2018 External Quality Review

SANDHILLS CENTER

Submitted: September 28, 2018

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

Table of Contents

EXECUTIVE SUMMARY 1
A. Overall Findings 1
B. Overall Recommendations 2

METHODOLOGY 6

FINDINGS 7
A. Administration 7
Information Systems Capabilities Assessment 10
Strengths 16
Weaknesses 17
Recommendations 17
Corrective Actions 18
B. Provider Services 18
Strengths 21
Weaknesses 21
Corrective Action 22
Recommendations 22
C. Enrollee Services 24
Strengths 26
Weaknesses 26
Corrective Action 27
Recommendations 27
D. Quality Improvement 27
Performance Measure Validation 29
Performance Improvement Project Validation 41
Strengths 45
Weaknesses 46
Recommendations 46
Corrective Action 46
E. Utilization Management 46
Strengths 49
Weaknesses 50
Corrective Actions 51
Recommendations 51
F. Grievances and Appeals 52
Grievances 52
Appeals 53
Strengths 59
Weaknesses 59
Corrective Actions 61
Recommendations 62
G. Delegation 63
Strengths 66
Weaknesses 67
Corrective Action 67

Table of Contents

Recommendation ... 67
H. Program Integrity ... 67
Strengths ... 69
Weaknesses ... 69
Recommendations ... 70
I. Financial Services ... 70
Strengths ... 73
Weaknesses ... 73
Recommendations ... 73
J. Encounter Data Validation ... 73

ATTACHMENTS ... 76
A. Attachment 1: Initial Notice, Materials Requested for Desk Review ... 77
B. Attachment 2: Materials Requested for Onsite Review ... 89
C. Attachment 3: EQR Validation Worksheets ... 91
D. Attachment 4: Tabular Spreadsheet ... 161
E. Attachment 5: Encounter Data Validation Report ... 221

EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 requires State Medicaid Agencies that contract with Prepaid Inpatient Health Plans (PIHPs) to evaluate their compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358 (42 CFR § 438.358)*. This review determines the level of performance demonstrated by the Sandhills Center (Sandhills) This report contains a description of the process and the results of the 2018 External Quality Review (EQR) The Carolinas Center for Medical Excellence (CCME) conducted for the North Carolina Department of Health and Human Services' (NC DHHS) Division of Medical Assistance (DMA).

Goals of the review are to include the following:

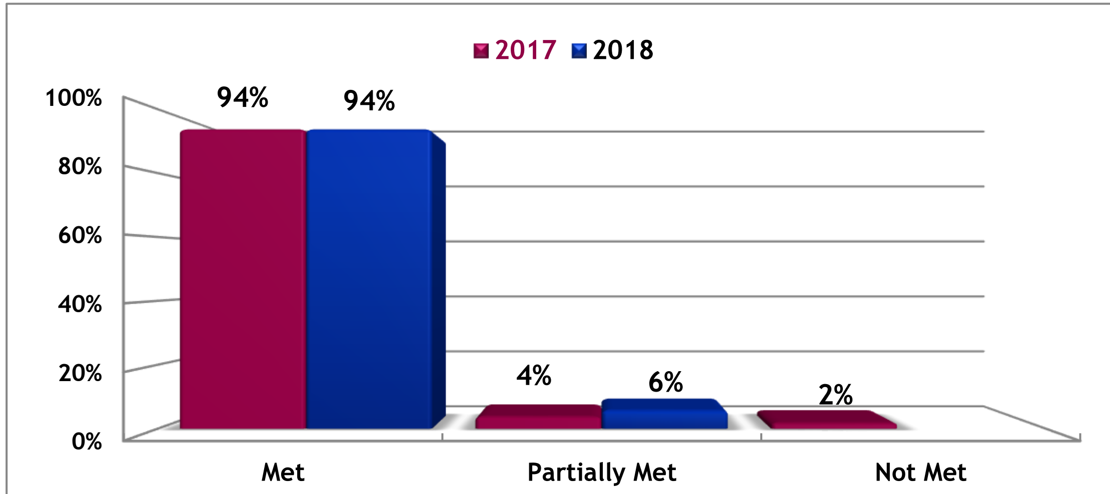
- Determine if Sandhills complies with service delivery as mandated by their DMA Contract
- Provide feedback for potential areas of further improvement
- Verify the delivery and determine the quality of contracted health care services

The process used for the EQR was based on the Centers for Medicare & Medicaid Services (CMS) protocols for EQR of Medicaid Managed Care Organizations (MCOs) and PIHPs. The review includes a Desk Review of documents, a two-day Onsite visit, compliance review, validation of performance improvement projects (PIPs), validation of performance measures (PMs), validation of encounter data, an Information System Capabilities Assessment (ISCA) Audit, and Medicaid program integrity review of the health plan.

A. Overall Findings

The 2018 Annual EQR reflects that Sandhills achieved a "Met" score for 94% of the standards reviewed. As Figure 1 indicates, 6% of the standards were scored as "Partially Met," and none of the standards scored as "Not Met." *Figure 1, Annual EQR Comparative Results* provides a comparison of Sandhills' 2017 review results to 2018 results.

Figure 1: Annual EQR Comparative Results



B. Overall Recommendations

CCME provides recommendations that address each of the review findings, which are explained in detail under each respectively labeled section of this report. CCME identified the following global recommendations for improvement, which should be implemented along with the detailed recommendations in each section.

Administration

Sandhills' policies and procedures were all annually reviewed in April 2018. Per Sandhills' procedure *Core 3a Policy-Procedure Maintenance Review Approval*, all procedures are visited by the Compliance Committee as a part of the annual review. However, this step was omitted in this past year's annual review process.

Sandhills has 732 policies and procedures that are duplicative and, at times, contradictory. Sandhills also struggles to nimbly, and in a timely manner, update and correct their policy and procedure set when changes are needed. During the Onsite interviews, staff rarely referenced policies and procedures when describing departmental processes. CCME recommends that Sandhills develop a workplan to streamline their policies and procedures to be more user friendly to staff and achieve a better compliance with contractual and federal requirements.

Sandhills has comprehensive enrollment and claims processing systems in place. Staff were able to speak to their processes and provided a demonstration of the enrollment and claims data captured in AlphaMCS.

Documents that CCME reviewed to understand clinical oversight revealed Sandhills' needs to update and clarify the roles and responsibilities of their Chief Clinical Officer (CCO)/Medical

Director, their delegated Peer Reviewer agency, and the clinical relationship with Dr. Kenneth Marks. These issues are described in more detail in the Administrative section of this report.

Sandhills implemented various processes to address encounter submission denials attributed to provider taxonomy discrepancies. Sandhills continues to work with DMA to resolve outstanding issues, and continues to work diligently to resolve corrective actions from last year's audit. For claims with dates of service as of July 2017, the encounter denial percentage is at 1%. 8,000 claims (January 2015-Aug 2017) are pending submission to DMA. Sandhills provided a comprehensive summary report on how they addressed backlogged encounters and how they reduced denials attributed to provider taxonomy codes.

Currently, Sandhills captures up to 14 diagnosis codes in their provider portal but submits only up to two diagnosis codes in encounter data submissions. Sandhills is working in AlphaMCS to begin submitting up to 12 secondary codes for encounter data submissions. As discussed Onsite, NCTracks can capture up to 25 diagnosis codes for institutional claims and 12 diagnosis codes for professional encounters. Sandhills is willing to adjust their system to follow DMA's recommendations.

Provider Services

The Provider Services review includes Network Adequacy and Credentialing and Recredentialing. The only "Partially Met" item for this review was due to Sandhills not completing the *State Exclusion List* query as part of the credentialing or recredentialing process until June 2018. For applications approved in June 2018, Sandhills went back and completed the *State Exclusion List* query. Several files did not contain items needed for the EQR. In response to CCME's request during the Onsite visit, Sandhills provided additional documents. CCME recommends verifying credentialing and recredentialing files contain all required items, as outlined in the Recommendations section of the EQR report.

Enrollee Services

The Enrollee Services review focuses on enrollee rights and responsibilities, enrollee PIHP program education, behavioral health and chronic disease management education, and the Call Center. There is a concentrated effort to keep all Call Center staff updated on the website changes. In addition, Call Center staff receive updates through organized training and emails from the Community Relations and Communications Director. Adding information in the *Member Handbook* to address Sandhills' procedure on referrals for Specialty Care would be helpful. Also, ensure there is a policy, procedure or desk reference that addresses the format of enrollee materials. Confirm that all communications staff are kept up to date about policies and procedures on enrollee materials. Written material should be at least 12 point per *CFR 438.10 (D(6) (ii)* unless it is a large print document, which should be no smaller than 18 point per *CFR 438.10 (d) (3)*. Sandhills should continue to work with Cardinal Innovations through the corrective action process to improve the Sandhills rollover call metrics.

Quality Improvement

Sandhills implemented PIPs and PM-related recommendations, and corrective actions from the last EQR. Sandhills has a strong process for monitoring evidence-based, Clinical Practice Guidelines. The *Integrated Care Project* is an example of active and engaged physician participation in Quality Improvement (QI) projects. The Global Quality Improvement Committee (GQIC) has three of the seven meetings reviewed without a Quorum. Sandhills needs to work to restructure, increase interest, recruit new members, or consolidate provider committees to meet the GQIC quorum. There is a workgroup to review measures needing improvement for the *ECHO Survey*. This workgroup has minutes and reports progress to needed committees. This evidence of improvement for each of identified measure is not tracked in a dedicated document, which makes it hard to see improvement.

Utilization Management

A key Sandhills EQR component focuses on Utilization Management (UM), Care Coordination, and the Transition to Community Living Initiative (TCLI) programs. CCME's concerns relate to missing information from the programs' policies and procedures, inadequate documentation within the Care Coordination and TCLI files, and the lack of a marketing plan to promote TCLI to Sandhills' stakeholders.

Grievances and Appeals

CCME's review of Sandhills' grievance processes showed that all grievances were resolved in a timely manner. Information within the grievance files, while improved from last year, still remains incomplete and unclear within the grievant notifications. Sandhills uses the terms "Complaint" and "Grievance" inter changeably within their grievance files, *Member Handbook* and *Medicaid Provider Manual*. Using both terms could confuse members and stakeholders. Policies and procedures do not accurately capture all of the internal processes staff and the CCO/Medical Director follow when resolving grievances.

The EQR of Sandhills' appeals processes, files, and other materials also showed that all appeals were processed timely and overall, within the required contractual procedures. CCME's main concerns focused on Sandhills' policies and procedures, and the lack of accurate details, particularly around the expedited and extended appeal processes. These details are discussed within the appeals section of this report. Other concerns noted are that Sandhills accepts and processes appeals that providers submit even though they do not include the written or "signed" consent of the enrollee. This contractual requirement is incorrect in the procedures and was demonstrated within the appeal files as well. Sandhills' *Member Handbook* and *Medicaid Provider Manual* also lack clear details to sufficiently inform their members and providers about the enrollees' rights to appeal.

Delegation

Sandhills reported four delegated entities. The submitted delegate files include contracts, with Business Associate Agreements (BAA) for the delegates who have access to Protected

Health Information (PHI). Sandhills completed a pre-delegation audit when one delegate was added and submitted evidence of the required monitoring for its delegates. Sandhills needs to execute a Delegation Agreement and BAA with Dr. Marks, who is performing required functions. To comply with *DMA Contract, Section 7.6.4 Exclusions*, Sandhills should revise the Pre-Delegation checklists and the monitoring tools to include the query of the *State Exclusion List*.

Program Integrity

Overall, during the 2018 EQR for program integrity (PI), Sandhills updated and provided all documentation including policies and procedures that meet contractual requirements. CCME recommends that Sandhills enhance their data mining systems to include enrollee fraud, waste, and abuse. Sandhills may then be able to capture more allegations and further investigate to prevent more instances of enrollee fraud, waste and abuse. CCME also recommends that for future audits, Sandhills upload case files for file review in a streamlined and systematic fashion to ease EQR file examination.

Financial Services

Sandhills scored a “Met” for all the Financial Services standards for the 2018 EQR. Sandhills exceeded the contract benchmarks for current ratio and medical loss ratio. The PIHP maintains a suitable accounting system and upgraded to the 2018 version. Sandhills policies and procedures are detailed and meet contractual standards. CCME recommends the following policy and/or procedure changes: tying policies to contract or CFR requirements, adding the risk reserve payment due date to *Procedure 31b*, updating details of the incurred but not reported (IBNR) procedure, and updating *Procedure 32a* for storage of financial records to ten years. CCME also recommends resubmitting and communicating any DMA report changes to DMA staff.

Encounter Data Validation

Based on the analysis of Sandhills' encounter data, we have concluded that the data submitted to DMA is complete and accurate. However, minor issues were noted with both institutional and professional encounters due to missing additional diagnosis codes.

METHODOLOGY

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

On July 11, 2018, CCME sent notification to Sandhills that the annual EQR was being initiated (see *Attachment 1*). This notification included:

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

Further, an invitation was extended to the health plan to participate in a pre-Onsite conference call with CCME and DMA to offer Sandhills an opportunity to seek clarification on the review process and ask questions regarding any of the Desk Materials CCME requested.

The review consisted of two segments. The first was a Desk Review of materials and documents received from Sandhills on August 1, 2018 and reviewed in CCME's offices (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. Also included in the Desk Review was an examination of credentialing, grievance, utilization, care coordination, case management, and appeal files.

The second segment was a two-day, Onsite review conducted on August 29 through August 30, 2018, at Sandhills corporate office in West End, North Carolina. CCME's Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's Onsite activities included:

- Entrance and Exit Conferences
- Interviews with Sandhills' Administration and Staff

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

FINDINGS

The EQR findings are summarized in the following pages of this report and are based on the regulations set forth in *42 CFR § 438.358* and the contract requirements between Sandhills and NC DHHS' DMA. CCME identifies strengths, weaknesses, corrective action items, and recommendations where applicable. The report identifies areas of review as meeting a standard "Met", acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated." These standards are recorded on the tabular spreadsheet (*Attachment 4*).

A. Administration

The Administration review focused on the PIHP's policies, procedures, staffing, compliance and confidentiality, information system, and encounter data capture and reporting.

Policies & Procedures

Sandhills' policies and procedures are well organized and accounted for on the *Master List of Policies and Procedures*. Review of individual policies and procedures show an active revision process. Thirteen percent of Sandhills' policies and procedures were revised in the past year. Sandhills developed and implemented approximately 15 new policies and procedures in the past year, as well.

All policies and procedures were annually reviewed in April 2018. Per Sandhills' procedure *Core 3a Policy-Procedure Maintenance Review Approval*, all procedures are reviewed by the Compliance Committee as a part of the annual review. However, this step was omitted in this past year's annual review process. Sandhills should either update this procedure to accurately reflect the Compliance Committee involvement in the annual review process or come into compliance with the procedure.

Overall, the policies and procedures are well written but are often duplicative and incongruent to one another. For example, Sandhills has 20 policies and procedures governing the Medicaid appeals process. There is a *Standard Medicaid Appeal Process Timeframe (Medicaid)* procedure and an *Appeals Process (Medicaid)* procedure. Both of these procedures define, differently and incorrectly, who can file an appeal. This duplication prevents Sandhills from accurately and nimbly updating, revising and correcting policies and procedures. Similarly, Sandhills has 126 policies and procedures governing Care Coordination. During Onsite interviews, few staff referenced policies and procedures and were unaware of the errors within them.

The average number of policies and procedures managed by other PIHPs is 225. Sandhills maintains 732 policies and procedures. It was discussed during multiple portions of the Onsite interview that Sandhills' policies and procedures set is too cumbersome to be

consistently useful to staff. Sandhills struggles to effectively, consistently and in a timely manner update and revise their policy and procedure set. Streamlining their policy and procedure set would reduce these liabilities.

Organizational Staffing/ Management

Recent changes to Sandhills' organizational structure elicited discussion during the Onsite interviews. The Quality Management (QM) Director position has been vacant since May of 2018 and the department was restructured to consist of this director position and two administrative support positions. Staff explained that, while the department is small, QM functions pervade multiple departments. Mary Kidd, previously the Complaints and Incident Report Manager, assumed the QM Director position on September 1, 2018 but has been serving in the capacity of QM Director and Complaints and Incident Report Manager since the position was previously vacated. The Incident Report Manager position is currently posted.

The Care Management/Utilization Management (UM) Director position has been vacant since January of 2018. This position was accepted by Sarah Glanville, LCSW who was previously the Program Integrity (PI) Director. She began serving as the Care Management/UM Director during the Onsite.

Dr. Kahlil Tanas, who served as the Associate Medical Director, retired in July of 2018. Sandhills recently contracted the consultative services of Dr. Kenneth Marks. Review of his scope of work shows his primary function is to "provide consultative services in the area of clinical and quality management issues." It should be noted that Sandhills could not provide a viable contract for Dr. Marks' services. This is discussed in greater detail in the Delegation portion of this report. Dr. Carraway explained that Dr. Marks typically provides services "a few hours a week" and that his primary focus is assistance with special projects.

This leaves Dr. Carraway, per *DMA Contract*, to solely provide the "substantial involvement in functions that support QA/Pl, such as credentialing, utilization review, and the monitoring of PIHP's Network Providers."

Dr. Carraway chairs, co-chairs and attends several committees that address Sandhills' clinical functions. CCME's review of committee minutes show he actively participates in the QM, Critical Incidents, Clinical Leadership Team, and Clinical Advisory Committees. However, Dr. Carraway did not attend the UM Committee in the past year, which is a concern because his job description says that he is co-chair of this committee and the *Committee Membership 2017-2018* document shows he is also a voting member. During the Onsite interview with Dr. Carraway, he reported he has to be selective in his committee attendance but is routinely

involved with the directors, managers and committee members that keep him abreast of escalating issues. He also described active involvement in the clinical departments through ad hoc communications. A recommendation from last year's EQR was to capture these ad hoc consultations in a communication log. Sandhills provided a sample log during the Onsite.

Dr. Carraway's current job description was initiated in 2013 and does not accurately capture his current duties and committee memberships as described during the Onsite. Names of committees are out of date and departmental oversight, both direct and designated, is no longer accurate in this description. This job description should be updated and aligned with Dr. Carraway's current departmental oversight, committee membership and attendance, and the Medical Director requirements in the *DMA Contract, Sections 6.7.6 and 7.1.3*.

Another update that is needed is to the current Prest & Associates (Prest) contract last addended December 9, 2009 and signed March 8, 2010. This addendum includes that Prest will provide "consultation, supervision and oversight" to the Utilization Management Committee. Further, this oversight extends to, as needed, "serve as back up to the Sandhills Centre Medical Director when volume necessitates or when the Medical Director is not available". This language should be corrected to guard against any conflicts of interest, real or perceived, of Prest involvement between UM functions and their role as the delegated Peer Reviewer entity. For example, as Prest is reimbursed for each peer and appeal review, their documented, potential influence over the UM department and volume of peer and appeal referrals to Prest could be considered a conflict of interest.

Confidentiality

Sandhills has over 20 policies and procedures addressing their confidentiality practices and requirements including:

- Information Confidentiality, Integrity and Availability-Annual Risk Assessment
- Information Confidentiality and Security-Prevention of Confidentiality and Security Breaches
- Information Confidentiality and Security-Detection, Containment and Correction for Breach
- Confidentiality of Individually-Identifiable Health Information
- Health Insurance Portability & Accountability Act
- Authorization for Use and Disclosure of Protected Health Information
- De-Identification of Protected Health Information

- HIPAA Security Risk Analysis
- Minimum Necessary Disclosures
- Use and Disclosure of Protected Health Information
- Notice of Privacy Practices
- Privacy Complaints
- Revoking Authorizations

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

Sandhills staff training procedure explains that new staff are trained in confidentiality specific to their new position within the first two days of employment. Additional training to new staff is provided during the new employee orientation that is completed within the new staff's first month of employment.

Information Systems Capabilities Assessment

IPRO, in contract with CCME and as required by CMS protocol, conducted the yearly review of Sandhills' Information Systems Capabilities Assessment (ISCA).

Sandhills, like many other behavioral health PIHPs in North Carolina, uses the AlphaMCS transactional system, a hosted system environment produced by Mediware. Mediware modifies the user interface and does backend programming updates to the system.

Sandhills completed the 2018 ISCA tool and submitted supporting documentation, workflows, policies and procedures. IPRO reviewed all submitted materials and responses, and re-reviewed materials submitted for last year's audit. Sandhills' staff were prepared to speak on existing processes and reports at the Onsite audit. Questions regarding the ISCA tool and follow-up on last year's audit findings were discussed with the PIHP. Sandhills' staff was prepared to do live demonstrations and display enrollment and claims data elements in the AlphaMCS system at Sandhills' new office location in West End, North Carolina on August 30th, 2018.

Enrollment Systems

Sandhills has experienced a stable enrollment growth over the past three years (2015-2017); year-end enrollment for 2017 is 189,550 members in comparison to 186,544 members in 2015.

The ISCA tool and supporting documentation for enrollment systems loading processes clearly defined the process for enrollment data updates in AlphaMCS. Mediware receives the global eligibility file (GEF) from DMA quarterly, and loads the file into AlphaMCS.

Daily updates are provided to Sandhills via 'deltas' and loaded into AlphaMCS by Mediware to make appropriate additions, deletions, or changes to client information in the system. Sandhills uses exception reports, which are produced by Mediware, to capture enrollment data that did not successfully update. Historical data is stored within the AlphaMCS system. All eligibility data (start and end dates) for members are maintained and updated; no information is deleted.

Enrollees are identified by unique patient IDs. As discussed Onsite and explained within the ISCA tool, the enrollment system is set to establish one patient id for a member. In the rare case of members with multiple ids, enrollment staff will identify these members, research discrepancies and make changes as appropriate. Member deaths are captured through the GEF file or providers will inform the PIHP of member deaths. If the information is manually entered in AlphaMCS, there is an additional verification process in place with a validation against the death registry.

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

Claims Systems

Sandhills' claims are processed in the AlphaMCS system. Claims payments occur within the accounting system, Great Plains Dynamic Accounting system. There was no significant staff turnover in the department, and new billing is implemented each quarter for the AlphaMCS system.

ISCA responses as well as claims process workflows, daily denial reports and sample audit reports provided an overview of Sandhills' claims processing and reporting. Supporting documentation for the ISCA audit shows that nearly 100% of clean claims are processed within 30 days. Approximately 98% of professional claims and 98% of institutional claims are received within 90 days after service date. Sandhills routinely conducts claims audits on 3% of approved claims and 3% of denied claims.

The majority of institutional and professional claims received are electronic (HIPAA or Provider Web portal). If required fields are missing from a claim, the provider portal does not allow the claim to be processed, and for other electronically submitted claims, providers receive a 999 transaction file letting them know data elements are missing on the submitted claims. As per last year's audit suggestion, the PIHP discussed Onsite how they have included provider taxonomy discrepancies in their daily denial reports and how their staff resolve these issues. Denial reports capture relevant information so that immediate resolution can happen. The PIHP's goal is to process remittances within the week.

About 88% of both institutional and professional claims received and processed are paid while the rest are denied. For professional encounters, 99.01% of claims are auto-adjudicated. For institutional encounters, 89.01% of claims are auto-adjudicated.

Staff demonstrated Onsite the capture of claims information in AlphaMCS, the standard paper forms and provider portal entry screens for claims submissions and claims denial reports used by staff. As discussed in prior audits, the PIHP could benefit from the addition of ICD-10 procedure codes, diagnosis-related groups (DRGs) and Logical Observation Identifiers Names and Codes (LOINC) codes. Staff discussed Onsite that if submitted on the claim, ICD-10 procedure codes and DRGs are captured in the backend data but are not included for state encounter submissions. Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) are captured for professional encounters and revenue codes are captured for institutional encounters. Additionally, AlphaMCS can capture up to 14 diagnosis codes for both professional and institutional encounters, but currently submits only up to two diagnosis codes for encounter submissions to the state. Rarely does the PIHP see their providers submit more than a few diagnosis codes on submitted claims. As per communication with DMA, IPRO discussed with the PIHP that NCTracks is capable of capturing up to 25 diagnosis codes for institutional encounters and up to 12 diagnosis codes for professional encounters. Sandhills is cooperative with state requirements and is in the testing phase of including more codes in their encounter submissions to the state via AlphaMCS system.

Sandhills conducts weekly claims audits. Staff explained audit processes Onsite and stated that paper claims are audited pre and post data entry within a two-day timeframe. Additional audit processes that affect the finance and claims team were also discussed Onsite.

Reporting

Sandhills' data systems capture and store enrollment and claims information. All eligibility data is loaded into the AlphaMCS system and Mediware also maintains a backup at a secondary Mediware facility. Sandhills is provided a daily backup that is saved on an onsite database. As stated in the ISCA, the Sandhills' server is replicated between the primary and secondary data centers.

A disaster recovery procedure was provided prior to the Onsite audit for review. When asked Onsite if there were any unplanned events, disasters or disruptions to their enrollment, claims or encounter submission processes, Sandhills stated there were no disruptions.

Internal claims reports were provided as supplemental documentation for the ISCA audit. Claim denial reports capture claim discrepancies for timely resolution, the claims lag report provided displays 98% of claims are received within 90 days after the service date,

the sample claims audit reports indicate Sandhills has oversight and monitoring of its claims processes and the Claims DMA encounter submission report indicates Sandhills processes clean claims data within the 30-day standard.

Encounter Data Submissions

Sandhills has a defined process in place for their encounter data submission, with 837 files submitted to DMA weekly, and 835 files received back from DMA through the NCTracks system. Sandhills uses the 835 file from NCTracks to review denials. Sandhills can track claims from the adjudication process to their encounter submissions status.

For denied encounters, Sandhills produced and uses a program based on the Adam Holtzman paid and denied report to track, review, and rebill encounters that remain in the denied status. Encounter staff ask credentialing specialists to resolve provider taxonomy discrepancies with providers when an update is needed in AlphaMCS or NCTracks. Encounter staff also work closely with enrollment and UM teams to resolve other denial reasons that may be attributed to enrollment updates or approved services.

Table 1, Comparative of Encounter Data provides a breakdown of encounter data acceptance/denial rates for the 2017 year, with a 2016 comparison:

Table 1: Comparative of Encounter Data

2017	Initially Accepted	Denied, Accepted on Re-submission	Denied, Not Yet Accepted	Total
Institutional	28,989	2,048	167	31,204
Professional	1,002,336	95,689	40,527	1,138,552
2016	**Initially Accepted**	**Denied, Accepted on Re-submission**	**Denied, Not Yet Accepted**	**Total**
Institutional	29,901	2,721	239	32,861
Professional	964,594	229,408	30,389	1,224,391

The percentage of denied institutional encounter submissions, not yet accepted was 0.5% (167/31,204) for 2017, which is comparable to 0.7% of 2016 institutional encounter submissions. The percentage of denied professional encounter submissions, not yet accepted was 3.6% (239/32,861) for 2017 compared to 2.4% of 2016 institutional encounter submissions. Last year's audit findings showed that professional encounters had a very high denial rate for professional claims, and Sandhills had a large number of denied encounters awaiting resubmission. Sandhills proactively addresses the high denial rate by continuing their process to reconcile their provider data against NCTracks, tracking claims from adjudication to state submission, using daily denial reports to resolve provider claims with incorrect taxonomy codes, and improved interdepartmental

collaborations to resolve encounter denials. As discussed Onsite, the PIHP's monthly encounter submissions meet the DMA standard for 95% encounter acceptance rate.

For encounter data submissions, Sandhills submits the first two diagnosis codes on the claim. As discussed during the claims processing section of the Onsite audit, CCME recommends that Sandhills include the appropriate number of diagnosis codes for standard 837P and 837I encounters. NCTracks can store up to 25 diagnosis codes for institutional claims and 12 diagnosis codes for professional claims. Sandhills is willing to work with DMA on meeting the state's required standards for data submissions and is adjusting the AlphaMCS system to accommodate requested changes.

The Corrective Action Plan (CAP) from last year's audit was for Sandhills to review and resubmit all backlogged encounters as far back as July 2014. As stated within the ISCA tool, the PIHP has completed the rebilling of historical encounters back to July 2014. The PIHP has been diligent in its review of backlogged encounters and provided to IPRO a CAP summary report detailing the steps they have taken to address the prior year's efforts and outcomes of their corrective action steps. The following discussion is a summary of the provided report.

The tables provided for supportive evidence and documentation in the summary report include the following:

- Claims Lag Table (January 2015- August 2018)
- Encounter Claims not submitted to NCTracks (January 2015-June 2018)
- Taxonomy Denials by Calendar Year (2017, 2018)
- Claims Denial Rate for Encounters with Dates of Service January 2015 – March 2017

The steps taken to address prior year's audit concerns:

1. Sandhills created an encounter data team.
2. Sandhills developed an internal database to track each claim through its history from adjudication to state submission.
3. Interdepartmental communications are established for denial resolution.

Sandhills implemented taxonomy code edits in their claims review processes and stopped payments to providers submitting claims with incorrect codes. As a result of their efforts:

1. Sandhills' internal database allows staff to know the status of a claim at any point in its history.

2. Sandhills experienced successful submission of 500,000 historical claims from January 2015 to March 2017. Less than 8,000 claims (from January 2015 to Aug 2017) remain for submission to NCTracks as of Aug 30, 2018.
3. Sandhills' denial percentage from January 2015 to March 2017 was 15% (as of March 2017). As of August 21, 2018, the denial percentage for the same period decreased to 2%.
4. NCTracks experienced a significant decrease in denials attributed to taxonomy. For the current 2018 calendar year, less than 4,000 claims were denied for taxonomy discrepancies, a significant decrease from the prior calendar year.

Table 2 : Taxonomy Denials by Calendar Year (2017, 2018)

Denial Reason	Calendar Year 2017	2018
RENDERING PROVIDER MUST BE ENROLLED FOR RENDERING TAXONOMY CODE	38,476	654
PROVIDER MUST BE ENROLLED FOR BILLING TAXONOMY	28,766	3,319
TOTAL	**67,242**	**3,973**

Figure 2, Administration Comparative Findings indicates the scoring for Administration for 2018 compared to the scores received in the 2017 EQR.

Figure 2: Administration Comparative Findings

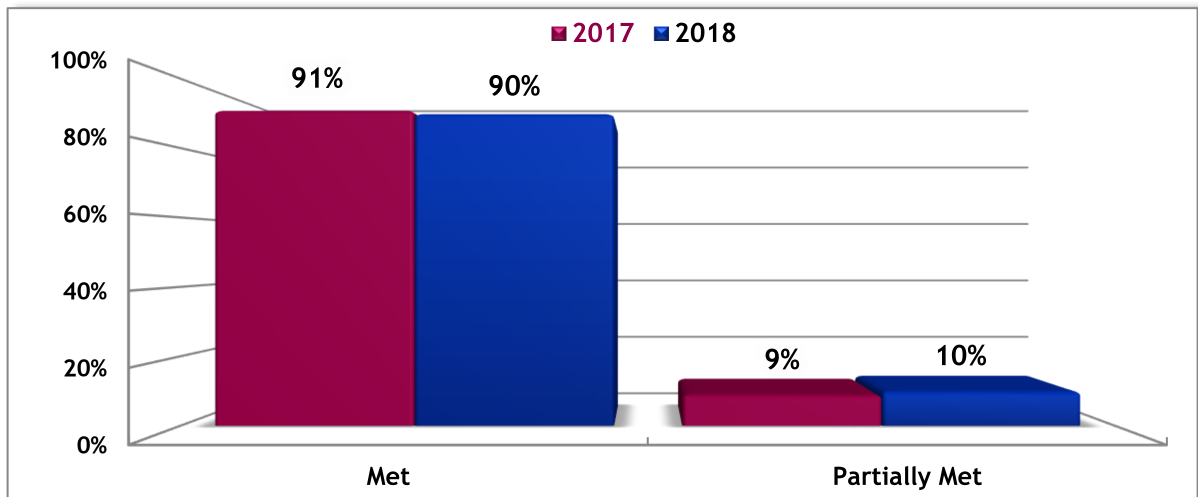


Table 3: Administration

Section	Standard	2018 Review
Management Information Systems	The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 diagnosis codes received on an 837 Institutional and an 837 Professional file, capabilities of receiving and storing ICD-10 procedure codes on an 837 Institutional file	**Partially Met**
	The MCO has the capabilities in place to submit the State required data elements to DMA on the encounter data submission	**Partially Met**

Strengths

- Sandhills' policies and procedures are well organized and accounted for on the *Master List of Policies and Procedures*.
- Sandhills has over 20 policies and procedures addressing their confidentiality practices and requirements.
- Sandhills' training procedure explains that new staff are trained in confidentiality specific to their new position within the first two days of employment. Additional training to new staff is provided during the new employee orientation that is completed within the new staffs first month of employment.
- The PIHP has a comprehensive enrollment and claims processing system.
- Sandhills is cooperative with DMA's recommendations. They include provider taxonomy discrepancies in their claims audit denial reports.
- The PIHP made significant improvements by reducing the rate of denied encounter submissions to the state and meets the state standard for encounter acceptance rates monthly.
- The PIHP diligently rebills backlogged encounters and provided supportive tables and figures showing the positive outcome of their efforts to resolve encounter data discrepancies (from claims processing to DMA encounter submissions). This satisfies the CAP from the prior year.
- Finance, claims, and encounter staff are knowledgeable about their processes and are dedicated to improving encounter data submissions and reducing the number of denials.

Weaknesses

- Per Sandhills' procedure *Core 3a Policy-Procedure Maintenance Review Approval*, all procedures are visited by the Compliance Committee as a part of the annual review. This step required by this procedure did not occur in 2018.
- Sandhills' policies and procedures set are too cumbersome to be consistently useful to staff, and Sandhills struggles to effectively and consistently make timely updates and revisions to their policy and procedure set.
- Dr. Carraway's job description should be updated and aligned with his current departmental oversight, committee membership and attendance, and the Medical Director requirements in the *DMA Contract, Sections 6.7.6 and 7.1.3*.
- Prest's contract addendum signed in 2010 shows their agreement to provide "consultation, supervision and oversight" to the Utilization Management Committee and further, to "serve as back up to the Sandhills Centre Medical Director when volume necessitates or when the Medical Director is not available". This contractual language creates a liability of conflicts of interest, real or perceived, between Prest's involvement with UM functions and their role as the delegated Peer Reviewer entity.
- Sandhills only captures up to 14 diagnosis codes for both institutional and professional claims.
- Sandhills currently submits up to two diagnosis codes for encounter data submissions. AlphaMCS is currently being tested to submit up to 12 secondary diagnosis codes, however, institutional claims are able to submit up to 25 diagnosis codes.

Recommendations

- Sandhills should either update *Core 3a Policy-Procedure Maintenance Review Approval* to reflect the current annual procedure review process or take steps to remain in compliance with this procedure. Compliance with this procedure would be evident within the Compliance Committee minutes.
- Develop a workplan that lays out a process for streamlining Sandhills' set of policies and procedures to specifically identify overlapping and duplicative policies and procedures.
- Update and revise Dr. Carraway's job description to be aligned with his current departmental oversight, committee membership and attendance, and the Medical Director requirements in the *DMA Contract, Sections 6.7.6 and 7.1.3.*
- The language in Prest's contract should be amended to accurately reflect their current responsibilities and guard against the liability of conflicts of interest, real or perceived, between Prest's involvement with UM functions and their role as the delegated Peer Reviewer entity.

Corrective Actions

- Update the system and provider web portal to be able to accept up to 25 ICD-10 diagnosis codes for an 837I.
- Update the encounter data submission process to allow for all ICD-10 CM diagnosis codes submitted on an institutional and professional 837 HIPAA file to be submitted to NCTracks. Twenty-five ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837I and the maximum number that is captured by NCTracks. NCTracks can capture up to 12 diagnosis codes for professional claims.

B. Provider Services

The Sandhills' Provider Services EQR is comprised of Credentialing and Recredentialing, and Network Adequacy (including Provider Accessibility, Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, and Practitioner Medical Records). CCME reviewed relevant policies and procedures, the *Medicaid Provider Manual*, Clinical Advisory Committee (CAC) and Credentialing Subcommittee (CS) meeting minutes and documents, provider network information, credentialing/recredentialing files, practice guidelines, provider training materials, *the 2017 Community Behavioral Health Service Needs, Providers and Gaps Analysis* ("*Gaps Analysis*"), and the Sandhills website.

The *Provider Credentialing Plan Procedure, N-CR 1a-19a, N-NM 3a,* defines the "Scope of Responsibilities & Duties" of the Sandhills Clinical Advisory Committee (CAC), including the Credentialing Subcommittee (CS). Anthony Carraway, MD, a Board-Certified Psychiatrist and Sandhills' Chief Clinical Officer (CCO), chairs the CAC and the CS. The *Provider Credentialing Plan Procedure* (*N-CR 1a-19a, N-NM 3a*), states the CCO "will designate a non-Sandhills' physician subcommittee member to chair the meeting in the event that the CCO/Medical Director is unable to attend." A quorum is defined as "a majority of more than ½ of non-Sandhills Center staff voting members."

Policy N-CR 1, 4, Practitioner and Facility Credentialing Program Plan, indicates the CAC is responsible for reviewing the initial and recredentialing criteria annually. Approval of "clean" credentialing and recredentialing applications is delegated by the CAC to the CCO, who "oversees clinical aspects of the credentialing/re-credentialing Program" (*Policy N-CR 2, Credentialing Program Oversight; Policy N-CR 3, Credentialing Committee*). The lists of Medical Director-approved "clean" applications are sent via email to CAC members for review/CS approval.

Policy N-CR3, Credentialing Committee, indicates the CS is composed "ONLY of non-Sandhills members of the CAC who hold active and unrestricted licensure in their field and these members are the only ones casting votes on credentialing/re-credentialing

matters. In the case of a tie vote, Sandhills CCO/Medical Director casts the deciding vote."

CS meetings are typically held via conference call, and votes are sometimes submitted by email. CS meeting notes indicate which members are "voting" members, which members are present, which member(s) made specific motions, and which members cast votes at specific meetings. There were 12 CS meetings from 07/27/17 through 06/20/18. A quorum was present at all meetings, though one committee member did not attend any of the meetings or conference calls, nor submit any votes. Five of the voting members attended between 75% and 92% of the meetings. One voting member attended 67% of the meetings.

CCME's credentialing and recredentialing file review showed the files are well-organized and contain appropriate information, with some exceptions, as outlined in the following "Weaknesses" section and in the Tabular Spreadsheet. Sandhills did not start conducting the required query of the *State Exclusion List* until 06/27/18. Many of the submitted files did not contain proof of Worker's Compensation/Employer's Liability insurance coverage. Sandhills submitted a statement that "solo providers do not have the ability to bill for or link other providers to their contract".

Though a solo provider may not have another practitioner billing under their Tax ID, they could very easily have additional employees. In North Carolina, Worker's Compensation/Employer's Liability insurance is needed if there are three or more employees. Therefore, Sandhills needs to have a mechanism for applicants to confirm how many employees are in their practice, counting non-clinical staff. At the Onsite, Sandhills indicated they developed a form that providers now sign, to verify whether they transport enrollees (would need auto insurance) and whether they have three or more employees (would need Worker's Compensation/Employer's Liability insurance).

Sandhills has an *Annual Training Plan* for providers and offers sessions throughout the year. Provider Orientation materials, including a Program Integrity presentation addressing fraud/waste/abuse, are posted on the website. The Training Coordinator plans and facilitates an annual orientation for providers, with the sessions typically held in two locations for convenient provider access. Sandhills has a Provider Help Desk with a direct line and email address. *Provider Help Desk Questions and Answers* are posted on the website each month.

The Sandhills Network Development Department is responsible for the annual gaps and needs analysis. The last *Gaps Analysis* report was submitted in June 2017. The deadline for submitting the 2018 report is September 21, 2018. At the Onsite, Sandhills staff reported the gaps and needs identified in their data-gathering for the next *Gaps Analysis* report are "pretty much the same as last year." Opioid treatment is still an area of focus, with continued efforts to add providers, including those who deliver medically-assisted

(Methadone/Suboxone) opioid treatment. The expected Spring 2018 opening of a facility-based crisis program in Asheboro has been delayed to December. Sandhills is going to build a facility-based crisis center for children in Richmond County, with an anticipated opening in late fall of 2019. The center will serve children from all counties in the Sandhills catchment area. The program will have "23-hour chairs and beds."

Quarterly *Managed Care Accessibility Analysis* reports are presented in the Health Network Committee meetings and in the Quality Management Committee (QMC) meetings. The reports include Geo Access maps and charts with data regarding the percentage of enrollees who have access to at least two providers within 30 miles, broken down by service. There is no accompanying analysis of the reports. Though Sandhills consistently did not meet the access standard for Multisystemic Therapy (MST) for the three quarters of available reports, there is no evidence of any efforts to increase enrollee access by recruiting providers. At the Onsite, Sandhills staff reported they would add MST providers if they applied, though the website does not list MST providers among those who are invited to apply to be credentialed.

The following chart indicates Sandhills received a score of "Met" for 99% of the standards during the Provider Services review. The score of "Partially Met" in both Credentialing and Recredentialing is due to Sandhills not conducting the required query of the *State Exclusion List* until 06/27/18.

Figure 3, Provider Services Comparative Findings, provides a comparison of the 2017 scores versus the 2018 scores.

Figure 3: Provider Services Findings

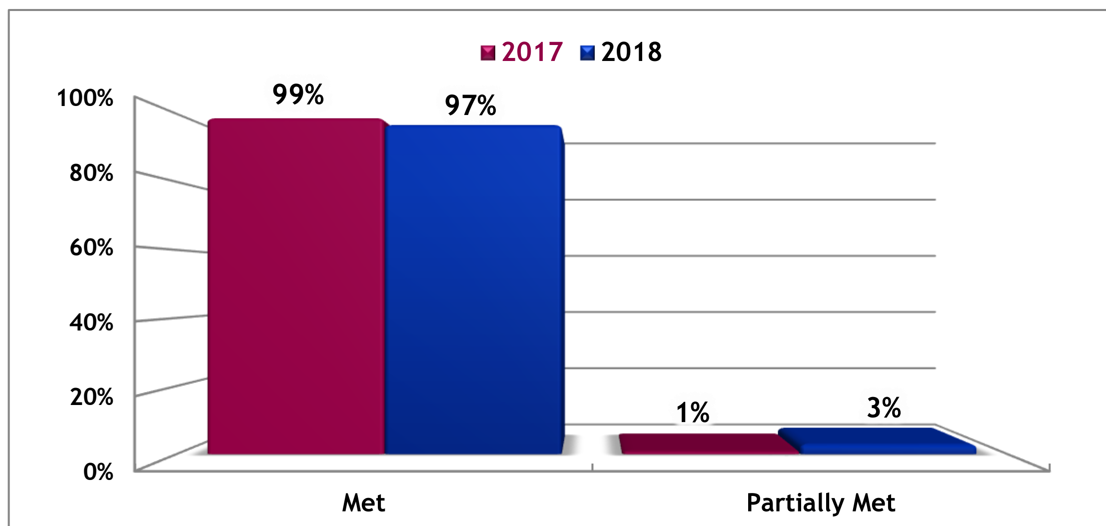


Table 4: Provider Services

Section	Standard	2018 Review
Credentialing and Recredentialing	Credentialing: Verification of information on the applicant, including: Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	**Partially Met**
	Recredentialing: Verification of information on the applicant, including: Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	**Partially Met**

Strengths

- Credentialing and recredentialing files are well-organized and contain checklists to help guide the process.
- Sandhills has a Provider Help Desk with a dedicated phone number and email address to assist providers with any issues.
- Sandhills posts provider Frequently Asked Questions (FAQs) and answers on its website.
- Sandhills developed a "Mystery Shopper" process to monitor provider compliance with accessibility standards.
- The Sandhills website includes Provider Orientation and other materials that would be helpful to providers.
- In June 2018, Sandhills increased provider reimbursement rates for "providers of community-based Intermediate Care Facilities, Outpatient Services including Evaluation and Management Coding, and all Innovations services".

Weaknesses

- The submitted credentialing and recredentialing files did not contain some of the required information {i.e., proof of all of the required types of insurance or an explanation of why it would not be required; Ownership Disclosure; no Primary Source Verification (PSV) of education for one physician who was not board-certified; no PSV of Division of Health Service Regulation (DHSR) licensure or site visit reports in some files}. At the Onsite, Sandhills provided additional information, and reported they now have a form for providers to complete regarding whether they need automobile insurance or Worker's Compensation/ Employer's Liability insurance.

- Sandhills did not complete the *State Exclusion List* query as part of the credentialing and recredentialing process until June 2018. For applications approved in June 2018, Sandhills went back and completed the *State Exclusion List* query.
- In some files, the Credentialing Specialist's initials nearly covered the date the PSV was printed, making it difficult to determine when the PSV was pulled and whether "no element is older than 180 days." One file had three date stamps for the date of receipt of the application. One of the dates was marked through, over and over, making it completely unreadable. Another of the date stamps on the application was written over numerous times, actually changing the date originally stamped on the application. The third date stamp on the file was legible.
- Six of the 12 practitioners were not recredentialed within three years, with recredentialing ranging from three days (one file) to 25 days (two files) past the three year mark.
- There is no evidence the quarterly *Managed Care Accessibility Analysis* reports are analyzed to identify gaps, nor that strategies are developed to address identified gaps.
- The Performance Standards listed in #7 of *Procedure CORE 34a, Access to Services*, do not indicate that providers must provide face-to-face emergency care immediately for life-threatening situations.
- The link on page 18 of the *Medicaid Provider Manual* to the Clinical Practice Guidelines went to "Page Not Found" on the Sandhills website.
- The *Medicaid Provider Manual* does not include the "right of enrollees who live in Adult Care Homes to report to the appropriate regulatory authority any suspected violation of their enrollee rights as outlined in *NCGS § 131-D21*". Sandhills added this information to the *Medicaid Provider Manual* during the Onsite; however, the addition is not relevant for the current EQR.
- *Procedure HIM 4a, Clinical and Business Records,* references the *Basic Medicaid Billing Guide*. The *Medicaid Provider Manual* references the *NCTracks Provider Claims and Billing Assistance Guide*. This document is now the *NCMMIS Provider Claims and Billing Assistance Guide*.

Corrective Action

- Ensure all credentialing and recredentialing files include evidence of the query of the *State Exclusion List*, as required by *DMA Contract, Section 1.14.4* and by the *Provider Credentialing Plan Procedure, N-CR 1a-19a, N-NM 3a*.

Recommendations

- Verify credentialing and recredentialing files contain the following items. Please note, if Sandhills does not keep a copy of the relevant information in the individual

credentialing or recredentialing files, retrieve copies from the relevant files and upload as part of the credentialing/recredentialing files for the EQR Desk Review.

- Proof of all required insurance coverage (or the relevant statement from the provider about why it is not required) and verification that the individual provider is listed among those covered under the policies. If the provider is not named on the Certificate of Insurance, a letter from the agency provider or insurance company indicating the provider is covered under the policy is acceptable. For providers joining already-contracted agencies, include copies of the insurance coverage for the agency, and verification that the provider is covered under the PIHPs. See *DMA Contract, Section 7.7*.
- PSV of education for physicians who are not board-certified (a North Carolina Medical License is not PSV of education). Correct the Provider Credentialing Plan Procedure, N-CR 1a-19a, N-NM 3a, and any other documents containing the list of required materials, to indicate that Sandhills will conduct PSV of education of physicians. See *DMA Contract, Attachment O*.
- Ownership Disclosure information, including by the agency for the employee. (*DMA Contract, Attachment O)*.
- PSV of DHSR licensure or current site visit report (*DMA Contract Section 7.9, 42 CFR § 455.432, Provider Credentialing Plan Procedure, N-CR 1a-19a, N-NM 3a*).

- To comply with the requirement in the *Provider Credentialing Plan Procedure, N-CR 1a-19a, N-NM 3a*, regarding information over 180 days old, ensure dates are legible, not written over, and not changed. If an incorrect date is listed, draw a single line through it, make the needed change, and initial the change. Credentialing Specialist's initials should not cover the date the PSV is printed.

- Per the *Provider Credentialing Plan Procedure, N-CR 1a-19a, N-NM 3a*, ensure providers are recredentialed within three years of the date of the approval of initial credentialing or the most recent recredentialing.

- Analyze reports such as the quarterly *Managed Care Accessibility Analysis* reports to determine gaps and develop strategies to address identified gaps.

- Include the *DMA Contract, Attachment S* requirement for providers to "provide face-to-face emergency care immediately for life-threatening emergencies" in the "Performance Standards" listed in *Procedure CORE 34a, Access to Services*.

- Correct the link in the *Medicaid Provider Manual* to the Clinical Practice Guidelines. Have a staff member periodically check links to ensure they work.

- Review the Member Rights section in the *Medicaid Provider Manual* to ensure all rights are included. Revise the *Medicaid Provider Manual* to include the right of enrollees who live in Adult Care Homes to report to the appropriate regulatory authority any suspected violation of their enrollee rights as outlined in *NCGS § 131-D21*. See *DMA Contract 6.13.2*.

- Correct all references to the Basic Medicaid Billing Guide or to the NCTracks Provider Claims and Billing Assistance Guide, which is now the NCMMIS Provider Claims and Billing Assistance Guide. See *DMA Contract, Section 8.2.1*.

C. Enrollee Services

CCME reviewed Sandhills' Enrollee Services, including relevant policies and procedures, the *Member Handbook*, Call Center scripts, orientation materials, new member correspondence and documentation, enrollee continuing education offerings, and Sandhills' website. Corrective actions and recommendations from the last EQR were implemented and Sandhills continues to work on maintaining those new practices.

Customer Service (CS) Director Gene McRae leads the CS Department. The department consists of the Member Eligibility and Enrollment Coordinator, and six Specialists, a CS Coordinator, 11 CS Representatives, a Call Center Supervisor, and 13 Licensed Clinical Specialists. Sandhills consistently meets call center metrics within their call center. Sandhills has a delegation contract with Cardinal Innovations for "overflow calls" and Cardinal answers

an average of 15 calls per month. Cardinal has failed to meet the call metrics for several months during the review period. Sandhills is working with Cardinal on a corrective action plan to meet the metrics, although it difficult given the small amount of rollover calls. One missed call metric will likely cause them to miss the percentage goal. The catchment area has a large percentage of Spanish speaking members. There were 11 translations for members on the Call Center Access to Care line in July, 2018. There is a CS emphasis on translation in the Call Center and with the providers. Sandhills covers the cost of translation for the providers for the first five appointments for each member.

Within 14 days of the initial request for services, Sandhills provides new enrollees with a Welcome Letter and a copy of the *Notice of Privacy Practices*. The letter directs members to the PIHP website for information about member rights, appeal rights, a list of providers, and services to meet behavioral health needs. The letter includes the 24-hour Access to Care phone number for CS and the TTY phone number. The website also provides copies of the *Member Handbook* in English or Spanish and instructions to call the Access to Care phone number if a printed copy is needed in English, Spanish, or large print format.

There are offerings for enrollee continuing education on the website calendar. Most of the current enrollee events are support groups. Clicking on the event displays more detailed information. Call Center staff are aware of new training opportunities by email from Anne Kimble, Community Relations and Communications Director. Ms. Kimble sends any new support resources that will help Call Center staff update enrollees. Mike Markoff, CS Coordinator, recently organized CS staff training to raise awareness of the new updates on the website that enrollees can be directed to when there is a caller who would benefit.

The searchable "Provider Directory" on the website includes the non-English languages spoken by providers, and whether the provider is accepting new clients. Website searches can be conducted in English or in Spanish, and the Provider Directory is available for print or download.

The following chart indicates Sandhills received a score of "Met" for 94% of the standards during the Enrollee Services review. Standards with scores of "Partially Met" and "Not Met" are detailed in Table 5.

Figure 4, Enrollee Services Findings, provides a comparison of 2017 scores versus 2018 scores.

Figure 4: Enrollee Services Findings

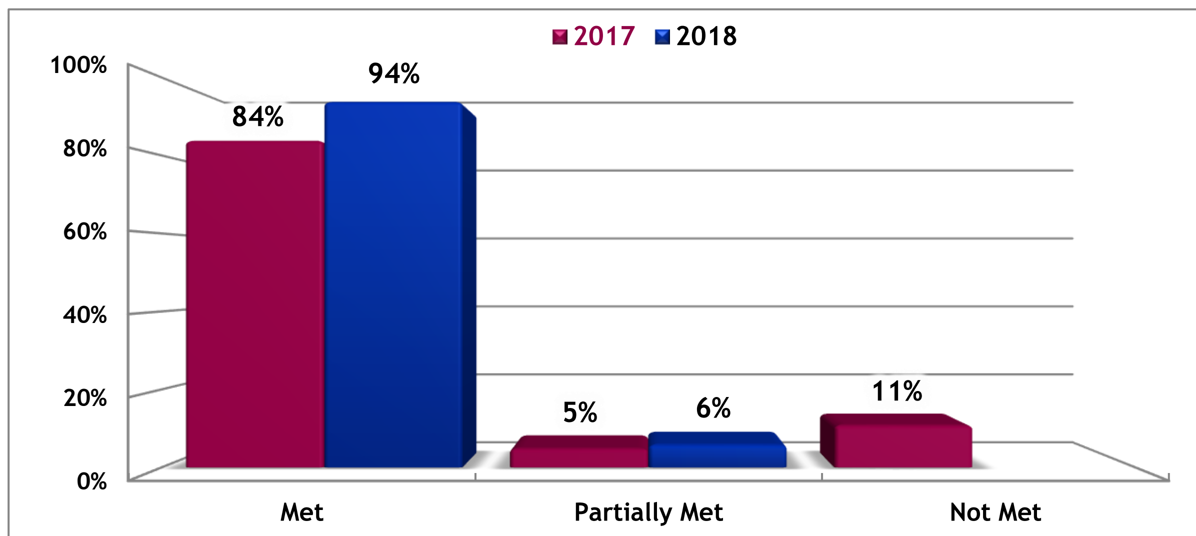


Table 5: Enrollee Services

Section	Standard	2018 Review
Enrollee PIHP Program Education	Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in CFR 438.10 (f) (61) and 438.10 (g) at least 30 calendar days before the intended effective date of the change; and (2) . termination of their provider within fifteen (15) calendar days after PIHP receives notice that DMA or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider	**Partially Met**

Strengths

- Sandhills recently organized Call Center staff training to raise awareness to the new updates on the website that enrollees can be directed to when there is a caller who would benefit.
- The searchable "Provider Directory" on the website includes the non-English languages spoken by providers, and whether the provider is accepting new clients.

Weaknesses

- Page 12 of the *Member Handbook* has a section called "Can I receive services from non-network providers." It gives three examples of when a member may receive services from a non-network provider. None of the examples refers to "Specialty Care." Ultimately, members are to call the Access to Care line if they have questions about a provider outside the Sandhills network.
- Two of the five terminating provider files CCME reviewed indicate that Sandhills did not notify the affected enrollees that the provider was no longer in their network within the required 15-day period after Sandhills was aware of the termination.
- Staff were unaware of a policy, procedure, or desk reference addressing the format of written materials to enrollees. All enrollee written materials should be at least 12 point per *CFR 438.10 (d) (6) (ii)* unless it is a large print document and that should be no smaller than 18 point per *CFR 438.10 (d) (3)*.
- Call Center rollover calls answered by Cardinal frequently do not meet the Call Center metric standards.

Corrective Action

- Ensure all relevant Sandhills staff are updated and follow the process for notifying enrollees of their provider terminating the Sandhills network within 15 days of the termination notice date.

Recommendations

- Adding information in the *Member Handbook* to address Sandhills' procedure on referrals for Specialty Care would be helpful.
- Ensure there is a policy, procedure or desk reference addressing the format of enrollee materials and update all Communications staff. Written material should be at least 12 point per *CFR 438.10 (D(6) (ii)* unless it is a large print document and that should be no smaller than 18 point per *CFR 438.10 (d) (3)*.
- Continue working with Cardinal through the corrective action process to improve their Sandhills rollover call metrics.

D. Quality Improvement

The Quality Improvement (QI) review focuses on the QI program, the QI committees, performance measures, performance improvement projects (PIPs), provider participation in QI activities, and the annual evaluation of the QI program.

Sandhills' *2018-19 Quality Management Program/Plan* outlines how the program measures and improves the quality of care and services provided to enrollees. Sandhills' Board of Directors (BOD) has ultimate authority and responsibility for Quality Management (QM). The BOD delegates these responsibilities to the Chief Executive Officer and the QM Committee (QMC). The QM Director has the day-to-day operational responsibility for the QM Program. The QM Director position was vacant during our Onsite visit, but Mary Kidd will assume that position on September 1, 2018. Various staff perform the position's duties since May 31, 2018 when Carol Robertson retired. Pam Morgan is contracted on a part-time basis to support the Utilization Review Accreditation Commission (URAC) accreditation process, Division of Medical Assistance (DMA)/ Division of Mental Health (DMH) contract requirements, and to bridge the QM Director position duties. Dr. Anthony Carraway, Chief Clinical Officer (CCO)/Medical Director, co-chairs the QMC with the QM Director. The *QM Program/Plan* outlines the CCO responsibilities within the QM program.

Sandhills has a strong process for monitoring provider, evidence-based, clinical practice guidelines and focuses on nine guidelines. Sandhills employs a monitoring tool for each of the guidelines and monitors providers during the routine monitoring processes. Karen Kern, Provider Network Clinical Monitoring Manager, oversees this monitoring to identity trends that can highlight issues with providers and positive work in the provider

community. Findings are reported quarterly in the *Sandhills Center LME-MCO Quarterly Routine Monitoring Report*.

Sandhills concentrates its efforts on the organization's *Integrated Care initiative*. This effort began in November 2016 and is headed by Debra Carbone, Integrated Care Outreach Clinician. In the past year Sandhills continues to support eight providers and added three additional providers into the initiative. Providers receive training and resources on evidence-based practices and components of integrated care, access to reports, data interpretation skills, and meaningful use of data through clinical actions.

Sandhills analyzed and reported provider and enrollee survey results to QMC, Global Quality Improvement Committee (GQIC), and the Provider Forum. The results were also posted on their website. Theresa Clark, Project Manager/Business Analyst, identifies each *Experience of Care & Health Outcomes (ECHO) Survey* question that scores 5% or more on the negative side of the state average and forms a work group to address those areas. The work group is made up of departmental staff working within the area related to the identified survey question. These measures are examined from year to year to identify potential survey score improvements that may result from these efforts. The data collected is not contained in one document. They are all separate and updates are reported to different committees and groups. CCME recommends information be tracked together in one project document.

The QMC meets monthly and had a quorum present at each of the reviewed meetings. QMC is comprised of Sandhills' staff and one Consumer and Family Advisory Committee member. The GQIC meets every other month and is comprised of 18 network providers who are voting members and five Sandhills' staff who are non-voting members. Sandhills' staff who attend the GQIC meetings also attend QMC meetings, allowing information to flow from the providers to the QMC meeting attendees. Three of the past seven meetings reviewed did not have a quorum in attendance. The meetings without a quorum occurred in March, May, and July of 2018. During the Onsite discussion, QM staff explained ways Sandhills identified to improve attendance including new topics of discussion, getting an RSVP before the meeting, and recruiting new members.

The QM Director prepares the *Quality Management Program Evaluation* annually. It is a narrative document that provides an analysis of progress toward the QM Department goals for the fiscal year. The *QM Program Evaluation* submitted for Desk Review is for fiscal year 2017-18. It contains a summary of the program, Goals for 2017-18, the evaluation process, current and newly closed QIPs, satisfaction survey results, 2017-18 QM program goals/objectives findings, a list of additional accomplishments, and effectiveness of program/conclusions. Sandhills presents the annual *QM Program Evaluation* to both the QMC and the BOD. CCME recommended that barriers and recommendations be documented with the 2017-18 QM program goals/objectives findings. The fields for barriers and recommendations was blank in the document.

Performance Measure Validation

As part of the EQR, CCME conducted the independent validation of DMA-selected B and C Waiver performance measures.

Table 6: B Waiver Measures

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

Table 7: C Waiver Measures

C WAIVER MEASURES	
Number and percentage of new waiver enrollees who have a LOC prior to receipt of services	Proportion of PCPs that are completed in accordance with DMA requirements
Proportion of providers that meet licensure, certification, and/or other standards prior to their furnishing waiver services	Proportion of records that contain a signed Freedom of Choice Statement
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Proportion of participants reporting their Care Coordinator helps them understand which waiver services are available to them
Proportion of providers reviewed according to PIHP monitoring schedule to determine continuing compliance with licensing, certification, and contract and waiver standards	Proportion of participants reporting they have a choice between providers
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	Proportion of claims paid by the PIHP for Innovations waiver services that have been authorized in the service plan

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

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

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

The reported results for these measures are included in the following tables for 2016 and 2017. The percentage rate covers the timeframe of July 1, 2016 through June 30, 2017.

Table 8: A.1. Readmission Rates for Mental Health

30-day Readmission Rates for Mental Health	2016	2017	Change
Inpatient (Community Hospital Only)	9.0%	7.4%	-1.6%
Inpatient (State Hospital Only)	0.0%	0.0%	0.0%
Inpatient (Community and State Hospital Combined)	8.9%	7.4%	-1.5%
Facility Based Crisis	0.0%	0.0%	0.0%
Psychiatric Residential Treatment Facility (PRTF)	19.8%	6.7%	-13.1%
Combined (includes cross-overs between services)	9.5%	8.0%	-1.5%

Note. Decrease in rate is improvement for readmission rates.

Table 9: A.2. Readmission Rate for Substance Abuse

30-day Readmission Rates for Substance Abuse	2016	2017	Change
Inpatient (Community Hospital Only)	3.9%	8.7%	4.8%
Inpatient (State Hospital Only)	0.0%	0.0%	0.0%
Inpatient (Community and State Hospital Combined)	3.8%	8.6%	4.8%
Detox/Facility Based Crisis	10.6%	7.5%	-3.1%
Combined (includes cross-overs between services)	5.5%	9.6%	4.1%

Table 10: A.3. Follow-Up after Hospitalization for Mental Illness

Follow-up after Hospitalization for Mental Illness	2016	2017	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	35.9%	38.8%	2.9%
Percent Received Outpatient Visit Within 30 Days	57.0%	58.1%	1.1%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	NA	NA	NA
Percent Received Outpatient Visit Within 30 Days	NA	NA	NA
PRTF			
Percent Received Outpatient Visit Within 7 Days	28.9%	22.2%	-6.7%
Percent Received Outpatient Visit Within 30 Days	66.7%	46.7%	-20.0%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	35.7%	38.4%	2.7%
Percent Received Outpatient Visit Within 30 Days	57.2%	57.8%	0.6%

Table 11: A.4. Follow-Up After Hospitalization for Substance Abuse

Follow-up after Hospitalization for Substance Abuse	2016	2017	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NR
Percent Received Outpatient Visit Within 7 Days	21.1%	18.2%	-2.9%
Percent Received Outpatient Visit Within 30 Days	30.3%	32.6%	2.3%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	0%	71.4%	71.4%
Percent Received Outpatient Visit Within 7 Days	0%	71.4%	71.4%
Percent Received Outpatient Visit Within 30 Days	0%	85.7%	85.7%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NR
Percent Received Outpatient Visit Within 7 Days	21.0%	19.6%	-1.4%
Percent Received Outpatient Visit Within 30 Days	30.2%	34.0%	3.8%

**NR = Denominator is equal to zero.*

Table 12: B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2016	2017	Change
Ages 13-17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	9.8%	52.7%	42.9%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	47.5%	39.5%	-8.0%
Ages 18-20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	14.9%	59.9%	45.0%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	34.9%	40.1%	5.2%
Ages 21-34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	17.8%	53.3%	35.5%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	43.6%	37.5%	-6.1%
Ages 35-64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	17.6%	56.0%	38.4%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	45.7%	41.9%	-3.8%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	14.8%	56.6%	41.8%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	42.0%	42.4%	0.4%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	16.7%	55.2%	38.5%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	44.3%	40.1%	-4.2%

Table 13: D.1. Mental Health Utilization-Inpatient Discharges and Average Length of Stay

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		2016	2017	Change	2016	2017	Change
3-12	Male	0.2	0.2	0.0	35.7	24.5	-11.2
	Female	0.2	0.2	0.0	16.5	9.0	-7.5
	Total	0.2	0.2	0.0	26.8	18.7	-8.1

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		2016	2017	Change	2016	2017	Change
13-17	Male	1.1	1.1	0.0	53.4	42.1	-11.3
	Female	2.1	1.9	-0.2	23.3	24.1	0.8
	Total	1.6	1.5	-0.1	33.8	30.8	-3.0
18-20	Male	1.2	1.0	-0.2	6.8	15.4	8.6
	Female	1.3	1.1	-0.2	6.5	11.4	4.9
	Total	1.2	1.1	-0.1	6.7	13.1	6.4
21-34	Male	3.9	3.8	-0.1	7.0	7.8	0.8
	Female	1.5	1.3	-0.2	5.9	5.6	-0.3
	Total	2.0	1.8	-0.2	6.3	6.6	0.3
35-64	Male	2.7	1.7	-1.0	7.0	11.9	4.9
	Female	2.2	2.4	0.2	6.3	6.5	0.2
	Total	2.4	2.5	0.1	6.6	8.6	2.0
65+	Male	0.5	0.4	-0.1	33.7	13.5	-20.2
	Female	0.3	0.4	0.1	24.4	15.4	-9.0
	Total	0.3	0.4	0.1	28.6	14.8	-13.8
Unknown	Male	0.0	0.0	0.0	0.0	0.0	0.0
	Female	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0
Total	**Male**	**1.1**	**1.1**	**0.0**	**19.0**	**18.4**	**-0.6**
	Female	**1.2**	**1.1**	**-0.1**	**11.3**	**11.2**	**-0.1**
	Total	**1.1**	**1.1**	**0.0**	**14.5**	**14.2**	**-0.3**

Table14: D.2. Mental Health Utilization -% of Members that Received at Least 1 Mental Health Service in the Category Indicated during the Measurement Period

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
3-12	Male	11.39%	11.68%	0.29%	0.18%	0.22%	0.04%	0.28%	0.37%	0.09%	11.35%	11.54%	0.19%
	Female	8.05%	8.26%	0.21%	0.17%	0.17%	0.00%	0.11%	0.17%	0.06%	8.00%	8.17%	0.17%
	Total	9.76%	10.02%	0.26%	0.18%	0.19%	0.01%	0.20%	0.27%	0.07%	9.72%	9.89%	0.17%
13-17	Male	14.97%	14.15%	-0.82%	0.98%	1.05%	0.07%	0.79%	0.71%	-0.08%	14.64%	13.75%	-0.89%
	Female	16.15%	16.00%	-0.15%	1.73%	1.73%	0.00%	0.29%	0.30%	0.01%	15.94%	15.68%	-0.26%
	Total	15.55%	15.06%	-0.49%	1.35%	1.38%	0.03%	0.54%	0.51%	-0.03%	15.28%	14.70%	-0.58%
18-20	Male	10.33%	9.05%	-1.28%	1.11%	0.95%	-0.16%	0.02%	0.11%	0.09%	10.21%	8.76%	-1.45%
	Female	10.30%	11.80%	1.50%	1.09%	1.01%	-0.08%	0.03%	0.08%	0.05%	10.02%	11.46%	1.44%
	Total	10.32%	10.51%	0.19%	1.10%	0.98%	-0.12%	0.02%	0.10%	0.08%	10.10%	10.20%	0.10%
21-34	Male	25.05%	24.70%	-0.35%	2.76%	2.81%	0.05%	0.02%	0.00%	-0.02%	24.73%	24.36%	-0.37%
	Female	18.57%	18.28%	-0.29%	1.32%	1.13%	-0.19%	0.02%	0.04%	0.02%	18.42%	18.17%	-0.25%
	Total	19.95%	19.65%	-0.30%	1.63%	1.49%	-0.14%	0.02%	0.03%	0.01%	19.77%	19.49%	-0.28%
35-64	Male	22.57%	22.58%	0.01%	2.37%	2.34%	-0.03%	0.01%	0.02%	0.01%	22.23%	22.27%	0.04%
	Female	24.78%	24.75%	-0.03%	1.94%	1.89%	-0.05%	0.03%	0.04%	0.01%	24.50%	24.49%	-0.01%
	Total	23.96%	23.94%	-0.02%	2.10%	2.06%	-0.04%	0.02%	0.03%	0.01%	23.66%	23.67%	0.01%
65+	Male	5.52%	6.03%	0.51%	0.50%	0.45%	-0.05%	0.00%	0.00%	0.00%	5.23%	5.79%	0.56%
	Female	4.88%	5.48%	0.60%	0.28%	0.38%	0.10%	0.00%	0.00%	0.00%	4.78%	5.32%	0.54%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	Total	5.07%	5.65%	0.58%	0.34%	0.40%	0.06%	0.00%	0.00%	0.00%	4.91%	5.47%	0.56%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	Male	14.28%	14.17%	-0.11%	0.92%	0.95%	0.03%	0.28%	0.32%	0.04%	14.10%	13.93%	-0.17%
	Female	14.15%	14.37%	0.22%	1.01%	0.97%	-0.04%	0.09%	0.12%	0.03%	13.99%	14.19%	0.20%
	Total	14.20%	14.29%	0.09%	0.97%	0.96%	-0.01%	0.17%	0.20%	0.03%	14.04%	14.07%	0.03%

Table 15: D.3. Identification of Alcohol and Other Drug Services

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
3-12	Male	0.02%	0.03%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.02%	0.00%
	Female	0.02%	0.01%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.01%	-0.01%
	Total	0.02%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.02%	0.00%
13-17	Male	1.10%	0.95%	-0.15%	0.03%	0.04%	0.01%	0.43%	0.32%	-0.11%	0.76%	0.74%	-0.02%
	Female	1.12%	0.97%	-0.15%	0.10%	0.07%	-0.03%	0.47%	0.37%	-0.10%	0.84%	0.78%	-0.06%
	Total	1.11%	0.96%	-0.15%	0.06%	0.05%	-0.01%	0.45%	0.35%	-0.10%	0.80%	0.76%	-0.04%
18-20	Male	2.48%	2.28%	-0.20%	0.26%	0.24%	-0.02%	0.63%	0.58%	-0.05%	2.04%	1.92%	-0.12%
	Female	1.96%	2.38%	0.42%	0.18%	0.18%	0.00%	0.54%	0.70%	0.16%	1.68%	2.04%	0.36%
	Total	2.19%	2.33%	0.14%	0.22%	0.21%	-0.01%	0.58%	0.64%	0.06%	1.84%	1.99%	0.15%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
21-34	Male	6.94%	7.72%	0.78%	0.55%	0.70%	0.15%	1.18%	1.28%	0.10%	6.41%	7.19%	0.78%
	Female	6.34%	6.66%	0.32%	0.39%	0.45%	0.06%	1.27%	1.18%	-0.09%	5.81%	6.32%	0.51%
	Total	6.47%	6.89%	0.42%	0.42%	0.50%	0.08%	1.25%	1.20%	-0.05%	5.94%	6.50%	0.56%
35-64	Male	7.91%	8.64%	0.73%	1.07%	0.90%	-0.17%	1.25%	1.53%	0.28%	7.05%	7.88%	0.83%
	Female	5.04%	5.43%	0.39%	0.40%	0.44%	0.04%	1.11%	1.09%	-0.02%	4.45%	4.99%	0.54%
	Total	6.10%	6.62%	0.52%	0.64%	0.61%	-0.03%	1.16%	1.25%	0.09%	5.41%	6.07%	0.66%
65+	Male	1.34%	1.87%	0.53%	0.14%	0.17%	0.03%	0.32%	0.45%	0.13%	1.13%	1.60%	0.47%
	Female	0.39%	0.34%	-0.05%	0.07%	0.04%	-0.03%	0.07%	0.05%	-0.02%	0.30%	0.33%	0.03%
	Total	0.67%	0.82%	0.15%	0.09%	0.08%	-0.01%	0.14%	0.17%	0.03%	0.55%	0.73%	0.18%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**Male**	**2.14%**	**2.32%**	**0.18%**	**0.23%**	**0.22%**	**-0.01%**	**0.42%**	**0.45%**	**0.03%**	**1.87%**	**2.09%**	**0.22%**
	Female	**2.43%**	**2.60%**	**0.17%**	**0.18%**	**0.19%**	**0.01%**	**0.55%**	**0.53%**	**-0.02%**	**2.16%**	**2.40%**	**0.24%**
	Total	**2.31%**	**2.48%**	**0.17%**	**0.20%**	**0.20%**	**0.00%**	**0.49%**	**0.50%**	**0.01%**	**2.03%**	**2.27%**	**0.24%**

Table 16: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Anson	0.04%	0.04%	0.00%	1.82%	3.73%	1.91%	1.82%	2.53%	0.71%	7.10%	4.48%	-2.62%
Guilford	0.01%	0.02%	0.01%	1.60%	0.88%	-0.72%	1.60%	2.26%	0.66%	3.46%	4.40%	0.94%
Harnett	0.02%	0.02%	0.00%	0.77%	0.55%	-0.22%	0.77%	1.11%	0.34%	3.27%	3.31%	0.04%
Hoke	0.02%	0.08%	0.06%	2.49%	0.66%	-1.83%	2.49%	1.06%	-1.43%	4.96%	5.31%	0.35%
Lee	0.02%	0.00%	-0.02%	0.73%	0.71%	-0.02%	0.73%	1.53%	0.80%	4.69%	5.89%	1.20%
Montgomery	0.00%	0.00%	0.00%	1.06%	1.17%	0.11%	1.06%	2.58%	1.52%	3.64%	7.05%	3.41%
Moore	0.00%	0.00%	0.00%	1.86%	1.68%	-0.18%	1.86%	2.95%	1.09%	8.10%	10.64%	2.54%
Randolph	0.00%	0.03%	0.03%	1.18%	1.13%	-0.05%	1.18%	1.76%	0.58%	5.60%	6.55%	0.95%
Richmond	0.00%	0.00%	0.00%	2.99%	0.76%	-2.23%	2.99%	2.70%	-0.29%	5.91%	9.07%	3.16%
	35-64			65+			Unknown			Total		
Anson	6.04%	6.63%	0.59%	1.10%	0.77%	-0.33%	0.00%	0.00%	0.00%	2.98%	2.89%	-0.09%
Guilford	5.43%	6.88%	1.45%	1.13%	1.25%	0.12%	0.00%	0.00%	0.00%	1.75%	2.24%	0.49%
Harnett	3.58%	3.80%	0.22%	0.17%	0.23%	0.06%	0.00%	0.00%	0.00%	1.25%	1.38%	0.13%
Hoke	6.38%	7.86%	1.48%	0.84%	0.94%	0.10%	0.00%	0.00%	0.00%	2.20%	2.42%	0.22%
Lee	3.36%	5.35%	1.99%	0.21%	0.51%	0.30%	0.00%	0.00%	0.00%	1.35%	1.98%	0.63%
Montgomery	5.14%	7.05%	1.91%	0.76%	0.90%	0.14%	0.00%	0.00%	0.00%	1.78%	2.64%	0.86%
Moore	5.41%	7.99%	2.58%	0.77%	0.81%	0.04%	0.00%	0.00%	0.00%	2.50%	3.60%	1.10%
Randolph	4.55%	5.82%	1.27%	0.03%	0.31%	0.28%	0.00%	0.00%	0.00%	1.11%	2.32%	1.21%
Richmond	6.01%	8.50%	2.49%	0.54%	1.43%	0.89%	0.00%	0.00%	0.00%	2.63%	3.77%	1.14%

Table 17: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Anson	0.04%	0.04%	0.00%	1.82%	3.73%	1.91%	1.82%	2.53%	0.71%	7.10%	4.48%	-2.62%
Guilford	0.01%	0.02%	0.01%	1.60%	0.88%	-0.72%	1.60%	2.26%	0.66%	3.46%	4.40%	0.94%
Harnett	0.02%	0.02%	0.00%	0.77%	0.55%	-0.22%	0.77%	1.11%	0.34%	3.27%	3.31%	0.04%
Hoke	0.02%	0.08%	0.06%	2.49%	0.66%	-1.83%	2.49%	1.06%	-1.43%	4.96%	5.31%	0.35%
Lee	0.02%	0.00%	-0.02%	0.73%	0.71%	-0.02%	0.73%	1.53%	0.80%	4.69%	5.89%	1.20%
Montgomery	0.00%	0.00%	0.00%	1.06%	1.17%	0.11%	1.06%	2.58%	1.52%	3.64%	7.05%	3.41%
Moore	0.00%	0.00%	0.00%	1.86%	1.68%	-0.18%	1.86%	2.95%	1.09%	8.10%	10.64%	2.54%
Randolph	0.00%	0.03%	0.03%	1.18%	1.13%	-0.05%	1.18%	1.76%	0.58%	5.60%	6.55%	0.95%
Richmond	0.00%	0.00%	0.00%	2.99%	0.76%	-2.23%	2.99%	2.70%	-0.29%	5.91%	9.07%	3.16%
	35-64			65+			Unknown			Total		
Anson	6.04%	6.63%	0.59%	1.10%	0.77%	-0.33%	0.00%	0.00%	0.00%	2.98%	2.89%	-0.09%
Guilford	5.43%	6.88%	1.45%	1.13%	1.25%	0.12%	0.00%	0.00%	0.00%	1.75%	2.24%	0.49%
Harnett	3.58%	3.80%	0.22%	0.17%	0.23%	0.06%	0.00%	0.00%	0.00%	1.25%	1.38%	0.13%
Hoke	6.38%	7.86%	1.48%	0.84%	0.94%	0.10%	0.00%	0.00%	0.00%	2.20%	2.42%	0.22%
Lee	3.36%	5.35%	1.99%	0.21%	0.51%	0.30%	0.00%	0.00%	0.00%	1.35%	1.98%	0.63%
Montgomery	5.14%	7.05%	1.91%	0.76%	0.90%	0.14%	0.00%	0.00%	0.00%	1.78%	2.64%	0.86%
Moore	5.41%	7.99%	2.58%	0.77%	0.81%	0.04%	0.00%	0.00%	0.00%	2.50%	3.60%	1.10%
Randolph	4.55%	5.82%	1.27%	0.03%	0.31%	0.28%	0.00%	0.00%	0.00%	1.11%	2.32%	1.21%
Richmond	6.01%	8.50%	2.49%	0.54%	1.43%	0.89%	0.00%	0.00%	0.00%	2.63%	3.77%	1.14%

B Waiver Validation Results

The overall validation score was in the "Fully Compliant" range, with an average validation score of 100% across the ten measures. The following tables display the validation scores for each of Sandhills' ten measures, as well as the combined the final validation for the ten measures to present an overall validation score for Sandhills (see Performance Measure Validation Worksheets for details).

Table 18: B Waiver Performance Measure Validation Scores 2017

Measure	Validation Score Received
A.1. Readmission Rates for Mental Health	100%
A.2. Readmission Rate for Substance Abuse	100%
A.3. Follow-Up After Hospitalization for Mental Illness	100%
A.4. Follow-Up After Hospitalization for Substance Abuse	100%
B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	100%
D.1. Mental Health Utilization-Inpatient Discharges and Average Length of Stay	100%
D.2. Mental Health Utilization	100%
D.3. Identification of Alcohol and other Drug Services	100%
D.4. Substance Abuse Penetration Rate	100%
D.5. Mental Health Penetration Rate	100%
Average Validation Score & Audit Designation	100% FULLY COMPLIANT

C Waiver Measures

Changes made to the measures were validated for review of 2016-2017 C Waiver measures. Sandhills selected eight new measures, and retained two previously validated measures. Sandhills included documentation for all ten C Waiver measures. Sandhills' reported rates are displayed in the following table.

Table 19: C Waiver Measures Rates 2016-2017

Performance measure	Data Collection	July 1, 2016-June 30, 2017*
Proportion of Level f Care evaluations completed at least annually for enrolled participants	Semi Annually	755/755=100%

Performance measure	Data Collection	July 1, 2016- June 30, 2017*
Proportion of Level of Care evaluations completed using approved processes and instrument	Semi Annually	755/755=100%
Proportion of New Level of Care evaluations completed using approved processes and instrument	Semi Annually	20/20=100%
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Annually	30/35=85.71%
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	Annually	178/178=100%
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	Annually	1103/1103=100%
Proportion of Individual Support Plans that address identified health and safety risk factors	Semi Annually	764/764=100%
Percentage of participants reporting that their Individual Support Plan has the services that they need	Annually	1103/1103=100%
Proportion of individuals for whom an annual ISP and/or needed updates took place	Annually	1103/1103=100%
Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval	Quarterly	15/16=93.75%

**NA= Denominator is equal to zero.*

C Waiver Validation Results

Validation scores are "Fully Compliant" with an average validation score of 100% across the 10 measures. The validation scores are shown in table TBD, *C Waiver Performance Measure Validation Scores 2018*. Documentation included the data collection methodology, data validation, and data sources, as well as the latest reported rates. The validation worksheets offer detailed information on point deduction when validating each *C Waiver* measure.

Table 20: C Waiver Performance Measure Validation Scores 2018

Measure	Percentages Reported
Number and percent of new waiver enrollees who have a LOC prior to receipt of services.	100%

Measure	Percentages Reported
Proportion of providers that meet licensure, certification, and/or other standards prior to their furnishing waiver services.	100%
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan.	100%
Proportion of providers reviewed according to PIHP monitoring schedule to determine continuing compliance with licensing, certification, contract and waiver standards.	100%
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals.	100%
Proportion of PCPs that are completed in accordance with DMA requirements.	100%
Proportion of records that contain a signed freedom of choice statement.	100%
Proportion of participants reporting their Care Coordinator helps them to know what waiver services are available.	100%
Proportion of participants reporting they have a choice between providers.	100%
Proportion of claims paid by the PIHP for Innovations wavier services that have been authorized in the service plan.	100%
Average Validation Score & Audit Designation	100% FULLY COMPLIANT

Performance Improvement Project Validation

CCME conducted PIP validations in accordance with the CMS-developed protocol titled, EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012. The protocol validates project components and its documentation to provide an assessment of the overall study design and project methodology. The components assessed are as follows:

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

In 2017, four PIP projects were reviewed. PIPs were based on analysis of comprehensive aspects of enrollee needs and services, and rationale for each topic was documented. Three of the four (75%) PIPs reviewed were designated in the “High Confidence” range and one was in the “Not Credible” range. The common issue among the PIPs was lack of information regarding barriers that are being addressed by the listed interventions and clear presentation of the results.

For the 2018 review, CCME validated four projects. The Child Mental Health Level III PIP was the only PIP that was reviewed in 2017 and 2018. Access to Behavioral Health (BH) Assessment, TCLI Transition Days, and EBP Specialty were the other three PIPs reviewed and validated for 2018.

For the Child Mental Health Level III PIP, there were issues noted around the lack of varying interventions to adjust for the poor improvement in the rate. The same action step regarding education for the Utilization Management (UM) staff was listed for the remeasurement periods from January through July of 2018, but no new barriers or interventions were added to the report since November 2016. During the Onsite meeting, Sandhills noted that an edit in the AlphaMCS software system is now back in place, which should lead to an improvement in the rates for next review cycle.

The following table is a summary of the validation scores for each Project for current and previous review cycles.

Table 21: Performance Improvement Project Validation Scores

Project Type	Project	2018 Validation Score	2017 Validation Score
Clinical	Maximizing the Benefit of Child Mental Health Level III	79/85=93% High Confidence in Reported Results	85/90=94% High Confidence in Reported Results
	Increase the number of members authorized for Psychosocial Rehabilitation Services with correct diagnosis or sufficient clinical information	Not validated; Closed Nov 2017	109/110 = 99% High Confidence in Reported Results
	EBP Specialty	84/85=99% High Confidence in Reported Results	Not Validated
Non-Clinical	Shaping the Network to improve provider choice and ensure members access to quality services	Not validated	89/89=100% High Confidence in Reported Results
	Increase timely completion and submission of Quality of Life Surveys	Not validated: Closed	35/61=57% Not Credible

Project Type	Project	2018 Validation Score	2017 Validation Score
	Access to Routine BH Assessments	105/111=95% High Confidence in Reported Results	Not Validated
	TCLI Transition Days	78/85=92% High Confidence in Reported Results	Not Validated

The tables that follow list the specific errors by project and include recommendations to correct the errors.

Table 22: Maximizing the Benefit of Child Mental Health Level III

Section	Reasoning	Recommendation
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	The rate has been increasing the last two quarters, although no new interventions are being initiated. The report shows that education for outpatient providers is ongoing, but no other interventions have been initiated since November 2016 in the uploaded report.	In addition to the education, initiate plans for interventions that will decrease the number.
Was there any documented, quantitative improvement in processes or outcomes of care?	The rate improved for a few quarters but has been increasing the past two quarters (decrease in rate is improvement).	Determine if there are new education process or support tools to decrease the number.

Table 23: Evidence Based Practices Employed By Provider Network

Section	Reasoning	Recommendation
Was there any documented, quantitative improvement in processes or outcomes of care	The rate initially improved, but then decreased the past quarters for both bipolar and PTSD tools.	Determine if there are new initiatives that can be implemented to increase YES responses.

Table 24: Access To Routine Behavioral Health Assessments In a Timely And Appropriate Manner

Section	Reasoning	Recommendation
Were qualified staff and personnel used to collect the data?	Personnel involved in calls and data entry were not listed in the report.	Include the personnel involved in calls, data entry, and analysis in the report.
Is there any statistical evidence that any observed performance improvement is true improvement?	Statistical analyses were not conducted.	Because sampling is utilized, a statistical test (z test or Fisher's exact) should be conducted and reported.

Table 25: TCLI Transition Days

Section	Reasoning	Recommendation
Did the study design clearly specify the sources of data?	Sources of data were not clearly specified.	The data source from which the spreadsheet is developed needs to be added to the report.
Did the study design prospectively specify a data analysis plan?	Data analysis plan was not clearly documented.	Include the data analysis plan in the report.
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Interventions have been initiated based on results and issues with database, but the barriers that are linked to each intervention are not clear in the report.	Revise the report to display the specific barriers that are being addressed by the interventions.

Figure 5, Quality Improvement Findings, provides a comparison of Sandhills' current EQR Quality Improvement results to the 2017 review results.

Figure 5: Quality Improvement Findings

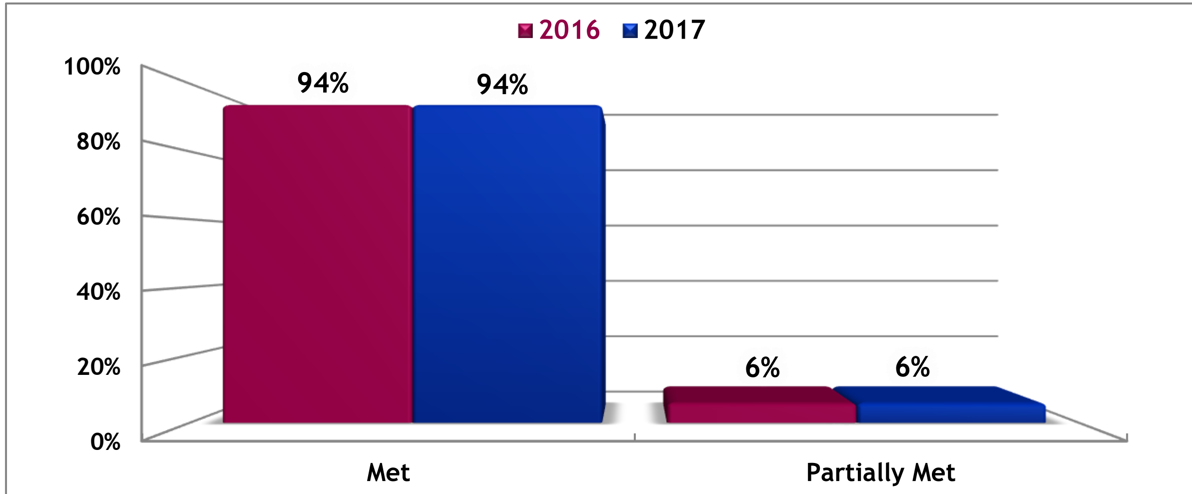


Table 26: Quality Improvement

Section	Standard	2018 Review
Quality Improvement	The composition of the QI Committee reflects the membership required by the contract.	**Partially Met**

Strengths

- Sandhills has a strong process for monitoring provider, evidence-based, clinical practice guidelines and had identified seven evidence-based practice guidelines. This has expanded to nine and there is a monitoring tool used for each of these nine during routine monitoring. There is a quarterly monitoring report, which has a section to report data for this monitoring.
- The integrated care project is an example of active and engaged physician participation in QI projects.
- PIPs were based on analysis of comprehensive aspects of enrollee needs and services, and rationale for each topic was documented.
- Performance measure query was accurate for B Waiver measures. Reports for B Waiver measures were well organized and accurately presented.
- All PIPs scored in the high confidence validation range.

Weaknesses

- GQIC has three of the seven meetings reviewed without a quorum. Meetings without quorum were March 8th and May 10, and July 12, 2018.
- There is a workgroup to review measures needing improvement for the *ECHO Survey*. Those measures are defined to be 5% or more outside the state average. This workgroup has minutes and reports progress to needed committees. This evidence of improvement for each of these measures identified is not tracked in a dedicated document making it hard to see improvement.
- The FY 2017-18 QM Program Goals and Objective Findings section of the *QM Program Evaluation* did not have documentation in the barriers and recommendations fields.

Recommendations

- Document *ECHO Survey* measures identified to be 5% or more outside the state average in a dedicated document so improvement can be seen. Track interventions, barriers, and outcomes for each measure. Keep a record of the survey results on those measures annually to analyze improvements or alter interventions.
- In the *QM Program Evaluation*, document barriers and recommendations with the 2017-18 QM program goals/objectives findings when appropriate. The fields for barriers and recommendations were blank in the document for all goals/objectives.

Corrective Action

- Work to restructure, increase interest, recruit new members, or consolidate provider committees so that Sandhills can meet the quorum set for GQIC.

E. Utilization Management

The EQR of Sandhills' Utilization Management (UM) functions includes an examination of multiple policies and procedures, the *Utilization Management Plan, The Care Coordination Program Description, Proof of Program Effectiveness, Quality Oversight of TCLI Initiative; TCLI Quality of Life Surveys Closed Report, the Medicaid Provider Manual,* the *Member Handbook,* and a file review of 55 UM decisions.

Dr. Anthony Caraway, Chief Clinical Officer (CCO)/Medical Director, is responsible for all Sandhills clinical operations. In addition to clinical oversight, he is involved in a variety of committees, including co-chairing the *Quality Management Committee (QMC).*

The Care Management/Utilization Management (CM/UM) Director position has been vacant since January 2018. At the time of the Onsite interview, Ms. Sarah Glanville from the Program Integrity Department had accepted the position as CM/UM Director with a start date of

September 1, 2018. The CM/UM Director supervises three Deputy Directors who oversee the daily UM functions.

During the Onsite interview, the process for requesting a Non-Covered Service for consideration of "new technology" was described by Sandhills' UM staff. Staff explained the process can be initiated by a legal guardian through the use of the Sandhills *Non-Covered Services Form*. However, there is no reference to this process or form in Sandhills' policies and procedures and no guidance offered to stakeholders on the Sandhills' website, in the *Member Handbook*, or in the *Medicaid Provider Manual*.

CCME's Onsite discussion revealed Sandhills has an established process for detecting and analyzing the overutilization and underutilization of services. The process includes examining over spending or underspending by geographic areas and by service. While adequately described during the Onsite, this process is not reflected in any policy or procedure.

The *UM Committee Minutes* from May 16, 2017, indicate approval of *the Early Childhood Services Intensity Instrument (ESCII©)* for children ages three to six years old. The Onsite discussion indicated that implementation of this tool was in fall of 2017 with a formal training to providers in June of 2018. The review of policies and procedures did not include the required use of this tool. The requirement of this tool, as indicated in *DMA Contract, Section 7.4.2*, needs to be added to a policy or procedure.

Information regarding emergency and post emergency services was added to *Procedure CC 19 a, Coordination of Care via Emergency and Post-Inpatient Care Follow-up*, upon CCME's recommendation last year. The information is consistent with *42 CFR § 438.114* and in *DMA Contract, Section 6.3*.

CCME reviewed *Procedure CC 22a, MH/SA Care Coordination Levels of Care Coordination*. This procedure is specific to MH/SA Care Coordination members and provides limited information about Care Coordination oversight of the Person-Centered Planning process with MH/SA members. During the Onsite interview, Care Coordination staff could describe significant involvement in the development of the *Person Centered Plan*. This involvement should be added to *Procedure CC 22a* to support Sandhills comprehensive monitoring of treatment planning.

The Care Coordination file review indicated that the Individual Support Plans (ISP) for members in the NC 1915c Innovation Waiver Program are well-documented and provide details on how to support members in their home and community. CCME noted that in several files the progress/monitoring notes were brief, incomplete, and did not indicate specific follow up activities for the enrollee.

The review of the MH/SA and I/DD progress notes by Care Coordination resulted in findings that progress notes were not completed in the required timeframes. The findings include that six of 20 files had gaps in progress notes or missing progress notes with undocumented rationale. In four files there were late entry notes and two of these files had three or more late entry notes. The date of the service was not indicated on the notes.

Sandhills needs to better monitor progress note documentation for timeliness and completeness and add details to their policies and procedures of this improved monitoring process.

The Transition to Community Living Initiative (TCLI) program has clear policies and procedures in the areas required by *DMA Contract, Amendment 2, Section 15*. However, *Policy and Procedure CC 32, 32a Monitoring of Transition Services and Stakeholder Follow-Along, bullet 6 states*, “Transitions are to occur within 90 days of the initial planning meeting.” The *DMA Contract, Section 15.2*, states, “The continued need for Care Coordination after the 90-day timeframe shall be based on whether the individual meets special healthcare needs population criteria following the 90-day timeframe.” Enhancing *Procedure CC 32a* to include the DMA language will better reflect the continuation of care coordination for special health needs population.

Pre-Transition Quality Of Life surveys *(QOL* surveys) were present in all files review. However, three of the files did not have an 11 or 24 month survey. During the Onsite interview it was stated that the *QOL surveys* were monitored for the incoming members, but not for members already in the TCLI program. Per *DMA Contract Section 15.4 a.* PHIP shall administer the *QOL surveys* for the TCLI Special Healthcare Population, not a select group of TCLI members.

The TCLI Communication Plan continues to need development. While TCLI information was added to the *Medicaid Provider Manual*, as recommended in the *2017 EQR*, TCLI information was not added to the *Member Handbook*. Additionally, Sandhills’ website does not include all of the information required *by DMA Contract, Section 15.11*. On the website, there is no information about the availability of “materials and training about the crisis hotline” and the “availability of information for enrollees with limited English proficiency.”

The overall score for the UM section is noted in *Figure 6, Utilization Management Findings*.

Figure 6: Utilization Management Findings

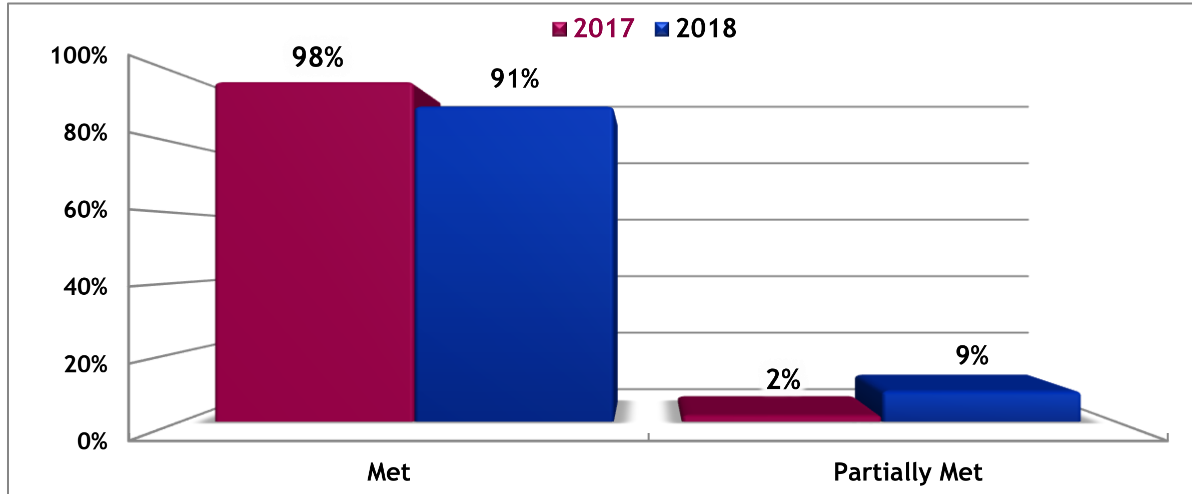


Table 27: Utilization Management

Section	Standard	2018 Review
Utilization Management	Consideration of new technology	Partially Met
	Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations	Partially Met
	The PIHP applies the Care Coordination policies and procedures as formulated	Partially Met
	The PIHP will develop a TCLI communication plan that includes materials and training about crisis hotline, services for enrollees with limited English	Partially Met

Strengths

- All UM decisions were completed within the required timeframes.
- Sandhills began using the ESCII© Assessment Tool for children during 2017 and a full rollout with training was completed with providers in June 2018.
- The definition of emergency care and post -stabilization care was added to Procedure CC 19 a, *Coordination of* Care *via Emergency and Post-Inpatient Care Follow*.
- Sandhills has two Hospital based Care Coordinators/Hospital MH/SA Specialist, who are remotely located. They are assigned specific hospitals and monitor transitions and services for members.

- The qualifications for the In-Reach Specialist or Peer Support Specialists job description includes that the Transition Coordinators are certified Peer Support Specialist.

Weaknesses

- There is no description of the process for requesting a Non-Covered Service for consideration of "new technology" and Non-Covered services in Sandhills' policies and procedures and no guidance offered to stakeholders on the Sandhills' website, in the Member Handbook, or in the Medicaid Provider Manual.
- While adequately described during the Onsite, the process for identifying and addressing overutilization and underutilization of services is not described in any policy or procedure.
- Sandhills began using the ESCII© Assessment Tool for children during 2017, but the required use of this tool is not noted in any policy or procedure.
- MH/SA Care Coordination policies and procedures have limited information about the oversight of the Person Centered planning process completed by Care Coordination regarding the oversight of the development process with MH/SA members.
- Review of the Care Coordination files showed several files where notes were brief, incomplete, and not filed within the timeframes required by Sandhills' policies and procedures.
- There is no suggested structure for MH/SA Care Coordination progress notes to guide staff in sufficiently documenting treatment planning and follow up activities.
- Sandhills *Policy and Procedure CC 32, 32a Monitoring of Transition Services and Stakeholder Follow-Along* states, "Transitions are to occur within 90 days of the initial planning meeting file review many files closed if due to not follow up after 2 attempts." This is not in accordance with *DMA Contract, Section 15.2* which requires "The continued need for Care Coordination after the 90-day timeframe shall be based on whether the individual meets special healthcare needs population criteria following the 90-day timeframe."
- Sandhills' does not monitor the implementation and completion 11 and 24 month QOL surveys. As a result, several of the TCLI files reviewed were lacking these surveys.
- Information regarding the availability of the TCLI program is not present in the *Member Handbook* and is incomplete on the Sandhills' website. On the website, there is no information about the availability of "materials and training about the crisis hotline" and the "availability of information for enrollees with limited English proficiency." This information is required by *DMA Contract, Section 15.11*.

Corrective Actions

- Describe the process for requesting a Non-Covered Service for consideration of "new technology" in Sandhills' procedures. Add information on how initiate this request to the *Medicaid Provider Manual* and the *Member Handbook*.
- Implementation of the *ESCII*© assessment tool was initiated for children, ages three to six years. The use of this tool needs to be added to a policy or procedure as indicated in the *DMA Contract, Section 7.4* and to verify that Sandhills has implemented the tool.
- Enhance the monitoring of MH/SA and I/DD Care Coordination notes to ensure notes are complete, reflect treatment planning and follow up activities, and are submitted timely, as required by Sandhills' policies and procedures.
- Add information regarding the availability of the TCLI program to the *Member Handbook* ensure information on the website reflects the availability of "materials and training about the crisis hotline" and the "availability of information for enrollees with limited English proficiency." This information is required by *DMA Contract, Section 15.11*.

Recommendations

- Include in policy and/or procedure the process that Sandhills uses to monitor Overutilization and Underutilization.
- Include in the MH/SA Care Coordination policies and procedures the involvement by care coordinators in the development of the *Person Centered Plan*.
- Select a progress MH/SA Care Coordination note structure, for example a SOAP (Subjective, objective, assessment and plan) or PIE (problem, intervention, evaluation) format. This will ensure treatment planning follow up activities by staff are more adequately captured. Define the required note structure in policies and procedures.
- Add to *Procedure 32a*, bullet six, language that includes "The continued need for Care Coordination after the 90-day timeframe shall be based on whether the individual meets special healthcare needs population criteria following the 90-day timeframe", per the *DMA Contract 15.2.1*.
- Continue to monitor and ensure all members of the TCLI program complete QOL surveys that is inclusive of the three monitoring intervals; pre- transition, 11- and 24- month transition timeframes. When a member cannot be located or refuses to complete the QOL survey, enter a note into the members record regarding the barrier to completion of the survey.

F. Grievances and Appeals

Grievances

The EQR for Sandhills' grievance process included an examination of *Policy CORE 35, Procedure 35a Consumer Complaint Process- Medicaid,* 25 grievance files and an Onsite interview. Grievances are handled by the Customer Services Department and Mr. Gene McRae, Licensed Clinical Social Worker (LCSW), as the Director. Ms. Mary Kidd, BA, is the Complaints and Incident Report Manager and had oversight of the grievance process. At the time of the Onsite review, Mary Kidd was transitioning to another internal position and the Complaints and Incidents Report Manager position, effective September 10th, 2018.

Sandhills' grievance processes are guided by *Procedure CORE 35a, Consumer Complaint Process-Medicaid*. Overall, this procedure provides information about the internal steps staff must take during the grievance process. Details include the definition of a grievance, the timeframe for resolving grievances, and internal steps staff takes to receive, log, triage, investigate, and resolve grievances. It is important to note that Sandhills uses the terms "grievance" and "complaint" interchangeably within this procedure. Meanwhile, the *Member Handbook* and *Medicaid Provider Manual* both use only the term "grievance".

Within the files reviewed, these terms were also used interchangeably. For example, an acknowledgment letter was sent to acknowledge the receipt of a "complaint". However, the resolution notice sent used the term "grievance". Using one term throughout Sandhills' policies and procedures, notifications, and staff documentation will decrease any potential confusion by staff and stakeholders.

A limitation of this policy and procedure is related to the description of the timeframe to notify the complainant in writing about the results of the grievance. While this information is within the procedure, it is only noted directly under "high risk grievance" information. Information regarding the written grievance acknowledgements and resolution notifications needs to be added to the beginning of this procedure for clarification.

In the past review year, *Procedure CORE 35a* was revised to include; "Chief Clinical Officer/ Medical Director Involvement" in the grievance process. During the Onsite interview, Sandhills shared a monitoring form that had been implemented in the past year. This form captures the Chief Clinical Officer's (CCO) consultation/involvement in a grievance case by documenting the details of CCO's involvement, the CCO's signature and the date of the review/consultation. The consultation form is not mentioned within the "Chief Clinical Officer/Medical Director Involvement" section of the grievance procedure. Adding a reference about the form or including the form into the procedure would further verify the CCO/Medical Director's involvement in the grievance process.

During the Onsite interview, staff were not aware of the grievance record retention timeframes required by *DMA Contract*. Information regarding record retention was found in *Procedure HIM 4a Clinical and Business Records*. This procedure contains information regarding the retention of grievance records indicating, “Sandhills shall maintain all Services Management Records in accordance with the terms specified by the Division of Medicaid Assistance for the purposes of audit and program management.” This procedure should be updated to include the grievance record retention requirement of five years as stated in *DMA Contract, Attachment M, Section B.2*. This will help to keep staff informed as well as ensure that records, external to the AlphaMCS grievance portal, are also retained for the required timeframe.

During the EQR grievance file review, CCME noted that the grievance files had two different forms completed to initiate the grievance process. Sandhills incorporated the 2017 EQR recommendation regarding logging of grievances to ensure all required elements related to the complaint/grievance logs were captured by staff. The “Sandhills Complaint Intake Form” is now completed by staff and sent to the email grievance group to initiate the grievance process.

Sandhills also created a web-based form “File A Complaint” that is available on the Sandhills Website and completed by the grievant, in English or Spanish, when the “Complaint” is submitted the form/information is sent to an email grievance group. Both formats contain the same information, including required elements for logging a grievance. However, none of this information is captured procedurally. The implementation of both of these new forms should be added to Sandhills’ policies and/or procedures.

Review of the grievance files showed that grievance resolution letters contained minimal information. The documentation in the resolution letters did not reflect all of the steps that were completed during the review/ investigation process. It was also noted that in the partially substantiated letters there was minimal to no information to indicate what part of a grievance was substantiated and what part was unsubstantiated. While it is understood that, in some grievances, minimal feedback is warranted, including the steps taken during the review of the grievance into all decision letters will better clarify to grievants the outcomes of Sandhills’ grievance resolution.

Appeals

EQR of the appeals functions at Sandhills involves review of 25 first level appeal files, five second level appeal files, appeals data and the appeals tracking sheet. An extensive policy and procedure review was also completed for compliance with the *DMA Contract* and federal regulations governing the Medicaid appeals process.

Sandhills processed approximately 150 Medicaid first level appeals during the year under review and participated in approximately 45 second level appeals. File review showed that all first level appeals were processed in a timely manner and, overall, appellants notified appropriately. All appeal decisions within the files were rendered by appropriate physician

peer reviewers. It was noted in three of the files reviewed, that Sandhills accepted requests for appeal from providers without the signed consent of the enrollee. This was discussed in last year's EQR and is required per *DMA Contract, Attachment M, G.1*.

While appeal data is reported to the UM Committee on a monthly basis, only numbers are reported. There is no identification of appeal trends, potential quality improvement opportunities, or next steps for addressing trends. Sandhills would benefit from a deeper analysis of appeal trends.

Five of the 25 first level, appeal files were appeals that were requested to be expedited. Expedited appeals were also noted to have been processed timely but oral notifications were not documented in the three of the five files. In the previous year's EQR, it was recommended that an expedited checklist be developed to guide staff through the various notifications involved with expedited appeals. This checklist was evident in the two expedited appeal files processed after December of 2017 and significantly improved staff's compliance with required notifications. However, these checklists still lacked sufficient details to understand the notification steps appeal staff took. For example, the checklist requires the date and time of notifications, but when completed by staff, still does not reflect by whom and to whom notifications were given. This is particularly confusing as Sandhills' procedure indicates that the member will be notified, but in three of the five expedited files, the provider submitted the appeal.

Similarly, the appeal files processed within the standard timeframe lacked adequate detail to capture steps taken by appeal staff. For example, steps taken by appeals staff to coordinate with appellants are not captured in the appeal communication log. Two files showed staff assisted with the submission of additional appeal information but none of these interactions were captured within the file. Staff should ensure that they capture all interactions with appellants around appeals within the files. This is particularly important when staff provide assistance with appeal procedural steps, as PIHP assistance with the appeal process is emphasized in the *DMA Contract, Section A.1.a*.

When additional information was obtained for appeal consideration, staff labelled this as simply "additional documentation". To better clarify what is reviewed as part of the appeal record, appeal staff should label each document individually (e.g., "letter from mother", "Psychological testing 4/22/18", "additional home modification quote", etc.) in both the appeal report sent to Prest, as well as the resolution notification to the appellant.

Sandhills has 10 core policies and procedures that govern the Medicaid appeals process. These policies and procedures are:

- *Policy 33 Non Certification Appeals Process*
- *Procedure 33a Non Certification Appeals Process (Medicaid)*
- *Policy 34 Appeals Process*
- *Procedure 34a Appeals Process (Medicaid)*
- *Policy 38 Expedited Appeals Process Timeframe*
- *Procedure 38a Expedited Appeals Process Timeframe (Medicaid)*
- *Policy 39 Standard Appeals Process*
- *Procedure 39a Standard Appeals Process (Medicaid)*
- *Policy 41 Appeal Record Documentation*
- *Procedure 41a Appeal Record Documentation (Medicaid)*

While required, contractual elements are dispersed throughout these 10 core policies and procedures, they frequently contradict one another. For example, *Procedure 39 Standard Appeals Process Timeframe*, states that "Requests for a standard appeal must be made in writing by the member." Yet *Policy 34, Appeals Process* states that appeals can be submitted "by the member and/or member's legal representative". Further, *Procedure 33 Non-Certification Appeal Process (Medicaid)* states that "a provider acting on behalf of the member may appeal the decision". However, none of these policies and procedures contain the correct definition of who can file an appeal. As mentioned earlier, the *DMA Contract* requires enrollee's signed consent, when anyone other than the enrollee or their legal guardian requests an appeal. The need for a plan by Sandhills to streamline their policy and procedure set is discussed in greater detail in the Administrative section of this report, but did have the biggest impact on the scoring on appeals standards.
The following provides information about required elements not accurately captured in Sandhills' policies and procedures and other stakeholder materials.

Who can file an appeal

This information is incorrect across all policies and procedures. As discussed above, Per *DMA Contract, Attachment M, Section G.1*, "Pursuant to *42 CFR § 438.402(b)*, the Enrollee, legally responsible person, or a Provider or other designated personal representative, acting on behalf of the Enrollee and with the Enrollee's signed consent, may file a PIHP internal appeal." For this same reason, the description of who can file an appeal is incorrect on the website and in the *Medicaid Provider Manual* and *Member Handbook*. The *Medicaid Provider*

Manual is also misleading as it addresses "you" as the appellant, but appeals are an enrollee right.

Neither the *Member Handbook* nor the *Medicaid Provider Manual* clarify when appellants will be notified when an appeal is received and when the appeal is resolved. The importance of explaining the expected notifications from Sandhills to potential appellants was discussed during the Onsite.

<u>The definition of an appeal</u>

All of Sandhills' policies and procedures indicate that the definition of an appeal is "a request for an administrative review of an adverse benefit determination". However, *DMA Contract, Attachment M, G.1* states, "PIHP shall define appeal as the request for review of an adverse benefit determination as defined by 42 CFR § 438.400."

<u>The process for requesting an appeal</u>

Within the *Medicaid Provider Manual,* the language is unclear regarding appeal information. There are two sections; an "Appeals" section and a "Reconsiderations" section. Information in these two sections differs significantly but appears to be explaining the first level, Medicaid appeals process. During the Onsite discussion, the difference between these two sections could not be provided.

<u>Exhaustion of Sandhills' internal appeal process</u>

None of Sandhills' policies or procedures or the *Member Handbook* indicate that the first level appeal process with Sandhills must be exhausted prior to an appellant requesting a second level appeal at the Office of Administrative Hearings. This is required in the *DMA Contract, Attachment M, H (1)* and *42 CFR § 438.402(c)(1)(i)(A)*. This procedural information is noted in the *Medicaid Provider Manual* and on Sandhills' website.

<u>Timeframe for appellants to file an appeal</u>

None of Sandhills' policies or procedures accurately define the allowable timeframe for an appeal to be submitted. This was a recommendation from last year that was not implemented. The *DMA Contract, Attachment M, Sections G (2)* and *E (5)* specify that an appellant has "60 calendar days from the from the date on the adverse benefit determination" and "the date of mailing shall be the date specified on the Notice." This information is correct in the *Member Handbook* but incorrect in the *Medicaid Provider Manual*. Sandhills' website also incorrectly says the enrollee has "30 days from the date of notification" to file an appeal. This should be corrected to reflect the enrollee has 60 days from the <u>mailing</u> date of the denial notification.

Expedited appeal resolution notification

None of Sandhills' policies or procedures clearly indicate that notification of the resolution of an expedited appeal will occur within 72 hours of the receipt of the appeal, as is required by *DMA Contract, Attachment M, Section H (5)*. Sandhills' policies and procedures indicate that an oral notification will occur within that timeframe and a written notification will follow. However, should the oral notification not occur, the written notification must be mailed within those same 72 hours to comply with the contractual requirement. The *Medicaid Provider Manual*, under the Reconsideration section, mentions providers can assist with filing expedited appeal requests but gives no indication as to how or that the resolution notification will occur within 72 hours. The *Member Handbook* is also devoid of information about the right of an appellant to request an expedited appeal and Sandhills' required notifications related to expedited appeal resolutions.

Criteria for expedited appeals

No Sandhills' policies and procedures contain the criteria by which expedited appeals should be reviewed to determine whether they are accepted. The *DMA Contract, Attachment M, Section H (1)*, specifies that "PIHP shall establish and implement an expedited review process for appeals for situations in which PIHP determines, based on a request from an Enrollee or from a Provider on behalf of an Enrollee, that taking the time for a standard resolution could seriously jeopardize an Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function."

Denial of requests to expedite appeals

During the Onsite, it was clarified that Sandhills does not deny requests for expedited appeals. Sandhills' policies and procedures do not include this decision by Sandhills to bypass this denial process nor do they address the process for denying an expedited appeal request. Sandhills should either ensure the policies and procedures include all of the procedural steps required by *DMA Contract, Attachment M, Section H (9) (a) and (b)* when a request for an expedited appeal is denied, or clarify their decision to accept all requests for expedited appeals in their policies and procedures.

Extensions of the standard and expedited appeal resolution timeframe

During the Onsite, it was clarified that Sandhills does not extend standard or expedited appeal timeframes. However, Sandhills' policies and procedures do not reflect this. Sandhills should either revise their policies and procedures to accurately reflect the requirements around timeframe extension or explain, procedurally, that extensions by Sandhills do not occur. Currently, none of their policies or procedures contain the elements for extensions of appeal resolution timeframes required by *DMA Contract, Attachment M, Section H (5) and*

(6). Sandhills does grant extensions requested by the appellant and this is reflected within Sandhills' procedures.

Documentation within the appeal record of the need for additional information and how the delay of appeal resolution is in the best interest of the enrollee would best demonstrate to DMA the need for an extension.

Additionally, should Sandhills decide to procedurally keep the appeal extension option, the *Medicaid Provider Manual* should explain that an appellant can file a grievance if they disagree with the decision by Sandhills to extend this timeframe.

Faxing of confidential, appeal materials

Procedure 33a, Section 1.m indicates Sandhills faxes the appeal record to their peer review delegate. It was confirmed during the Onsite interview that this practice does not occur. Any statements about faxing PHI should be removed from Sandhills' policies and procedures as they use more secure methods for sharing Protected Health Information (PHI) with peer reviewers.

Figure 7, Grievances and Appeals Comparative Findings indicates the scoring for Grievances and Appeals for 2018 compared to the scores received in the 2017 EQR.

Figure 7: Grievances and Appeals Comparative Findings

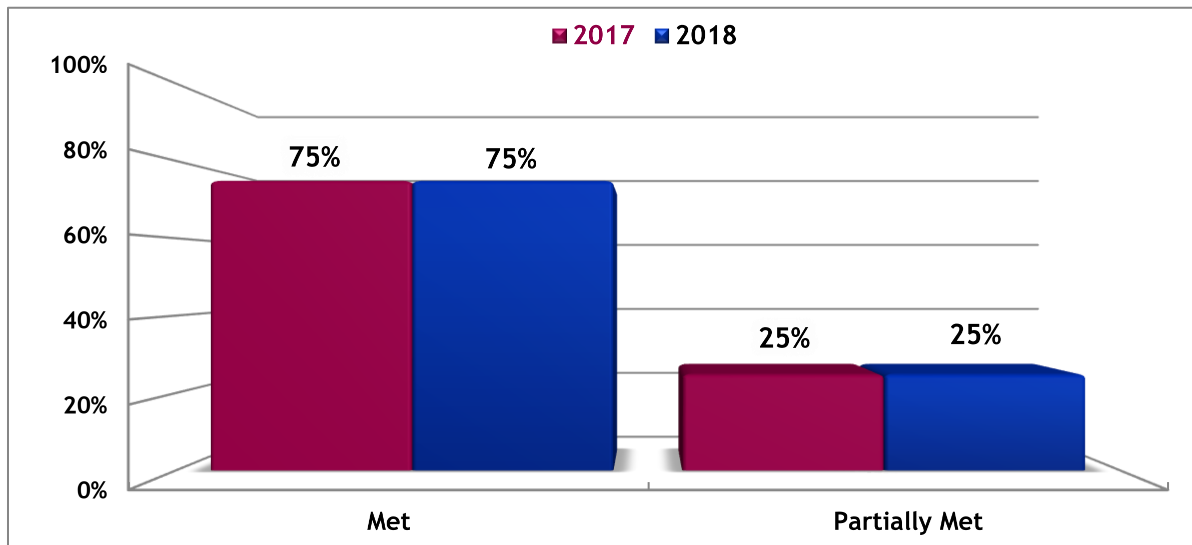


Table 28: Grievances and Appeals

Section	Standard	2018 Review
Appeals	The definitions of an adverse benefit determination and an appeal and who may file an appeal;	Partially Met
	The procedure for filing an appeal;	Partially Met
Appeals	A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	Partially Met
	Timeliness guidelines for resolution of the appeal as specified in the contract;	Partially Met
	The PIHP applies the appeal policies and procedures as formulated	Partially Met

Strengths

- Record retention is addressed in *Procedure HIM 4a Clinical and Business Records* and contains information regarding the retention or grievance records indicating “Sandhills shall maintain all Services Management Records in accordance with the terms specified by the Division of Medicaid Assistance for the purposes of audit and program management.”
- The appeals files showed all appeal decisions were rendered timely and by appropriate appeal peer reviewers.
- During the Onsite interviews, appeals staff demonstrated thorough knowledge of the appeals process.

Weaknesses

- The terms “grievance” and “complaint” are used interchangeably through Sandhills’ policies and procedures, grievance notifications, and staff documentation. This may be confusing to grievants.
- Information about the implementation of two new, electronic forms for filing grievances is not within any policy or procedure.

- There is no clear explanation within Sandhills' policies and procedures that captures the required grievance notifications and their timeframes.
- *Procedure Core 35a Consumer Complaint Process- Medicaid*, was revised to include section, "Chief Clinical Officer/ Medical Director Involvement" But there is no reference to the new CCO consultation form that was developed and implemented in the past year by Sandhills.
- File review showed that Sandhills routinely accepts appeals from providers without signed consent from the enrollee.
- While appeal data is reported to the UM Committee on a monthly basis, only numbers are reported. There is no evidence that analysis occurs.
- The Expedited Appeal checklist lacks sufficient details to understand the notification steps taken by appeal staff.
- The appeal files lacked adequate detail of steps taken by appeal staff, especially when assisting appellants in the submission of additional appeal information.
- When additional information was submitted by appellants for appeal consideration, staff labeled this as simply "additional documentation" and did not specify what was received or reviewed by the appeal reviewers.
- Sandhills' policies and procedures do not include information regarding the requirement of signed consent by the enrollee when anyone other than the enrollee files an appeal.
- Sandhills' website, *Medicaid Provider Manual* and *Member Handbook* do not provide clear information regarding who can file an appeal.
- The *Medicaid Provider Manual* is written using the pronoun "you", implying that appeal rights belong to the provider and not the enrollee.
- Neither the Member Handbook nor the Medicaid Provider Manual clarify when appellants will be notified of receipt of when an appeal is received, and when members will be notified of the resolution.
- Sandhills' policies and procedures define an appeal as "a request for administrative review of an adverse benefit determination by Sandhills Center." This does not parallel the definition given in the DMA contract and federal regulations, which do not include the word "administrative".
- The appeal process is unclear in the *Medicaid Provider Manual* as it has both a "Reconsideration" section and "Appeals" section with overlapping information and no explanation about the difference between the two.
- None of Sandhills' policies or procedures or the *Member Handbook* indicate that the first level appeal process with Sandhills must be exhausted prior to an appellant requesting a second level appeal with the Office of Administrative Hearings.

- None of Sandhills' policies or procedures accurately define the allowable timeframe for an appeal to be submitted.
- The *Medicaid Provider Manual* and website also incorrectly define the timeframe for an appellant to file an appeal.
- None of Sandhills' policies or procedures clearly indicate that notification of the resolution of an expedited appeal will occur within 72 hours of the receipt of the appeal.
- The *Medicaid Provider Manual,* Reconsideration section mentions providers can assist with filing expedited appeal requests but gives no indication as to how or that the resolution notification will occur within 72 hours.
- The *Member Handbook* does not include information about the right of an appellant to request an expedited appeal and Sandhills' required notifications related to expedited appeal resolutions.
- None of Sandhills' policies and procedures contain the criteria by which expedited appeals should be reviewed.
- During the Onsite, it was clarified that Sandhills does not deny requests for expedited appeals but this is not reflected in Sandhills' policies and procedures.
- The *Medicaid Provider Manual* does not explain the right of an appellant to file a grievance if Sandhills extends the appeal timeframe.
- During the Onsite, it was clarified that Sandhills does not extend standard or expedited appeal timeframes. However, Sandhills' policies and procedures do not reflect this.
- *Procedure 33a, Section 1 (m)* indicates Sandhills faxes the appeal record to their peer review delegate. Staff reported during the Onsite that this is inaccurate.

Corrective Actions

- Add to Sandhills' policies and procedures the requirement of signed consent by the enrollee, when anyone other than the enrollee requests an appeal.
- Correct the Sandhills' website, Medicaid Provider Manual and Member Handbook to reflect that signed consent by the enrollee, when anyone other than the enrollee files an appeal, is required.
- Once the policies and procedures are accurately updated, train staff on the requirement that the enrollee's signed consent is required when anyone other than the enrollee or their legal guardian requests an appeal.

- Either define the difference between the reconsideration and appeal process in the *Medicaid Provider Manual*, or combine into one section that accurately explains Sandhills' first level, Medicaid appeal process.
- Add to Sandhills' policies or procedures that the timeframe for filing an appeal is within 60 days of the mailing date of the UM denial notification.
- Correct Sandhills' policies or procedures to clearly indicate that notification of the resolution of an expedited appeal will occur within 72 hours of the receipt of the appeal.
- Add the correct criteria for expedited appeals to Sandhills' policies and procedures, to include "that taking the time for a standard resolution could seriously jeopardize an Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function."
- Clarify, in applicable policies and procedures, the information regarding whether requests for expedited appeals are denied.
- Correct the *Medicaid Provider Manual* to explain that an appellant has the right to file a grievance, if Sandhills extends the appeal timeframe.
- Clarify in Sandhills' policies and procedures whether appeal timeframes are extended by Sandhills.

Recommendations

- Use one term throughout Sandhills' policies and procedures, notifications, and staff documentation to decrease any potential confusion by staff and stakeholders.
- Describe within Sandhills policies and/or procedures, the process for implementation of the *Chief Clinical Officer/Medical Director grievance consultation form*.
- Add a statement to the beginning of Sandhills' grievance policy and/or procedure that clarifies when grievance resolution notifications are required to be sent.
- Correct the definition of an appeal in Sandhills' policies and procedures to remove the word "administrative" from the definition.
- Add details to the expedited appeal checklist that captures steps taken by staff around oral and written notifications of the resolution of an expedited appeal. Specifically, who provides the notification and to whom the oral notification is made.

- Increase the monitoring of appeal communication records to ensure that all interactions with appellants, either written or oral, are captured within the appeal file. Add this monitoring process to a policy or procedure.
- As a part of the appeal file monitoring, ensure staff specify the additional appeal information submitted by appellants in the records sent to the appeal peer reviewer and the resolution notification.
- Correct the language in the appeals section of the *Medicaid Provider Manual* to address the provider by changing the pronouns from "you", where applicable.
- Add information to Sandhills' policies and procedures and the *Member Handbook* to indicate that the first level appeal process with Sandhills must be exhausted prior to an appellant requesting a second level appeal at the Office of Administrative Hearings.
- Correct the *Medicaid Provider Manual* and website to define the timeframe for an appellant to file an appeal is within 60 days of the mailing date of the UM denial notification.
- Clarify in the *Member Handbook* and the *Medicaid Provider Manual* the timeframes by which an appellant can expect an acknowledgement letter and resolution notification from Sandhills when processing standard and expedited appeals. Include the required timeframes of these notifications.
- Add information to the *Member Handbook* regarding the enrollee's right to request an expedited appeal.
- Ensure that appeals data is not just reported, but analyzed for trends and quality improvement opportunities.
- Correct *Procedure 33a, Section 1 (m)* by removing the statement that Sandhills faxes the appeal record to their peer review delegate.

G. Delegation

CCME's EQR of the Delegation section included a review of the relevant policies and procedures, the Delegate List, the Delegation Contracts/Letters of Agreement, and the Delegation Monitoring Tools. There were no corrective actions and only one recommendation from the last EQR. Sandhills implemented CCME's recommendation.

Sandhills reported four delegated entities, as evidenced in *Table 18, Delegated Entities*.

Table 29: Delegated Entities

Delegated Entities	Service
Prest & Associates (Prest)	Peer Review/ UM
University of North Carolina (UNC) Faculty/ Physicians	Credentialing
Cardinal Innovations	Call roll over and Screening, Triage, Referral (STR) functions
Cone Health	Credentialing

The April 2018 Quality Management Committee (QMC) meeting minutes include "Carol also announced the hiring of a new Associate Medical Director starting May 1, 2018". The May 2018 QMC meeting minutes state "Dr. Marks started May 1st, 2018 and will review all TCLI cases as he has both medical and psychiatric background." Dr. Marks is not listed on the Organizational Chart.

During the Onsite, Sandhills provided a one-page, unsigned *Scope of Work Between Sandhills Center For MH, DD & SAS And Kenneth J. Marks, D.O.*, which Dr. Carraway indicated he and Dr. Marks worked on together. Sandhills subsequently provided a signed copy of the *Scope of Work* agreement. Though the QMC minutes indicate Dr. Marks started on May 1, 2018, the *Scope of Work* is "effective July 1, 2018 through June 30, 2019".

Sandhills does not have a Delegation Agreement and Business Associates Agreement (BAA, covering confidentiality/Health Information Portability and Accountability Act (HIPAA), etc.) with Dr. Marks. The *Scope of Work* document includes a one sentence "Primary Purpose", a three-item "Description of Responsibilities and Duties" and includes information about "Terms and Compensation". There is no information about confidentiality, Protected Health Information (PHI), etc.

Quarterly performance reviews and a formal annual assessment of each delegated entity are referenced in Sandhills *Procedure Core 8a, Delegation Contracts* and in *Core 9, 9a Delegation Oversight*. Sandhills submitted evidence of the quarterly reviews and annual assessment of each delegate listed in Table 18 above.

The Delegation Checklists for UNC Faculty/Physicians and Cone Health do not include the required query of the *State Exclusion List*. During the Provider Services Onsite, Sandhills staff reported they started checking the *State Exclusion List* as part of their internal credentialing and recredentialing queries in June 2018. However, there is no evidence the delegated entities are conducting the required query of the *State Exclusion List*.

As Sandhills did not consider Dr. Marks' work to be a delegation, they did not conduct a Predelegation Assessment or conduct any formal monitoring.

Cardinal Innovations (Cardinal) provides primary call roll-over and Screening/Triage/ Referral (STR) functions for Sandhills. At the last EQR, it was noted that Sandhills did not consider this to be a delegated function. The contract with Cardinal that was submitted with Desk Materials for this EQR was "entered into as of July 1, 2017". The contract includes a Business Associates Agreement (BAA).

At the 2017 EQR, CCME recommended that Sandhills monitor those services, as required by *DMA Contract Section 11.1.2.d*. On July 2, 2018, E. McRae, Sandhills Customer Service Director, completed a Sandhills *Contracted Provider Assessment Form* for Cardinal's provision of "primary call roll-over/STR".

Quarterly Access reports from Cardinal are presented to the QMC. Cardinal did not meet standards for "Abandoned Calls" or "Calls Answered within 30 Seconds" in 14 out of the 15 months from April 2017 through June 2018 (including 11 out of 12 months from July 2017 through June 2018). Each report notes that a Plan of Correction (POC) was required. The POCs typically indicate that the Access Standard wasn't met due to the low volume of calls answered by Cardinal, meaning, for example, that any abandoned calls result in the Access Standard not being met.

At the Onsite, Sandhills staff noted, "It has been an upward trend. They are meeting the metrics in the most recent months. They had a software issue that has been resolved. Metrics are still not quite met, but it is better."

The contract with Prest was effective May 22, 2009, but the signatures were not dated. An Addendum effective December 09, 2009 was signed in March 2010. Another Addendum effective December 21, 2009 was signed on 12/28/09. No BAA (addressing HIPAA requirements) was submitted with the Desk Materials but was provided when CCME asked about it at the Onsite.

A letter from Prest dated June 29, 2017 states "Prest & Associates, Inc. ("Prest") has entered into an agreement with an affiliate of ExamWorks, Inc." The letter also states, "Upon the closing of the Acquisition (the "Closing"), Prest will assign to ExamWorks all of its rights and interest in and to the Agreement." Sandhills staff reported they have no contract with ExamWorks, but Prest continues to function under the "Prest" name, including that invoices are from, and payments are made to, Prest.

Sandhills entered into a contract with Cone Health for Delegated Credentialing of Cone Health personnel, as of 12/01/17. A pre-delegation assessment was completed before the contract became effective.

The following chart indicates Sandhills received a score of "Partially Met" for 50% of the standards during the Delegation review. The score of "Partially Met" is due to the lack of a Delegation Agreement and BAA with Dr. Marks.

Figure 8, Provider Services Comparative Findings, provides a comparison of the 2017 scores versus the 2018 scores.

Figure 8: Delegation Comparative Findings

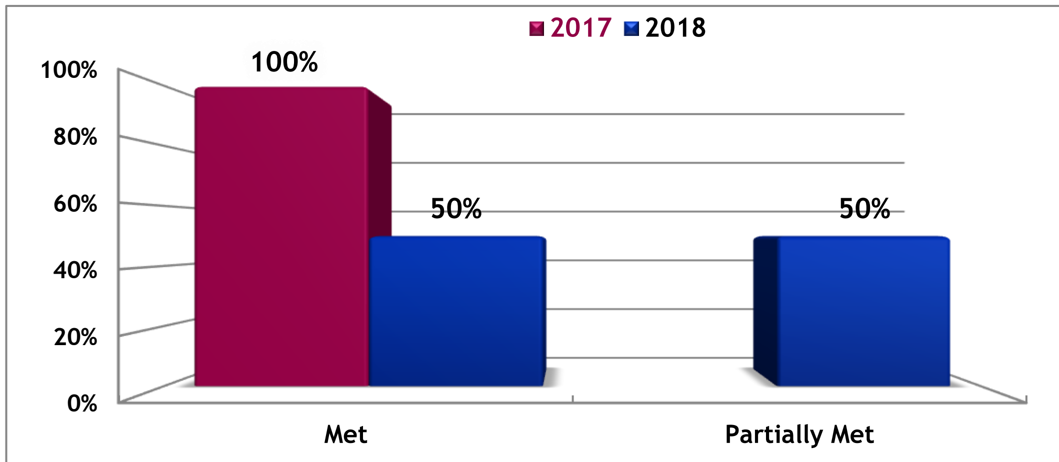


Table 30: Delegation

Section	Standard	2018 Review
Delegation	The PIHP has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions	Partially Met

Strengths

- Sandhills has an executed contract with four delegates, including BAA with those delegates that have access to PHI.
- Sandhills conducted quarterly performance reviews and annual monitoring for four delegates.
- Sandhills conducted the pre-delegation review before delegating credentialing to Cone Health.

Weaknesses

- There is no delegation agreement/contract and BAA for Dr. Marks.
- The Pre-Delegation Checklists for credentialing functions do not include the query of the *State Exclusion List*. There is no evidence the *State Exclusion List* is being checked by the delegates.

Corrective Action

- Execute with Dr. Marks a delegation agreement/contract with BAA that meets the requirements of *DMA Contract Section 11, Subcontracts*.

Recommendation

- Add the query of the *State Exclusion List* to the Pre-Delegation Checklists and to monitoring tools for the annual assessment of entities to whom credentialing has been delegated, to ensure the required queries are being conducted.

H. Program Integrity

As required by its contract with CCME, IPRO is tasked with assessing PIHP compliance with federal and state regulations regarding program integrity functions.

IPRO's review of Sandhills began in the beginning of August 2018 with a Desk Review of review of Sandhills' program integrity (PI) files and documentation. IPRO analyzed the files and documentation and conducted Onsite reviews on August 30, 2018 with the Corporate Compliance Officer and Program Integrity staff to review the offsite documentation and file review findings.

File Review

IPRO requested the universe of PI files from Sandhills for the 2017-2018 review period and selected a random sample of 15 files with a two (2) file oversample for a total of 17 files.

Contract Requirement: the PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of an allegation of fraud. If the PIHP determines that a complaint or allegation rises to potential fraud, the PIHP shall forward the information and any evidence collected to DMA within five (5) business days of the final determination of the findings. It is required that all case records be stored electronically by the PIHP.

Findings:

- Fifteen (15) of fifteen (15) files reviewed were compliant with this requirement.

Contract Requirement: In each case where PIHP refers to DMA an allegation of fraud involving a Provider, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:

- Subject (name, Medicaid provider ID, address, provider type);
- Source/origin of complaint;
- Date reported to the PIHP or, if developed by the PIHP, the date the PIHP initiated the investigation;
- Description of the suspected intentional misconduct, with specific details including: the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated, and dates of suspected misconduct;
- Amount paid to the provider for the last three years or during the period of the alleged misconduct, whichever is greater;
- All communications between the PIHP and the provider concerning the conduct at issue, when available;
- Contact information for PIHP staff persons with practical knowledge of the workings of the relevant programs; and
- Sample/exposed dollar amount, when available.

Findings:

- Two (2) of fifteen (15) files were referred to DMA following a potential credible allegation of fraud involving a provider.
- Two (2) of two (2) files that were referred to DMA were fully compliant with this requirement.

Contract Requirement: in each case of suspected enrollee fraud, the PIHP shall provide DMA program integrity with:

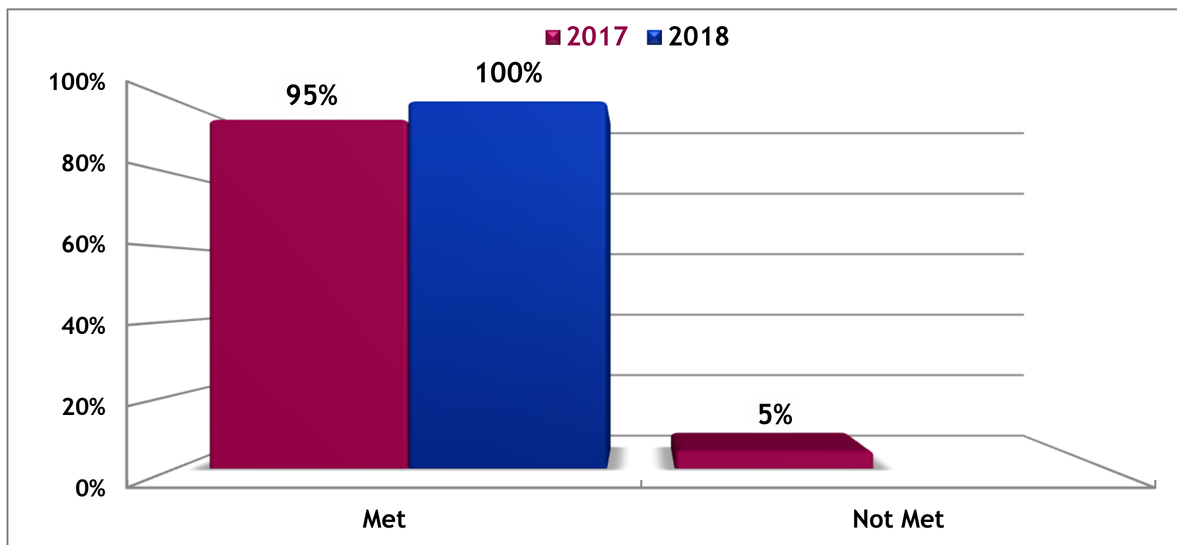
- The enrollee's name, birth date, and Medicaid number;
- The source of the allegation;
- The nature of the allegation;
- Copies of all communications between the PIHP and the provider concerning the conduct at issue;
- Contact information for PIHP staff persons with practical knowledge of the allegation;
- The date reported to the State; and
- The legal and administrative status of the case.

Findings:

- No cases under review involved suspected enrollee fraud.

The following chart indicates Sandhills received a score of “Met” for 100% of the PI standards.

Figure 9: Program Integrity Findings



Strengths

- Sandhills has good processes in place to prevent fraud, waste, and abuse within the organization, as well as to conduct thorough investigations of credible allegations of fraud, waste, and abuse.
- Sandhills educates staff, providers, and members on PI through training, postings on the PHIP website, and within member/provider materials.
- Sandhills provided all of the necessary documentation and files which contained all contractual requirements.

Weaknesses

- It was discussed Onsite that data mining systems are only used to capture provider fraud, waste, and abuse. Additionally, Sandhills confirmed that there was one (1) allegation of enrollee fraud for the review period. Moving forward, there is opportunity for Sandhills to use data mining systems to increase their ability to capture enrollee fraud, waste, and abuse in addition to provider fraud, waste, and abuse.

Recommendations

- Enhance the data mining systems to include enrollee fraud, waste, and abuse. Sandhills can then capture more allegations and investigate to prevent further instances of enrollee fraud, waste and abuse.

I. Financial Services

CCME reviewed the following Sandhills' Desk Review Materials prior to the Onsite visit:

- Financial policies and procedures
- Audited financial statements and footnotes dated June 30, 2017
- Balance sheet and income statements dated March 31, 2018, and April 30, 2018
- Medicaid monthly financial reports for May and June 2018
- 820 and 834 file reconciliation process and analysis for May and June 2018
- Claims processing aging reports, as well as claims processing procedures
- Finance Department staffing structure
- Fiscal year budget ordinance for 2017-2018
- Budget to actual expenses report for Medicaid for May and June 2018
- Administrative *Cost Allocation Plan* FY 2018
- Medicaid risk reserve bank statements for May and June 2018

After reviewing Sandhills' Desk Review materials, CCME conducted an Onsite visit and interview on August 30, 2018. In reviewing Sandhills' financial operations, CCME used a standardized EQR Finance Desk Review and Onsite administrative interview guide. CCME also reviewed deficiencies from prior EQRs to determine whether they were corrected. In addition to the standardized Desk Review inquiries, CCME asked additional interview questions in the following areas:

- Policies and procedures development and staff communication
- Staffing changes in finance
- Accounting system
- Budget development
- Internal audit function
- Board of Directors' oversight

- Reconciliation of the Global Eligibility File against the 820 group premium payment file and 834 benefit enrollment file
- Calculation of incurred but not reported (IBNR) amount

Although Sandhills demonstrates ongoing financial stability, it is operating at a profit for Medicaid, but at a loss for non-Medicaid activities. Sandhills' audit report, as of June 30, 2017, has no audit findings with an unqualified opinion. During fiscal year 2017, its total net position decreased by $5,799,062.

Sandhills exceeded the contract benchmark for current ratio and Medical Loss Ratio (MLR). Sandhills' Medicaid current ratio is 8.55 with a total current ratio of 7.76 for May 2018. The Medicaid current ratio is 7.94 with a total current ratio of 7.61 for June 2018 (benchmark is 1.00). Sandhills' Medicaid year-to-date MLR is 91.7% for May 2018, and 92.7% for June 2018 (benchmark is 85%). Sandhills' Medicaid total assets on May 31, 2018, are $159,374,464 and overall total assets are $176,325,165. As of June 30, 2018, Medicaid total assets are $155,341,675 and total assets are $169,594,466.

Sandhills meets standard *42 Code of Federal Regulations (CFR) § 433.32(a)* for maintaining an appropriate accounting system (Great Plains). Sandhills uses the following Great Plains modules: general ledger, accounts payable, fixed assets, cash management, and human resources. Sandhills upgraded to Great Plains version 2018. They use AlphaMCS for claims processing.

Sandhills met the contract standard of ten years required by *DMA Contract*. It retains financial records for eight years offsite and two years onsite. Within Great Plains, records are not purged and remain accessible. Sandhills keeps records longer if any unresolved audit findings exist. Sandhills' *Maintenance of Financial Records Procedure 32a* addresses compliance with DMA requirements for record retention for all financial records. However, CCME recommends that Sandhills add language to this procedure for the ten-year retention required by *DMA Contract, Section 8.3.2*.

Sandhills' management reviews Sandhills' policies and procedures annually each February. All finance policies and procedures CCME reviewed reflect an annual review date of February 2018. Financial policy and procedure updates are communicated via email to all staff. Sandhills has adequate policies and procedures documenting its Medicaid procedures. CCME recommends enhancing the procedures to cite *DMA Contract* and/or CFR requirements. Additionally, CCME recommends that *Procedure 31b, Restricted Risk Reserve Account* be modified to add the five business day deadline, and that the *IBNR Calculation Procedure*, be enhanced to reflect changes in computation methodology.

Sandhills' *Cost Allocation Plan* meets the requirements for allocating the administrative costs between federal, state, and local based on revenue as required by *42 CFR § 433.34*. Sandhills

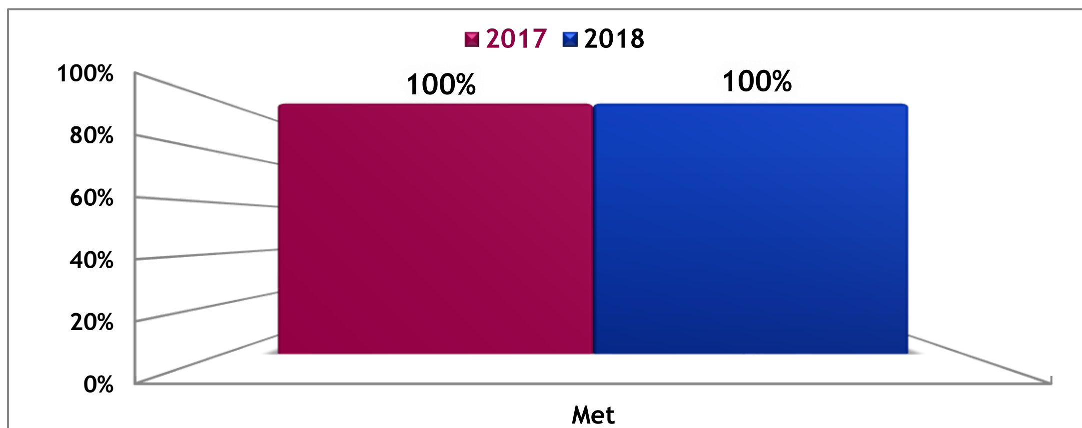
had no disallowed costs per the audit report and Onsite interview. Annually, Sandhills submits a cost allocation plan to DMA to determine the percentage of Medicaid's share of administrative costs. Currently this percentage is 80%. The administrative expenses are recorded by expense type in the general ledger and are then allocated to the different funding sources based on a percentage of total revenues received (except county funding). Sandhills' cost allocation calculation is reviewed by the Finance Director quarterly. Medicaid funds are properly segregated through the chart of accounts in the Great Plains general ledger, examples of which were disclosed at the Onsite interview.

Sandhills' Medicaid Risk Reserve account meets the minimum requirement of 2% of the capitation payment per month required by *DMA Contract, Section 1.9*. Sandhills reached 11.1% of its required percentage of annualized capitation maximum (15%) as of June 30, 2018, with a balance of $29,960,911. Once DMA receives the capitation payment, the Financial Analyst calculates the risk reserve payment and the Finance Director or the Accounting Manager reviews the calculation and pays the risk reserve contribution to the risk reserve account at First Bank within five business days by check. All deposits were made timely, and CCME did not find any unauthorized withdrawals. Sandhills provided CCME with bank statements demonstrating the risk reserve deposit and balance.

Sandhills made a correction to the January DMA report in February 2018. Any changes to DMA reports should be communicated to DMA, and the reports thoroughly reviewed and resubmitted to DMA.

Sandhills continues to meet all of the standards in the Financial Services area as indicated in Figure 10.

Figure 10: Financial Services Comparative Findings



Strengths

- Sandhills has well-documented finance policies and procedures that are reviewed and updated annually.
- Sandhills retains financial records for the required, ten years.
- Sandhills has improved its 820/834 analysis, and the reconciliation is organized and easy to follow.

Weaknesses

- Not all policies and procedures detail who is responsible for duties, nor do they cite contract requirements.
- *Risk Reserve Payment Procedure 31b* does not note the five day due date.
- *Procedure 32a* does not contain the record retention timeframe of ten years, as required by DMA Contract Section 8.3.2.
- *Procedure 31d*, *Incurred but Not Reported Liability* does not reflect the change in Sandhills' methodology addressing the regression analysis model.
- The January 2018 financial report was changed by Sandhills' staff but this change and reason for it was not communicated to DMA.

Recommendations

- Implement a best practice of enhancing policies and procedures by adding details about who is responsible for duties and citing contract requirements.
- Add five day due date to *Risk Reserve Payment Procedure 31b*.
- Add language to *Procedure 32a* for the ten-year retention required by *DMA Contract Section 8.3.2*.
- Update procedure for *Incurred but Not Reported Liability* (*Procedure 31d*) to reflect change in methodology to regression analysis model.
- Communicate any changes to monthly financial reports to DMA and resubmit reports.

J. Encounter Data Validation

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

The scope of our review, guided by the CMS Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid by Sandhills for the period of

January 2017 through December 2017. All claims paid by Sandhills should be submitted and accepted as a valid encounter to DMA. Our approach to the review included:

- A review of Sandhills' response to the Information Systems Capability Assessment (ISCA)
- Analysis of Sandhills' converted 837 encounter files
- A review of DMA's encounter data acceptance report

Results and Recommendations

Issue: Taxonomy code for Billing and Rendering providers

Taxonomy values were consistently populated, however, this is the primary denial for all Sandhills encounters submitted. This information is key for passing the front end edits put in place by the State and to effectively price the claim. NCTracks is expecting the correct combination of NPI, taxonomy and procedure code. The taxonomy code did not always match up with the Taxonomy values enrolled in NCTracks for the Billing and/or Rendering Provider. These errors result in denials by DMA that must be corrected and resubmitted.

Resolution

Continue to follow the process built by Sandhills and AlphaMCS. As time passes and providers are educated, the initial denials due to invalid taxonomy codes should naturally go down. Denials have already dropped dramatically overall and specifically for invalid taxonomy codes. In the 2017 review, invalid taxonomies made up 70% of all denials, and now only account for 48% of denials.

Issue: Other Diagnosis

Other Diagnosis was only populated 6% of the time for institutional and professional claims. Principal and Admitting diagnoses populated consistently where appropriate, however, no more than one additional diagnosis was received for any claim. Sandhills should be capturing up to maximum allowed.

Resolution

Sandhills should expand the number of diagnosis codes being captured in their system. This update will also require Sandhills to modify their 837 mapping to ensure all diagnosis codes captured are sent to DMA moving forward.

Conclusion

Based on the analysis of Sandhills' encounter data, we have concluded that the data submitted to DMA is complete and accurate. Minor issues were noted with both institutional and professional encounters due to missing additional diagnosis codes.

Sandhills should take corrective action to resolve the issues identified specifically with Billing Taxonomy, Rendering Taxonomy, and missing diagnosis codes. As indicated in Sandhills' ISCA response, they have already defined a strategy to address issues with invalid or missing taxonomy codes, as well as a reconciliation process to address all DMA denials noted in the report above. The issue with missing diagnosis codes does not impact the ability to price the claims; however, it will have an impact to DMA's ability to provide proper oversight and measure effectiveness. Sandhills should work with AlphaMCS to capture all diagnosis codes as transmit to DMA as soon as possible.

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

The complete Encounter Data Validation Report can be found as *Attachment 5*.

ATTACHMENTS

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

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

July 11, 2018

Ms. Victoria Whitt
Chief Executive Officer
Sandhills Center
1120 Seven Lakes Drive
West End, NC 27376

Dear Ms. Whitt,

At the request of the Department of Health and Human Services, Division of Medical Assistance (DMA), this letter serves as notification that the 2018 External Quality Review (EQR) of Sandhills Center is being initiated. The review will be conducted by us, The Carolinas Center for Medical Excellence (CCME), and is a contractual requirement. The review will include both a desk review (at CCME) and a two-day onsite visit at Sandhills Center's office in West End, NC that will address all contractually required services.

CCME's review methodology and process will include all of the EQR protocols required by the Centers for Medicare and Medicaid Services (CMS) for Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans. CCME's EQR process is included with this notice and the CMS EQR protocols can be found at:

https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

CCME's review team plans to conduct the onsite visit at Sandhills Center on August 29, 2018 through August 30, 2018. For your convenience, a tentative agenda for the two-day review is enclosed.

In preparation for the desk review, the items on the enclosed **Materials Requested for Desk Review** list are to be submitted electronically, and are due no later than **August 1, 2018**. As indicated in item 40 of the review list, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted by the aforementioned deadline.

Further, as indicated on item 44 of the list, Encounter Data Validation (EDV) will also be part of this review. Our subcontractor, Health Management Systems (HMS) will be evaluating this component. Please read the documentation requirements for this section carefully and make note of the submission instructions as they differ from the other requested materials.

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

The location for the file transfer site is:

https://eqro.thecarolinascenter.org

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

Katherine Niblock, MS, LMFT
EQR Project Manager

Enclosure(s) – 6
Cc: Renee Rader, DMA Quality Manager
Tasha Griffin, DMA EQRO Contract Manager
Deb Goda, DMA Behavioral Health Unit Manager

External Quality Review 2018

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy. *(Please do not embed files within word documents)*

2. Organizational chart of all staff members including names of individuals in each position including their degrees and licensure, and include any current vacancies. In addition, please include any positions currently filled by outside consultants/vendors. Further, please indicate staffing structure for Transitions Community Living Initiative (TCLI) program.

3. Current Medical Director, medical staff job descriptions.

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

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

6. A summary of the status of all best practice recommendations and corrective action items from the previous External Quality Review.

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

8. List of new services added to the provider network in the past 12 months (July 2017 – June 2018) by provider.

9. List of executed single case agreements by provider and level of care during the past 12 months (July 2017 – June 2018).

10. Network turnover rate for the past 12 months (July 2017 – June 2018) including a list of providers that were terminated by cause and list of providers that did not have their contracts renewed. For five providers termed in the last 12 months (July 2017 – June 2018), who were providing service to enrollees at the time of the termination notice, submit the termination letter to or from the provider, and the notification (of provider termination) letters sent to three consumers who were seeing the provider at the time of the termination notice.

11. List of providers credentialed/recredentialed in the last 12 months (July 2017 – June 2018).

12. A current provider manual and provider directory.

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

14. The Quality Improvement work plans for 2017 and 2018.

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

16. Minutes of committee meetings for the months of July 2017 – June 2018 for **all** committees reviewing or taking action on enrollee-related activities. For example, quality committees, quality subcommittees, credentialing committees, compliance committee, etc.

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

17. Membership lists and a committee matrix for **all** committees, including the professional specialty of any non-staff members. Please indicate which members are voting members. Include the required quorum for each committee.
18. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.
19. Copies of the most recent provider profiling activities conducted to measure contracted provider performance.
20. Results of the most recent office site reviews, record reviews and a copy of the tools used to complete these reviews.
21. A copy of staff handbooks/training manuals, orientation and educational materials, and scripts used by Call Center personnel, if applicable.
22. A copy of the enrollee handbook and any statement of the enrollee bill of rights and responsibilities if not included in the handbook.
23. A copy of any enrollee and provider newsletters, educational materials and/or other mailings, including the packet of materials sent to new enrollees and the materials sent to enrollees annually.
24. A copy of the Grievance, Complaint and Appeal logs for the months of July 2017 – June 2018. Please indicate the disability type (MH/SA, I/DD) and whether the enrollee is in the TCLI program for each entry.
25. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.
26. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal PIHP compliance with these standards.
27. Practice guidelines developed for use by practitioners, including references used in their development, when they were last updated and how they are disseminated. Also, policies and procedures for researching, selecting, adopting, reviewing, updating, and disseminating practice guidelines.

28. All information supplied as orientation to new providers, including a copy of the provider handbook or manual.
29. A copy of the provider contract/application.
30. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the PIHP, and any reports of activities submitted by the subcontractor to the PIHP. Also, completed evaluations of entities conducted before delegation is granted.
31. Contracts for all delegated entities.
32. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used. Include annual evaluation, if applicable.
33. Please provide an excel spreadsheet with a list of enrollees that have been placed in care coordination since April 2015. Please indicate the disability type (MH/SA, I/DD).
34. Please provide an excel spreadsheet with a list of enrollees that have been place in the TCLI program since April 2015. Please include the following: number of individuals transitioned to the community, number of individuals currently receiving Care Coordination, number of individuals connected to services and list of services receiving, number of individuals choosing to remain in ACH connected to services and list of services receiving.
35. Information regarding the following selected Performance Measures:

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

C WAIVER MEASURES	
Proportion of Level of Care evaluations completed at least annually for enrolled participants	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals
Proportion of Level of Care evaluations completed using approved processes and instrument	Proportion of Individual Support Plans that address identified health and safety risk factors
Proportion of New Level of Care evaluations completed using approved processes and instrument	Percentage of participants reporting that their Individual Support Plan has the services that they need
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Proportion of individuals for whom an annual plan and/or needed update took place

C WAIVER MEASURES	
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval

Required information includes the following for each measure:

a. Data collection methodology used (administrative, medical record review, or hybrid) including a full description of those procedures;
b. Data validation methods/ systems in place to check accuracy of data entry and calculation;
c. Reporting frequency and format;
d. Complete exports of any lookup / electronic reference tables that the stored procedure / source code uses to complete its process;
e. Complete calculations methodology for numerators and denominators for each measure, including:
    i. The actual stored procedure and / or computer source code that takes raw data, manipulates it, and calculates the measure as required in the measure specifications;
    ii. All data sources used to calculate the numerator and denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    iii. All specifications for all components used to identify the population for the numerator and denominator;
f. The latest calculated and reported rates provided to the State.

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

36. Documentation of all Performance Improvement Projects (PIPs) completed or planned in the last year, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. research question (s), analytic plans, reasons for choosing the topic including how the topic impacts the Medicaid population overall, measurement definitions, qualifications of personnel collecting/abstracting the data, barriers to improvement and interventions planned or implemented to address each barrier, calculated result, results, etc.)
37. Summary description of quality oversight of the Transition to Community Living Initiative, including monitoring activities, performance metrics, and results.
38. Data and/or reports for the Transition to Community Living Initiative (e.g., numbers of in-reach completed, housing slots filled, completed transitions, numbers of enrollees in supported employment, numbers of enrollees assigned to assertive community treatment [ACT], etc.) for the period July 2017 – June 2018.
39. Call performance statistics for the period of July 2017 – June 2018, including average speed of answer, abandoned calls, and average call/handle time for customer service representatives (CSRs).
40. Provide electronic copies of the following files:

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

Proof of all insurance coverages. For practitioners joining already-contracted agencies, include copies of the insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.	Notification of the effective date of credentialing.
Site visit reports. If practitioner is joining an agency that previously had a site visit, include the report; for licensed sites, include verification of DHSR licensure for the site.	Ownership disclosure information/form

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

The credentialing files should include all of the following:

Proof of original credentialing date and all recredentialing dates, including the current recredentialing	Site visit/assessment reports, if the provider has had a quality issue or a change of address.
Proof of all insurance coverages .For practitioners who are employed at already-contracted agencies, include copies of the insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.	Ownership disclosure information/form

c. Ten MH/SA, ten I/DD and five TCLI files medical necessity approvals made from July 2017 – June 2018, including any medical information and approval criteria used in the decision. Please select MEDICAID ONLY files and submit the entire file.

d. Ten MH/SA, ten I/DD and five TCLI files medical necessity denial files for any denial decisions made from July 2017 – June 2018. Include any medical information and physician review documentations used in making the denial determination. Please include all correspondence or notifications sent to providers and enrollees. Please select MEDICAID ONLY files and submit the entire file.

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

41. Provide the following for Program Integrity:
    a. File Review: Please produce a listing of all active files during the review period (July 2017 – June 2018) including:
        i. Date case opened
        ii. Source of referral
        iii. Category of case (enrollee, provider, subcontractor)
        iv. Current status of the case (opened, closed)
    b. Program Integrity Plan and/or Compliance Plan.
    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.
    e. All 'Attachment Y' reports collected during the review period.
    f. Provider Manual and Provider Application.
    g. Enrollee Handbook.
    h. Subcontractor Agreement/Contract Template.
    i. Training and educational materials for the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
    j. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse.
    k. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees.
    l. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to DMA or any other State or Federal agency.
    m. Code of Ethics and Business Conduct.
    n. Internal and/or external monitoring and auditing materials.
    o. Materials pertaining to how the PIHP captures and tracks complaints.
    p. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
        i. DMA approved reporting templates.
    q. Sample Data Mining Reports.
    r. DMA Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
    s. Monthly reports of NCID holders/FAMS-users in PIHP.
    t. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
    u. Corrective action plans including any relevant follow-up documentation.
    v. Policies/Procedures for:
        i. Program Integrity
        ii. HIPAA and Compliance
        iii. Internal and external monitoring and auditing
        iv. Annual ownership and financial disclosures
        v. Investigative Process
        vi. Detecting and preventing fraud

vii. Employee Training
viii. Collecting overpayments
ix. Corrective Actions
x. Reporting Requirements
xi. Credentialing and Recredentialing Policies
xii. Disciplinary Guidelines

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

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

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

43. Provide the following for Financial Reporting:
a. Most recent annual audited financial statements.
b. Most recent annual compliance report
c. Most recent two months' State-required DMA financial reports.
d. Most recent two months' balance sheets and income statements including associated balance sheet and income statement reconciliations.
e. Most recent months' capitation/revenue reconciliations.

f. Most recent reconciliation of claims processing system, general ledger, and the reports data warehouse. Provide full year reconciliation if completed.
g. Most recent incurred but not reported claims medical expense and liability estimation. Include the process, work papers, and any supporting schedules.
h. Any other most recent month-end financial/operational management reports used by PIHP to monitor its business. Most recent two months' claims aging reports.
i. Most recent two months' receivable/payable balances by provider. Include a detailed list of all receivables/payables that ties to the two monthly balance sheets.
j. Any P&Ps for finance that were changed during the review period.
k. PIHP approved annual budget for fiscal year in review.
l. P&Ps regarding program integrity (fraud, waste, and abuse) including a copy of PIHP's compliance plan and work plan for the last twelve months.
m. Copy of the last two program integrity reports sent to DMA's Program Integrity Department.
n. An Excel spreadsheet listing all of the internal and external fraud, waste, and abuse referrals, referral agent, case activity, case status, case outcome (such as provider education, termination, recoupment and recoupment amount, recoupment reason) for the last twelve months.
o. A copy of PIHP's Special Investigation Unit or Program Integrity Unit Organization chart, each staff member's role, and each staff member's credentials.
p. List of the internal and external program integrity trainings delivered by PIHP in the past year.
q. Description and procedures used to allocate direct and overhead expenses to Medicaid and State funded programs, if changed during the review period.
r. Claims still pending after 30 days.
s. Bank statements for the restricted reserve account for the most recent two months.
t. A copy of the most recent cost allocation plan.
u. A copy of the PIHP's accounting manual.
v. A copy of the PIHP's general ledger chart of accounts.
w. Any finance Corrective Action Plan
x. Detailed medical loss ratio calculation, including the following requirements under CFR § 438.8:
    i. Total incurred claims
    ii. Expenditures on quality improvement activities
    iii. Expenditures related to PI requirements under §438.608
    iv. Non-claims costs
    v. Premium revenue
    vi. Federal, state and local taxes, and licensing and regulatory fees
    vii. Methodology for allocation of expenditures
    viii. Any credibility adjustment applied
    ix. The calculated MLR
    x. Any remittance owed to State, if applicable
    xi. A comparison of the information reported with the audited financial report required under §438.3 (m)
    xii. The number of member months

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

a. Include all adjudicated claims (paid and denied) from January 1, 2017 – December 31, 2017. Follow the format used to submit encounter data to DMA (i.e., 837I and 837P). If you archive your outbound files to DMA, you can forward those to HMS for the specified time period. In addition, please convert each 837I and 837P to a pipe delimited text file or excel sheet using an EDI translator. If your EDI translator does not support this functionality, please reach out immediately to HMS.
b. Provide a report of all paid claims by service type from January 1, 2017 – December 31, 2017. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

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

B. Attachment 2: Materials Requested for Onsite Review

Sandhills

External Quality Review 2018

MATERIALS REQUESTED FOR ONSITE REVIEW- REVISED

1. Copies of all committee minutes for committees that have met since the desk materials were uploaded.
2. Copy of Corporate Compliance January 2018 meeting minutes.
3. Proof of initial credentialing and all recredentialing dates for the practitioner and agency recredentialing files submitted for desk review. Typically, this would be the letter sent to the provider at the time of approval of initial credentialing and at recredentialing. A Re-Credentialing File List with dates was submitted, but proof of initial credentialing was not found in the recredentialing files.
4. PREST Delegation Performance Review report for April 2018 through June 2018.
5. Delegations, except for PREST: Dates of the Quality Management Committee meetings including quarterly reports and annual presentation, as referenced in *Core 8a, Delegation Contracts and in Core 9, 9 Delegation Oversight.*(QMC minutes were submitted for one meeting each with information for UNC and for Cone Health.)
6. Supervision contracts:
   - [redacted]: LCAS-A
   - [redacted], LPA
7. Site visit report in initial credentialing file of LP [redacted] is illegible. Please upload a legible copy.
8. Case Summary and/or referral for PI Case file #9.
9. Written agreement (i.e., contract) template with the closed provider network that contains the program integrity requirements for Sandhills.
10. Sign-in sheets and meeting minutes for monthly DMA/DHB meetings to indicate that qualified staff are attending.
11. Policy and procedure that Sandhills uses for self-audits.

<u>All items can be uploaded on the CCME File Transfer Site (folder 49, Other Info):</u>

https://eqro.thecarolinascenter.org

C. Attachment 3: EQR Validation Worksheets

- Performance Measures Validation Worksheet:
    - Readmission Rates for Mental Health
    - Readmission Rates for Substance Abuse
    - Follow-Up After Hospitalization for Mental Illness
    - Follow-Up After Hospitalization for Substance Abuse
    - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
    - Mental Health Utilization- Inpatient Discharges and Average Length of Stay
    - Mental Health Utilization
    - Identification of Alcohol and Other Drug Services
    - Substance Abuse Penetration Rate
    - Mental Health Penetration Rate

- Performance Improvement Project Validation Worksheets:
    - Access to Routine Behavioral Health Assessments in A Timely and Appropriate Manner- Non-Clinical
    - Maximizing the Benefit of Child Mental Health Level III
    - Evidence-Based Practices Employed by Provider Network- Clinical
    - TCLI- Transition Days Non-Clinical

- Innovation Measures Validation Worksheets:
    - Innovations Measure: Level of CARE Evaluation
    - Innovations Measure: LEVEL of CARE Evaluations Completed Using Approved Processes and Instruments
    - Innovations Measure: NEW Level of Care Evaluations Completed Using Approved Processes and Instruments
    - Innovations Measure: Proportion of Providers That Implemented an Approved Corrective Action Plan
    - Innovations Measure: Proportion of Providers Wherein All Staff Completed Mandated Training
    - Innovations Measure: Proportion of ISPS In Which Services and Supports Reflect Participant Assessed Needs and Life Goals

- Innovations Measure: ISPS Address Identified Health and Safety Risk Factors
- Innovations Measure: Participants Reporting That ISP Has Services They Need
- Innovations Measure: Individuals for Whom an Annual ISP and or Needed Updates Took Place
- Innovations Measure: New Waiver Participants Are Receiving Services According to ISP Within 45 Days of Approval

CCME EQR PM Validation Worksheet

Plan Name:	**Sandhills**
Name of PM:	**READMISSION RATES FOR MENTAL HEALTH**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**August 2018**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only (5)	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only (5)	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid (5)	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling (5)	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling (5)	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling (5)	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting (5)	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	Sandhills
Name of PM:	READMISSION RATES FOR SUBSTANCE ABUSE
Reporting Year:	7/1/2016-6/30/2017
Review Performed:	August 2018

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculation was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only (5)	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only (5)	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid (5)	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling (5)	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling (5)	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling (5)	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting (5)	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	Sandhills
Name of PM:	FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS
Reporting Year:	7/1/2016-6/30/2017
Review Performed:	August 2018

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1. Documentation (10)	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	MET	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Data sources used to calculate denominator values are complete.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	MET	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	MET	Data sources used to calculate the numerator are complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only (5)	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only (5)	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid (5)	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling (5)	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling (5)	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling (5)	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting (5)	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	Sandhills
Name of PM:	FOLLOW-UP AFTER HOSPITALIZATION FOR SUBSTANCE ABUSE
Reporting Year:	7/1/2016-6/30/2017
Review Performed:	August 2018

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1. Documentation (10)	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	MET	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Data sources used to calculate denominator values are complete.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	MET	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	MET	Data sources used to calculate the numerator are complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only (5)	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only (5)	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid (5)	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling (5)	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling (5)	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling (5)	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting (5)	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	Sandhills
Name of PM:	INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT
Reporting Year:	7/1/2016-6/30/2017
Review Performed:	August 2018

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only (5)	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only (5)	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid (5)	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling (5)	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling (5)	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling (5)	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting (5)	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Sandhills**
Name of PM:	**MENTAL HEALTH UTILIZATION- INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**August 2018**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator–Medical Record Abstraction Only (5)	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator–Hybrid Only (5)	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid (5)	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling (5)	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling (5)	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling (5)	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting (5)	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	Sandhills
Name of PM:	MENTAL HEALTH UTILIZATION
Reporting Year:	7/1/2016-6/30/2017
Review Performed:	August 2018

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1. Documentation (10)	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	MET	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Data sources used to calculate denominator values are complete.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	MET	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only (5)	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only (5)	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid (5)	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling (5)	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling (5)	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling (5)	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting (5)	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

VALIDATION SUMMARY

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

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

Plan's Measure Score	55
Measure Weight Score	55
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	Sandhills
Name of PM:	IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES
Reporting Year:	7/1/2016-6/30/2017
Review Performed:	August 2018

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only (5)	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only (5)	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid (5)	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling (5)	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling (5)	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling (5)	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting (5)	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Sandhills**
Name of PM:	**SUBSTANCE ABUSE PENETRATION RATE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**August 2018**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only (5)	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only (5)	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid (5)	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling (5)	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling (5)	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling (5)	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Measure was reported accurately.
R2. Reporting (5)	Was the measure reported according to State specifications?	**MET**	Measure was reported according to State specifications.

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

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

Plan's Measure Score	55
Measure Weight Score	55
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**Sandhills**
Name of PM:	**MENTAL HEALTH PENETRATION RATE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**August 2018**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Complete documentation for calculations was in place.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources used to calculate denominator values are complete.
D2. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only (5)	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only (5)	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid (5)	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling (5)	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling (5)	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling (5)	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

Plan Name:	**SANDHILLS CENTER**
Name of PIP:	**ACCESS TO ROUTINE BEHAVIORAL HEALTH ASSESSMENTS IN A TIMELY AND APPROPRIATE MANNER- NON-CLINICAL**
Reporting Year:	**2017**
Review Performed:	**August 2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	There was a trend of low number of "Yes" answers for the following questions "Is there evidence of coordination of care with other services/providers or prescribing providers?" on both the Bipolar Disorder and PTSD tools.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is stated on page 2 in "Focus of Project" section.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is defined in measurable goal section.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**Met**	Random sampling based on sample size of 20 was utilized.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**Met**	Sample size chosen by plan.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	Sample size chosen by plan.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and computed as a percentage.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Not Met**	Personnel involved in calls and data entry were not listed in the report. *Recommendation: Include the personnel involved in calls, data entry, and analysis in the report.*
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions have been initiated based on results and issues with database.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses were conducted quarterly.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results and findings are presented clearly.

Component / Standard (Total Points)	Score	Comments
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Analysis identified initial and repeat measurements.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Conclusions and recommendations based on findings were included in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	The rate initially improved, but then decreased, and is now back to above baseline rate.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement appears to be a result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Not Met**	Statistical analyses were not conducted. *Recommendation: Because sampling is utilized, a statistical test (z test or Fisher's exact) should be conducted and reported.*
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	105
Project Possible Score	111
Validation Findings	95%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**SANDHILLS CENTER**
Name of PIP:	**MAXIMIZING THE BENEFIT OF CHILD MENTAL HEALTH LEVEL III**
Reporting Year:	**2017**
Review Performed:	**August 2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Baseline data revealed an issue with outpatient treatment for children.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is stated on page 2 in "Focus of Project" section.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is defined in measurable goal section.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and computed as a percentage.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Partially Met**	The rate has been increasing the last two quarters, although no new interventions are being initiated. The report shows that education for outpatient providers is ongoing, but no other interventions have been initiated since November 2016. *Recommendation: In addition to the education, initiate plans for interventions that will decrease the number.*
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses were conducted quarterly.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results and findings are presented clearly.

Component / Standard (Total Points)	Score	Comments
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Analysis identified initial and repeat measurements.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Conclusions and recommendations based on findings were included in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	The rate improved for a few quarters, but has been increasing the past two quarters (decrease in rate is improvement). *Recommendations: Determine if there are new education process or support tools to decrease the number.*
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Np improvement reported.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not calculated as sampling is not being utilized.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	No improvement over the past two quarters, thus sustainment cannot be judged.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	79
Project Possible Score	85
Validation Findings	**93%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	SANDHILLS CENTER
Name of PIP:	EVIDENCE-BASED PRACTICES EMPLOYED BY PROVIDER NETWORK-CLINICAL
Reporting Year:	2017
Review Performed:	August 2018

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	There was a trend of low number of “Yes” answers for the following questions “Is there evidence of coordination of care with other services/providers or prescribing providers?” on both the Bipolar Disorder and PTSD tools.
1.2 Did the MCO’s/PIHP’s PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO’s/PIHP’s PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is stated on page 2 in “Focus of Project” section.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is defined in measurable goal section.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care.

Component / Standard (Total Points)	Score	Comments
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and computed as a percentage.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions have been initiated based on results and issues with database.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses were conducted quarterly.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results and findings are presented clearly.

Component / Standard (Total Points)	Score	Comments
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Analysis identified initial and repeat measurements.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Conclusions and recommendations based on findings were included in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	The rate initially improved, but then decreased the past quarters for both bipolar and PTSD tools. *Recommendations: Determine if there are new initiatives that can be implemented to increase YES responses.*
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Np improvement reported.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not calculated as sampling is not being utilized.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	No improvement over the past two quarters, thus sustainment cannot be judged.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	84
Project Possible Score	85
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

AUDIT DESIGNATION POSSIBILITIES

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

CCME EQR PIP Validation Worksheet

Plan Name:	**SANDHILLS CENTER**
Name of PIP:	**TCLI- TRANSITION DAYS NON-CLINICAL**
Reporting Year:	**2017**
Review Performed:	**August 2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Transition averaged 88 days in the most recent six months. The goal is 75 days.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is stated on page 2 in "Focus of Project" section.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is defined in measurable goal section.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Not Met**	Sources of data were not clearly specified. *Recommendation: The data source from which the spreadsheet is developed needs to be added to the report.*
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Not Met**	Data analysis plan was not clearly documented. *Recommendation: Include the data analysis plan in the report.*
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.

Component / Standard (Total Points)	Score	Comments
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Partially Met**	Interventions have been initiated based on results and issues with database, but the barriers that are linked to each intervention are not clear in the report. *Recommendation: Revise the report to display the specific barriers that are being addressed by the interventions.*
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NA**	Analysis plan was not specified in the report.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results and findings are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Analysis identified initial and repeat measurements.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Conclusions and recommendations based on findings were included in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	The rate improved in the most recent remeasurement.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement appears to be a result of the actions implemented.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not calculated as sampling is not being utilized.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	0
6.3	1	1

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

Project Score	78
Project Possible Score	85
Validation Findings	92%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	Sandhills
Name of PM	INNOVATIONS MEASURE: LEVEL OF CARE EVALUATION
Reporting Year	2017
Review Performed	August 2018

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

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G2. Documentation (10)	Appropriate and complete measurement plans, methodology, and performance measure specifications sources were documented.	**MET**	Plans, specifications and sources were documented.
G3. Data Reliability (2)	Data reliability methodology is documented (e.g., validation checks, inter-rater agreement, and/or basic data checks)	**MET**	Data validation methods are noted.
DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D3. Denominator (10)	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were accurate.	**MET**	Data sources were accurate.
D4. Denominator (5)	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N6. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N7. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate are in SHC Innovations Waiver Excel file
R4. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	**Sandhills**
Name of PM	**INNOVATIONS MEASURE: LEVEL OF CARE EVALUATIONS COMPLETED USING APPROVED PROCESSES AND INSTRUMENTS**
Reporting Year	**2017**
Review Performed	**August 2018**

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

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	**Sandhills**
Name of PM	**INNOVATIONS MEASURE: NEW LEVEL OF CARE EVALUATIONS COMPLETED USING APPROVED PROCESSES AND INSTRUMENTS**
Reporting Year	**2017**
Review Performed	**August 2018**

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

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

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

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

VALIDATION SUMMARY

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

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

Plan's Measure Score	55
Measure Weight Score	55
Validation Findings	100%

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	**Sandhills**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF PROVIDERS THAT IMPLEMENTED AN APPROVED CORRECTIVE ACTION PLAN**
Reporting Year	**2017**
Review Performed	**August 2018**

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	**Sandhills**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF PROVIDERS WHEREIN ALL STAFF COMPLETED MANDATED TRAINING**
Reporting Year	**2017**
Review Performed	**August 2018**

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	**Sandhills**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF ISPS IN WHICH SERVICES AND SUPPORTS REFLECT PARTICIPANT ASSESSED NEEDS AND LIFE GOALS**
Reporting Year	**2017**
Review Performed	**August 2018**

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

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	Sandhills
Name of PM	INNOVATIONS MEASURE: ISPS ADDRESS IDENTIFIED HEALTH AND SAFETY RISK FACTORS
Reporting Year	2017
Review Performed	August 2018

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

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

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

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

VALIDATION SUMMARY

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

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

Plan's Measure Score	55
Measure Weight Score	55
Validation Findings	100%

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	**Sandhills**
Name of PM	**INNOVATIONS MEASURE: PARTICIPANTS REPORTING THAT ISP HAS SERVICES THEY NEED**
Reporting Year	**2017**
Review Performed	**August 2018**

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

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	Sandhills
Name of PM	INNOVATIONS MEASURE: INDIVIDUALS FOR WHOM AN ANNUAL ISP AND OR NEEDED UPDATES TOOK PLACE
Reporting Year	2017
Review Performed	August 2018

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

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR INNOVATIONS MEASURES VALIDATION WORKSHEET

Plan Name	Sandhills
Name of PM	INNOVATIONS MEASURE: NEW WAIVER PARTICIPANTS ARE RECEIVING SERVICES ACCORDING TO ISP WITHIN 45 DAYS OF APPROVAL
Reporting Year	2017
Review Performed	August 2018

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

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

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

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

VALIDATION SUMMARY

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

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

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

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

AVERAGE VALIDATION PERCENTAGE & AUDIT DESIGNATION
100% FULLY COMPLIANT

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

D. Attachment 4: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

CCME PIHP Data Collection Tool

Plan Name:	Sandhills Center
Collection Date:	2018

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A. General Approach to Policies and Procedures						
1. The PIHP has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					All policies and procedures were annually reviewed in April 2018. Per Sandhills' *Procedure Core 3a Policy-Procedure Maintenance Review Approval*, all procedures are visited by the Compliance Committee as a part of the annual review. However, this step was omitted in this past year's annual review process. Sandhills should either update this procedure to accurately reflect the Compliance Committee involvement in the annual review process or come into compliance with the procedure. Sandhills' policies and procedures set are too cumbersome to be consistently useful to staff and Sandhills struggles to effectively, consistently make timely updates and revisions to their policy and procedure set. ***Recommendation:*** ***Sandhills should either update Core 3a Policy-Procedure Maintenance Review Approval to reflect the current annual procedure review process, or take steps to remain in compliance***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						with this procedure. Compliance with this procedure would be evident within the Compliance Committee minutes. *Develop a workplan that lays out a process for streamlining Sandhills' set of policies and procedures to specifically identify overlapping and duplicative policies and procedures.*
I. B. Organizational Chart / Staffing						
1. The PIHP's resources are sufficient to ensure that all health care products and services required by the State of North Carolina are provided to enrollees. At a minimum, this includes designated staff performing in the following roles:						
1.1 A full time administrator of day-to-day business activities;	X					
1.2 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities.	X					Dr. Carraway's current job description was initiated in 2013 and does not accurately capture his current duties and committee memberships as described during the Onsite. ***Recommendation:*** *Update and revise Dr. Carraway's job description to be aligned with his current departmental oversight, committee membership and attendance, and the Medical Director requirements in the DMA Contract, Sections 6.7.6 and 7.1.3.*
2. Operational relationships of PIHP staff are clearly delineated.	X					Prest's current contract, addended in 2010, added the provision that Prest & Associates agrees to provide "consultation, supervision and oversight" to the Utilization Management Committee and further, to "serve as back up to the Sandhills Centre Medical Director when volume

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						necessitates or when the Medical Director is not available". This language should be corrected to guard against any conflicts of interest, real or perceived, of Prest's involvement between Utilization Management (UM) functions and their role as the delegated Peer Reviewer entity. ***Recommendation:*** ***The language in Prest's contract should be amended to accurately reflect their current responsibilities and guard against the liability of conflicts of interest, real or perceived, between Prest's involvement with UM functions and their role as the delegated Peer Reviewer entity.***
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all PIHP staff positions, including those that are required by DMA contract.	X					
I. C. Confidentiality						
1. The PIHP formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					
2. The PIHP provides HIPAA/confidentiality training to new employees and existing staff.	X					Sandhills training procedure explains that new staff are trained in confidentiality specific to their new position within the first two days of employment. Additional training to new staff is provided during the new employee orientation that is completed within the new staffs first month of employment.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I D. Management Information Systems						
1. Enrollment Systems						
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Sandhills has defined processes in place for enrollment data updates. Mediware handles enrollment data updates using quarterly GEF files and daily 'deltas' and produces exception reports. Demographic data is captured in the AlphaMCS system and patients' IDs are unique to members. There are validation checks in place to ensure member data is updated and correct. Historical enrollment information is captured for all members in the AlphaMCS system.
1.2 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Mediware produces Exception Reports.
1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.	X					An Onsite review of the AlphaMCS member demographic screen and enrollment history were found to be compliant with this requirement.
2. Claims System						
2.1 The MCO processes provider claims in an accurate and timely fashion.	X					About 89% of institutional claims and 99% of professional claims are auto-adjudicated. Denial reports capture relevant information for immediate resolution of denied encounters, and it is the PIHP's goal to have remittance happen within the week.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.2 The MCO has processes and procedures in place to monitor review and audit claims staff.	X					Claims staff conduct weekly audits of 3% of paid and 3% of denied claims. Paper claims are audited pre and post data entry.
2.3 The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 procedure codes on an 837 Institutional file.		X				The provider portal captures up to 14 diagnosis codes for both institutional and professional claims, but the PIHP only submits up to 2 diagnosis codes for encounter submissions. Sandhills is willing to comply with state requested standards and make necessary adjustments in AlphaMCS. It was communicated to the PIHP that NCTracks will accept 12 diagnoses for professional and 25 diagnosis codes for institutional claims. ***Corrective Action:*** ***Update the system and provider web portal to be able to accept up to 25 ICD-10 diagnosis codes for an 837I.***
2.4 The MCO's claim system screens store and track claim information and claim adjudication/payment information.	X					The PIHP uses standard claims forms for institutional and professional encounters. Claims adjudication processes occur within the AlphaMCS system and daily denial reports are produced for timely claims resolution. Processes are in place of overriding claims and reviewing claims in a pended status. Sandhills provided an Onsite demonstration to show the claims data elements captured in AlphaMCS.
3. Reporting						
3.1 The MCO's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Sandhills captures all necessary data elements required for enrollment and claims reporting. Several example reports were provided pre-Onsite regarding claims processing, adjudication and DMA encounter submissions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.2 The MCO has processes in place to back up the enrollment and claims data repositories.	X					This was discussed Onsite and within the ISCA tool. All eligibility data is loaded into the AlphaMCS system and Mediware also maintains a backup at a secondary Mediware facility. Sandhills is provided a daily backup that is saved on an onsite database. A Disaster Recovery Plan was provided prior to the Onsite for review as well as a Disaster Recovery Test document.
4. Encounter Data Submission						
4.1 The MCO has the capabilities in place to submit the State required data elements to DMA on the encounter data submission.		X				Sandhills has indicated that AlphaMCS is currently undergoing modifications to submit additional diagnosis codes to the state (up to 12 secondary diagnosis codes). Currently their system captures up to 14 diagnosis codes on both institutional and professional files. CCME recommends modifying the AlphaMCS system to capture the standard number of diagnosis codes on 837I and 837P file formats, and to submit all diagnosis codes to the state. Twenty-five ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837I and the maximum number that NCTracks captures. For professional encounters, NCTracks can receive up to 12 ICD-10 diagnosis codes. ***Corrective Action: Update the encounter data submission process to allow for all ICD-10 CM diagnosis codes submitted on an institutional and professional 837 HIPAA file to be submitted to NCTracks. Twenty-five ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837I and the maximum number that is NCTracks captures . NCTracks can capture up to 12 diagnosis codes for professional claims.***
4.2 The MCO has the capability to identify, reconcile and track the encounter data submitted to DMA.	X					Sandhills developed an internal database to track the status of a claim through its history, from adjudication to encounter data submission.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.3 MCO has policies and procedures in place to reconcile and resubmit encounter data denied by DMA.	X					The PIHP has clear processes in place to address denied encounter submissions. A process based on the Adam Holtzman reports was put in place for staff to review and rebill denied encounters. Communications have been established between multiple departments to address encounter denials based on provider taxonomy codes, enrollment changes, and unauthorized services.
4.4 The MCO has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to DMA	X					Communications have been established between multiple departments to address encounter denials based on provider taxonomy codes, enrollment changes, and unauthorized services. Credentialing specialists reach out to providers whose information may need to be updated in AlphaMCS or NCTracks. Sandhills has bi-weekly meetings with DMA to discuss and resolve ongoing issues. Finance, claims and encounter staff are dedicated to improving encounter data submissions and are very knowledgeable about their processes.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II. A. Credentialing and Recredentialing						
1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					Several policies and procedures address the credentialing and recredentialing processes. *Procedure N-CR 1a-19a, N-NM 3a* is identified as the *Provider Credentialing Plan.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	X					The Credentialing Subcommittee (CS) of the Clinical Advisory Committee (CAC) is chaired by the Chief Clinical Officer (CCO)/ Medical Director. The CS had 12 meetings between 08/29/17 and 06/28/18, with a quorum present for each meeting. One committee member did not attend any of the meetings nor submit any votes, during the review period. Five of the voting members attended between 75 and 92%, and one member attended 67% of the meetings. Meetings are typically held via conference call, and votes are sometimes taken by email. Sandhills staff are nonvoting members of the committee, with the exception that the CCO/Medical Director votes in the event of a tied vote. The CS Committee Meeting Minutes contain evidence of the CS discussion and decision-making. *DMA Contract Section 7.7.3, Hospital Credentialing,* allows PIHPs to accept credentialing conducted by hospitals for their providers. Sandhills has delegated credentialing to the UNC Hospital System and to Cone Health. Several policies and procedures (*Core 6, 7, 6a, 7a Delegation Review Criteria and Review, Core 8, 8a Delegation Contracts, and Core 9, 9a Delegation Oversight)* direct the delegation processes.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of provider.	X					Credentialing and recredentialing files are well-organized and contain appropriate information. Issues identified with some files are detailed in the following standards.
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					Ten of the 12 practitioner and one of the four agency initial credentialing files were missing some of the required insurance verifications or a statement from the provider about why it is not required. CCME identified this issue in the previous two EQRs. In response to CCME's request during the Onsite visit, Sandhills provided additional documents. ***Recommendations: Verify credentialing files contain proof of all required insurance coverage (or the relevant statement from the provider about why it is not required), and that the individual provider is listed among those covered under the policies. If the provider is not named on the Certificate of Insurance, a letter from the agency provider or insurance company indicating the provider is covered under the policy is acceptable. For providers joining already-contracted agencies, include (in the files uploaded for Desk Review) copies of the insurance coverage for the agency, and verification the provider is covered under the plans. See DMA Contract, Section 7.7.***
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.3 Valid DEA certificate; and/or CDS certificate	X					
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					Professional education is Primary Source Verified (PSV) by most licensing boards. As noted at the last EQR, the NC Medical Board has indicated they do not conduct PSV of education for physicians. If a physician is board certified, the PSV of board certification serves as PSV for education, as the board conducts PSV of education. If the physician graduated from an international medical school, the PSV of the Educational Commission for Foreign Medical Graduates (ECFMG) certification serves as PSV for education, as ECFMG conducts PSV of education. Two initial credentialing files were submitted for physicians. One of the physicians is board certified. The other physician is not board certified. The file for that physician contained a copy of his transcript but lacked PSV of the physician's education. ***Recommendation**: If the physician is not board certified, ensure PSV of education is in the credentialing file. Correct the Provider Credentialing Plan Procedure, N-CR 1a-19a, N-NM 3a, and any other documents containing the list of required materials, to indicate that Sandhills will conduct PSV of education of physicians.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					
3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.8 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);		X				Sandhills did not complete the *State Exclusion List* query as part of the credentialing or recredentialing process until June 2018. For applications approved in June 2018, Sandhills went back and completed the *State Exclusion List* query. ***Corrective Action: Ensure all credentialing and recredentialing files include evidence of the query of the State Exclusion List, as required by DMA Contract, Section 1.14.4 and by the Provider Credentialing Plan Procedure, N-CR 1a-19a, N-NM 3a.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.10 Query for the System for Awards Management (SAM);	X					
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Ownership Disclosure is addressed.	X					The "Ownership Disclosure" question was marked "no" in four credentialing files, but no information regarding the owners, managing partners, etc. was provided. In response to CCME's request during the Onsite visit, Sandhills provided additional documents, taken from the agency files for the practitioners joining the agencies. ***Recommendation: Ensure credentialing files contain all items. If Sandhills does not keep a copy of the relevant Ownership Disclosure information in the individual credentialing file, retrieve copies from***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						the relevant file and upload as part of the credentialing files for the Desk Review.
3.1.16 Criminal background Check	X					
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.	X					Four of the individual credentialing files for licensed practitioners joining agencies contained a Division of Health Service Regulation (DHSR) license copy, but no PSV of the DHSR license. At the Onsite, Sandhills indicated the PSV of licensure is conducted as part of the Agency credentialing/recredentialing process. In response to CCME's request during the Onsite visit, Sandhills provided additional documents. ***Recommendation: Ensure credentialing files contain all items. If Sandhills does not keep a copy of the relevant site assessment or the PSV of the DHSR license in the individual credentialing file, retrieve copies from the relevant file and upload as part of the credentialing files for the Desk Review.***
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					The *Provider Credentialing Plan Procedure, N-CR 1a-19a, N-NM 3a*, states "information submitted for credentialing & re-credentialing cannot be over 180 days old". In some files, the Credentialing Specialist had initialed on top of the date on the PSV screenshot, making it difficult to confirm the date/that the PSV was pulled timely. One initial credentialing file had three different date stamps for the date of receipt of the application. One of the date stamps was completely marked through, to the point that it cannot be read at all. The date on another date stamp was repeatedly written over, changing the original date. The third date stamp was legible, with no mark through. Dates confirming the PSV of information or the date an application received should not be changed or written over. If the Credentialing Specialist is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						going to initial the PSV, ensure the initials do not overlap or cover the date of the PSV. If an incorrect date is stamped for the receipt of items, draw a single line through the incorrect date and initial it. ***Recommendation: To comply with the requirement in the Provider Credentialing Plan Procedure, N-CR 1a-19a, N-NM 3a, regarding information over 180 days old, ensure dates are legible, not written over, and not changed. If an incorrect date is listed, draw a single line through it, make the needed change, and initial the change.***
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files reviewed were organized and contained appropriate information. Issues regarding the recredentialing process are discussed in the standards that follow.
4.1 Recredentialing every three years;	X					Six of the twelve practitioners and one agency provider were not recredentialed within three years, with recredentialing ranging from three days (one file) to 25 days (2 files) past the three year mark. ***Recommendation: Per the Provider Credentialing Plan Procedure, N-CR 1a-19a, N-NM 3a, ensure providers are recredentialed within three years of the date of the approval of initial credentialing or the most recent recredentialing.***
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					Six of the 12 practitioner recredentialing files were missing some of the required insurance verifications or a statement from the provider about why it is not required. CCME identified this issue in the previous two EQRs. In response to CCME's request during the Onsite visit, Sandhills provided additional documents.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendations: Verify recredentialing files contain proof of all required insurance coverage (or the relevant statement from the provider about why it is not required), and that the individual provider is listed among those covered under the policies. If the provider is not named on the Certificate of Insurance, a letter from the agency provider or insurance company indicating the provider is covered under the policy is acceptable. For providers joining already-contracted agencies, include (in files submitted for Desk Review) copies of the insurance coverage for the agency, and verification the provider is covered under the PIHP. See DMA Contract, Section 7.7.
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
4.2.3 Valid DEA certificate; and/or CDS certificate	X					
4.2.4 Board certification if claimed by the applicant;	X					
4.2.5 Malpractice claims since the previous credentialing event;	X					
4.2.6 Practitioner attestation statement;	X					
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event;		X				Sandhills did not complete the *State Exclusion List* query as part of the credentialing or recredentialing process until June 2018. For applications approved in June 2018, Sandhills went back and completed the *State Exclusion List* query. ***Corrective Action: Ensure all credentialing and recredentialing files include evidence of the query of the State Exclusion List, as required by DMA Contract, Section 1.14.4 and by the Provider Credentialing Plan Procedure, N-CR 1a-19a, N-NM 3a.***
4.2.9 Requery of the SAM.	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event;	X					
4.2.11 Query of the Social Security Administration's Death Master File	X					
4.2.12 Query of the NPPES;	X					
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.2.14 Ownership Disclosure is addressed.	X					The "Ownership Disclosure" question was marked "no" in three recredentialing files, but no information regarding the owners, managing partners, etc. was provided. One recredentialing file listed EFT Authorized Staff, but no actual owners. In response to CCME's request during the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Onsite visit, Sandhills provided additional documents, taken from the agency files for the practitioners joining the agencies. ***Recommendation: Ensure recredentialing files contain all items. If Sandhills does not keep a copy of the relevant Ownership Disclosure information in the individual credentialing file, retrieve copies from the relevant file and upload as part of the recredentialing files submitted for the Desk Review.***
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					The Credentialing Subcommittee Meeting Notes reflect consideration of quality of care concerns and other items for recredentialing candidates.
5. The PIHP formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the PIHP for serious quality of care or service issues.	X					
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					
II B. Adequacy of the Provider Network						
1. The PIHP maintains a network of providers that is sufficient to meet the health care	X					*Procedure N-NM1a, Scope of Services (Medicaid)* states, "Sandhills Center has both a formal annual assessment process and an ongoing process to ensure network sufficiency." At the Onsite, Sandhills reported a Facility-Based Crisis Center in Asheboro, originally planned to open in the Spring of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
needs of enrollees and is consistent with contract requirements.						2018, then delayed until September 2018, will likely be delayed until at least December 2018. A Facility-Based Crisis Center (FBC) for Children will be built on land that is being purchased in Richmond County. The FBC for Children will serve enrollees in the entire Sandhills catchment area.
1.1 Enrollees have a Provider location within a 30 – mile distance of 30 minutes' drive time of their residence. Rural areas are 45 miles and 45 minutes. Longer distances as approved by DMA are allowed for facility based or specialty providers.	X					*Core 34a, Access to Services*, includes 30 minutes/30 miles, 45 minutes/45 miles access standards. Two of the three submitted quarterly *Managed Care Accessibility Analysis* reports showed improvement in the percentage of Medicaid enrollees with access to at least two opioid treatment providers within 30 miles. The third quarter report showed a significant jump in both the number of providers and the percentage of Medicaid enrollees with access to two Methadone/opioid treatment providers within 30 miles. At the Onsite, Sandhills staff reported they will verify the data, but believe the jump in third quarter is related to a provider adding sites. • July/August/September 2017 report: 7 providers; 37.8% of Medicaid enrollees had access to two providers within 30 miles. • October/November/December 2017 report: 7 providers, 35% of Medicaid enrollees had access to two providers within 30 miles. • January/February/March 2018: 31 providers, 94.5% of Medicaid enrollees had access to two providers within 30 miles. Each of the three reports indicated there were six Multi-Systemic Therapy (MST) providers. The percentage of Medicaid enrollees with access to two providers within 30 miles went from 29.4% in the first quarter report to 32.1% in the second quarter report to 55.8% in the third quarter. Despite improvement, the access standard was not met in any quarter, yet there is no evidence of any efforts to address this gap, nor is there evidence of analysis of the quarterly reports. ***Recommendation: Analyze reports to determine gaps; develop strategies to address identified gaps.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 Enrollees have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the enrollee may utilize an out-of-network specialist with no benefit penalty.	X					*Procedure N-CR1a-19a, N-NM 3a, Provider Credentialing Plan*, confirms Sandhills will pay for medically necessary services to be delivered with an in-network provider if available, or with an out-of-network provider if no in-network provider is available.
1.3 The sufficiency of the provider network in meeting enrollee demand is formally assessed at least annually.	X					Sandhills conducts the annual community needs and gaps analysis as required by DHHS and uses the information for its *Network Development Plan*. The last plan was the *2017 Community Behavioral Health Needs, Providers and Gaps Analysis Report*, with FY 2015-2016 data. The next report is due to DHHS in September 2018. At the Onsite, Sandhills staff reported that data gathered for the upcoming *Gaps Analysis report* reflects similar gaps to those identified at the *Gaps Analysis report* submitted in June 2017.
1.4 Providers are available who can serve enrollees with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Client-specific contracts are employed, if needed.
1.5 The PIHP demonstrates significant efforts to increase the provider network when it is identified as not meeting enrollee demand.	X					Sandhills increased reimbursement rates for providers of community-based Intermediate Care Facilities, Outpatient Services including Evaluation and Management Coding, and all Innovations services, effective July 1, 2018.
2. Provider Accessibility						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.1 The PIHP formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					*Procedure CORE 34a, Access to Services*, lists the standards for access to services. *Procedure N-NM 2a, Provider Network Access and Availability (Medicaid)*, addresses Access and Availability Standards for appointments and office wait times. The Performance Standards listed in #7 of *Procedure CORE 34a, Access to Services*, do not indicate that providers must provide face-to-face emergency care immediately for life-threatening situations. ***Recommendation: Include the DMA Contract, Attachment S requirement for providers to "provide face-to-face emergency care immediately for life-threatening emergencies" in the "Performance Standards" listed in Procedure CORE 34a, Access to Services.***
II C. Provider Education						
1. The PIHP formulates and acts within policies and procedures related to initial education of providers.	X					*Procedure N-NM 6a, Participating Provider Relations Program (Medicaid)*, addresses New Provider Orientation and Annual Orientation.
2. Initial provider education includes:						Relevant information was located in the *Medicaid Provider Manual, the Member Handbook*, or on Sandhills' website, unless otherwise indicated.
2.1 PIHP purpose and mission;	X					
2.2 Clinical Practice Standards;	X					The link on page 18 of the *Medicaid Provider Manual* to the Clinical Practice Guidelines on the Sandhills website did not work. ***Recommendation: Correct the link in the Medicaid Provider Manual to the Clinical Practice Guidelines. Have a staff member periodically check links to ensure they work.***
2.3 Provider responsibilities;	X					Provider responsibilities are addressed throughout the *Medicaid Provider Manual*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 PIHP closed network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability.	X					
2.5 Access standards related to both appointments and wait times;	X					
2.6 Authorization, utilization review, and care management requirements;	X					
2.7 Care Coordination and discharge planning requirements;	X					
2.8 PIHP dispute resolution process;	X					
2.9 Complaint investigation and resolution procedures;	X					
2.10 Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.11 Enrollee rights and responsibilities	X					The *Medicaid Provider Manual* lists enrollee rights but does not include the "right of enrollees who live in Adult Care Homes to report to the appropriate regulatory authority any suspected violation of their enrollee rights as outlined in *NCGS § 131-D21*". ***Recommendations: Review the Member Rights section in the Medicaid Provider Manual to ensure all rights are included. Revise the Medicaid Provider Manual to include the right of enrollees who live in Adult Care Homes to report to the appropriate regulatory authority any suspected violation of their enrollee rights as outlined in NCGS § 131-D21. See DMA Contract 6.13.2.***
2.12 Provider program integrity requirements that include how to report suspected fraud, waste and abuse, training requirements as outlined in the False Claims Act, and other State and Federal requirements.	X					Page 170 of *the Medicaid Provider Manual* has instructions for reporting fraud, waste and abuse. The *PI Orientation* has instructions for reporting fraud, waste and abuse.
3. The PIHP provides ongoing education to providers regarding changes and/or additions to its programs, practices, enrollee benefits, standards, policies and procedures.	X					A Training Calendar on the Sandhills website includes training opportunities, workshops and other available events for Sandhills' providers.
II D. Clinical Practice Guidelines for Behavioral Health Management						
1. The PIHP develops clinical practice guidelines for behavioral health management of its enrollees that are consistent with national or professional standards and covered benefits, are	X					*Procedure ADM 2a, Best Practices*, indicates the Clinical Advisory Committee (CAC) reviews and updates "all approved clinical practice guidelines on a yearly basis for use by Sandhills Center LME/MCO providers and adopts additional guidelines for use in tracking and monitoring of providers, also on a yearly basis."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.						
2. The PIHP communicates the clinical practice guidelines for behavioral health management and the expectation that they will be followed for PIHP enrollees to providers.	X					Page 18 of the *Medicaid Provider Manual* lists the "Sandhills Center Contracted Provider Responsibilities," including "Review Sandhills Center website for updates on a regular basis. Sandhills Center Clinical Practice Guidelines can be found in the Provider Service section." The *Medicaid Provider Manual* includes a link to the relevant page on the website, but the link goes to a "Page not found" page. The Clinical Practice Guidelines are accessible via a link on the Provider section of the Sandhills website. Page 27 of the *Medicaid Provider Manual* indicates it is a provider responsibility to "Maintain services at an optimal level to meet member needs by providing services in accordance with Sandhills Center Practice Guidelines." ***Recommendation: Correct the link in the Medicaid Provider Manual to the Clinical Practice Guidelines. Have a staff member periodically check links to ensure they work.***
II E. Continuity of Care						
1. The PIHP monitors continuity and coordination of care between providers.	X					*Procedure QM2a, Monitoring Continuity of Care,* addresses ensuring continuity of care between providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II F. Practitioner Medical Records						
1. The PIHP formulates policies and procedures outlining standards for acceptable documentation in the Enrollee medical records maintained by providers.	X					*Procedure HIM 4a, Clinical and Business Records*, and the *Medicaid Provider Manual* address standards for acceptable documentation in the enrollee medical records. A link on the Provider section of the Sandhills website goes to the *Records Management and Documentation Manual* page on the DHHS website. *Procedure HIM 4a, Clinical and Business Records*, references the *Basic Medicaid Billing Guide*. The *Medicaid Provider Manual* references the *NCTracks Provider Claims and Billing Assistance Guide*. This document is now the *NCMMIS Provider Claims and Billing Assistance Guide*. ***Recommendation: Correct all references to the Basic Medicaid Billing Guide or to the NCTracks Provider Claims and Billing Assistance Guide, which is now the NCMMIS Provider Claims and Billing Assistance Guide. See DMA Contract, Section 8.2.1.***
2. The PIHP monitors compliance with medical record documentation standards through formal periodic medical record audit and addresses any deficiencies with the providers.	X					
3. The PIHP has a process for handling abandoned records, as required by the contract.	X					*Procedure HIM 5a, Request for Provider Records*, addresses the process for handling abandoned records.

III. ENROLLEE SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III A. Enrollee Rights and Responsibilities						
1. The PIHP formulates policies outlining enrollee rights and procedures for informing enrollees of these rights.	X					
2. Enrollee rights include, but are not limited to, the right:	X					
2.1 To be treated with respect and due consideration of dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;						
2.3 To participate in decisions regarding health care;						
2.4 To refuse treatment;						
2.5 To be free from any form of restraint of seclusion used as a means of coercion, discipline, convenience or retaliation;						
2.6 To request and receive a copy of his or her medical record, except as set forth in 45 C.F.R. §164.524 and in N.C.G.S. § 122C-53(d), and to request that the medical record be						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
amended or corrected in accordance with 45 CFR Part 164.						
2.7 Of enrollees who live in Adult Care Homes to report any suspected violation of their enrollee rights, to the appropriate regulatory authority as outlined in NCGS§ 131-D21.						This was a corrective action item during last EQR that was corrected and maintained for this review.
III B. Enrollee PIHP Program Education						
1. Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid waiver managed care program which they are contractually entitled, including:	X					
1.1 A description of the benefits and services provided by the PIHP and of any limitations or exclusions applicable to covered services. These descriptions must have sufficient detail to ensure the Enrollees understand the benefits to which they are entitled and may include a web link to the PIHP Benefit Plan. This includes a descriptions of all Innovations Waiver services and supports;						
1.2 Benefits include access to a 2nd opinion from a qualified health care professional within the network, or arranges for the enrollees to obtain						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
one outside the network, at no cost to the enrollee;						
1.3 Updates regarding program changes;						
1.4 A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;						
1.5 An explanation of the Enrollee's responsibilities and rights and protection;						
1.6 An explanation of the Enrollee's rights to select and change Network Providers						
1.7 The restrictions, if any, on the enrollee's right to select and change Network Providers						
1.8 The procedure for selecting and changing Network Providers						
1.9 Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request);						
1.10 The non-English languages, if any, spoken by each Network Provider;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.11 The extent to which, and how, after-hours and emergency coverage are provided, including:						
1.11.1 What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services in accordance with 42 CFR§ 438.114 and EMTALA;						
1.11.2 The fact that prior authorization is not required for emergency services;						
1.11.3 The process and procedures for obtaining Emergency Services, the use of 911 telephone services or the equivalent;						
1.11.4 The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract;						
1.11.5 A statement that, subject to the provisions of the DMA this contract, the Enrollee has a right to use any hospital or other setting for Emergency care;						
1.12 The PIHP's policy on referrals for Specialty Care to include cost sharing, if any, and how to access						Page 12 of the *Member Handbook* has a section called "Can I receive services from non-network providers." It gives three examples of when a member may receive services from a non-network provider. None of the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
Medicaid benefits that are not covered under this Contract;						examples refers to "Specialty Care." Ultimately, members are to call the Access to Care line if they have questions about a provider outside the Sandhills network. ***Recommendation: Adding information in the Member Handbook to address Sandhills' procedure on referrals for Specialty Care would be helpful.***
1.13 Any limitations that may apply to services obtained from Out-of Network Providers, including disclosures of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of Network Providers, and the procedures for obtaining authorization for such services.						This is located on page 12 of the *Member Handbook*.
1.14 How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost-sharing;						This is located on page 11 of the *Member Handbook* in the section "Am I eligible for state-funded services."
1.15 Procedures for obtaining out-of-area or out-of-state coverage of or services, if special procedures exist;						The *Member Handbook* has a very brief description of the process for obtaining out-of-area coverage.
1.16 Information about medically necessary transportation services by the department of Social Services in each country;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.17 Identification and explanation of State laws and rules Policies regarding the treatment of minors;						
1.18 The enrollee's right to recommend changes in the PIHP's policies and procedures						
1.19 The procedure for recommending changes in the PHIP's policies and procedures;						
1.20 The Enrollee's right to formulate Advance Directives;						
1.21 The Enrollee's right to file a grievance concerning non-actions, and the Enrollee's right to file an appeal if PIHP takes an action against an Enrollee;						
1.22 The accommodations made for non-English speakers, as specified in 42 CFR §438.10(c)(5);						
1.23 Written information shall be made available in the non-English languages prevalent in the PIHP's services area.						
1.24 The availability of oral interpretation service for non-English languages and how to access the service;						
1.25 The availability of interpretation of written information in prevalent						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
languages and how to access those services						
1.26 Information on how to report fraud and abuse; and						
1.27 Upon an Enrollee's request, the PIHP shall provide information on the structure and operation of the agency and any physician incentive plans.						
1.28 Information on grievance, appeal and fair hearing procedures and information specified in CFR §438.10 (g) and CFR §438.10 (f) (6).						
2. Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.	X					
3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in CFR 438.10 (f) (61) and 438.10 (g) at least 30 calendar days before the intended effective date of the change; and (2) . termination of their provider within fifteen (15) calendar days after PIHP receives notice that DMA or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.		X				Two of the five terminating provider files CCME reviewed indicate that Sandhills did not notify the affected enrollees that the provider was no longer in their network within the required 15-day period after Sandhills was aware of the termination. ***Corrective Action: Ensure all relevant Sandhills staff are updated and follow the process for notifying enrollees of their provider terminating the Sandhills network within 15 days of the termination notice date.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation of prevalent non-English languages as required by the contract.	X					Staff were unaware of a policy, procedure, or desk reference addressing the required format of written materials to enrollees. All enrollee written materials should be at least 12 point *CFR 438.10 (D(6) (ii)* unless it is a large print document and that should be no smaller than 18 *point CFR 438.10 (d) (3).* ***Recommendation: Ensure there is a policy, procedure or desk reference addressing the format of enrollee materials, and update all Communications staff. Written material should be at least 12 point per CFR 438.10 (D(6) (ii) unless it is a large print document and that should be no smaller than 18 point per CFR 438.10 (d) (3).***
5. The PIHP maintains and informs Enrollees of how to access a toll-free vehicle for 24-hours Enrollee access to coverage information from the PIHP, including the availability of free oral translation services for all languages and care management services such as crisis interventions.	X					
III C. Behavioral Health and Chronic Disease Management Education						
1. The PIHP enables each enrollee to choose a Provider upon enrollment and provides assistance as needed.	X					
2. The PIHP informs enrollees about the behavioral health education services that are available to them and encourages them to utilize these benefits.	X					
3. The PIHP tracks the participation of enrollees in the behavioral health education services.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III D. Call Center						
1. The PIHP provides customer services that are responsible to the needs of the Enrollees and their families. Services include:	X					
1.1 Respond appropriately to inquiries by enrollees and their family members (including those with limited English proficiency);	X					
1.2 Connect enrollees, family members and stakeholders to crisis services when clinically appropriate;	X					
1.3 Provide information to enrollees and their family members on where and how to access behavioral health services;	X					
1.4 Train its staff to recognize third-party insurance issues, recipient appeals, and grievances and to route these issues to the appropriate individual;	X					
1.5 Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;	X					Call Center rollover calls answered by Cardinal frequently do not meet the Call Center metric standards. ***Recommendation: Continue working with Cardinal through the corrective action process to improve their Sandhills rollover call metrics.***
1.6 Process referrals twenty-four (24) hours per day, seven (7) days per week; 365 days per year; and	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.7 Process Call Center linkage and referral requests for services twenty-four (24) hours per day, seven (7) days per week, 365 days per year.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV A. The Quality Improvement (QI) Program						
1. The PIHP formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to enrollees.	X					
2. The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.	X					
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					There is no specific policy or procedure in place for detecting the over and underutilization of services, however, the activities of the Care Management (CM)/Utilization Management (UM) committee on page 17 of the UM Plan 2018-2019 document did state "monitors for appropriate utilization of resources and services by examining data."
4. The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.	X					There is a workgroup to review measures needing improvement for the *Experience of Care & Health Outcomes (ECHO)Survey*. Those measures are defined to be 5% or more outside the state average. This workgroup has minutes and reports progress to needed committees. This evidence

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						of improvement for each of these measures identified is not tracked in a dedicated document making it hard to see improvement. ***Recommendation: Document ECHO Survey measures identified to be 5% or more outside the state average in a dedicated document so improvement can be seen. Track interventions, barriers, and outcomes for each measure. Keep a record of the survey results on those measures annually to analyze improvements or alter interventions.***
5. The PIHP reports the results of the enrollee satisfaction survey to providers.	X					The *Echo Survey* results are presented in the Provider Forum meetings as well as several committee meetings.
6. The PIHP reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					
7. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, time frame for implementation and completion, and the person(s) responsible for the project(s).	X					
IV B. Quality Improvement Committee						
1. The PIHP has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The composition of the QI Committee reflects the membership required by the contract.		X				Global Quality Improvement Committee (GQIC) has three of the seven meetings throughout the last year without a Quorum. Meetings without quorums were March 8th, May 10, July 12, 2018. ***Corrective Action: Work to restructure, increase interest, recruit new members, or consolidate provider committees so that Sandhills can meet the quorum you set for GQIC.***
3. The QI Committee meets at regular intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV E. Provider Participation in Quality Improvement Activities						
1. The PIHP requires its providers to actively participate in QI activities.	X					The integrated care project is an example of active and engaged physician participation in QI projects
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					The *QM Program Evaluation* is a narrative document that analyzes the progress of the QM Department goals for fiscal year 2017-18. There is a section for Survey Results that lists the Perception of Care Survey and the Provider Survey. After discussion onsite, the Perception of Care Survey section should be labeled *ECHO Survey*. The FY 2017-18 QM Program Goals and Objective Findings section of the *QM Program Evaluation* did not have documentation in the barriers and recommendations fields. ***Recommendation: In the QM Program Evaluation, document barriers and recommendations with the 2017-18 QM program goals/objectives findings when appropriate. The fields for barriers and recommendations were blank in the document for all goals/objectives.***
2. The annual report of the QI program is submitted to the QI Committee and to the PIHP Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. The Utilization Management (UM) Program						
1. The PIHP formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					Sandhills has Policies and Procedures in place for the Utilization Management (UM) Program, (UM), Care Coordination, (CC) that are inclusive of the Transition to Living Initiative (TCLI) and Intellectual Developmental Disability (I/DD-CC) policies and procedures.
1.1 structure of the program;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					All UM decision were completed within the timeframes.
1.5 consideration of new technology;		X				There is no description of the process for requesting Non-Covered services in Sandhills' policies and procedures and no guidance offered to stakeholders on the Sandhills' website, in the Member Handbook, or in the Medicaid Provider Manual. *Corrective Actions: Describe the process for requesting a Non-Covered Service for consideration of "new technology" in Sandhills' procedures. Add information on how initiate this request to the Medicaid Provider Manual and the Member Handbook.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.6 the appeal process, including a mechanism for expedited appeal;	X					
1.7 the absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					
1.8 mechanisms to detect underutilization and overutilization of services.	X					While adequately described during the Onsite, the process for identifying and addressing overutilization and underutilization of services is not described in any policy or procedure. ***Recommendation: Include in policy and/or procedure the process that Sandhills uses to monitor Overutilization and Underutilization.***
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					
3. The UM program design is reevaluated annually, including Provider input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM Program is evaluated annually.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.		X				Sandhills began using the ESCII© Assessment Tool for children during 2017, but the required use of this tool is not noted in any policy or procedure.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Corrective Action: Implementation of the ESCII© assessment tool was initiated for children, ages three to six years. The use of this tool needs to be added to a policy or procedure as indicated in the DMA Contract, Section 7.4 and to verify that Sandhills has implemented the tool.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
4. Utilization management standards/criteria are consistently applied to all enrollees across all reviewers.	X					
5. Emergency and post stabilization care are provided in a manner consistent with contract and federal regulations.	X					*Procedure CC 19 a, Coordination of Care via Emergency and Post-Inpatient Care Follow-up*, provides information about what the Care Coordinator will do and the definition of emergency care and post - stabilization care was added to the procedure.
6. Utilization management standards/criteria are available for Providers.	X					
7. Utilization management decisions are made by appropriately trained reviewers	X					
8. Initial utilization decisions are made promptly after all necessary information is received	X					
9. Denials						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.1 A responsible effort that is not burdensome on the enrollee or the provider is made to obtain all pertinent information prior to making the decisions to deny services	X					
9.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
9.3 Denial decisions are promptly communicated to the provider and enrollee and include the basis for the denials of service and the procedure for appeal	X					Denials are completed promptly, and results are communicated.
V C. Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					The function of the Care Coordination Department and the Care Coordinators are described in the policy and procedures.
2. The case coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					
2.4 Develop treatment plans for enrollees that meet all requirements;	X					MH/SA Care Coordination policies and procedures have limited information about the oversight of the Person Centered planning process completed by Care Coordination regarding the oversight of the development process with MH/SA members. ***Recommendation: Include in the MH/SA Care Coordination policies and procedures the involvement by care coordinators in the development of the Person Centered Plan.***
2.5 Quality monitoring and continuous quality improvement;	X					
2.6 Determine of which Behavioral Health Services are medically necessary;	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					Sandhills has 2 hospital-based Care Coordinators/hospital MH/SA Specialists, who are remotely located. They are assigned specific hospitals and monitor transitions and services for members.
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					There is no suggested structure for MH/SA Care Coordination progress notes to guide staff in sufficiently documenting treatment planning and follow up activities. ***Recommendations: Select a progress MH/SA Care Coordination note structure, for example a SOAP (Subjective, objective, assessment and plan) or PIE (problem, intervention, evaluation)***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						format. This will ensure treatment planning follow up activities by staff are more adequately captured. Define the required note structure in policies and procedures.
2.10 Ensure privacy for each Enrollee is protected.	X					
3. The PIHP applies the Care Coordination policies and procedures as formulated.		X				Review of the Care Coordination files showed several files where notes were brief, incomplete, and not filed within the timeframes required by Sandhills' policies and procedures. ***Corrective Actions: Enhance the monitoring of MH/SA and I/DD Care Coordination notes to ensure notes are complete, reflect treatment planning and follow up activities, and are submitted timely, as required by Sandhills' policies and procedures.***
V. D Transition to Community Living Initiative						
1. Transition to Community Living functions are performed by appropriately licensed, or certified, and trained staff.	X					The qualifications for IN-Reach Specialist or Peer Support Specialists job description includes that the Transition Coordinators are certified Peer Support Specialist. Per *DMA Contract Section 15.1*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements includes all required elements.	X					Sandhills Policy and Procedure CC 32, 32a Monitoring of Transition Services and Stakeholder Follow-Along states, "Transitions are to occur within 90 days of the initial planning meeting file review many files closed if due to not follow up after 2 attempts." This is not in accordance with DMA Contract, Section 15.2 which requires "The continued need for Care Coordination after the 90-day timeframe shall be based on whether the individual meets special healthcare needs population criteria following the 90-day timeframe." ***Recommendation: Add to Procedure 32a, bullet six, language that includes "The continued need for Care Coordination after the 90-day timeframe shall be based on whether the individual meets special healthcare needs population criteria following the 90-day timeframe", per the DMA Contract 15.2.1.***
2.1 Care Coordination activities occur as required.	X					
2.2 Person Centered Plans are developed as required.	X					
2.3 Assertive Community Treatment, Peer Support Services, and Supported Employment services are included in the individual's transition, if applicable.	X					
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.5 QOL Surveys are administered timely.	X					Although a 100 % or the *QOL Pre-Transition Survey* was met, 3 of the files did not have an 11 or 24 month survey. Sandhills' does not monitor the implementation and completion 11 and 24 month QOL surveys. As a result, several of the TCLI files reviewed were lacking these surveys. ***Recommendation: Continue to monitor and ensure all members of the TCLI program complete QOL surveys that is inclusive of the three monitoring intervals; pre- transition, 11 and 24 month transition timeframes. When a member cannot be located or refuses to complete the QOL survey, enter a note into the members record regarding the barrier to completion of the survey.***
3. A diversion process is in place for individuals considering admissions into an Adult Care Home (ACH).	X					
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to DMA within the timeframes determined by DMA.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. The PIHP will develop a TCLI communication plan that includes materials and training about crisis hotline, services for enrollees with limited English proficiency and also to for external and internal stakeholders providing information on the TCLI initiative, resources, and system navigation tools, etc.		X				The TCLI initiative has been added to the Medicaid Provider Manual as recommended in the 2017 EQR. However, information has not been added to the Member Handbook as recommended in the 2017 EQR as indicated in the DMA Contract, Section 15. ***Corrective Action: Add information regarding the availability of the TCLI program to the Member Handbook ensure information on the website reflects the availability of "materials and training about the crisis hotline" and the "availability of information for enrollees with limited English proficiency." This information is required by DMA Contract, Section 15.11.***
6. A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures and processes, as required by NC DMA, and developed by the PIHP.	X					The findings of the file review did not always follow the TCLI Policies and Procedures: • Progress Notes did not have much detail and did not always indicate the plan. • There were many late entry note • There were gaps in service notes.

VI. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					
1.1 Definition of a grievance and who may file a grievance;	X					The terms "grievance" and "compliant" are used interchangeably through Sandhills' policies and procedures, grievance notifications, and staff documentation. This may be confusing to grievants. ***Recommendation:** Use one term throughout Sandhills' policies and procedures, notifications, and staff documentation to decrease any potential confusion by staff and stakeholders.*
1.2 The procedure for filing and handling a grievance;	X					Sandhills created two new electronic forms for grievances to be initiated. Neither of these forms nor the processes for completing them are captured in Sandhills' policies and procedures. ***Recommendation:** Add to Sandhills' policies and procedures the addition of new electronic forms and the processes related to completing and submitting these forms to grievance staff.*
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					There is no clear explanation within Sandhills' policies and procedures that captures the required grievance resolution notifications and their timeframes. ***Recommendation:** Add a statement to the beginning of Sandhills' grievance policy and/or procedure that clarifies when grievance resolution notifications are required to be sent.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					There is no reference to the new CCO consultation form that was developed and implemented in the past year. ***Recommendations: Describe within Sandhills policies and/or procedures, the process for implementation of the Chief Clinical Officer/Medical Director grievance consultation form.***
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Record retention is addressed in *Procedure HIM 4a Clinical and Business Records* and contains information regarding the retention or grievance records indicating "Sandhills shall maintain all Services Management Records in accordance with the terms specified by the Division of Medicaid Assistance for the purposes of audit and program management."
2. The PIHP applies the grievance policy and procedure as formulated.	X					The review of the grievance files indicated the following; The Decision letters did not indicate the steps taken for resolution until May 2018. From January on there was more information however the letters did not include all steps where indicated. The Partial Resolution Letters did not indicate in the letter what was partially resolved in the grievance investigation process.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to enrollee and/or provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;		X				Sandhills' policies and procedures are silent of regarding the requirement of signed consent by the enrollee when anyone other than the enrollee files an appeal. Sandhills' website, *Medicaid Provider Manual* and *Member Handbook* also do not provide clear information regarding who can file an appeal. File review showed that Sandhills routinely accepts appeals from providers without signed consent from the enrollee. The definition of an appeal across all policies and procedures is incorrect. ***Corrective Actions: Add to Sandhills' policies and procedures the requirement of signed consent by the enrollee when anyone other than the enrollee files an appeal. See DMA Contract, Attachment M, G.1.*** ***Correct the Sandhills' website, Medicaid Provider Manual and Member Handbook to reflect that signed consent by the enrollee, when anyone other than the enrollee files an appeal, is required.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Correct the definition of an appeal in Sandhills' policies and procedures to remove the word "administrative" from the definition. See DMA Contract, Attachment M, Section G.1.
1.2 The procedure for filing an appeal;		X				None of Sandhills' policies or procedures nor their *Member Handbook* indicate that the first level appeal process with Sandhills must be exhausted prior to an appellant requesting a second level appeal at the Office of Administrative Hearings. The requirement of completing Sandhills' first level review prior to requesting an appeal with OAH is not explained in the *Member Handbook*. None of Sandhills' policies or procedures accurately define the allowable timeframe for an appeal to be submitted. Within the Medicaid Provider Manual, the language is unclear regarding appeal information. There are two sections; an "Appeals" section and a "Reconsiderations" section. Information in these two sections differs significantly but appears to be explaining the first level, Medicaid appeals process. During the Onsite discussion, the difference between these two sections could not be provided. The *Medicaid Provider Manual* and website also incorrectly define the timeframe for an appellant to file an appeal. The *Medicaid Provider Manual* is written using the pronoun "you", implying that appeal rights belong to the provider and not the enrollee. ***Corrective Action: Add to Sandhills' policies or procedures that the timeframe for filing an appeal is within 60 days of the mailing date of the UM denial notification. See DMA Contract, Attachment M, Sections G.2 and E.5.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Either define the difference between the reconsideration and appeal process in the Medicaid Provider Manual, or combine into one section that accurately explains Sandhills' first level, Medicaid appeal process. *Recommendations: Correct the pronouns in the appeals section of the Medicaid Provider Manual to accurately reflect that appeal rights belong to the enrollee and not the provider.* *Add information to Sandhills' policies and procedures and the Member Handbook to indicate that the first level appeal process with Sandhills must be exhausted prior to an appellant requesting a second level appeal at the Office of Administrative Hearings.* *Correct the Medicaid Provider Manual and website to define the timeframe for an appellant to file an appeal is within 60 days of the mailing date of the UM denial notification.* *Clarify in the Member Handbook and the Medicaid Provider Manual the timeframes by which an appellant can expect an acknowledgement letter and resolution notification from Sandhills when processing standard and expedited appeals. Include the required timeframes of these notifications.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					When additional information was submitted by appellants for appeal consideration, staff labelled this as simply "additional documentation" and did not specify what was received or reviewed by the appeal reviewers. *Recommendation: As a part of the appeal file monitoring, ensure staff specify the additional appeal information submitted by appellants in the records sent to the appeal peer reviewer and the resolution notification.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;		X				None of Sandhills' policies or procedures clearly indicate that notification of the resolution of an expedited appeal will occur within 72 hours of the receipt of the appeal. The *Medicaid Provider Manual* is also unclear that an expedited appeal can be requested by an appellant and that the resolution notification will occur within 72 hours. The *Member Handbook* is also devoid of information about the right of an appellant to request an expedited appeal and Sandhills' required notifications related to expedited appeal resolutions. No Sandhills' policies and procedures contain the criteria by which expedited appeals should be reviewed. During the Onsite, it was clarified that Sandhills does not deny requests for expedited appeals but this is not reflected in Sandhills' policies and procedures. *Corrective Actions: Correct Sandhills' policies or procedures to clearly indicate that notification of the resolution of an expedited appeal will occur within 72 hours of the receipt of the appeal. See DMA Contract, Attachment M, Section H.5.* *Add the correct criteria for expedited appeals to Sandhills' policies and procedures, to include "that taking the time for a standard resolution could seriously jeopardize an Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function." See DMA Contract, Attachment M, Section H.1.* *Clarify in Sandhills' policies and procedures whether requests for expedited appeals are denied.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendations: Add information to the Member Handbook regarding the enrollee's right to request an expedited appeal.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				During the Onsite, it was clarified that Sandhills does not extend standard or expedited appeal timeframes. However, Sandhills' policies and procedures do not reflect this. The appeal process is unclear in the *Medicaid Provider Manual* as it has both a "Reconsideration" section and "Appeals" section with overlapping information and no explanation about the difference between the two. The *Medicaid Provider Manual* does not explain that the right of an appellant to file a grievance if Sandhills extends the appeal timeframe. ***Corrective Actions:*** ***Correct the Medicaid Provider Manual to explain that an appellant has the right to file a grievance if Sandhills extends the appeal timeframe. See DMA Contract, Attachment M, Section G.6.*** ***Clarify in Sandhills' policies and procedures whether appeal timeframes are extended by Sandhills.***
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The PIHP applies the appeal policies and procedures as formulated.		X				Three appeal files showed appeals were submitted by providers without signed permission from the enrollee or guardian. This practice does not protect the enrollee's appeal rights.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The Expedited Appeal checklist lacks sufficient details to understand the notification steps appeal staff took. The appeal files lacked adequate detail to capture steps taken by appeal staff, especially when providing assistance in the submission of additional appeal information When additional information was submitted by appellants for appeal consideration, staff labelled this as simply "additional documentation" and did not specify what was received or reviewed by the appeal reviewers. ***Corrective Action: Once the policies and procedures are accurately updated, train staff on the requirement that the enrollee's signed consent is required when anyone other than the enrollee or their legal guardian request an appeal. DMA Contract, Attachment M, Section G.1.*** ***Recommendations: Add details to the Expedited appeal checklist that captures steps taken by staff around oral and written notifications of the resolution of an expedited appeal. Specifically, to whom oral notifications are made.*** ***Increase the monitoring of appeal communication logs to ensure that all interactions with appellants, either written or oral, are captured within the appeal file. Add this monitoring process to a policy or procedure.***
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					While appeal data is reported to the UM Committee on a monthly basis, only numbers are reported. ***Recommendation: Ensure that appeals data is not only reported in the UM committee, but analyzed for trends. Include this analysis by the committee in the UM Plan.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					*Procedure 33a, 1.m* indicates Sandhills faxes the appeal record to their peer review delegate. ***Recommendation: Correct Procedure 33a, by removing the statement that Sandhills faxes the appeal record to their peer review delegate.***

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. Delegation						
1. The PIHP has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.		X				Sandhills has a signed and dated *Scope of Work* statement but does not have a delegation agreement and BAA with Dr. Marks. See requirements in *DMA Contract, Section 11*. ***Corrective Action: Execute with Dr. Marks a delegation agreement/contract that meets the requirements of DMA Contract Section 11, Subcontracts.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the PIHP if the PIHP were directly performing the delegated functions.	X					Sandhills presented to the Quality Management Committee (QMC) quarterly and annual assessments for the four currently-delegated entities. The Pre-Delegation Checklists for Credentialing functions do not include the query of the *State Exclusion* List. There is no evidence the *State Exclusion List* is being checked by the delegates. ***Recommendation: Add the query of the State Exclusion List to the Pre-Delegation Checklists and to monitoring tools for the annual assessment of entities to whom credentialing has been delegated, to ensure the required queries are being conducted. See DMA Contract, Section 1.14.4 and Section 7.6.4.***

VIII. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII A. General Requirements						
1. PIHP shall be familiar and comply with Section 1902(a)(68) of the Social Security Act, 42 C.F.R. Parts 438,455 and 1000 through 1008, as applicable, including proper payments to Providers and methods for detection of fraud and abuse.	X					This requirement is addressed on pages 3 and 4 of the *Corporate Compliance and Internal Audit Plan* and the *Fraud, Waste and Abuse Monitoring Policy (ADM 11) and Procedure (ADM 11a)*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents' and subcontractors,' compliance with the requirements of this Section 14.	X					This requirement is addressed on page 3 of the *Corporate Compliance and Internal Audit Plan*, which addresses the requirement that the PIHP have policies, procedures, and standards of conduct that comply with Federal and State requirements.
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					This requirement is addressed on pages 162 – 165 of the *Medicaid Provider Manual*. This requirement is also addressed on pages 6, 9, and 10-12 in the procurement contract for provision of services template.
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					This requirement is addressed in the *Investigative Process Policy and Procedure* and is illustrated by the PI Workflow.
VIII B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with 42 C.F.R. 438.608 that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the DMA Contract Administrator on an annual basis.	X					This requirement is addressed on page 5 of the *Corporate Compliance and Internal Audit Plan* for FY 2017-2018.

IX. FINANCIAL SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IX. Financial						
1. The PIHP has policies and systems in-place for submitting and reporting financial data.	X					Sandhills policies are reviewed annually in February of each year. Sandhills provided a list of policies that were updated with their Desk Materials, along with dates. All DMA reports are submitted on time. ***Recommendation: Enhance policies and procedures by adding details about who is responsible for duties and citing contract requirements.*** ***Add a five-day due date to Risk Reserve Payment Procedure 31b.*** ***Add language to Procedure 32a for the ten-year retention required by DMA Contract, Section 8.3.2***
2. The PIHP has and adheres to a cost allocation plan that meets the requirements of 42 CFR 433.34.	X					*Procedure 58a* outlines their policy for Administrative Cost Allocation. Sandhills calculates the total revenue by funding source first (state, federal, local/county, and Medicaid), then groups the revenue into two categories: Medicaid and non-Medicaid. The service expense is determined by applying the administrative percentages to the revenue. This percentage is applied to the general and administrative expenses. The calculation spreadsheet is prepared annually and is reviewed quarterly. It is an 80%/20% service/administrative approximate split. The Finance Manager reviews all allocations.
3. PIHP maintains detailed records of the administrative costs and expenses incurred as required by the DMA contract. (DMA Contract, Section 8.3).	X					Allocations are applied in financial reports such as the monthly *DMA Financial Guide*, but not booked in the general ledger. The administrative costs are easily identified by core code in Sandhills' chart of accounts.
4. Maintains an accounting system in accordance with 42 CFR 433.32 (a).	X					Sandhills uses Great Plains accounting system, version 2018 and AlphaMCS version 2.0.7.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. The PIHP follows a record retention policy of retaining records for ten years.	X					Sandhills keeps 2-3 years of financial records Onsite, and offsite for at least 8 years.
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution.	X					First Bank is the institution used for the reserve account and it is federally guaranteed. The Accounting Manager and Finance Director monitor the risk reserve.
7. The required minimum balance of the Risk Reserve Account meets the requirements of the DMA contract. (DMA Contract, Section 1.8 Restricted Risk Reserve Account)	X					Sandhills meets the risk reserve requirements. It is depositing 2% per month, and is at 11.1% as of this report. *Procedure 31b* outlines their procedure for processing the Restricted Reserve payment. At the Onsite interview, Sandhills described this process. All risk reserve deposits are within five business days. Sandhills had no unauthorized withdrawals.
8. All funds received by PIHP are accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as required by the DMA contract (DMA Contract, Section 1.9).	X					The capitation notification is received and the Accounting Manager computes a breakdown of this payment. The funds are received into the Medicaid services account and a check is cut for the risk reserve within five business days. These funds are segregated into separate bank accounts.
9. The Medical Loss Ratio (MLR) meets the requirements of 42 CFR 438.8 and the DMA contract (Amendment 2, Section 12.3 Item k).	X					The Medical Loss Ratio (MLR)meets or exceeds the 85% requirement. Sandhills MLR typically runs over 90%, and the most current reported percentage is 92.5% year to date.

E. Attachment 5: Encounter Data Validation Report

Sandhills

Encounter Data Validation Report

performed on behalf of

North Carolina
Department of Health and Human Services,
Division of Health Benefits

September 19, 2018

Prepared By:

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

Table of Contents

Background 3
Overview 3
Review of Sandhills' ISCA response 3
Analysis of Encounters 4
Encounter Accuracy and Completeness 9
Encounter Acceptance Report 10
Results and Recommendations 12
Conclusion 13
Appendix 1 14

This page intentionally left blank.

Background

Health Management Systems (HMS) has completed a review of the encounter data submitted by Sandhills to the North Carolina Department of Health and Human Services, Division of Medical Assistance (DMA), as specified in The Carolinas Center for Medical Excellence (CCME) agreement with DMA. CCME contracted with HMS to perform encounter data validation for each PIHP. North Carolina Senate Bill 371 requires that each PIHP submit encounter data "for payments made to providers for Medicaid and State-funded mental health, intellectual and developmental disabilities, and substance abuse disorder services. DHHS may use encounter data for purposes including, but not limited to, setting PIHP capitation rates, measuring the quality of services managed by PIHPs, assuring compliance with State and federal regulations, and for oversight and audit functions."

In order to utilize the encounter data as intended and provide proper oversight, DMA must be able to deem the data complete and accurate.

Overview

The scope of our review, guided by the CMS Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid by Sandhills for the period of January 2017 through December 2017. All claims paid by Sandhills should be submitted and accepted as a valid encounter to DMA. Our approach to the review included:

- A review of Sandhills' response to the Information Systems Capability Assessment (ISCA)
- Analysis of Sandhills' converted 837 encounter files
- A review of DMA's encounter data acceptance report

Review of Sandhills' ISCA response

The review of Sandhills' ISCA response was focused on section V. Encounter Data Submission. DMA requires each PIHP to submit their encounter data for all paid claims on a weekly basis via 837 institutional and professional transactions. The companion guides follow the standard ASC X12 transaction set with a few modifications to some segments. For example, the PIHP must submit their provider number and paid amount to DMA in the Contract Information CN104 and CN102 segment of Claim Information Loop 2300.

The 837 files are transmitted securely to CSRA and parsed using an EDI validator to check for errors and produce a 999 response to confirm receipt and any compliance errors. The behavioral health encounter claims are then validated by applying a list of edits provided by the state (See Appendix 1) and adjudicated accordingly by MMIS. Utilizing existing Medicaid pricing methodology, using the Billing or Rendering Provider accordingly, the appropriate Medicaid allowed amount is calculated for each encounter claim in order to shadow price what was paid by the PIHP.

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

Looking at claims with dates of service in 2017, Sandhills submitted 1,169,756 unique encounters to the State. To date, 3% of all 2017 encounters submitted have not been corrected and accepted by DMA. This is a big improvement compared to last year's review for which Sandhills had a denial rate of 12% for 2016 encounters submitted.

2017	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	31,204	28,989	2,048	167	1%
Professional	1,138,552	1,002,336	95,689	40,527	4%
Total	1,169,756	1,031,325	97,737	40,694	3%

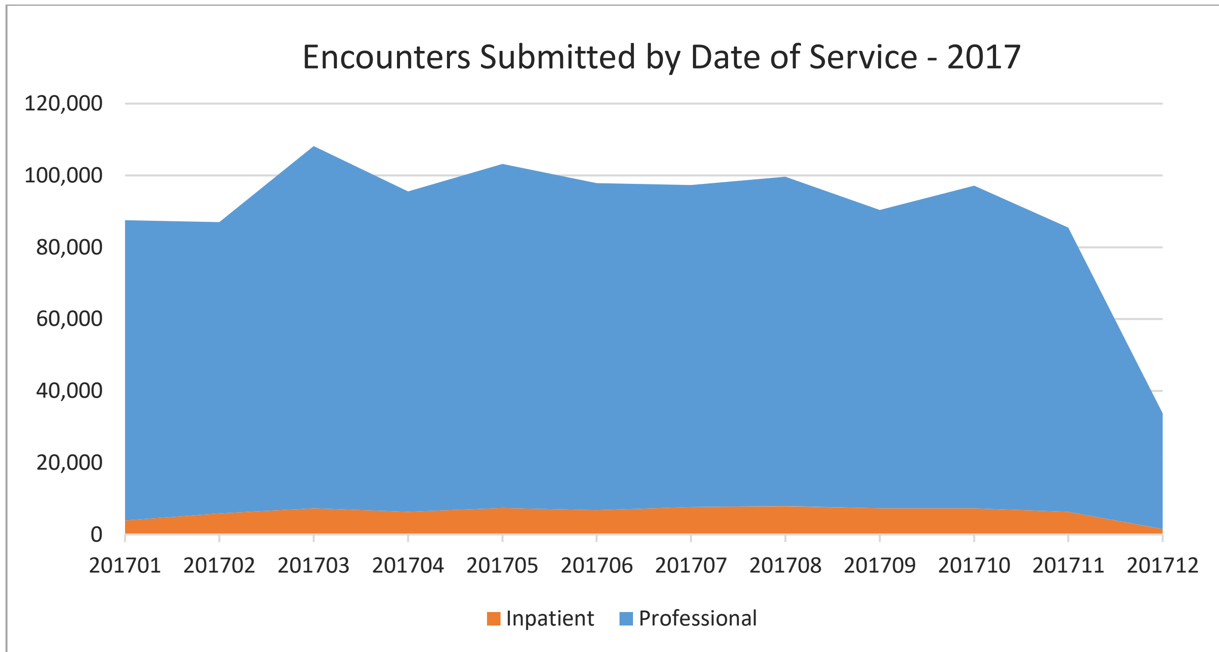
According to Sandhills' response and review of DMA's acceptance report, 48% of all outstanding and ongoing denials are related to invalid taxonomy codes for the Billing and Rendering Provider. Compared to other plans reviewed in 2017, Sandhills is doing a great job reconciling and mitigating denials. Sandhills' strategy for correcting encounter denials includes the following steps:

- Provider upload files (PUFs) to update essential provider taxonomy and address information
- Provider education guidelines
- Internal database and reporting tools
- Rebilling corrected encounter denials

Each plan leveraging AlphaMCS are taking advantage of resources and experts to work denials following the same process. AlphaMCS and the PIHPs they support should share their success and process with the other PIHPs that are struggling with higher denial volumes.

Analysis of Encounters

The analysis of encounter data evaluated whether Sandhills submitted complete, accurate, and valid data to DMA for all claims paid between January 1, 2017 through December 31, 2017. Sandhills worked with their EDI vendor to convert each 837I and 837P file submitted to DMA during the requested audit period to an excel spreadsheet and sent to HMS via SFTP. This included more than 1 million professional claims and 87,298 institutional claims. Some may have been resubmissions for denials or adjustments, however, there was not an easy way to identify a subsequent adjustment looking at the data elements provided.



In order to evaluate the data, HMS ingested and combined all 346 batch encounter files, and loaded them to a consolidated database. After data onboarding was completed, HMS applied proprietary, internally designed data analysis tools to review each data element, focusing on the data elements defined as required. These tools evaluate the presence of data in each field within a record as well as whether the value for the field is within accepted standards. Results of these checks were compared with general expectations for each data field and to the CMS standards adopted for encounter data. The table below depicts the specific data expectations and validity criteria applied. Professional and institutional files included older dates of service that were resubmitted to DMA during 2017.

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

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

Data Quality Standards for Evaluation of Submitted Encounter Data Fields Adapted and Revised from CMS Encounter Validation Protocol		
Data Element	***Expectation***	***Validity Criteria***
		fields have not been truncated. Also, a high percentage of names should have at least a middle initial.
Recipient Date of Birth	Should not be missing and should be a valid date.	< 2% missing or invalid
MCO/PIHP ID	Critical Data Element	100% valid
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	95% valid
Attending Provider ID	Should be an enrolled provider listed in the provider enrollment file (will accept the MD license number if it is listed in the provider enrollment file).	> 85% match with provider file using either provider ID or MD license number
Provider Location	Minimal requirement is county code, but zip code is strongly advised.	> 95% with valid county code > 95% with valid zip code (if available)
Place of Service	Should be routinely coded, especially for physicians.	> 95% valid for physicians > 80% valid across all providers
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% nonmissing and valid on physician or other applicable provider type claims (e.g., other practitioners)

Data Quality Standards for Evaluation of Submitted Encounter Data Fields Adapted and Revised from CMS Encounter Validation Protocol		
Data Element	***Expectation***	***Validity Criteria***
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid codes (using International Statistical Classifications of Diseases, Ninth Revision, Clinical Modification [ICD-9-CM] lookup tables) for practitioner providers (not including transportation, lab, and other ancillary providers)
Other Diagnosis	This is not expected to be coded on all claims even with applicable provider types, but should be coded with a fairly high frequency.	90% valid when present
Dates of Service	Dates should be evenly distributed across time.	If looking at a full year of data, 5%–7% of the records should be distributed across each month.
Unit of Service (Quantity)	The number should be routinely coded.	98% nonzero <70% should have one if Current Procedural Terminology (CPT) code is in 99200–99215 or 99241–99291 range.
Procedure Code	Critical Data Element	99% present (not zero, blank, or 8- or 9-filled). 100% should be valid, State-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Procedure Code Modifier	Important to separate out surgical procedures/ anesthesia/assistant surgeon, not applicable for all procedure codes.	> 20% non-missing. Expect a variety of modifiers both numeric (CPT) and AlphaMCS (Healthcare Common Procedure Coding System [HCPCS]).
Patient Discharge Status Code (Hospital)	Should be valid codes for inpatient claims, with the most common code being "Discharged to Home." For outpatient claims, the code can be "not applicable."	For inpatient claims, expect >90% "Discharged to Home." Expect 1%–5% for all other values (except "not applicable" or "unknown").
Revenue Code	If the facility uses a UB04 claim form, this should always be present	100% valid

Encounter Accuracy and Completeness

The table below outlines the key fields that were reviewed to determine if information was present, whether the information was the correct type and size, and whether or not the data populated was valid. Although we looked at the complete data set and validated all data values, the fields below are key to properly shadow pricing for the services paid by Sandhills.

Table: Evaluation of Key Fields

Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%
Recipient Name	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%
Recipient Date of Birth	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%
MCO/PIHP ID	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%
Provider ID	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%
Attending/Renderring Provider ID	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%
Provider Location	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%
Place of Service	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%
Specialty Code / Taxonomy - Billing	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%
Specialty Code / Taxonomy - Rendering / Attending	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%
Principal Diagnosis	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%
Other Diagnosis	1,120,675	95.84%	77,989	6.67%	77,989	6.67%	77,989	6.67%
Dates of Service	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%
Unit of Service (Quantity)	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%	1,169,340	100.00%
Procedure Code	1,130,056	96.64%	1,130,056	96.64%	1,130,056	96.64%	1,130,056	96.64%
Procedure Code Modifier	152,477	13.04%	152,477	13.04%	152,477	13.04%	152,477	13.04%
Patient Discharge Status Code Inpatient	15,635	17.91%	15,635	17.91%	15,635	17.91%	15,635	17.91%
Revenue Code	87,298	100.00%	87,298	100.00%	87,298	100.00%	87,298	100.00%

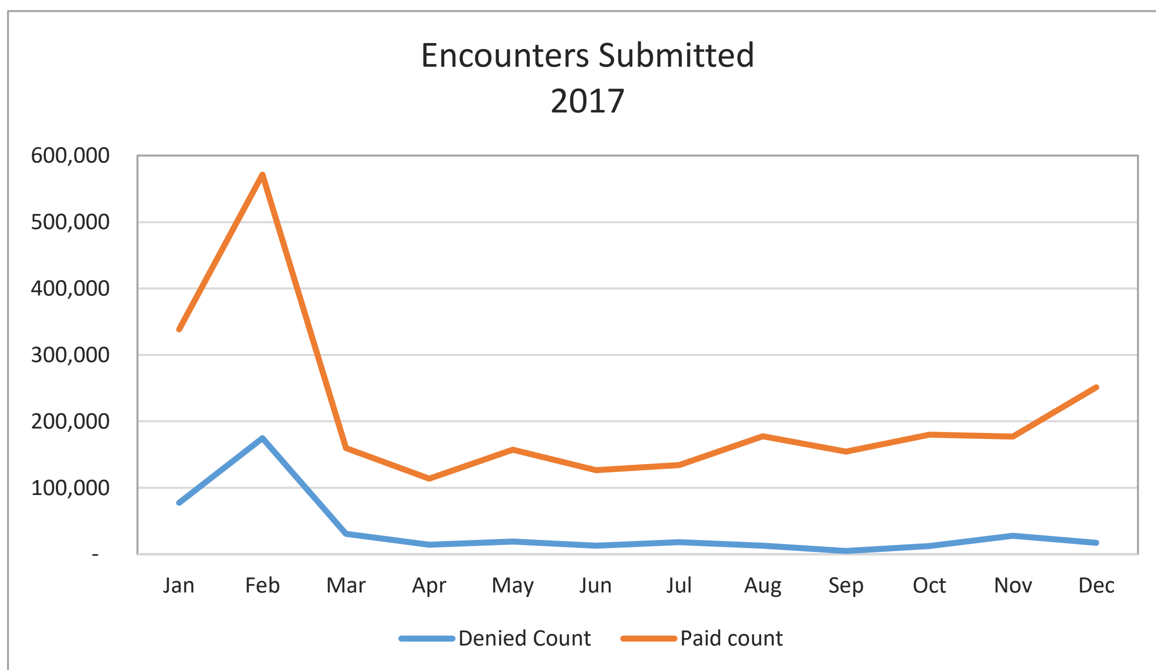
Overall, there were very few inconsistencies in the data other than the denial issues highlighted in Sandhills' ISCA response and DMA's encounter acceptance report. Institutional claims contained complete and valid data in 17 of the 18 key fields (94%) with noted issues to Other Diagnosis Codes. Only admitting and principal diagnosis codes were populated for institutional claims. There are very few outstanding institutional denials, and those that are denied are being reconciled following the process that Sandhills and AlphaMCS have put in place to resolve. The majority being the taxonomy variance between NCTracks and Sandhills' system.

Professional encounter claims submitted contained complete and valid data in 14 of the 15 key Professional fields (93%). The primary issue is the same as intuitional -- missing Other Diagnosis. The principal diagnosis code was populated 100% of the time, however, there was very little consistency in

additional diagnosis codes being present. Other Diagnosis codes should be populated more than 6% of the time. Sandhills should also be capturing and submitting more than the primary and secondary diagnosis codes.

Encounter Acceptance Report

In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by DMA. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write which made it difficult to tie back to the ISCA response and converted encounter files since only the Date of Service for each is available. During the 2016 weekly check write schedule, Sandhills submitted a total of 897,879 encounters to DMA. On average, 26% of all encounters submitted were denied.

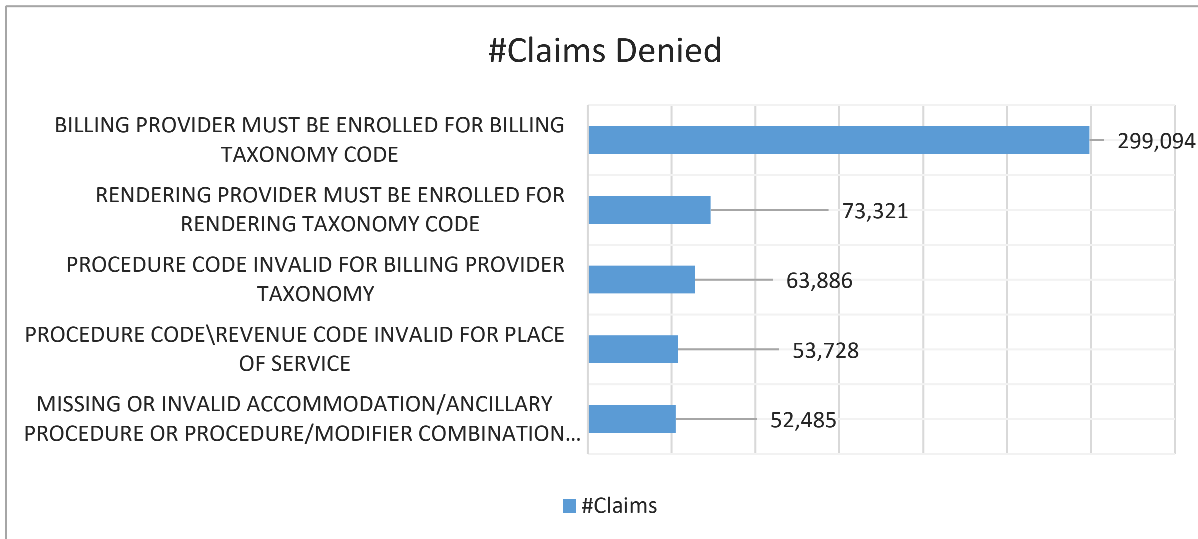


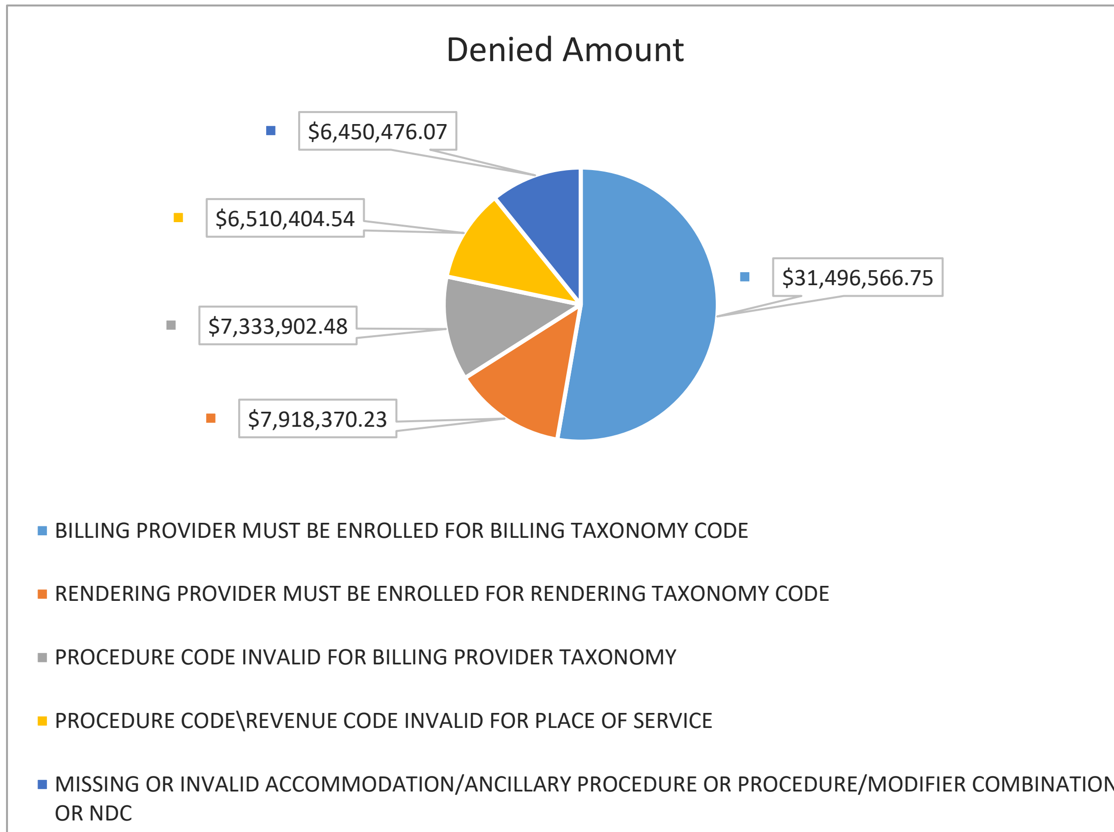
Evaluation of the top denials for Sandhills' encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis above. The top denials also align with the same denial reasons from the 2016 dates of services reviewed in last year's report. Encounters were denied primarily for:

- Billing provider must be enrolled for Billing Taxonomy code
- Rendering provider must be enrolled for Rendering Taxonomy code
- Procedure Code invalid for Billing Provider Taxonomy

- Procedure Code/Revenue Code invalid for Place of Service
- Missing or invalid accommodation/ancillary procedure or procedure/modifier combination

The charts below reflect the top 5 denials by paid amount.





Claim Edit Description	#Claims	Denied Amount
BILLING PROVIDER MUST BE ENROLLED FOR BILLING TAXONOMY CODE	195,921	$45,571,652.14
RENDERING PROVIDER MUST BE ENROLLED FOR RENDERING TAXONOMY CODE	38,800	$3,571,713.08
MCE - INVALID PATIENT STATUS	599	$2,922,142.57
TAXONOMY CODE FOR ATTENDING OR RENDERING PROVIDER MISSING	15,732	$1,431,975.33
DIAGNOSIS NON-SPECIFIC	1,570	$731,001.88

Results and Recommendations

Issue: Taxonomy code for Billing and Rendering providers

Taxonomy values were consistently populated; however, this is the primary denial for all Sandhills' encounters submitted. This information is key for passing the front end edits put in place by the State and to effectively price the claim. NCTracks is expecting the correct combination of NPI, taxonomy and

procedure code. The taxonomy code did not always match up with the taxonomy values enrolled in NCTracks for the Billing and/or Rendering Provider. These errors result in denials by the DMA that must be corrected and resubmitted.

Resolution:

Continue to follow the process built by Sandhills and AlphaMCS. As time passes and providers are educated, the initial denials due to invalid taxonomy codes should naturally go down. Denials have already dropped dramatically overall and specifically for invalid taxonomy codes. In the 2017 review, invalid taxonomies made up 70% of all denials, and now only account for 48% of denials.

Issue: Other Diagnosis

Other Diagnosis was only populated 6% of the time for institutional and professional claims. Principal and admitting diagnoses were populated consistently where appropriate, however, no more than one additional diagnosis was received for any claim. Sandhills should be capturing up to the maximum allowed.

Resolution:

Sandhills should expand the number of diagnosis codes being captured in their system. This update will also require Sandhills to modify their 837 mapping to ensure all diagnosis codes captured are sent to DMA moving forward.

Conclusion

Based on the analysis of Sandhills' encounter data, we have concluded that the data submitted to DMA is complete and accurate. However, minor issues were noted with both institutional and professional encounters due to missing additional diagnosis codes.

Sandhills should take corrective action to resolve the issues identified specifically with Billing Taxonomy, Rendering Taxonomy, and missing diagnosis codes. As indicated in Sandhills' ISCA response, they have already defined a strategy to address issues with invalid or missing taxonomy codes, as well as a reconciliation process to address all DMA denials noted in the report above. The issue with missing diagnosis codes does not impact the ability to price the claims; however, it will have an impact to DMA's ability to provide proper oversight and measure effectiveness. Sandhills should work with AlphaMCS to capture all diagnosis codes as transmit to DMA as soon as possible.

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

Appendix 1

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

00101	LN TDOS BEFORE FDOS	IGNORE
00105	INVLD TOOTH SURF ON RSTR PROC	IGNORE
00106	UNABLE TO DETERMINE MEDICARE	PAY AND REPORT
00117	ONLY ONE DOS ALLOWED/LINE	PAY AND REPORT
00126	TOOTH SURFACE MISSING/INVALID	IGNORE
00127	QUAD CODE MISSING/INVALID	IGNORE
00128	PROC CDE DOESNT MATCH TOOTH #	IGNORE
00132	HCPCS CODE REQ FOR REV CODE	IGNORE
00133	HCPCS CODE REQ BILLING RC 0636	IGNORE
00135	INVL POS INDEP MENT HLTH PROV	PAY AND REPORT
00136	INVLD POS FOR IDTF PROV	PAY AND REPORT
00140	BILL TYPE/ADMIT DATE/FDOS	DENY
00141	MEDICAID DAYS CONFLICT	IGNORE
00142	UNITS NOT EQUAL TO DOS	PAY AND REPORT
00143	REVIEW FOR MEDICAL NECESSITY	IGNORE
00144	FDOS AND TDOS MUST BE THE SAME	IGNORE
00146	PROC INVLD - BILL PROV TAXON	PAY AND REPORT
00148	PROC\REV CODE INVLD FOR POS	PAY AND REPORT
00149	PROC\REV CD INVLD FOR AGE	IGNORE
00150	PROC CODE INVLD FOR RECIP SEX	IGNORE
00151	PROC CD/RATE INVALID FOR DOS	PAY AND REPORT
00152	M/I ACC/ANC PROC CD	PAY AND REPORT
00153	PROC INVLD FOR DIAG	PAY AND REPORT

00154	REIMB RATE NOT ON FILE	PAY AND REPORT
00157	VIS FLD EXAM REQ MED JUST	IGNORE
00158	CPT LAB CODE REQ FOR REV CD	IGNORE
00164	IMMUNIZATION REVIEW	IGNORE
00166	INVALID VISUAL PROC CODE	IGNORE
00174	VACCINE FOR AGE 00-18	IGNORE
00175	CPT CODE REQUIRED FOR RC 0391	IGNORE
00176	MULT LINES SAME PROC, SAME TCN	IGNORE
00177	HCPCS CODE REQ W/ RC 0250	IGNORE
00179	MULT LINES SAME PROC, SAME TCN	IGNORE
00180	INVALID DIAGNOSIS FOR LAB CODE	IGNORE
00184	REV CODE NOT ALLOW OUTPAT CLM	IGNORE
00190	DIAGNOSIS NOT VALID	DENY
00192	DIAG INVALID RECIP AGE	IGNORE
00194	DIAG INVLD FOR RECIP SEX	IGNORE
00202	HEALTH CHECK SHADOW BILLING	IGNORE
00205	SPECIAL ANESTHESIA SERVICE	IGNORE
00217	ADMISSION TYPE CODE INVALID	PAY AND REPORT
00250	RECIP NOT ON ELIG DATABASE	DENY
00252	RECIPIENT NAME/NUMBER MISMATCH	PAY AND REPORT
00253	RECIP DECEASED BEFORE HDR TDOS	DENY
00254	PART ELIG FOR HEADER DOS	PAY AND REPORT
00259	TPL SUSPECT	PAY AND REPORT

00260	M/I RECIPIENT ID NUMBER	DENY
00261	RECIP DECEASED BEFORE TDOS	DENY
00262	RECIP NOT ELIG ON DOS	DENY
00263	PART ELIG FOR LINE DOS	PAY AND REPORT
00267	DOS PRIOR TO RECIP BIRTH	DENY
00295	ENC PRV NOT ENRL TAX	IGNORE
00296	ENC PRV INV FOR DOS	IGNORE
00297	ENC PRV NOT ON FILE	IGNORE
00298	RECIP NOT ENRL W/ THIS ENC PRV	IGNORE
00299	ENCOUNTER HMO ENROLLMENT CHECK	PAY AND REPORT
00300	BILL PROV INVALID/ NOT ON FILE	DENY
00301	ATTEND PROV M/I	PAY AND REPORT
00308	BILLING PROV INVALID FOR DOS	DENY
00313	M/I TYPE BILL	PAY AND REPORT
00320	VENT CARE NO PAY TO PRV TAXON	IGNORE
00322	REND PROV NUM CHECK	IGNORE
00326	REND PROV NUM CHECK	PAY AND REPORT
00328	PEND PER DMA REQ FOR FIN REV	IGNORE
00334	ENCOUNTER TAXON M/I	PAY AND REPORT
00335	ENCOUNTER PROV NUM MISSING	DENY
00337	ENC PROC CODE NOT ON FILE	PAY AND REPORT
00339	PRCNG REC NOT FND FOR ENC CLM	PAY AND REPORT
00349	SERV DENIED FOR BEHAV HLTH LM	IGNORE

00353	NO FEE ON FILE	PAY AND REPORT
00355	MANUAL PRICING REQUIRED	PAY AND REPORT
00358	FACTOR CD IND PROC NON-CVRD	PAY AND REPORT
00359	PROV CHRGS ON PER DIEM	PAY AND REPORT
00361	NO CHARGES BILLED	DENY
00365	DRG - DIAG CANT BE PRIN DIAG	DENY
00366	DRG - DOES NOT MEET MCE CRIT.	PAY AND REPORT
00370	DRG - ILLOGICAL PRIN DIAG	PAY AND REPORT
00371	DRG - INVLD ICD-9-CM PRIN DIAG	DENY
00374	DRG PAY ON FIRST ACCOM LINE	DENY
00375	DRG CODE NOT ON PRICING FILE	PAY AND REPORT
00378	DRG RCC CODE NOT ON FILE DOS	PAY AND REPORT
00439	PROC\REV CD INVLD FOR AGE	IGNORE
00441	PROC INVLD FOR DIAG	IGNORE
00442	PROC INVLD FOR DIAG	IGNORE
00613	PRIM DIAG MISSING	DENY
00628	BILLING PROV ID REQUIRED	IGNORE
00686	ADJ/VOID REPLC TCN INVALID	DENY
00689	UNDEFINED CLAIM TYPE	IGNORE
00701	MISSING BILL PROV TAXON CODE	DENY
00800	PROC CODE/TAXON REQ PSYCH DX	PAY AND REPORT
00810	PRICING DTE INVALID	IGNORE
00811	PRICING CODE MOD REC M/I	IGNORE

00812	PRICING FACTOR CODE SEG M/I	IGNORE
00813	PRICING MOD PROC CODE DTE M/I	IGNORE
00814	SEC FACT CDE X & % SEG DTE M/I	IGNORE
00815	SEC FCT CDE Y PSTOP SEG DT M/I	IGNORE
01005	ANTHES PROC REQ ANTHES MODS	IGNORE
01060	ADMISSION HOUR INVALID	IGNORE
01061	ONLY ONE DOS PER CLAIM	IGNORE
01102	PRV TAXON CHCK - RAD PROF SRV	IGNORE
01200	INPAT CLM BILL ACCOM REV CDE	DENY
01201	MCE - ADMIT DTE = DISCH DTE	DENY
01202	M/I ADMIT AND DISCH HRS	DENY
01205	MCE: PAT STAT INVLD FOR TOB	DENY
01207	MCE - INVALID AGE	PAY AND REPORT
01208	MCE - INVALID SEX	PAY AND REPORT
01209	MCE - INVALID PATIENT STATUS	DENY
01705	PA REQD FOR CAPCH/DA/CO RECIP	PAY AND REPORT
01792	DME SUPPLIES INCLD IN PR DIEM	DENY
02101	INVALID MODIFIER COMB	IGNORE
02102	INVALID MODIFIERS	PAY AND REPORT
02104	TAXON NOT ALLOWED WITH MOD	PAY AND REPORT
02105	POST-OP DATES M/I WITH MOD 55	IGNORE
02106	LN W/ MOD 55 MST BE SAME DOS	IGNORE
02107	XOVER CLAIM FOR CAP PROVIDER	IGNORE

02111	MODIFIER CC INTERNAL USE ONLY	IGNORE
02143	CIRCUMCISION REQ MED RECS	IGNORE
03001	REV/HCPCS CD M/I COMBO	IGNORE
03010	M/I MOD FOR PROF XOVER	IGNORE
03012	HOME HLTH RECIP NOT ELG MCARE	IGNORE
03100	CARDIO CODE REQ LC LD LM RC RI	IGNORE
03101	MODIFIER Q7, Q8 OR Q9 REQ	IGNORE
03200	MCE - INVALID ICD-9 CM PROC	DENY
03201	MCE INVLD FOR SEX PRIN PROC	PAY AND REPORT
03224	MCE-PROC INCONSISTENT WITH LOS	PAY AND REPORT
03405	HIST CLM CANNOT BE ADJ/VOIDED	DENY
03406	HIST REC NOT FND FOR ADJ/VOID	DENY
03407	ADJ/VOID - PRV NOT ON HIST REC	DENY
04200	MCE - ADMITTING DIAG MISSING	DENY
04201	MCE - PRIN DIAG CODE MISSING	DENY
04202	MCE DIAG CD - ADMIT DIAG	DENY
04203	MCE DIAG CODE INVLD RECIP SEX	PAY AND REPORT
04206	MCE MANIFEST CODE AS PRIN DIAG	DENY
04207	MCE E-CODE AS PRIN DIAG	DENY
04208	MCE - UNACCEPTABLE PRIN DIAG	DENY
04209	MCE - PRIN DIAG REQ SEC DIAG	PAY AND REPORT
04210	MCE - DUPE OF PRIN DIAG	DENY
04506	PROC INVLD FOR DIAG	IGNORE

04507	PROC INVLD FOR DIAG	IGNORE
04508	PROC INVLD FOR DIAG	IGNORE
04509	PROC INVLD FOR DIAG	IGNORE
04510	PROC INVLD FOR DIAG	IGNORE
04511	PROC INVLD FOR DIAG	IGNORE
07001	TAXON FOR ATTND/REND PROV M/I	DENY
07011	INVLD BILLING PROV TAXON CODE	DENY
07012	INVLD REND PROV TAXONOMY CODE	DENY
07013	INVLD ATTEND PROV TAXON CODE	PAY AND REPORT
07100	ANESTH MUST BILL BY APPR PROV	IGNORE
07101	ASC MODIFIER REQUIREMENTS	IGNORE
13320	DUP-SAME PROV/AMT/DOS/PX	DENY
13420	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
13460	POSSIBLE DUP-SAME PROV/PX/DOS	PAY AND REPORT
13470	LESS SEV DUPLICATE OUTPATIENT	PAY AND REPORT
13480	POSSIBLE DUP SAME PROV/OVRLAP	PAY AND REPORT
13490	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13500	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13510	POSSIBLE DUP/SME PRV/OVRLP DOS	PAY AND REPORT
13580	DUPLICATE SAME PROV/AMT/DOS	PAY AND REPORT
13590	DUPLICATE-SAME PROV/AMT/DOS	PAY AND REPORT
25980	EXACT DUPE. SAME DOS/ADMT/NDC	PAY AND REPORT
34420	EXACT DUP SAME DOS/PX/MOD/AMT	PAY AND REPORT

34460	SEV DUP-SAME PX/PRV/IM/DOS/MOD	DENY
34490	DUP-PX/IM/DOS/MOD/$$/PRV/TCN	PAY AND REPORT
34550	SEV DUP-SAME PX/IM/MOD/DOS/TCN	PAY AND REPORT
39360	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
39380	EXACT/LESS SEVERE DUPLICATE	PAY AND REPORT
49450	PROCDURE CODE UNIT LIMIT	PAY AND REPORT
53800	Dupe service or procedure	PAY AND REPORT
53810	Dupe service or procedure	PAY AND REPORT
53820	Dupe service or procedure	PAY AND REPORT
53830	Dupe service or procedure	PAY AND REPORT
53840	Limit of one unit per day	PAY AND REPORT
53850	Limit of one unit per day	PAY AND REPORT
53860	Limit of one unit per month	PAY AND REPORT
53870	Limit of one unit per day	PAY AND REPORT
53880	Limit of 24 units per day	DENY
53890	Limit of 96 units per day	DENY
53900	Limit of 96 units per day	DENY