	**Submission**
1.	NA	Percentage of Low Birthweight Births (Live Births Weighing Less than 2,500 Grams)	NC DHHS	Annually Calendar Year	June 1
2.	NA	Prenatal and Postpartum Care	NCQA	Annually Calendar Year	June 1
3.	NA	Rate of Screening for Pregnancy Risk	NC DHHS	N/A	N/A

Section VII. First Revised and Restated Attachment E.1. Table 4: Survey Measures and General Measures: Patient and Provider Satisfaction			
Ref #	**NQF #**	**Measure Name**	**Steward**
1.	0006	CAHPS Survey	AHRQ

[38] Pending additional feedback regarding the collection of clinical data. This measure will be accompanied by future guidance to limit screening in patients where it's not appropriate

Section VII. First Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
1.	Number and percent of new waiver enrollees who have a Level of Care (LOC) evaluation prior to receipt of services	NC DHHS	Annually Fiscal Year	November 1
2.	Number of Innovations Waiver applicants who received a preliminary screening for potential eligibility	NC DHHS	Annually Fiscal Year	November 1
3.	Proportion of Level of Care evaluations completed at least annually for enrolled participants	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
4.	Proportion of new Level of Care evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
5.	Proportion of Level of Care evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
6.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place	NC DHHS	Annually Fiscal Year	November 1
7.	Proportion of providers determined to be continually compliant with licensing, certification, contract and waiver standards according to PHP monitoring schedule.	NC DHHS	Annually Fiscal Year	November 1
8.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing waiver services.	NC DHHS	Annually Fiscal Year	November 1
9.	Proportion of Innovations Waiver providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of non-licensed, non-certified (c) waiver providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of monitored non-licensed, non-certified providers that are compliant with waiver requirements.	NC DHHS	Annually Fiscal Year	November 1

Section VII. First Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
12.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.	NC DHHS	Annually Fiscal Year	November 1
13.	Proportion of PCPs that are completed in accordance with DHB requirements.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
14.	Percentage of beneficiaries reporting that their ISP has the services that they need	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of ISPs that address identified health and safety risk factors	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
16.	Proportion of ISPs in which the services and supports reflect beneficiary assessed needs and life goals	NC DHHS	Annually Fiscal Year	November 1
17.	Proportion of individuals whose annual ISP was revised or updated	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
18.	Proportion of individuals for whom an annual ISP took place	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
19.	Number and percentage of waiver participants whose ISPs were revised, as applicable, by the Care Coordinator to address their changing needs	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 3 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

Section VII. First Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
20.	Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the ISP.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
21.	Proportion of new Innovations waiver beneficiaries who are receiving services according to their ISP within 45 days of ISP approval.	NC DHHS	Annually Fiscal Year	November 1
22.	Proportion of records that contain a signed freedom of choice statement	NC DHHS	Annually Fiscal Year	November 1
23.	Proportion of Innovations waiver beneficiaries reporting their Care Coordinator helps them to know what waiver services are available	NC DHHS	Annually Fiscal Year	November 1
24.	Proportion of Innovations waiver beneficiaries reporting they have a choice between providers	NC DHHS	Annually Fiscal Year	November 1
25.	Number and percentage of Innovations waiver beneficiary deaths where required BH I/DD TP follow-up interventions were completed as required	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
26.	Number and percent of actions taken to protect the Innovations waiver beneficiary, where indicated (Deaths will be excluded here) (Include: Consumer Injury, Consumer behavior-abuse, sexual acts, AWOL, illegal acts). Also, were appropriate agencies notified.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

Section VII. First Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
27.	Percentage of Innovations waiver beneficiaries who received appropriate medication	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
28.	Percentage of medication errors resulting in medical treatment for Innovations wavier beneficiaries	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
29.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
30.	Percentage of BH I/DD TP Provider Satisfaction Survey respondents who reported being given information on how to identify and report instances of abuse, neglect, exploitation, and unexplained death	NC DHHS	Annually July 1-June 30	November 1
31.	Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

Section VII. First Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
32.	Number and percentage of level 2 or 3 incidents where required BH I/DD TP follow- up interventions were completed as required	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
33.	Percentage of level 2 and 3 incidents reported within required timeframes	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
34.	Percentage of level 2 or 3 incident reports where the supervisor completed the "cause of the incident" and "what can be done to prevent future occurrences" fields	NC DHHS	Annually Fiscal Year	November 1
35.	Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
36.	Percentage of restrictive interventions (both restraint and seclusion) resulting in medical treatment	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
37.	The proportion of claims paid by the BH I/DD TP for Innovations Waiver services that have been authorized in the service plan.	NC DHHS	Annually Fiscal Year	November 1

Section VII. First Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
38.	The consistency of NC Innovations capitated rates (The proportion of the BH I/DD TP Innovations year to date PMPM compared to the NC Innovations capitated rate PMPM)	NC DHHS	Annually Fiscal Year	November 1
39.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver (ages 3 and older) who received at least one waiver service who also received a primary care or preventative health service.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 –March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
40.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver ages three (3) to six (6) who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
41.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver ages seven (7) to nineteen (19) who received a primary care or preventative health service during the measurement period or the year prior to the measurement period.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
42.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver ages twenty (20) and older who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

Section VII. First Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
1.	Number and percent of new waiver enrollees who have a LOC evaluation prior to receipt of services	NC DHHS	Annually Fiscal Year	November 1
2.	Proportion of Level of Care evaluations completed at least annually for enrolled beneficiaries	NC DHHS	Semi Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
3.	Proportion of Level of Care evaluations completed using approved processes and instrument	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
4.	Proportion of new Level of Care evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
5.	Number of new providers who meet licensure, certification, and/or other standards prior to furnishing waiver services	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1– June 30	a. May 1 b. November 11
6.	Proportion of new providers who meet licensure, certification, and/or other standards prior to furnishing waiver services	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1– June 30	a. May 1 b. November 11
7.	Proportion of providers reviewed according to PIHP monitoring schedule to determine continuing compliance with licensing, certification, contract and waiver standards	NC DHHS	Annually Fiscal Year	November 1
8.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place	NC DHHS	Annually Fiscal Year	November 1
9.	Proportion of monitored non-licensed, non-certified providers that successfully implemented an approved corrective action plan	NC DHHS	Annually Fiscal Year	November 1

Section VII. First Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
10.	Proportion of monitored providers wherein all staff completed all mandated training, excluding restrictive interventions, within the required timeframe.	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of PCPs that are completed in accordance with State Medicaid Agency's requirements	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of Individual Support Plans that address identified health and safety risk factors	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
13.	Percentage of participants reporting that their Individual Support Plan has the services that they need	NC DHHS	Annually Fiscal Year	November 1
14.	Proportion of person-centered plans that are completed in accordance with the State Medicaid Agency's requirements	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	NC DHHS	Annually Fiscal Year	November 1
16.	Proportion of individuals for whom an annual plan and/or needed update took place	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
17.	Proportion of new waiver beneficiaries receiving services according to their ISP within 45 days of ISP approval	NC DHHS	Annually Fiscal Year	November 1
18.	Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the Individual Support Plan	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April –June 30	a. February 1 b. May 1 c. August 1 d. November 1

Section VII. First Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
19.	Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available	NC DHHS	Annually Fiscal Year	November 1
20.	Proportion of beneficiaries reporting they have a choice between providers	NC DHHS	Annually Fiscal Year	November 1
21.	Proportion of records that contain a signed freedom of choice statement	NC DHHS	Annually Fiscal Year	November 1
22.	Number and Percent of Actions Taken to Protect the Beneficiary, where indicated	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April –June 30	a. February 1 b. May 1 c. August 1 d. November 1
23.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation as required.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April –June 30	a. February 1 b. May 1 c. August 1 d. November 1
24.	Number and Percentage of deaths where required BH I/DD TP follow-up interventions were completed as required	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April –June 30	a. February 1 b. May 1 c. August 1 d. November 1
25.	Percentage of medication errors resulting in medical treatment	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 –	a. February 1 b. May 1 c. August 1 d. November 1

Section VII. First Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
			March 31 d. April 1 – June 30	
26.	Percentage of beneficiaries who received appropriate medication	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
27..	Percentage of level 2 and 3 incidents reported within required time frames	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
28.	Percentage of level 2 or 3 incidents where required BH I/DD TP follow-up interventions were completed as required.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
29.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation as required	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

Section VII. First Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
30.	Percentage of restrictive interventions resulting in medical treatment	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 –June 30	a. February 1 b. May 1 c. August 1 d. November 1
31.	Percent of restrictive interventions used in an emergency after exhausting all other possibilities	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
32.	Percent of restrictive interventions used by a trained staff member.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 –June 30	a. February 1 b. May 1 c. August 1 d. November 1
33.	Percent of restrictive interventions that are documented according to state policy.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
34.	The percentage of waiver beneficiaries who had a primary care or preventative care visit during the waiver year.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 –	a. February 1 b. May 1 c. August 1 d. November 1

Section VII. First Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
			March 31 d. April 1 –June 30	
35.	The percentage of waiver beneficiaries age 22 and older who had a primary care or preventative care visit during the waiver year	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 –June 30	a. February 1 b. May 1 c. August 1 d. November 1
36.	The proportion of claims paid by the PIHP for NC TBI wavier services that have been authorized in the service plan	NC DHHS	Annually Fiscal Year	November 1

Appendix D: BH I/DD Tailored Plan Quality Metrics for State-Funded Services

Section VII. First Revised and Restated Attachment E.2. Table 2: Survey Measures and General Measure for State-funded Services				
Ref #	**Measure**	**Steward**	**Measurement Period**	**Report Due**
1.	Initiation of Services	NC DHHS	Quarterly a. July – September b. October – December c. January – March d. April - June	a. February 15 b. May 15 c. August 15 d. November 15
2.	Engagement in Services	NC DHHS	Quarterly a. July – September b. October – December c. January – March d. April - June	a. February 15 b. May 15 c. August 15 d. November 15
3.	Admission Rate and Length of Stay in Community Hospitals for Mental Health Treatment	NC DHHS	Quarterly a. July – September b. October – December c. January – March d. April - June	a. February 15 b. May 15 c. August 15 d. November 15
4.	State Hospital Readmissions within thirty (30) days and one hundred eighty (180) days	NC DHHS	Quarterly a. July – September b. October – December c. January – March d. April - June	a. February 15 b. May 15 c. August 15 d. November 14

Section VII. First Revised and Restated Attachment E.2. Table 2: Survey Measures and General Measure for State-funded Services				
Ref #	**Measure**	**Steward**	**Measurement Period**	**Report Due**
5.	ADATC Readmissions within thirty (30) days and one hundred eighty (180) days	NC DHHS	Quarterly a. July – September b. October – December c. January – March d. April - June	a. February 15 b. May 15 c. August 15 d. November 15
6.	Community MH Inpatient Readmissions within thirty (30) Days	NC DHHS	Quarterly a. July – September b. October – December c. January – March d. April - June	a. February 15 b. May 15 c. August 15 d. November 15
7.	Community SUD Inpatient Readmission within thirty (30) Days	NC DHHS	Quarterly a. July – September b. October – December c. January – March d. April - June	a. February 15 b. May 15 c. August 15 d. November 15
8.	TCLI Population Employment	NC DHHS	July - June	June 1
9.	Housing Retention: Maintains at Least Same Level of Individuals in Supportive Housing as Targeted Under TCLI*	NC DHHS	Quarterly a. July – September b. October – December c. January – March d. April - June	a. February 15 b. May 15 c. August 15 d. November 15

Section VII. First Revised and Restated Attachment E.2. Table 2: Survey Measures and General Measure for State-funded Services				
Ref #	**Measure**	**Steward**	**Measurement Period**	**Report Due**
10.	Housing Retention: No Fewer than 90% of People In Supportive Housing Slots Remain in Supportive Housing*	NC DHHS	Quarterly a. September + 12-month lookback b. December + 12-month lookback c. March + 12-month lookback d. June + 12-month lookback	a. November 15 b. February 15 c. May 15 d. August 15

Appendix E: BH I/DD Tailored Plan Network Adequacy Standards – MEDICAID

Certain service types not subject to separate adult and pediatric provider standards. These service types are marked with a (*) and include: hospitals, pharmacies, occupational, physical, or speech therapists, LTSS, and nursing facilities.

Section VII. First Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
1	Primary Care[39]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
2	Specialty Care	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members
3	Hospitals*	≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of members	≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of members
4	Pharmacies*	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of members
5	Obstetrics[40]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
6	Occupational, Physical, or Speech Therapists*	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of members

[39] Nurse Practitioners and Physician Assistants may be included to satisfy Primary Care access requirements.

[40] Measured on members who are female and age 14 or older. Certified Nurse Midwives may be included to satisfy OB/GYN access requirements.

Section VII. First Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
7	Outpatient BH Services	• ≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members • *Research-based BH treatment for Autism Spectrum Disorder (ASD)*: Not subject to standard	• ≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of members • *Research-based BH treatment for Autism Spectrum Disorder (ASD):* Not subject to standard
8	Location-Based Services	• P*sychosocial rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP): ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members* • *Child and Adolescent Day Treatment Services:* Not subject to standard	• *Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP):* ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members *Child and Adolescent Day Treatment Services:* Not subject to standard
9	Crisis Services	• *Professional treatment services in facility-based crisis program:* The greater of: o 2+ facilities within each BH I/DD Tailored Plan Region, OR o 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates). • *Facility-based crisis services for children and adolescents:* ≥ 1 provider within each BH I/DD Tailored Plan Region • *Non-Hospital Medical Detoxification:* ≥ 2 provider within each BH I/DD Tailored Plan Region • *Ambulatory Detoxification, Ambulatory withdrawal management with extended on-site monitoring, Clinically managed residential withdrawal:* ≥ 1 provider of each crisis service within each BH I/DD Tailored Plan Region • *Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)*: Not subject to standard	

Section VII. First Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
10	Inpatient BH Services	≥ 1 provider of each inpatient BH service within each BH I/DD Tailored Plan region	
11	Partial Hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members
12	Community/ Mobile Services	≥ 2 providers of community/mobile services within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients.	
13	All State Plan LTSS (except nursing facilities)*	≥ 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	
14	Nursing Facilities*	≥ 1 nursing facility accepting new patients in every county.	
15	Residential Treatment Services	• *Residential Treatment Facility Services*: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region, • *Substance Abuse Medically Monitored Residential Treatment:* Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region *(refer to 10A NCAC 27G.3400)* • *Substance Abuse Non-Medical Community Residential Treatment*: o *Adult:* Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to licensure requirements to be determined by the Department) o *Adolescent:* Contract with all designated CASPs within the BH I/DD Tailored Plan's Region o *Women & Children:* Contract with all designated CASPs within the BH I/DD Tailored Plan's Region • *Substance Abuse Halfway House*: o *Adult:* Access to ≥1 male and ≥1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)[41] o *Adolescent:* Access to ≥1 program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E) • *Psychiatric residential Treatment Facilities (PRTFs) & Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID:* Not subject to standard	

[41] BH I/DD Tailored Plans must also ensure that gender non-conforming recipients have access to substance abuse halfway house services.

Section VII. First Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
16	1915(c) HCBS Waiver Services: NC Innovations	• *Community Living & Support, Community Navigator, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living:* ≥ 2 providers of each Innovations waiver service within each BH I/DD Tailored Plan Region. • *Crisis Intervention & Stabilization Supports, Day Supports, Financial Support Services:* ≥ 1 provider of each Innovations waiver service within each BH I/DD Tailored Plan Region. • *Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modification*: Not subject to standard	
17	1915(c) HCBS Waiver Services: NC TBI Waiver (applicable to TBI Waiver participating counties only)	• *Community Networking, Life Skills Training, Residential Supports, Resource Facilitation, In-Home Respite, Supported Employment:* ≥ 2 providers of each TBI waiver service within each BH I/DD Tailored Plan Region. *Day Supports, Cognitive Rehabilitation, Crisis Intervention & Stabilization Supports:* ≥ 1 provider of each TBI waiver service within each BH I/DD Tailored Plan Region. • *Adult Day Health, Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Natural Supports Education, Occupational Therapy, Physical Therapy, Speech and Language Therapy, Vehicle Modification*: N/A	

Section VII. First Revised and Restated Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid		
Reference Number	**Service Type**	**Definition**
1.	Outpatient BH Services	• Outpatient BH services provided by direct-enrolled providers (adults and children) • Office-based opioid treatment (OBOT) • Research-based BH treatment for Autism Spectrum Disorder (ASD)
2.	Location-Based Services (BH I/DD)	• Psychosocial rehabilitation • Substance Abuse Comprehensive Outpatient Treatment • Substance Abuse Intensive Outpatient Program • Outpatient Opioid treatment (OTP) (adult) • Child and adolescent day treatment services

Section VII. First Revised and Restated Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid		
Reference Number	**Service Type**	**Definition**
3.	Crisis Services	• Facility-based crisis services for children and adolescents • Professional treatment services in facility-based crisis program (adult) • Ambulatory detoxification • Non-hospital medical detoxification (adult) • Ambulatory withdrawal management with extended on-site monitoring • Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)
4.	Inpatient BH Services	*Inpatient Hospital – Adult* • Acute care hospitals with adult inpatient psychiatric beds • Other hospitals with adult inpatient psychiatric beds • Acute care hospitals with adult inpatient substance use beds • Other hospitals with adult inpatient substance use beds *Inpatient Hospital – Adolescent / Children* • Acute care hospitals with adolescent inpatient psychiatric beds • Other hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent inpatient substance use beds • Other hospitals with adolescent inpatient substance use beds • Acute care hospitals with child inpatient psychiatric beds Other hospitals with child inpatient psychiatric beds
5.	Partial Hospitalization	• Partial hospitalization (adults and children)
6.	Residential Treatment Services	• Residential treatment facility services • Substance abuse non-medical community residential treatment • Substance abuse medically monitored residential treatment • Psychiatric residential treatment facilities (PRTFs) • Intermediate care facilities for individuals with intellectual disabilities ICF-IID:
7.	Community/Mobile Services	• Assertive community treatment • Community support team • Intensive in-home services • Multi-systemic therapy services • Peer supports • Diagnostic assessment

Section VII. First Revised and Restated Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid		
Reference Number	**Service Type**	**Definition**
8.	1915(c) HCBS Waiver Services: NC Innovations	• Assistive Technology Equipment and Supplies • Community Living and Support • Community Networking • Community Transition • Crisis Services: Crisis Intervention & Stabilization Supports • Day Supports • Financial Support Services • Home Modifications • Individual Directed Goods and Services • Natural Supports Education • Residential Supports • Respite • Specialized Consultation • Supported Employment • Supported Living • Vehicle Modifications
9.	1915(c) HCBS Waiver Services: NC TBI Waiver	• Adult Day Health • Assistive Technology • Cognitive Rehabilitation (CR) • Community Networking • Community Transition • Crisis Supports Services • Day Supports • Home Modifications • In Home Intensive Support • Life Skills Training • Natural Supports Education • Occupational Therapy • Physical Therapy • Remote supports • Residential Supports • Resource Facilitation • Respite • Specialized Consultation • Speech and Language Therapy • Supported Employment • Supported living • Vehicle Modifications

Section VII. First Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	**Visit Type**	**Description**	**Standard**
Primary Care			
1	Preventive Care Service – adult, 21 years of age and older	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears	Within thirty (30) calendar days
1a	Preventive Care Services – child, birth through 20 years of age		Within fourteen (14) calendar days for member less than six (6) months of age. Within thirty (30) calendar days for members six (6) months or age and older.
2	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
3	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within twenty-four (24) hours
4	Routine/Check-up without Symptoms	Non-symptomatic visits for routine health check-up.	Within thirty (30) calendar days
Prenatal Care			
5	Initial Appointment – 1st or 2nd Trimester	Care provided to a member while the member is pregnant to help keep member and future baby healthy, such as checkups and prenatal testing.	Within fourteen (14) calendar days
5a	Initial Appointment – high risk pregnancy or 3rd Trimester		Within five (5) calendar days
Specialty Care			
6	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

Section VII. First Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	**Visit Type**	**Description**	**Standard**
7	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within twenty-four (24) hours
8	Routine/Check-up without Symptoms	Non-symptomatic visits for health check.	Within thirty (30) calendar days
Behavioral Health, I/DD, and TBI Services			
9	Mobile Crisis Management Services	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Within two (2) hours
10	Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Emergency Services available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
11	Emergency Services for Mental Health	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

Section VII. First Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	**Visit Type**	**Description**	**Standard**
12	Emergency Services for SUDs	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State- funded Recipients*	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
13	Urgent Care Services for Mental Health	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Within twenty-four (24) hours
14	Urgent Care Services for SUDs	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Within twenty-four (24) hours
15	Routine Services for Mental Health	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Within fourteen (14) calendar days
16	Routine Services for SUDs	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health*	Within forty-eight (48) hours

Section VII. First Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	**Visit Type**	**Description**	**Standard**
		Choice Members and State-funded Recipients	

Section VII. First Revised and Restated Attachment F.1. Table 4: Specialty Care Providers for Medicaid	
Reference Number	**Service Type**
1.	Allergy/Immunology
2.	Anesthesiology
3.	Cardiology
4.	Dermatology
5.	Endocrinology
6.	ENT/Otolaryngology
7.	Gastroenterology
8.	General Surgery
9.	Gynecology
10.	Infectious Disease
11.	Hematology
12.	Nephrology
13.	Neurology
14.	Oncology
15.	Ophthalmology
16.	Optometry
17.	Orthopedic Surgery
18.	Pain Management (Board Certified)
19.	Psychiatry
20.	Pulmonology
21.	Radiology
22.	Rheumatology
23.	Urology

Appendix F: BH I/DD Tailored Plan Network Adequacy Standards – STATE-FUNDED

BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients for service types marked with a (^).

Section VII. First Revised and Restated Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
1	Outpatient BH Services	≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of recipients[42]	≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of recipients
2	Location-Based Services^	• *Substance Abuse Intensive Outpatient Program, Outpatient Opioid Treatment (OTP)*: ≥ 2 providers of each location-based service within 30 minutes or 30 miles of residence for at least 95% of recipients • *Child and Adolescent Day Treatment Services*: Not subject to standard	• *Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, Outpatient Opioid Treatment (OTP)*: ≥ 2 providers of each location-based service within 45 minutes or 45 miles of residence for at least 95% of recipients • *Child and Adolescent Day Treatment Services*: Not subject to standard
3	Crisis Services^	• *Facility based crisis for adults:* The greater of: ○ 2+ facilities within each BH I/DD Tailored Plan Region, OR ○ 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates for the most recent year available). • *Non-Hospital Medical Detoxification:* ≥ 2 provider within each BH I/DD Tailored Plan Region • *Ambulatory Detoxification :* ≥ 1 provider of each crisis service within • each BH I/DD Tailored Plan Region	

[42] The Department defines recipients for the purposes of network adequacy as those who received State-funded services in the previous year.

Section VII. First Revised and Restated Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
4	Inpatient BH Services	≥ 1 provider within each BH I/DD Tailored Plan Region	
5.	Reserved		
6.	Community/Mobile Services^	• Each service, 100% of eligible recipients must have a choice of 2 provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients. High Fidelity Wraparound ≥ 2 provider within one hour	
		• *Assertive Engagement: 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of recipients*[43]	• *Assertive Engagement: ≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of recipients*

7	Residential Treatment Services	• *Residential Treatment Facility Services*: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region
		• *Substance Abuse Halfway House*:
		  • *Adult:* Access to ≥ 1 male and ≥1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)[44]
		  • *Adolescent:* Access to ≥1 program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)
		• *Substance Abuse Medically Monitored Community Residential Treatment*: Access to ≥1 licensed provider
		• *Substance Abuse Non-Medical Community Residential Treatment*:
		  • *Adult:* Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to licensure requirements to be determined by the Department)
		  • *Adolescent:* Contract with all designated CASPs within the BH I/DD Tailored Plan's Region
		  • *Women & Children:* Contract with all designated CASPs within the BH I/DD Tailored Plan's Region	

[43] The Department defines recipients for the purposes of network adequacy as those who received State-funded services in the previous year.

[44] BH I/DD Tailored Plans must also ensure that gender non-conforming recipients have access to substance abuse halfway house services.

Section VII. First Revised and Restated Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
		• *Substance Use Residential Supports & Mental Health Recovery Residential Services:* To be determined	
8	Employment and Housing Services	• *Residential Services (I/DD and TBI and Adult MH), Respite Services, Individual Placement and Support (I/DD and TBI and Substance Use):* 100% of eligible recipients must have a choice of two (2) provider agencies within each BH I/DD Tailored Plan Region. • *Individual Placement and Support-Supported Employment (Adult MH):* 100% of eligible individuals must have a choice of two (2) provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥1 provider that is accepting new patients. • *I/DD & TBI Day Supports. Community Living & Support, I/DD & TBI Residential Services,* IDD Supported Employment*:*100% of eligible recipients must have access to ≥1 provider agency within each BH I/DD Tailored Plan Region. • *Clinically Managed Population-specific High Intensity Residential Programs:* To be determined • *TBI Long-Term Residential Rehabilitation Services*: To be Determined	

Section VII. First Revised and Restated Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standards							
Reference Number	**Service Type**	**Classification**	**Disability Group**				
			I/DD or TBI	**Adult MH**	**Child MH**	**Adult SUD**	**Child SUD**
1	Outpatient BH Services	Outpatient Services	Y	Y	Y	Y	Y
		Diagnostic Assessment	Y	Y	Y	Y	Y
2	Location-Based Services^	Psychosocial Rehabilitation		Y			
		Substance Abuse Comprehensive Outpatient				Y	

Section VII. First Revised and Restated Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standards							
Reference Number	**Service Type**	**Classification**	**Disability Group**				
			I/DD or TBI	**Adult MH**	**Child MH**	**Adult SUD**	**Child SUD**
		Substance Abuse Intensive Outpatient Program				Y	Y
		Outpatient Opioid Therapy				Y	
3	Crisis Services^	Facility-based crisis program for adults	Y	Y		Y	
		Mobile Crisis	Y	Y	Y	Y	Y
		Non-hospital Medical Detoxification				Y	
		Ambulatory Detoxification				Y	
4	Inpatient BH Services	Inpatient Hospital (including Three-way Contract Bed)	Y	Y	Y	Y	Y
5.	Reserved						
6	Residential Treatment Services	Substance Abuse Halfway House				Y	Y
		Substance Abuse Medically Monitored Residential Treatment				Y	
		Substance Abuse Non-Medical Community Residential Treatment				Y	
		Substance Use Residential Service & Supports				Y	Y
		Mental Health Recovery and Residential Services		Y			

Section VII. First Revised and Restated Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standards							
Reference Number	**Service Type**	**Classification**	**Disability Group**				
			I/DD or TBI	**Adult MH**	**Child MH**	**Adult SUD**	**Child SUD**
		Clinically managed population specific high intensity residential services				Y	
7	Community/Mobile Services^	Assertive Community Treatment		Y			
		Assertive Engagement		Y		Y	
		Community Support Team		Y		Y	
		Peer Supports		Y		Y	
		Transition Management Service		Y			
		High Fidelity Wraparound			Y		Y
		Intensive In-home			Y		Y
		Case Management		Y		Y	
		Multi-Systemic Therapy			Y		Y
8	Employment and Housing Services	I/DD & TBI Day Supports	Y				
		Community Living & Support	Y				
		I/DD & TBI Residential Services	Y				
		Supported Employment	Y				
		Residential Supports	Y	Y			

Section VII. First Revised and Restated Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standards							
Reference Number	**Service Type**	**Classification**	**Disability Group**				
			I/DD or TBI	**Adult MH**	**Child MH**	**Adult SUD**	**Child SUD**
		Respite Services	Y		Y		Y
		Individual Placement and Supports (IPS)-Supported Employment		Y		Y	
		TBI Long-term Residential Rehabilitation Services	Y				
		Clinically Managed Population-specific High Intensity Residential Programs				Y	

Section VII. First Revised and Restated Attachment F.2. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
BH Care/I/DD			
1	Mobile Crisis Management Services	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Within two (2) hours
2	Facility-Based Crisis Management Services (FBC for Adult, Non-Hospital Medical Detox)	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Immediately available twenty-four (24) hours a day, three hundred sixty-five (365) days a year.
3	Emergency Services for Mental Health	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State- funded Recipients*	Immediately available twenty-four (24) hours a day, three hundred sixty-five (365) days a year.
4	Emergency Services for SUDs	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Immediately available twenty-four (24) hours a day, three hundred sixty-five (365) days a year.

Section VII. First Revised and Restated Attachment F.2. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
5	Urgent Care Services for Mental Health	Refer to *Section VII.Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Within twenty-four (24) hours
6	Urgent Care Services for SUDs	Refer to *Section VII.Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Within twenty-four (24) hours
7	Routine Services for Mental Health	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Within fourteen (14) calendar days
8	Routine Services for SUDs	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Within forty-eight (48) hours