Quality Management Plan

FY2022

Revised August 23, 2021

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1. Alliance's QM Philosophy & Scope

a. Description of Alliance

Alliance Health (Alliance) is a public-sector local management entity/managed care organization administering behavioral health services for the North Carolina counties of Cumberland, Durham, Johnston and Wake. Alliance authorizes Medicaid and state funds for members in the Alliance Region who need services for mental health, intellectual/developmental disabilities and substance use/addiction. North Carolina is undergoing Medicaid Transformation at this time, and Alliance has been awarded a contract to operate as a Behavioral Health and Intellectual/Developmental Disabilities (BH I/DD) Tailored Plan. This will result in Alliance authorizing Medicaid and state funds related to physical health and pharmacy benefits starting July 2022. In addition, Mecklenburg and Orange County will realign to join Alliance in December 2021, increasing the number of individuals served by approximately 50%.

At this time, Alliance receives funding on a capitated per-member, per-month (PMPM) basis, which covers both treatment services and administrative costs, for the entire Medicaid Network population in the four Alliance counties. Alliance also receives a limited allocation from the Department for State-funded MH/IDD/SA services, and some competitive grant funding.

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.

The NC Innovations Waiver is a 1915(c) Home and Community Based Services waiver (formerly the Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities). 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 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, through a three-year Medicaid waiver pilot, in Alliance's four-county region. 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 QM Plan, 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 outcomes. In FY2022, Alliance will place a focus on meeting the Tailored Plan Readiness goals to ensure a smooth transition in care to all members and recipients.

b. Alliance's Mission

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

c. Alliance's Vision

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

d. 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.

e. Alliance Members

Alliance's coverage area includes a total population of 1,911,842. By far the largest county by population is Wake, exceeding the population of the other three counties combined. Wake and Durham are the most densely populated counties, reflecting their more urbanized settings. Johnston is the least densely populated county.

Population by County in Alliance Catchment Area				
County	Population[1]	Square Miles[2]	Persons per Square Mile	Medicaid Enrollees[3]
Cumberland	333,209	652	511	14,389
Durham	320,322	286	1120	9,120
Johnston	212,401	791	269	5,761
Wake	1,109,883	835	835	17,109
Total	1,975,815	2,564	771	46,098

The service area includes both urban and rural areas but the majority of the population lives in urban areas. Because of the proximity to relatively dense population areas such as Raleigh, Durham and Fayetteville, all Alliance counties are classified as 'metropolitan/urban' counties according to United States Office of Management and Budget criteria.

The four counties that make up Alliance Behavioral Health Care are racially and ethnically diverse. Across the Alliance area, the primary ethnic group is Caucasian followed by Black and Hispanic/Latino. There is some variability across region, however. Johnston has a higher percentage of white population,

[1] https://ncosbm.opendatasoft.com/pages/nc-complete-count-committee/
[2] https://www.census.gov/quickfacts/fact/table/US/PST045219
[3] Network Adequacy & Accessibility Report FY2021

with Black and Hispanic/Latino populations roughly the same percentage. Compared to the state average, Alliance has a higher percentage of Hispanic/Latino population with Durham and Johnston having the highest percentage in the Alliance area.

Race and Ethnicity by County in Alliance's Catchment Area[4]					
	Cumberland	Durham	Johnston	Wake	North Carolina
White alone	51%	50.9%	78.2%	67.1%	72.3%
Black or African American alone	36.9%	37.6%	15.3%	20.6%	20.4%
American Indian and Alaska Native alone	1.5%	0.4%	0.5%	0.3%	1.6%
Asian alone	2.4%	4.7%	0.6%	6.2%	1.1%
Native Hawaiian and Other Pacific Islander alone	0.2%	0.0%	0.0%	0.0%	0.1%
Two or More Races	5.8%	2.8%	2.5%	2.7%	2.1%
Hispanic or Latino	10.9%	13.3%	13.1%	9.9%	7%

Languages Spoken by County in Alliance's Catchment Area[5]					
	Cumberland	Durham	Johnston	Wake	North Carolina
English Only	88.5%	81%	88.3%	83.5%	92.3%
Spanish	6.8%	12.2%	10.6%	8.3%	5.9%
Indo-European	2.2%	2.9%	0.6%	3.5%	0.9%
Asian Language	2%	2.6%	0.2%	3.3%	0.8%
Other Language	0.5%	1.2%	0.2%	1.3%	0.2%

Alliance's catchment area is experiencing higher than average population growth and is challenged to meet the needs of a diverse population with important needs such as those who do not speak English, homeless individuals with mental illness and substance use disorders, and members of the military, veterans and their families.

f. Alliance Providers

Alliance depends on a strong and diverse network of agencies and group practices, licensed independent practitioners and hospitals to provide the range of high-quality services and supports required by the densely-populated Alliance region. Alliance has credentialed providers and most organization types available in every county, as well as prescribers and licensed practitioners.

All Alliance providers are required to be active, engaged, and culturally competent members of our System of Care:

- Participate in quality improvement activities including individual satisfaction surveys, provider satisfaction surveys, clinical studies, incident reporting, performance improvement projects, and outcomes requirements.

[4] https://ncosbm.opendatasoft.com/pages/nc-complete-count-committee/
[5] https://ncosbm.opendatasoft.com/pages/nc-complete-count-committee/

- Participate in the education of stakeholders and individuals on system access, services and supports available, appeals and grievances, Advanced Directives and the Provider Network.
- Actively participate in community collaborative efforts to develop prevention, education and outreach programs.
- Work in collaboration with other Providers, individuals and families.
- Assist in the development of educational materials and brochures on mental illness, developmental disabilities and substance abuse to educate the community about the needs of people with disabilities.
- Be responsive to the cultural and linguistic needs of the individuals the agency serves.
- Pursue the acquisition of knowledge relative to cultural competence and the provision of services in a culturally competent manner. Provide culturally competent services and ensure the cultural sensitivity of staff members. Develop a Cultural Competency Plan and comply with cultural competency requirements.
- Demonstrate individual-friendly services and attitudes. The Network Provider must have a system to ensure good communication with members and families

Alliance engages providers in multiple venues aimed at improving quality including: serving as representatives on the Global Quality Management Committee (QMC) of the board of directors, serving as voting members on the Provider Quality subcommittee, and a large number of disability and service-specific provider collaboratives aimed at sharing knowledge and best practices.

As reported in the FY2021 Network Adequacy & Accessibility Report, services available in the network include a broad array of Medicaid and State-funded care, and providers served 46,098 Medicaid members and 17,885 recipients with State funds in FY2021.

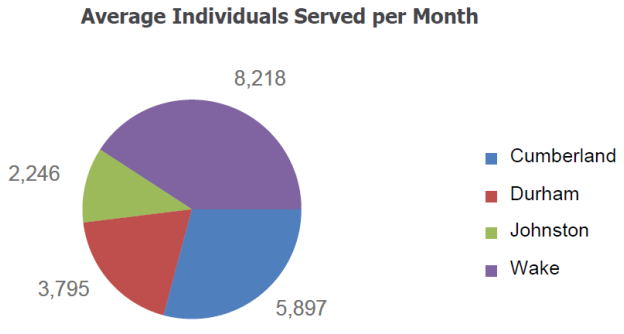
The following chart provides a summary of service expenditures for FY 2021:

Medicaid Funding

From Paid Claims Data (Date of Service)

Average Individuals Served per Month	Average Monthly Payments	Average Penetration rate
20,155	$34.9M	7.49%

Service Groups	Paid Amount
Innovations	$117,991,423
ICF/MR	$99,865,567
Outpatient	$60,628,047
Inpatient	$26,001,111
Other Services	$23,909,610
IIHS	$23,642,174
BH LT Residential	$22,169,636
PRTF	$16,795,719
ACTT	$14,699,475
1915 (b)(3) Services	$7,759,036
Peer Support	$5,140,137
Case Management	$566,595

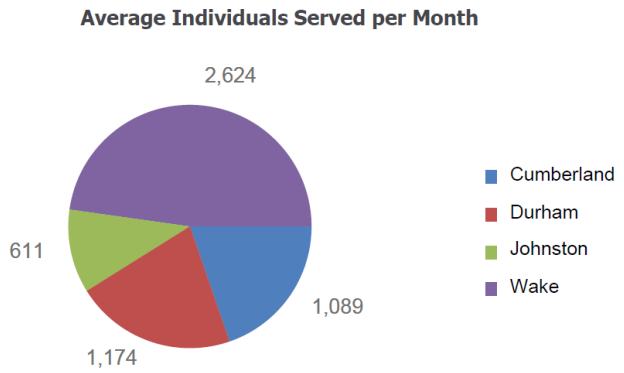


Non-Medicaid Funding

From Paid Claims Data (Date of Service)

Average Individuals Served per Month	Average Monthly Payments	Average Penetration rate
5,498	$3.7M	3.01%

Service Groups	Paid Amount
Outpatient	$13,944,120
Inpatient	$11,781,337
BH LT Residential	$6,182,882
Community Support	$4,912,680
Crisis Services	$4,342,271
ACTT	$2,506,576
MST	$386,013
Psych Rehab	$270,832
IIHS	$103,991
Other Services	$1,757



Contracts between Alliance and MH/SUD/IDD providers create reciprocal partnerships designed to ensure an integrated system of quality services and supports is available to Cumberland, Durham, Johnston and Wake County residents. All contracts between Alliance and providers contain requirements that promote person and family-centered treatment, sound clinical and business practices, and delivery of high-quality services within Alliance's System of Care.

Alliance uses performance indicators, outcome measures and other factors to determine selection and retention of providers in its network; however, member access to care will remain the primary determining factor.

The continual self-assessment of services, operations, and implementation of Quality Improvement Plans (QIPs) to improve outcomes to members is a value and expectation that Alliance extends to its providers. Providers are required to comply with all quality assurance and improvement standards outlined in North Carolina Administrative Code as well as in the Alliance Contract. These items include:

- The establishment of a formal Continuous Quality Improvement Committee to evaluate services, plan for improvements, assess progress made towards goals, and implement quality improvement projects and follow through with recommendations from the projects. This does not apply to Licensed Independent Practitioners.
- The assessment of need as well as the determination of areas for improvement should be based on accurate, timely, and valid data. The provider's improvement system, as well as systems used to assess services, will be evaluated by Alliance at the provider's qualifying review.
- The submissions of accurate and timely data, as requested, including claims for services delivered, no later than the deadline set by Alliance. Assessment of program fidelity, effectiveness, and efficacy shall be derived from data and any data requested. Providers shall be prepared to submit any and all data, reports, and data analysis upon request.
- Meeting performance standards set by Alliance and by the NC Department of Health and Human Services (NC DHHS) for behavioral health services.
- Developing cultural competencies to serve diverse members of our communities well.

2. Purpose of the Alliance Quality Program

Quality Management 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 must meet a variety of Quality Management requirements. These are set by Alliance's contracts with the NC DHHS; by the federal government's Medicaid waiver process; and by accreditation requirements.

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 MCO processes.

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 outcomes for enrollees served. It also describes how administrative and clinical functions are integrated into the overall scope and purpose of the Quality Management Department.

The Quality Management Plan is updated annually by Alliance staff led by the Chief Medical Officer and Senior Vice President of Quality Management. The Global Quality Management Committee (QMC) subcommittee of the board of directors, reviews, edits, and approve the Quality Management Plan annually. 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.

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:

- To ensure individual members receive services that are appropriate and timely;
- To use evidence-based treatments that result in measurable clinical outcomes;
- To ensure Alliance focuses on health and safety of members, protection of rights, and to monitor and continually improve the provider network;
- To 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;
- To build local partnerships with individuals who depend on the system for services and supports, with community stakeholders, and with the providers of service; and

- To demonstrate an interactive, mutually supportive, and collaborative partnership between the State agencies and Alliance n 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 outlined in the quality workplan and summarized in the table 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.	82%
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	38%
TCLI Primary Care Visits	To increase the rate of confirmed primary care provider appointments with members in the TCL 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
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

NCQA Health Plan Accreditation	To successfully implement Tailored Plan meeting NCQA Health Plan Accreditation Standards.	6/30/2022

Additional internal and contractual performance targets are listed below:

Call Center Performance

Metric	Goal
Call Abandonment Rate	<5%
Live Answer within 30 seconds	95%

Contract Super Measures

Metric	Goal
Medicaid - Mental Health 7-Day Follow Up	40%
Medicaid - Substance Use 7-Day Follow Up	40%
Medicaid - Innovations Waiver Primary Care	90%
Non-Medicaid - Mental Health 7-Day Follow Up	40%
Non-Medicaid - Substance Use 7-Day Follow Up	40%

Medicaid Performance Measures

Metric	Goal
Care Coordination Assignment	85%
Authorizations Processed within Timeframes	95%
Claims Proceed within 30 Days	90%
Resolution of Grievances within 30 Days	90%
Access to Care - Emergent	97%
Access to Care - Urgent	82%
Access to Care - Routine	75%

Innovations Waiver Measures

Metric	Goal
Members receiving services within 45 days of ISP	85%
Percent of Actions Taken to Protect the Beneficiary	85%
Incidents reported within timeframes	85%
Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.	85%
Medication errors resulting in medical treatment.	<15%

Metric	Goal
Beneficiaries who received appropriate medication	85%
Incidents where required LME/PIHP follow-up interventions were completed	85%
Percentage of incidents referred to the DSS or DHSR	85%
Percentage of restrictive interventions resulting in medical treatment.	<15%
Level of Care evaluations completed at least annually for enrolled beneficiaries	85%
Level of Care evaluations completed using approved processes and instrument	85%
New Level of Care evaluations completed using approved processes and instrument	85%
Individual Support Plans that address identified health and safety risk factors	85%
PCPs that are completed in accordance with DMA requirements.	85%
New enrollees who have a LOC prior to receipt of services	85%
New licensed providers that meet licensure, certification, and/or other standards	85%
Providers reviewed according to PIHP monitoring schedule	85%
Providers for whom appropriate remediation has taken place	85%
Providers that successfully implemented an approved corrective action plan	85%
Monitored providers wherein all staff completed all mandated training	85%
ISPs in which the services and supports reflect participant assessed needs and life goals	85%
Beneficiaries reporting that their ISP has the services that they need	85%
Individuals for whom an annual plan and/or needed update took place	85%
Beneficiaries who are receiving services as specified in the ISP	85%
Records that contain a signed freedom of choice statement	85%

Metric	Goal
Beneficiaries reporting their Care Coordinator helps them to know what waiver services are available	85%
Beneficiaries reporting they have a choice between providers	85%
Beneficiaries age 21 and older who had a primary care visit during year	85%
Claims paid by the PIHP for Innovations wavier services authorized in the service plan	85%

TBI Waiver Measures

Metric	Goal
Members receiving services within 45 days of ISP	85%
Percent of Actions Taken to Protect the Beneficiary	85%
Percentage of incidents referred to DSS or DHSR as required	85%
Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.	85%
Medication errors resulting in medical treatment.	<15%
Beneficiaries who received appropriate medication	85%
Incidents reported within timeframes	85%
Incidents where required LME/PIHP follow-up interventions were completed	85%
Percentage of restrictive interventions resulting in medical treatment.	<15%
Percentage of restrictive interventions used after all other possibilities	85%
Percentage of restrictive interventions used by trained staff	85%
Percentage of restrictive interventions documented according to state policy	85%
Level of Care evaluations completed at least annually for enrolled beneficiaries	85%
Level of Care evaluations completed using approved processes and instrument	85%
New Level of Care evaluations completed using approved processes and instrument	85%

Metric	Goal
Individual Support Plans that address identified health and safety risk factors	85%
PCPs that are completed in accordance with DMA requirements.	85%
New enrollees who have a LOC prior to receipt of services	85%
New licensed providers that meet licensure, certification, and/or other standards	85%
Providers reviewed according to PIHP monitoring schedule	85%
Providers for whom appropriate remediation has taken place	85%
Providers that successfully implemented an approved corrective action plan	85%
Monitored providers wherein all staff completed all mandated training	85%
ISPs in which the services and supports reflect participant assessed needs and life goals	85%
Beneficiaries reporting that their ISP has the services that they need	85%
Proportion of PCPs that are completed in accordance with State Medicaid Agency's requirements	85%
Beneficiaries who are receiving services as specified in the ISP	85%
Records that contain a signed freedom of choice statement	85%
Beneficiaries reporting their Care Coordinator helps them to know what waiver services are available	85%
Beneficiaries reporting they have a choice between providers	85%
Beneficiaries age 21 and older who had a primary care visit during year	85%
Claims paid by the PIHP for TBI wavier services authorized in the service plan	85%

Grievances and Complaints

Metric	Goal
Quality of Care	<10/10,000 members
Access	<10/10,000 members
Attitude/Service	<10/10,000 members

Metric	Goal
Billing/Financial	<10/10,000 members
Quality of Practitioner Office Site	<10/10,000 members

Appeals

Metric	Goal
Quality of Care	<10/10,000 members
Access	<10/10,000 members
Attitude/Service	<10/10,000 members
Billing/Financial	<10/10,000 members
Quality of Practitioner Office Site	<10/10,000 members

5. Principles and Strategies of the QM Program

Alliance's quality program is based on the principles of Continuous Quality Improvement.

a. 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 audits or 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.

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 and administrative success

b. Accreditation

Alliance also demonstrates its commitment to Continuous Quality Improvement via accreditation. Alliance is accredited as a Managed Behavioral Healthcare Organization (MBHO) with Long-Term Services and Supports (LTSS) distinction by the National Committee for Quality Assurance (NCQA). This accreditation offers additional standards and guidance for developing programs aimed at supporting members with complex and long term needs and integrating that work closely with the physical healthcare delivery network.

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.

a. Chief Medical Officer

The Alliance Health Chief Medical Officer (CMO) serves as the designated behavioral healthcare practitioner overseeing the operations of the quality management program. The CMO is a co-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 Coordination, Call Center, Network Management, and Quality Improvement.

b. 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 four functional areas:

- 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 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.
- 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, geomapping, and the implementation and interpretation of surveys.

- 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.

c. Provider Network Development and Evaluation

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.

- Develops and maintains 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
- Supports the Credentialing committee to ensure that all providers and practitioners meet requirements to participate in the Alliance provider network

d. Care Management

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.

- 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

e. 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.

f. Community Health and Well Being

Focused on promoting quality partnerships and collaborative change and redesigning systems of care to improve health outcomes and promote healthy communities. We work 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 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.

- Champions Health Literacy efforts aimed and ensuring that members and their families can understand and direct their treatment.

- Support the Consumer Family Advisory Councils (CFAC) in advising the Alliance administration and Board of Directors
- Leverage partnerships to increase access to permanent and temporary housing for the people we serve.
- Lead stigma reduction and Mental Health First Aid campaigns in our communities.

g. 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.

h. Office of Compliance and Risk Management

The Compliance division 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. 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.

7. Quality Committee Structure

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

a. Global Quality Management Committee (QMC)

The Alliance Global Quality Management Committee (QMC) 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 Quality Improvement Projects (QIP) 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 representatives from Alliance's Consumer and Family Advisory Council (CFAC), and two non-voting provider representatives.

b. 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 Global 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 sections c-h below.
Responsibilities	• The implementation of the Alliance Quality Plan • Monitoring of quality improvement goals and activities • Identifying opportunities for improvement within the provider network and Alliance operations • Monitor performance with regard to key quality indicators of Alliance internal and external functional areas including over/under utilization, member outcomes, network performance, etc.
Reports to	Global 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: • Chair of Care Management Subcommittee • Chair of Utilization Management Subcommittee • Chair of Member Experience Subcommittee • Chair of Provider Quality Subcommittee • Chair of Social Determinates of Health Subcommittee • Chair of Delegation and Accreditation Oversight Subcommittee • Chair of the 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.

c. 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 committee 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 committee 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
Committee Chair	• Chief Medical Officer (co-chair) • Senior Director of Utilization Management (co-chair)
Committee Composition	• Finance • Provider Networks • Care Management • Quality Management
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.

d. Provider Quality – CQI Subcommittee

Purpose	The purpose of the Provider Quality Subcommittee is threefold: a) to engage Alliance providers in developing, evaluating and approving guidelines for clinical practice across the network, b) to engage Alliance providers in the systematic monitoring and evaluation of provider performance measures required by NCDHHS and included in Alliance provider contracts, and c) 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 Committee 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
Committee Chair	• Director of Network Evaluation (co-chair) • Chief Medical Officer or designee (co-chair)
Committee Composition	• Ten Clinical subject matter experts (from MH/SUD and IDD) • Alliance pharmacist *Membership on this committee, outside of the chairs, is entirely made up of providers. Providers on this committee represent a cross section of different service types, settings, and geographic locations within Alliance's catchment area.
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.

e. Social Drivers of Health – CQI Subcommittee

Purpose	The purpose of this committee is to ensure the environmental conditions impacting members are addressed and to make recommendations about aligning SDOH efforts with care management and network providers. This committee reviewed SDOH assessments and interventions to align efforts across the system so they can be most effective. This committee is chaired by Senior Director of Clinical Innovations.
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
Committee Chair	• Senior Director of Clinical Innovation (Chair)
Committee Composition	• Community Health and Wellbeing • Care Management • Quality Management • Medical Management
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.

f. Care Management – CQI Subcommittee

Purpose	The purpose of this committee is to align care management resources to improve the efficacy of the care delivery network and optimize member outcomes. This committee assists in defining and monitoring the quality of care management services being delivered.
Responsibilities	• Monitor impact of Care Management efforts and identify improvement opportunities • Create framework for evaluating outcomes and functions of internal and eventual external care management efforts • Monitor relationship between care management and service providers to ensure members receive the care they need in a timely and appropriate manner
Reports to	CQI
Committee Chair	• Senior Vice President of Population Health and Care Management (Chair) •
Committee 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
Committee Meetings	The Chair of the Committee will establish the agenda for each Committee meeting. 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.

g. 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 committee.
Responsibilities	• Monitor impact of Care Management efforts and identify improvement opportunities • Create framework for evaluating outcomes and functions of internal and eventual external care management efforts • Monitor relationship between care management and service providers to ensure members receive the care they need in a timely and appropriate manner
Reports to	CQI
Committee Chair	• Quality Management Specialist (Chair)
Committee Composition	• Senior Director of Care Management • Provider Networks • Care Management • Medical Management • Pharmacy
Committee Meetings	The Chair of the Committee will establish the agenda for each Committee meeting. 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.

h. 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 committee 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
Committee Chair	• Chief Compliance Officer
Committee Composition	• Corporate Compliance • Quality Management • Provider Networks • Access Call Center

	• Utilization Management
Committee Meetings	The Chair of the Committee will establish the agenda for each Committee meeting. 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.

i. Health Equity – CQI Subcommittee*

This committee is new for FY2022. The Health Equity Committee is a centralize 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. The charter for this committee is still under development. The Committee is chaired by a QM representative.

h. Pharmacy & Therapeutics – CQI Subcommittee*

This committee is new for FY2022. The Pharmacy and Therapeutics committee exists to promote the appropriate use of high quality and cost-effective pharmaceuticals for Alliance Members and to ensure compliance with appropriate standards and state and federal regulations. This committee will include network pharmacists, physicians, and will be co-chaired by Alliance's Pharmacy Director and Deputy Chief Medical Officer.

8. Quality Activities

a. 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 our 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.

We encourage our staff and providers to recognize that culture makes us who we are. Culture not only determines how we see the world and each other, but greatly impacts how we 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. We envision that our 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 shall be made available by telephone or in-person to ensure that Enrollees are able to communicate with Alliance and Network Providers. Providers and Alliance shall make oral interpretation services available free of charge to each Enrollee. This applies to non-English languages as specified in 42 C.F.R. § 438.10(c)(5). TDD (telecommunication devices for the deaf) must also be made available by providers for persons who have impaired hearing or a communication disorder.

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 (CQI) 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.

b. 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 PCP or 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 and Incident 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 ninety (90) 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) working days, then QM staff will send a letter to the complainant updating progress on the grievance resolution and the anticipated resolution date.

c. 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 to Alliance within seventy-two (72) hours of the incident. The report also must be reported in the state's web-based Incident Response Improvement System (IRIS). All crisis providers are required to report incidents that occur during the provision of crisis services.

The QM Department's Grievance and 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, 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, 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.

d. 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.

e. 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 UM Committee, a CQI subcommittee, and Clinical operations leadership are responsible for detecting over and under-utilization and analyze claims (encounter) data and authorization data on a monthly basis to determine utilization patterns. Data analysis will identify the potential need for further review. Data reviewed includes:

- Average Length of stay in inpatient and residential facilities
- Provider treating multiple family members individually
- Members receiving multiple services
- High cost/high utilized service trends
- Use of evidenced based services
- Inpatient Readmissions
- High volume of authorized units compared to billing
- Higher than average costs per treatment episodes

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 utilization review manager for a record review or may refer cases to the Compliance Department for a 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.

f. 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 and Provider Networks Departments plays a significant role in developing training to inform stakeholders and staff of quality processes in general, and processes actively subject to quality improvement activities.

g. Value Based Contracting

Alliance will continue to support the Value-Based contracts (VBC) launched in 2021 in order to evaluate a full year of data on the effectiveness of the contracting approach. Additionally, Alliance has executed a VBC with Triangle Springs inpatient facility in order to improve both Medicaid MH and SUD follow-up measures. Alliance has negotiated a VBC model with providers participating in the OneCare Cumberland

network to incentivize the timely response to electronically referred individuals from Cape Fear Valley Health System and the Cumberland County Crisis Response Center and to improve 7 day follow up for State and Medicaid SUD and MH follow-up.