2022 External Quality Review

SANDHILLS CENTER

Submitted: September 21, 2022

Prepared on behalf of
North Carolina Medicaid

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EXECUTIVE SUMMARY

The *Balanced Budget Act of 1997* requires State Medicaid Agencies that contract with Prepaid Inpatient Health Plans (PIHPs) to evaluate their compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358 (42 CFR § 438.358)*. This review determines the level of performance demonstrated by Sandhills Center (Sandhills). This report contains a description of the process and the results of the 2022 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the North Carolina Medicaid (NC Medicaid).

Goals of the review are to:

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

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

A. Overall Findings

Federal regulations require MCOs to undergo a review to determine compliance with federal standards set forth in *42 CFR Part 438, Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. Specifically, the requirements related to:

- Coordination and Continuity of Care (*§ 438.208*)
- Coverage and Authorization of Services (*§ 438.210*)
- Provider Selection (*§ 438.214 and § 438.240*)
- Confidentiality (*§ 438.224*)
- Grievance and Appeal Systems (*§ 438, Subpart F*)
- Health Information Systems (*§ 438.242*)
- Quality Assessment and Performance Improvement Program (*§ 438.330)*

Due to the COVID-19 pandemic, CCME implemented a focused review. This decision was based on the issuance by the State of the COVID-19 flexibilities PIHP Contract Amendment #9. This PIHP contract amendment stated PIHPs "shall be held harmless for any documentation or other PIHP errors identified through the EQR that are not directly related to member health and safety through the Term of the Amendment." The focused review included comprehensive review of the PIHP's health systems capabilities and provider credentialing and recredentialing documentation and processes. The review includes validation of the PIHP's Performance Improvement Projects, Performance Measures, and Encounter data. Lastly, a thorough review of the PIHP's utilization Management, Grievances, and Appeals processes were conducted. What was not reviewed were the PIHP's network adequacy, availability of services, Subcontractual relationships, and Clinical Practice Guidelines (*42 CFR § 438.206, § 438.207, § 438.230, and § 438.236,* respectively*)*.

To access the health plan's compliance with fed regs and contract, CCME's review was divided into six areas. The following is a high-level summary of the review results for those areas. Additional information regarding the reviews, including strengths, weaknesses, and recommendations, are included in the narrative of this report.

B. Overall Recommendations

The following provides a global or high-level summary of the status of the Recommendations and Corrective Action items from the 2021 EQR and the findings of the 2022 EQR. Specific Recommendations and Corrective Actions are detailed in each section of this report.

Administration

42 CFR § 438.224 and 42 CFR § 438.242

In the 2021 EQR, Sandhills met all the Administrative standards and received no Corrective Actions or Recommendations. In the 2022 EQR, Sandhills again met all of the Administrative standards and received no Corrective Actions or Recommendations.

The 2022 review revealed that Sandhills can capture of up to 29 ICD-10 Diagnosis codes on Institutional claims and 12 ICD-10 Diagnosis codes on Professional claims. Sandhills can also submit all ICD-10 Diagnosis codes submitted by the provider on the encounter data extracts to NC Medicaid. Sandhills has maintained their very high acceptance rate of encounter data submissions this review year (99.52%) for the combined Professional and Institutional extracts.

Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

In Sandhills' 2021 EQR of Credentialing/Recredentialing, there were no items requiring Corrective Action and two Recommendations, one of which applied to both credentialing and recredentialing files. Sandhills addressed the Recommendations from the last EQR. In the current EQR, Sandhills met 100% of the Credentialing/Recredentialing standards, with no identified Weaknesses, Corrective Action items, or Recommendations.

Quality Improvement

42 CFR § 438.330

In the 2021 EQR, Sandhills met 100% of the Quality standards and received four Recommendations related to four PIPs that were validated. All Recommendations were implemented.

For the 2022 EQR, Sandhills met all standards with no Corrective Actions. All PIPs were validated in the High Confidence range. There is one Recommendations regarding the Routine Appointments Kept PIP to address the measurement rate decline which was the lowest rate since the PIP began. Sandhills was Fully Compliant for (b) Waiver and (c) Waiver PMs and no Recommendations were issued for the PMs.

Utilization Management

42 CFR § 438.208

In the 2021 EQR, Sandhills met 100% of the Utilization Management standards and received three Recommendations. The first Recommendation was for Sandhills to revise the Procedure CC 12a, I/DD Deinstitutionalization Planning to include the exclusions to the Waiver cost limits/funding cap as listed in *NC Joint Communication Bulletin #J362*. The remaining two Recommendations targeted issues found within the Mental Health/Substance Use (MH/SU), Intellectual/Developmental Disability (I/DD), and Transition to Community Living Initiative (TCLI) Care Coordination files selected by Sandhills and submitted for the 2021 EQR.

In the 2022 EQR, there was evidence that Sandhills correctly revised Procedure CC 12a. Sandhills also provided evidence of their efforts to review and improve the completeness, accuracy, and timeliness of Care Coordination documentation. However, evaluation of Sandhills' review methods, review tools, and outcome data showed overall their efforts are not resulting in a significant improvement in quality, completeness, and timeliness. This was corroborated with the Care Coordination files selected by Sandhills and submitted for this 2022 EQR. For example, MH/SU and I/DD late progress note reports submitted by Sandhills showed a decrease in the past year regarding compliance with timely submission of progress notes. Additionally, performance measure reports submitted by Sandhills showed the individual file reviews of MH/SU and I/DD enrollee

files and that performance decreased in compliance from the previous EQR. Review of the TCLI files submitted by Sandhills for this year's EQR also showed a pattern of late progress notes, missing or late Quality of Life surveys, and late completion of In-Reach tools.

CCME is again recommending Sandhills continue to enhance their current processes for ensuring all Care Coordination documentation is compliant with Sandhills' procedures and will improve the quality, completeness, and timeliness of documentation.

Grievances and Appeals

42 CFR § 438, Subpart F, 42 CFR 483.430

In the 2021 EQR, Sandhills met 100% of the Grievance and Appeal standards, resulting in no Corrective Actions. CCME issued one Recommendation in Grievances and three Recommendations in Appeals. The Grievance Recommendation targeted documentation of required notifications in their Grievance monitoring process for extended resolution timeframes. This Recommendation was not incorporated into the written Grievance monitoring process for the 2022 EQR and remains a Recommendation for the 2022 EQR. The first Appeal Recommendation targeted documentation updates for Appeals initiated orally. An additional written request is not required. This was partially implemented and remains a Recommendation for the 2022 EQR. The second Appeal Recommendation was to ensure all Appeals have a written resolution, even if the Appeal was withdrawn or invalid. This was implemented. CCME's third Appeal Recommendation was for Appeal Coordinators to confirm guardianship and document that in the Appeal file and to add the guardianship verification to the Appeal Monitoring Tool. This was not implemented and remains a Recommendation for the 2022 EQR.

In this 2022 EQR, Sandhills met 100% of the Grievance and Appeal standards, resulting in no Corrective Actions. CCME issued one Recommendation in Grievances and two Recommendations in Appeals. All the Recommendations were follow-up from 2021 EQR Recommendations that were not implemented.

Program Integrity

42 CFR § 438.455 and *1000* through *1008, 42 CFR § 1002.3(b)(3), 42 CFR § 438.608 (a)(vii)*

In the 2021 EQR, Sandhills met 100% of the Program Integrity (PI) standards and received two Recommendations. The first Recommendation was issued to improve the timeliness and consistency of Compliance trainings given to Sandhills' Board of Directors. A second Recommendation was issued to encourage Sandhills to continue to apply strategies to reduce the backlog of older PI cases. There was evidence in the 2022 EQR that Sandhills addressed and implemented both 2021 Recommendations.

In the 2022 EQR, Sandhills again met 100% of the Program Integrity standards and two Recommendations have been issued. CCME recommends Sandhills ensure the correct

report template is used when summarizing the investigative findings, as required by Sandhills' PI procedure. The remaining Recommendation addresses the lack of documentation around Sandhills' handling of provider self-reports of potential fraud, waste, and abuse. During the Onsite, staff could describe a detailed, internal process but acknowledged this process was not documented.

Encounter Data Validation

The analyses of Sandhills' encounter data showed that the data submitted to NC Medicaid is complete and accurate. Only one issue was found with Other Diagnosis codes being frequently absent on both Professional and Institutional encounters.

Overall, Sandhills continue to make progress in improving the accuracy of encounter data over the past few years and should continue to be vigilant in resolving issues related to Billing Taxonomy, Rendering Taxonomy, and Procedure codes. Additionally, Sandhills should continue to remind providers of their responsibility to ensure that the coding on claims is accurate, with added emphasis on Other Diagnosis codes. Sandhills should revisit its strategy to address invalid or missing codes, as well as a reconciliation process and make necessary adjustments to further reduce denials. The goal is to avoid denials by improving synchronization of data with NCTracks, in particular the Global Provider File. This improvement would, in turn, reduce the follow-up needed to correct and resubmit encounters.

Missing Other Diagnosis codes on Professional and Institutional claims do not impact the ability to price the claims, and, therefore, do not end up being reported as denials. However, the lack of data may impact NC Medicaid's ability to provide proper oversight, including measurement of quality of care and setting appropriate fees and rates. Sandhills is encouraged to work with its providers to make sure they are documenting and coding all diagnoses.

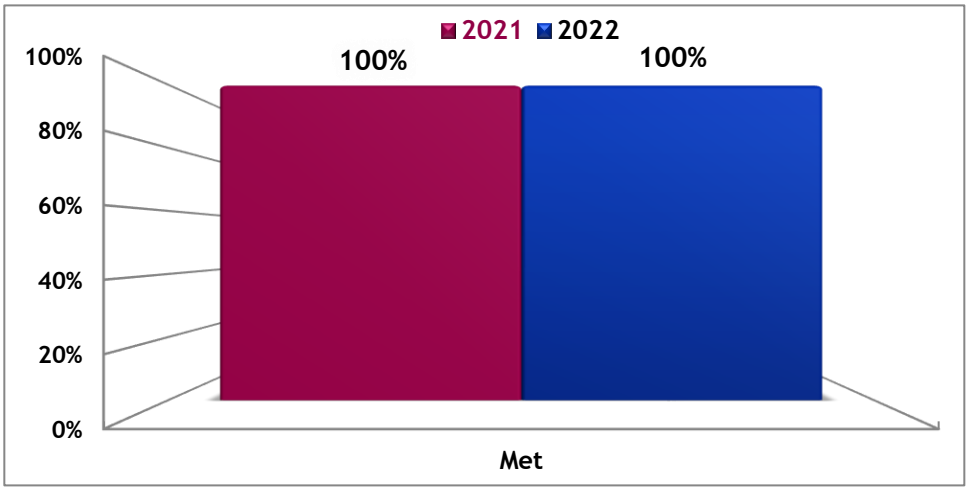
Corrective Actions and Recommendations from Previous EQR

During the 2021 EQR, Sandhills met all of the EQR standards, and no items required Corrective Action. Fifteen Recommendations were issued. During the current EQR, CCME assessed the degree to which the PIHP implemented the Recommendations, and this assessment is outlined in each respective section.

Conclusions

Overall, Sandhills has met the requirements set forth in their contract with NC Medicaid. The 2022 Annual EQR shows Sandhills has achieved a "Met" score for 100% of the standards reviewed. As the following chart indicates, none of the standards were scored as "Partially Met," and none of the standards scored as "Not Met." *Figure 1, Annual EQR Comparative Results*, provides an overview of the scoring of the current annual review as compared to the findings of the 2021 review.

Figure 1: Annual EQR Comparative Results



The following is a summary of key findings and recommendations or opportunities for improvement. Specific details of strengths, weaknesses, and Recommendations can be found in the sections that follow.

Table 1: Sandhills' 2022 EQR Overall Strengths, Weaknesses, Recommendations and Corrective Actions

	Strengths	Weaknesses	Corrective Actions/ Recommendations
Quality	Sandhills can capture of up to 29 ICD-10 Diagnosis codes on Institutional claims and 12 ICD-10 Diagnosis codes on Professional claims.	Measurement rate declined to lowest rate since start of PIP for Routine Appointments Kept PIP.	Routine Appointments Kept PIP: Assess impact of texts and call reminders and determine if there are methods to obtain evidence that members have received texts and are speaking to staff on phone calls
	Sandhills can submit all ICD-10 Diagnosis codes submitted by the provider on the encounter data extracts to NC Medicaid.	Evaluation of Sandhills' documentation review methods, tools, and outcome data showed, overall, efforts are not resulting in a significant improvement in the quality, completeness, and timeliness of Care Coordination documentation and overall compliance with Sandhills' policies and procedures.	Enhance the current MH/SU and I/DD documentation monitoring process to ensure continued progress in Care Coordination documentation quality, completeness, and timeliness and overall compliance with Sandhills' policies and procedures.

	Strengths	Weaknesses	Corrective Actions/ Recommendations
	Sandhills added a Provider Support Portal that allows providers to submit a ticket and get answers to their questions, instead of calling the Provider Help Desk. This allows Sandhills to have the questions in writing and provides an opportunity for providers to complete a survey about their experience.	Review of the TCLI files submitted by Sandhills for this year's EQR showed a pattern of late progress notes, missing or late Quality of Life surveys, and late completion of In-Reach tools.	Ensure Sandhills' process of monitoring TCLI Care Coordination documentation continues to target not only timeliness of progress notes, but the timeliness, completeness, and accuracy of all documentation (e.g., Quality of Life surveys, In-Reach tools, etc.)
	(b) Waiver Measures included all necessary documentation, and measures were reported according to specifications.		
	c) Waiver Measures met or exceeded State benchmark rates.		
	All PIPs scored in the High Confidence range.		
Timeliness	Sandhills' current NC Medicaid encounter data acceptance rate is 99.52% for the combined Professional and Institutional extracts. Sandhills has maintained their very high acceptance rate of encounter data submissions this review year.	The written Grievance monitoring process for extended resolution timeframes does not include monitoring for notifications required by *42 CFR § 438.408 (c)(2)* and by Sandhills' Procedure CORE 35a on page six which states, "If the timeframe is extended, the member will receive prompt oral notice. Within 2 calendar days, the member will receive a written notice of the reason to extend the timeframe."	As in the 2021 EQR, CCME recommends that Sandhills enhance the written Grievance monitoring process for extended resolution timeframes to include review of notifications required by *42 CFR § 438.408 (c)(2)* and by Sandhills' Procedure CORE 35a, on page six which states, "If the timeframe is extended, the member will receive prompt oral notice. Within 2 calendar days, the member will receive a written notice of the reason to extend the timeframe."

	Strengths	Weaknesses	Corrective Actions/ Recommendations
	In two of the MH/SU files reviewed where the enrollee was new to Care Coordination, contacts by Care Coordinators were compliant with the engagement frequency required in Procedure CC 22a, Levels of Care Coordination provided to MH/SU Care Coordination Enrollees.		
Access to Care	Sandhills developed a tool specific to Community Support Team (CST) and Transitions to Community Living Initiative (TCLI), which helped providers pinpoint areas in which they need improvement, and Sandhills provides technical assistance to assist providers make the needed improvements.	The *Medicaid/State Provider Manual* contains incorrect information. A written Appeal is no longer required following the submission of an oral Appeal, per *42 CFR § 438.402 (c)(3)(ii)* and *438.406 (b)(3).*	Guardianship verification was not documented in any of the files reviewed and was not included as an element to review on the Sandhills Appeal Audit Tool.
	The files selected and submitted by Sandhills for the EQR provided good examples of the effectiveness of Care Coordinator interventions.		
	Sandhills staff reported additional training is planned for the Care Coordinators to address a weakness identified in the Experience of Care and Health Outcome (ECHO) survey. Training will focus on information that allows Care Coordinators to communicate the Appeals process more effectively.		
	Sandhills implemented an internal peer-to-peer process in Appeals after the 2021 EQR to help with training and consistency within the Appeals Department. This process has been received well by staff.		

METHODOLOGY

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

On June 27, 2022, 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 PIHP to participate in a pre-Onsite conference call with CCME and NC Medicaid for purposes of offering Sandhills an opportunity to seek clarification on the review process and ask questions regarding any of the Desk Materials requested by CCME.

The review consisted of two segments. The first was a Desk Review of materials and documents received from Sandhills on August 10, 2022 and reviewed by CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. Also included in the Desk Review was a review of Credentialing, Grievance, Utilization, Care Coordination, and Appeal files.

The second segment of the EQR is typically a two-day, Onsite review conducted at the PIHP's offices. However, due to COVID-19, this Onsite was conducted through a teleconference platform on August 25, 2022. This Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the onsite visit, see *Attachment 2*. CCME's onsite activities included:

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

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

FINDINGS

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

A. Administration

42 CFR § 438.208

Information Systems Capabilities Assessment

The review of Sandhills' system capabilities involved the use of the Information Systems Capabilities Assessment (ISCA) tool and review of supporting documentation such as Sandhills' claim audit reports, enrollment workflows, and Sandhills' Information Technology (IT) staffing patterns. This system analysis was completed as specified in the Centers for Medicare and Medicaid Services (CMS) External Quality Review Protocol. During the virtual site review, Sandhills staff presented the enrollment and claims systems overview. Questions regarding the ISCA tool were discussed with Sandhills staff during the Onsite.

In the 2021 EQR, Sandhills met 100% of the Administration EQR standards and no Recommendations or Corrective Actions were issued.

Table 2: 2021 EQR Administration Findings

2021 EQR Administration Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
2022 EQR Follow up: No Recommendations or Corrective Actions were issued in the 2021 Administrative EQR.		

During the 2022 EQR ISCA review, it was confirmed that Sandhills uses the Alpha+ system to process member enrollment and claims, submit encounters, and generate reports. Sandhills transitioned from AlphaMCS to the Alpha+ platform in quarter two (Q2) 2021. However, there were no major changes in processes or functionality of the platform.

The ISCA tool and supporting documentation for enrollment processing defined the process for importing enrollment data to the Alpha+ enrollment system. During the Onsite, Sandhills provided a demonstration of the Alpha+ enrollment system. The system

maintains member enrollment history. The Global Eligibility File (GEF) was imported daily into the Alpha+ system by Sandhills staff.

The daily eligibility update file was compared to existing eligibility in the Alpha+ system. The member enrollment records were processed and compared against the existing enrollment information in the database. Based on the comparison with the existing data in the database, an add, change, or delete edit code for the member record was determined. Enrollees were identified by unique system-generated Patient IDs. When the GEF file was loaded, members are matched by their Social Security number, name, and date of birth. New members were identified when there was no matching Social Security number, name and date of birth existing in the member database. A unique Patient ID was generated and assigned to new members. Sandhills had a process to generate error reports when errors were encountered during the GEF load process.

Sandhills stores the Medicaid identification number received on the GEF. During the Onsite, Sandhills indicated that they rarely received members with multiple IDs but can research and merge the information into one Patient ID. The historical claims and authorizations for the member are also merged into one Patient ID. Sandhills was able to store up to seven historical Medicaid IDs.

During the Onsite system demonstration, staff displayed the enrollment information that was stored within Alpha+. The Alpha+ system captures demographic data such as race, ethnicity and language, and coordination of benefit (COB) information.

Sandhills' enrollment counts for the past three years are presented in Table 3.

Table 3: Enrollment Counts

2019	2020	2021
188,722	186,201	68,457

Sandhills experienced nearly 70% reduction in enrollment after July 2021 due to transition of membership to NC Medicaid Managed Care. Sandhills' claims and authorizations were processed in the Alpha+ system. The processes for collecting, adjudicating, and reporting claims were reviewed using the ISCA response and supporting documentation provided. A demonstration of Sandhills' provider web portal and Alpha+ claims processing system was performed during the Onsite, including Institutional and Professional claim screens.

Sandhills received claims via three methods: 837 electronic file, provider web portal, and paper claims. During the Onsite, Sandhills stated that they received claims from out-of-network providers on paper. Table 4 details the percentage of 2021 claims received via each of the three methods.

Table 4: Percent of claims with 2021 dates of service that were received via Electronic (HIPAA File, Provider Web Portal) or Paper forms

Source	HIPAA File	Paper	Provider Web Portal
Institutional	82%	>1%	15%
Professional	79%	>1%	24%

Sandhills adjudicated claims on a nightly basis. Data from the ISCA confirms that 99.86% of Professional claims and 91.90% of Institutional claims were auto adjudicated on 2021. On the Alpha+ system, Sandhills captured up to 29 ICD-10 Diagnosis codes via the provider web portal and up to 29 ICD-10 Diagnosis codes via HIPAA files for Institutional claims. For Professional claims, Sandhills can receive and store up to 12 ICD-10 Diagnosis codes via both the provider web portal and HIPAA files. Sandhills captures ICD-10 Procedure codes and Diagnosis Related Groups (DRGs), if they are submitted on the claim. Sandhills pends claims that have a claim header amount of $5,000 or more. Emergency Department (ED) claims and Professional ED claims that had a place of service of ER were also pended. The pended claims were manually reviewed and completed daily.

Sandhills utilized the Alpha+ system to generate reports with real-time data. A local reporting database was also used to create reports. The enrollment, provider, claims, and authorization information that was captured in the Alpha+ system was available in the local reporting database. Sandhills maintains an internal database that is a copy of the Alpha+ database and is refreshed each night through a backup copy of the database. During the Onsite, Sandhills noted that they also utilize raw GEF and global provider files to create reports. Full enrollment and claims history are maintained in the Alpha+ system.

During the Onsite, Sandhills indicated that the reporting database is backed up nightly. Sandhills had a defined process for their encounter data submission, with 837 files submitted to NC Medicaid and 835 files returned from NC Medicaid through the NC Medicaid system. Encounters that are approved by Sandhills are submitted to NC Medicaid. Sandhills can track claims from the adjudication process to their encounter submissions status. The 835 file from NC Medicaid is used to review denials. The extraction, submission, and reconciliation of encounter data are fully automated. During the Onsite, Sandhills demonstrated their encounter reconciliation system for NC Medicaid.

Table 5: Volume of 2020 and 2021 Submitted Encounter Data

2021	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	26,932	5,229	222	32,383
Professional	1,242,347	181,146	6,809	1,430,302
2020	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	28,928	3,866	531	31,925
Professional	1,255,022	90,448	2,133	1,347,603

Sandhills has an acceptance rate of 99.52% for both Professional and Institutional encounters with dates of service in 2021. Sandhills reported that the top three denial reason for encounters submitted in 2021 were:

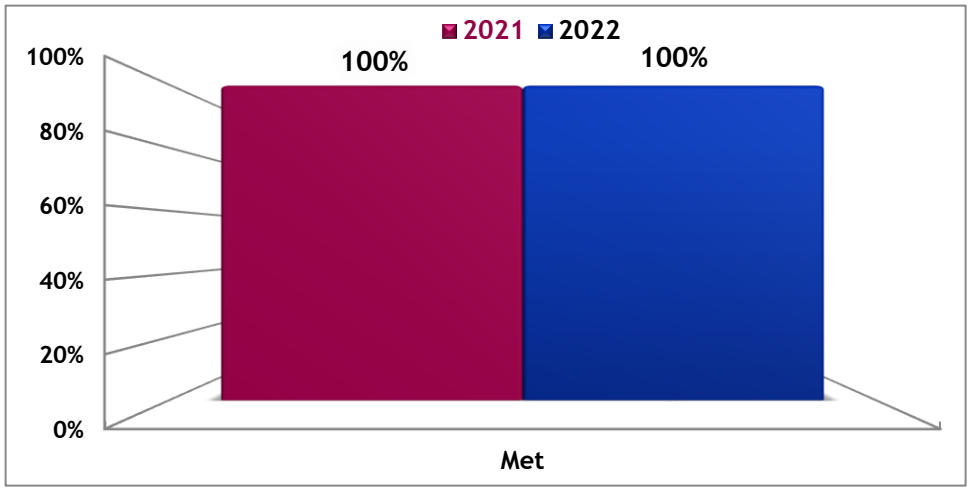
- Procedure code/Revenue Code invalid for place of service
- Procedure is invalid for the diagnosis
- Pricing for the procedure/modifier combination is not found for the date span on claim line

On average, Sandhills submits an encounter within five days from the time of adjudication to NC Medicaid. It takes approximately 24 days to correct and resubmit an encounter to NC Medicaid. Sandhills uses the Adam Holtzman's paid and denied report and the weekly 835 file to identify encounters that were denied. As stated in the ISCA, Sandhills has 625 Institutional and 4,111 Professional encounters still awaiting resubmission as of July 27, 2022.

During the ISCA virtual site review, Sandhills demonstrated an encounter data Paid and Deny application that Sandhills developed based on Adam Holtzman's paid and denied report. Sandhills' application was used to identify the reason for rejection of the encounter and track the encounter through the different stages for resubmission. Sandhills exceeds the NC Medicaid standards for encounter submissions and has less than 5% denial rate of their encounter data submissions. For Institutional encounters, Sandhills submits up to 29 ICD-10 Diagnosis codes, and, for Professional encounters, Sandhills submits up to 12 ICD-10 Diagnosis codes to NC Medicaid. Sandhills was able to submit all ICD-10 Diagnosis codes received on Institutional claims to NC Medicaid.

Figure 2 demonstrates that Sandhills met all the Administration standards in the 2021 and 2022 EQR.

Figure 2: Administration Findings



Strengths

- Sandhills can capture of up to 29 ICD-10 Diagnosis codes on Institutional claims and 12 ICD-10 Diagnosis codes on Professional claims.
- Sandhills can submit all ICD-10 Diagnosis codes submitted by the provider on the encounter data extracts to NC Medicaid.
- Sandhills' current NC Medicaid encounter data acceptance rate is 99.52% for the combined Professional and Institutional extracts. Sandhills has maintained their very high acceptance rate of encounter data submissions this review year.

B. Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

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

Sandhills met 100% of the Credentialing/Recredentialing standards in the 2021 EQR. CCME issued two Recommendations, one of which applied to both credentialing and recredentialing files. Sandhills implemented the 2021 Recommendations, as presented in *Table 6*.

Table 6: 2021 EQR Provider Services Findings

2021 EQR Credentialing/Recredentialing findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
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.	***Recommendation: Ensure the accuracy of the Credentialing Committee meeting minutes. For example, if the minutes state "See QM Issues Below", verify the minutes include the referenced information. If the column is regarding LPs, rather than LIPs, correct the column heading.***	**Y**
2022 EQR Follow up: In this 2022 EQR, the submitted/reviewed Credentialing Committee meeting minutes include language changes Sandhills instituted to address the 2021 EQR Recommendation.		
Credentialing and Recredentialing: Ownership Disclosure is addressed	***Recommendation: Ensure credentialing and recredentialing files include Ownership Disclosure information, including by the agency for the employee. See NC Medicaid Contract, Attachment O and Sections 1.13 and 1.14. If Sandhills does not keep a copy of the relevant ownership disclosure information in the credentialing or recredentialing file, retrieve copies from the relevant file and upload as part of the credentialing or recredentialing files for the EQR Desk Review.***	**Y**
2022 EQR Follow up: In this 2022 EQR, all of the submitted credentialing files, and all except one of the submitted recredentialing files included the Ownership Disclosure. Sandhills submitted the missing Ownership Disclosure for the recredentialing file upon CCME's request.		

Procedures N-CR 01a-19a, N-NM 03a, NRR 04a, designated as the *Sandhills Center Provider Credentialing Program Plan Procedures,* guide the credentialing and recredentialing processes. Dr. Anthony Carraway, a Board-Certified Psychiatrist and Sandhills' Chief Medical Officer/Chief Clinical Officer (CMO/CCO), is "responsible for oversight of the clinical aspects of the credentialing program." During the review period, Sandhills delegated credentialing to UNC and Moses Cone hospital systems for their employees. The two hospital systems submitted a monthly credentialing roster to Sandhills. The individual practitioners were entered as "delegates" in the Alpha system and were not available for direct referrals.

Per Procedure NCR 03a Credentialing Committee, Dr. Carraway approves "clean" applications and chairs the Credentialing Committee. The Credentialing Committee includes Sandhills staff members and "non-Sandhills Center members who hold active and unrestricted licensure in their field." Sandhills staff members do not vote, with the exception that Dr. Carraway casts the deciding vote in the event of a tie.

A quorum is defined as "a majority of more than ½ of non-Sandhills Center staff voting members." The sample of Credentialing Committee meeting minutes reviewed for this EQR indicated a quorum was present. The Credentialing Committee meeting minutes reflect discussion of, and the committee's decisions regarding, the "flagged" applications.

CCME's review of the submitted credentialing and recredentialing files showed they were organized and contained appropriate information. One of the four submitted practitioner credentialing files did not contain Ownership Disclosure information identifying the owner, managing employees and others, as outlined in the *NC Medicaid Contract*, *Attachment B, Section 1.13* and *1.14*, and *Attachment O*. One of the four practitioner credentialing files did not include evidence of automobile insurance, as indicated on the "*Provider Insurance Coverage – Attestations*" form. Sandhills submitted the Ownership Disclosure and the Certificate of Insurance in response to CCME's request on the Missing Desk Materials list.

Orientation materials, training opportunities and events, the *Medicaid/State Provider Manual*, and provider forms and documents are posted on the Sandhills website. With their contracts, new providers receive communications directing them to the materials.

Sandhills offers an Annual Provider Orientation, which was provided electronically in May 2022 due to the pandemic. The Annual Provider Orientation slides, posted on the Sandhills website, include information from the Network Operations, Network Management, Quality Management, Customer Services, Care Coordination, and Population Health Departments. A presentation by the Program Integrity Director included information on fraud, waste, and abuse.

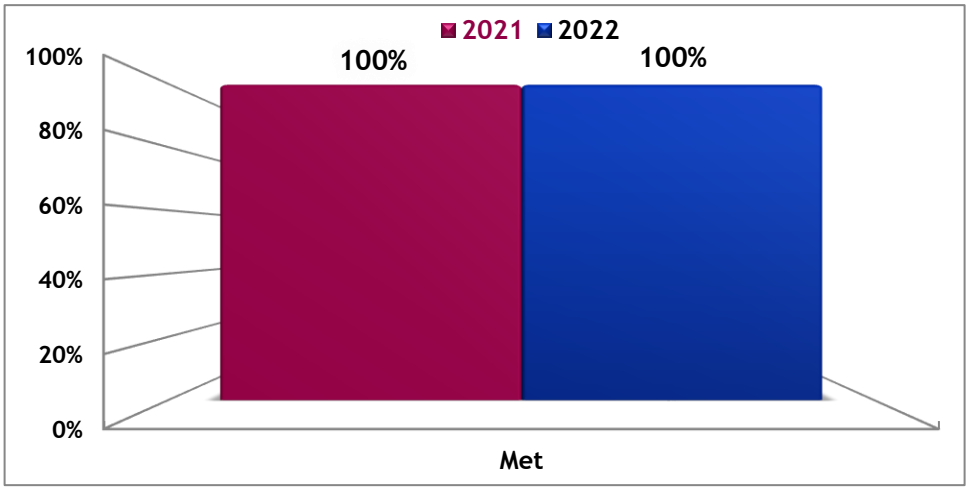
At the Onsite review for the 2021 EQR, Sandhills staff reported they had issued several RFPs, with providers selected for Facility-Based Crisis, Child and Adolescent, and Child and Adolescent Day Treatment. Staff reported they added the Partial Hospital program at Moses Cone and a Facility-Based Crisis provider in Asheboro. Though providers were also selected for Level II and Level III group homes, Sandhills reported "some of those providers needed to locate sites and the current real estate market has been a huge barrier." Staff also reported RFPs were" recently posted for High Fidelity Wrap Around and In-Home Skill Building services."

During the Onsite review for the current EQR, staff reported Sandhills has "made quite a bit of progress" toward meeting the gaps discussed at the 2021 EQR. For example, Sandhills added Facility-Based Crisis providers in Greensboro and Richmond. Some Level II and Level III providers were added, and Sandhills recently completed an RFP process for Day Treatment, which will be added in Randolph, Harnett, and Moore counties.

Sandhills reported "no Network Adequacy and Accessibility report was required" this fiscal year, but noted they continue to run quarterly geo-mapping reports and present them at the quarterly Network Committee meetings and Quality Management meetings. Sandhills identified gaps in Medicaid-funded Partial Hospital, Ambulatory Detox, B-3 Respite and B-3 Peer Support, but reported any needed services are provided via Client-Based Agreements.

In the current EQR, Sandhills met 100% of the Credentialing/ Recredentialing standards, with no identified Weaknesses, Corrective Action items or Recommendations. *Figure 3, Provider Services Comparative Findings*, provides an overview of 2022 scores compared to 2021 scores.

Figure 3: Provider Services Comparative Findings



Strengths

- Sandhills developed a tool specific to Community Support Team (CST) and Transitions to Community Living Initiative (TCLI), which helped providers pinpoint areas in which they need improvement, and Sandhills provides technical assistance to assist providers make the needed improvements.

- Sandhills added a Provider Support Portal that allows providers to submit a ticket and get answers to their questions, instead of calling the Provider Help Desk. This allows Sandhills to have the questions in writing and provides an opportunity for providers to complete a survey about their experience.

C. Quality Improvement

42 CFR § 438.330

The 2022 Quality Improvement (QI) EQR included Performance Measures (PMs) and Performance Improvement Projects (PIPs) validation. CCME conducted a Desk Review of the submitted (b) and (c) Waiver Performance Measures (PMs) and a review of each PIP's *Quality Improvement Project (QIP) Form* for validation, using CMS standard validation protocols. An Onsite discussion occurred to clarify measurement rates for each of the areas.

In the 2021 EQR, Sandhills met 100% of the Quality standards and received four Recommendations related to the four PIPs that were validated. The Recommendations and the status of implementation in the 2022 EQR are presented in Table 7.

Table 7: 2021 EQR PIP Recommendations

Project(s)	Recommendation	Recommendation Implemented in 2022 (Y/N/NA)
Assure Consistent Connection to Community Services	***Recommendation: Determine if provider has adequate staff and adequately trained staff to ensure referrals to follow-up are made and recipients are connected to services.***	**Y**
TCLI Timeliness Documentation Submission	***Recommendation: Present the results using a table with the numerator, denominator, and rate instead of bar charts so each element of each indicator rate is easily identified.***	**Y**

Project(s)	Recommendation	Recommendation Implemented in 2022 (Y/N/NA)
NC-TOPPS Interview Data Accuracy	***Recommendation: All results for all timepoints should be presented in a single table. The bar charts should contain consistent labels that show the timepoint for the rate such as baseline, Year 1, Year 2, or Q4 2021 since a full year is not included. The term measure should be removed, as it does not add any valuable information for the reader.***	**Y**
Routine Appointments Kept	***Recommendation: Determine if there are other specific barriers to keeping appointments. Continue to evaluate the impact of the funding and location changes as related to lack of appointments being kept.***	**Y**

For the 2022 EQR, five active PIPs were submitted and four were validated: HCC Routine Appointments Kept, HCC NC TOPPS Interview Data Accuracy, Assure Consistent Connection to Community Services for Facility Based Crisis (FBC) Services, and Timeliness Documentation Submission for Transition to Community Living (TCLI). Although the PIP titled "Increase EBP for Medication Management Care Coordination" is labeled as active, there are no data available due to monitoring reviews remaining suspended per Deputy Secretary for Behavioral Health & IDD and Deputy Secretary for N.C. Medicaid directives.

Table 8 displays the PIP project title and interventions for the current review year.

Table 8: 2021 PIP Recommendations

Project(s)	Interventions
Assure Consistent Connection to Community Services - Clinical	Licensed Care Coordinators assigned to all providers, additional providers to assist in FBC, education and training for low-performing providers
TCLI Timeliness Documentation Submission – Non Clinical	Education and training for staff, continued monitoring
NC-TOPPS Interview Data Accuracy- Non Clinical	NC-TOPPS training presentation; Reminders given at the quarterly Provider Forum. Training Coordinator to work on creating a Virtual training for all providers
Routine Appointments Kept – Non Clinical	Continue sending reminder texts and reminder calls. Continue making follow-up calls to attempt to get the member linked to services within 14 days; Talk with a specific walk-in clinic provider to resume participation in the slot scheduler to allow for appointments to be scheduled in that area

Performance Measure Validation

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

Table 9: (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 10: (c) Waiver Measures

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

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

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

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

(b) Waiver Measures Reported Results

In comparing FY2020 and FY2021 rates, there was one rate with substantial improvement (>10%). Follow-up After Hospitalization for Substance Abuse for the Detox and FBC 30-Day rate improved from 22.2% to 43.34%, a 21.2% improvement. Follow-up After Hospitalization for mental illness declined for FBC population by 33.3% for the 7- and 30-Day rate, although there were only 6 members included in the denominator. The Onsite meeting included discussion of factors influencing the decline and improvement in the year-over-year trends. The current rate in comparison to last year's rate is presented in the *Tables 11* through *20*.

Table 11: A.1. Readmission Rates for Mental Health

30-day Readmission Rates for Mental Health	FY 2020	FY 2021	Change
Inpatient (Community Hospital Only)	10.8%	9.4%	-1.40%
Inpatient (State Hospital Only)	12.5%	16.7%	4.20%
Inpatient (Community and State Hospital Combined)	10.8%	9.4%	-1.40%
Facility Based Crisis	6.7%	11.1%	4.40%
Psychiatric Residential Treatment Facility (PRTF)	14.3%	8.2%	-6.10%
Combined (includes cross-overs between services)	11.0%	9.3%	-1.70%

Table 12: A.2. Readmission Rate for Substance Abuse

30-day Readmission Rates for Substance Abuse	FY 2020	FY 2021	Change
Inpatient (Community Hospital Only)	8.9%	5.6%	-3.30%
Inpatient (State Hospital Only)	0.0%	2.7%	2.70%
Inpatient (Community and State Hospital Combined)	7.0%	5.0%	-2.00%
Detox/Facility Based Crisis	7.9%	6.5%	-1.40%
Combined (includes cross-overs between services)	7.2%	5.4%	-1.80%

Table 13: A.3. Follow-Up after Hospitalization for Mental Illness

Follow-up after Hospitalization for Mental Illness	FY 2020	FY 2021	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	40.4%	37.9%	-2.5%
Percent Received Outpatient Visit Within 30 Days	59.6%	54.3%	-5.3%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	83.3%	50.0%	**-33.3%**
Percent Received Outpatient Visit Within 30 Days	100%	66.7%	**-33.3%**
PRTF			
Percent Received Outpatient Visit Within 7 Days	30.0%	26.8%	-3.2%
Percent Received Outpatient Visit Within 30 Days	61.7%	53.6%	-8.1%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	40.2%	37.6%	-2.6%
Percent Received Outpatient Visit Within 30 Days	59.8%	54.3%	-5.5%

Table 14: A.4. Follow-Up After Hospitalization for Substance Abuse

Follow-up after Hospitalization for Substance Abuse	FY 2020	FY 2021	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	17.5%	24.1%	6.6%
Percent Received Outpatient Visit Within 30 Days	30.2%	33.7%	3.5%

Follow-up after Hospitalization for Substance Abuse	FY 2020	FY 2021	Change
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	5.6%	0%	-5.6%
Percent Received Outpatient Visit Within 7 Days	11.1%	20.8%	9.7%
Percent Received Outpatient Visit Within 30 Days	22.2%	43.4%	21.2%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	17.1%	23.6%	6.5%
Percent Received Outpatient Visit Within 30 Days	29.7%	35.1%	5.4%

Table 15: B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2020	FY 2021	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	45.3%	37.9%	-7.4%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	30.2%	20.7%	-9.5%
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	43.8%	40.1%	-3.7%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	25.4%	17.4%	-8.0%
Ages 21–34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	52.5%	44.5%	-8.0%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	40.9%	32.9%	-8.0%
Ages 35–64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)35.8%	50.4%	48.0%	-2.4%
Percent With 2 Or More Services or Visits Within 30 Days After 50.0%Initiation (Engagement)	35.8%	37.5%	1.7%

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2020	FY 2021	Change
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	50.0%	55.7%	5.7%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	44.2%	46.8%	2.6%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	50.3%	46.4%	-3.9%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	36.6%	34.7%	-1.9%

Table 16: D.1. Mental Health Utilization-Inpatient Discharges and Average Length of Stay

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3–12	Male	0.2	0.1	-0.1	40.3	57.1	16.8
	Female	0.3	0.2	-0.1	26.9	32.5	5.6
	Total	0.2	0.1	-0.1	32.4	42.2	9.8
13–17	Male	0.8	0.6	-0.2	46.6	74.1	27.5
	Female	1.7	1.7	0	24.2	28.9	4.7
	Total	1.3	1.1	-0.2	31.4	41	9.6
18–20	Male	1.3	1.2	-0.1	10.6	11.3	0.7
	Female	1.3	1.4	0.1	8	14.4	6.4
	Total	1.3	1.3	0.0	9.3	13	3.7
21–34	Male	3.9	3.4	-0.5	8.9	7.4	-1.5
	Female	1.4	1.2	-0.2	6.3	7	0.7
	Total	1.9	1.7	-0.2	7.5	7.2	-0.3
35–64	Male	2.7	2.1	-0.6	7.8	8.7	0.9
	Female	1.7	1.4	-0.3	7.6	7.7	0.1
	Total	2.1	1.7	-0.4	7.7	8.1	0.4

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
65+	Male	0.3	0.2	-0.1	12.5	24.8	12.3
	Female	0.2	0.2	0.0	11.7	14.6	2.9
	Total	0.3	0.2	-0.1	12	17.5	5.5
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**	**1.0**	**0.9**	**-0.1**	**17**	**20.5**	**3.5**
	Female	**1.0**	**0.9**	**-0.1**	**13.3**	**15.2**	**1.9**
	Total	**1.0**	**0.9**	**-0.1**	**14.9**	**17.4**	**2.5**

Table 17: D.2. Mental Health Utilization -% of Members that Received at Least 1 Mental Health Service in the Category Indicated during the Measurement Period

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3-12	Male	10.57%	8.49%	-2.08%	0.04%	0.02%	-0.02%	0.19%	0.08%	-0.11%	10.52%	8.46%	-2.06%
	Female	8.01%	6.71%	-1.30%	0.02%	0.02%	0.00%	0.06%	0.03%	-0.03%	8.00%	6.70%	-1.30%
	Total	9.33%	7.62%	-1.71%	0.03%	0.02%	-0.01%	0.13%	0.06%	-0.07%	9.30%	7.60%	-1.70%
13-17	Male	13.27%	10.90%	-2.37%	0.19%	0.13%	-0.06%	0.30%	0.19%	-0.11%	13.17%	10.81%	-2.36%
	Female	16.00%	15.30%	-0.70%	0.24%	0.19%	-0.05%	0.16%	0.08%	-0.08%	15.92%	15.28%	-0.64%
	Total	14.62%	13.06%	-1.56%	0.21%	0.16%	-0.05%	0.23%	0.14%	-0.09%	14.53%	13.01%	-1.52%
18-20	Male	8.00%	6.97%	-1.03%	0.04%	0.01%	-0.03%	0.01%	0.01%	0.00%	7.99%	6.96%	-1.03%
	Female	10.68%	10.96%	0.28%	0.01%	0.01%	0.00%	0.01%	0.00%	-0.01%	10.68%	10.96%	0.28%
	Total	9.39%	9.03%	-0.36%	0.03%	0.01%	-0.02%	0.01%	0.01%	0.00%	9.38%	9.02%	-0.36%
21-34	Male	23.61%	18.94%	-4.67%	0.00%	0.00%	0.00%	0.06%	0.00%	-0.06%	23.61%	18.94%	-4.67%
	Female	17.88%	15.27%	-2.61%	0.01%	0.01%	0.00%	0.02%	0.00%	-0.02%	17.87%	15.27%	-2.60%
	Total	19.16%	16.08%	-3.08%	0.00%	0.01%	0.01%	0.03%	0.00%	-0.03%	19.15%	16.08%	-3.07%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
35-64	Male	21.70%	19.30%	-2.40%	0.00%	0.01%	0.01%	0.00%	0.00%	0.00%	21.70%	19.30%	-2.40%
	Female	22.49%	19.57%	-2.92%	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	22.49%	19.57%	-2.92%
	Total	22.20%	19.47%	-2.73%	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	22.20%	19.47%	-2.73%
65+	Male	9.28%	4.28%	-5.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.71%	4.28%	-0.43%
	Female	7.32%	4.27%	-3.05%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.86%	4.27%	-0.59%
	Total	8.00%	4.27%	-3.73%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.81%	4.27%	-0.54%
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**	**13.33%**	**10.97%**	**-2.36%**	**0.06%**	**0.04%**	**-0.02%**	**0.15%**	**0.07%**	**-0.08%**	**12.99%**	**10.94%**	**-2.05%**
	Female	**13.84%**	**12.27%**	**-1.57%**	**0.05%**	**0.04%**	**-0.01%**	**0.05%**	**0.02%**	**-0.03%**	**13.59%**	**12.27%**	**-1.32%**
	Total	**13.62%**	**11.71%**	**-1.91%**	**0.05%**	**0.04%**	**-0.01%**	**0.09%**	**0.04%**	**-0.05%**	**13.33%**	**11.70%**	**-1.63%**

Table 18: D.3. Identification of Alcohol and Other Drug Services

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3–12	Male	0.02%	0.01%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.01%	-0.01%
	Female	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
	Total	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
13–17	Male	0.87%	0.58%	-0.29%	0.01%	0.01%	0.00%	0.16%	0.12%	-0.04%	0.75%	0.49%	-0.26%
	Female	0.58%	0.48%	-0.10%	0.00%	0.00%	0.00%	0.10%	0.05%	-0.05%	0.50%	0.45%	-0.05%
	Total	0.73%	0.53%	-0.20%	0.00%	0.00%	0.00%	0.13%	0.09%	-0.04%	0.62%	0.47%	-0.15%
18–20	Male	1.70%	1.26%	-0.44%	0.03%	0.00%	-0.03%	0.16%	0.05%	-0.11%	1.62%	1.21%	-0.41%
	Female	1.98%	1.24%	-0.74%	0.00%	0.03%	0.03%	0.32%	0.10%	-0.22%	1.83%	1.17%	-0.66%
	Total	1.84%	1.25%	-0.59%	0.01%	0.02%	0.01%	0.24%	0.08%	-0.16%	1.73%	1.19%	-0.54%
21–34	Male	7.22%	5.94%	-1.28%	0.21%	0.23%	0.02%	0.86%	0.50%	-0.36%	6.99%	5.80%	-1.19%
	Female	6.93%	5.04%	-1.89%	0.14%	0.18%	0.04%	0.80%	0.41%	-0.39%	6.71%	4.91%	-1.80%
	Total	6.99%	5.24%	-1.75%	0.16%	0.19%	0.03%	0.81%	0.43%	-0.38%	6.77%	5.11%	-1.66%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
35–64	Male	8.90%	8.01%	-0.89%	0.15%	0.17%	0.02%	1.07%	0.62%	-0.45%	8.54%	7.66%	-0.88%
	Female	6.12%	5.30%	-0.82%	0.07%	0.10%	0.03%	1.02%	0.56%	-0.46%	5.79%	4.96%	-0.83%
	Total	7.16%	6.29%	-0.87%	0.10%	0.13%	0.03%	1.04%	0.58%	-0.46%	6.82%	5.94%	-0.88%
65+	Male	1.49%	2.06%	0.57%	0.02%	0.05%	0.03%	0.30%	0.23%	-0.07%	1.41%	1.92%	0.51%
	Female	0.34%	0.57%	0.23%	0.00%	0.00%	0.00%	0.07%	0.08%	0.01%	0.30%	0.50%	0.20%
	Total	0.74%	1.09%	0.35%	0.01%	0.02%	0.01%	0.15%	0.13%	-0.02%	0.68%	0.99%	0.31%
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**	**2.23%**	**2.02%**	**-0.21%**	**0.04%**	**0.05%**	**0.01%**	**0.28%**	**0.17%**	**-0.11%**	**2.13%**	**1.92%**	**-0.21%**
	Female	**2.64%**	**2.25%**	**-0.39%**	**0.04%**	**0.06%**	**0.02%**	**0.38%**	**0.21%**	**-0.17%**	**2.51%**	**2.14%**	**-0.37%**
	Total	**2.46%**	**2.15%**	**-0.31%**	**0.04%**	**0.05%**	**0.01%**	**0.34%**	**0.20%**	**-0.14%**	**2.34%**	**2.05%**	**-0.29%**

Table 19: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	3-12			13-17			18-20			21-34		
Anson	0.00%	0.00%	0.00%	1.03%	0.51%	-0.52%	0.98%	1.90%	0.92%	5.16%	4.95%	-0.21%
Guilford	0.02%	0.01%	-0.01%	0.60%	0.57%	-0.03%	1.53%	1.11%	-0.42%	4.34%	3.48%	-0.86%
Harnett	0.04%	0.01%	-0.03%	0.90%	0.81%	-0.09%	1.50%	1.24%	-0.26%	4.46%	5.00%	0.54%
Hoke	0.02%	0.04%	0.02%	1.30%	0.40%	-0.90%	2.13%	1.29%	-0.84%	3.49%	4.35%	0.86%
Lee	0.00%	0.02%	0.02%	0.99%	0.52%	-0.47%	2.01%	1.52%	-0.49%	5.95%	6.58%	0.63%
Montgomery	0.00%	0.00%	0.00%	0.70%	0.48%	-0.22%	2.86%	2.65%	-0.21%	8.08%	8.18%	0.10%
Moore	0.00%	0.02%	0.02%	0.49%	0.73%	0.24%	1.61%	2.07%	0.46%	11.29%	9.46%	-1.83%
Randolph	0.01%	0.01%	0.00%	0.58%	0.67%	0.09%	1.06%	1.03%	-0.03%	5.37%	5.58%	0.21%
Richmond	0.02%	0.00%	-0.02%	1.45%	1.01%	-0.44%	3.32%	3.36%	0.04%	11.24%	11.67%	0.43%
	35-64			65+			Unknown			Total		
Anson	6.72%	5.79%	-0.93%	0.30%	1.22%	0.92%	0.00%	0.00%	0.00%	2.42%	2.34%	-0.08%
Guilford	6.84%	5.95%	-0.89%	1.20%	1.27%	0.07%	0.00%	0.00%	0.00%	2.10%	1.82%	-0.28%
Harnett	4.96%	5.55%	0.59%	0.52%	0.61%	0.09%	0.00%	0.00%	0.00%	1.83%	2.03%	0.20%
Hoke	5.48%	5.80%	0.32%	0.74%	1.30%	0.56%	0.00%	0.00%	0.00%	1.90%	1.93%	0.03%
Lee	8.08%	9.51%	1.43%	0.98%	1.95%	0.97%	0.00%	0.00%	0.00%	2.53%	2.83%	0.30%
Montgomery	10.07%	10.47%	0.40%	0.91%	1.74%	0.83%	0.00%	0.00%	0.00%	3.26%	3.46%	0.20%
Moore	10.03%	10.38%	0.35%	0.53%	0.75%	0.22%	0.00%	0.00%	0.00%	3.74%	3.67%	-0.07%
Randolph	5.72%	5.89%	0.17%	0.40%	0.54%	0.14%	0.00%	0.00%	0.00%	2.00%	2.11%	0.11%
Richmond	11.19%	12.82%	1.63%	1.31%	2.32%	1.01%	0.00%	0.00%	0.00%	4.81%	5.27%	0.46%

Table 20: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	3-12			13-17			18-20			21-34		
Anson	6.35%	4.26%	-2.09%	11.15%	8.28%	-2.87%	5.89%	5.13%	-0.76%	12.07%	11.63%	-0.44%
Guilford	7.52%	5.95%	-1.57%	14.82%	13.32%	-1.50%	9.16%	10.40%	1.24%	12.07%	12.29%	0.22%
Harnett	8.23%	7.31%	-0.92%	13.68%	13.73%	0.05%	9.91%	10.29%	0.38%	11.45%	11.44%	-0.01%
Hoke	8.18%	8.16%	-0.02%	13.39%	12.19%	-1.20%	10.81%	9.69%	-1.12%	10.98%	12.20%	1.22%
Lee	6.73%	5.90%	-0.83%	11.02%	11.02%	0.00%	8.54%	8.10%	-0.44%	12.00%	12.87%	0.87%
Montgomery	6.08%	6.33%	0.25%	13.31%	11.80%	-1.51%	7.57%	9.64%	2.07%	11.94%	11.21%	-0.73%
Moore	8.28%	8.25%	-0.03%	14.95%	15.13%	0.18%	9.25%	10.87%	1.62%	15.78%	17.15%	1.37%
Randolph	6.88%	6.95%	0.07%	12.91%	13.91%	1.00%	8.57%	9.39%	0.82%	11.25%	13.12%	1.87%
Richmond	10.89%	9.06%	-1.83%	16.89%	14.83%	-2.06%	11.21%	10.98%	-0.23%	17.12%	19.04%	1.92%
	35-64			65+			Unknown			Total		
Anson	17.21%	17.38%	0.17%	6.50%	5.65%	-0.85%	0.00%	0.00%	0.00%	10.17%	9.00%	-1.17%
Guilford	18.10%	17.42%	-0.68%	3.91%	4.34%	0.43%	0.00%	0.00%	0.00%	10.99%	10.29%	-0.70%
Harnett	15.54%	14.57%	-0.97%	6.76%	5.64%	-1.12%	0.00%	0.00%	0.00%	10.88%	10.37%	-0.51%
Hoke	17.60%	17.69%	0.09%	5.15%	4.83%	-0.32%	0.00%	0.00%	0.00%	11.07%	11.00%	-0.07%
Lee	16.77%	16.37%	-0.40%	4.23%	3.79%	-0.44%	0.00%	0.00%	0.00%	9.77%	9.49%	-0.28%
Montgomery	19.17%	18.37%	-0.80%	8.33%	7.58%	-0.75%	0.00%	0.00%	0.00%	10.63%	10.44%	-0.19%
Moore	20.71%	21.38%	0.67%	8.90%	5.64%	-3.26%	0.00%	0.00%	0.00%	12.87%	13.06%	0.19%
Randolph	16.53%	16.61%	0.08%	2.92%	3.76%	0.84%	0.00%	0.00%	0.00%	10.03%	10.67%	0.64%
Richmond	21.66%	23.41%	1.75%	7.36%	5.85%	-1.51%	0.00%	0.00%	0.00%	14.86%	14.57%	-0.29%

(b) Waiver Validation Results

All measures received a validation score of 100% and were found Fully Compliant. The stored procedures have been updated to address NC Medicaid's most recent changes to the measures. Table 21 contains validation scores for each of the 10 (b) Waiver Performance Measures.

Table 21: (b) Waiver Performance Measure Validation Scores

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

(c) Waiver Measures Reported Results

Five (c) Waiver Measures were chosen for validation. The rates reported by Sandhills, and the State benchmarks are displayed in *Table 22: (c) Waiver Measures Reported Results 2021 - 2022*. Documentation on data sources, data validation, source code, and calculated rate for the five measures was provided. Additionally, all rates exceeded the State Performance Benchmarks.

Table 22: (c) Waiver Measures Reported Results 2021-2022

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	969/969 = 100%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	969/969 = 100%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	54/63 = 85.71%	85%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	1851/1851 = 100%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	63/63 = 100%	85%

** Latest reported rates are shown in the Excel file submitted by Sandhills "SHC Innovations Waiver 11 01 2021 Submissions" for annual rate and "SHC Innovations Waiver Reporting 05 01 2022" for quarterly rates.*

(c) Waiver Validation

All (c) Waiver Measures met the validation requirements and were Fully Compliant as shown in *Table 23, (c) Waiver Performance Measure Validation Scores*. The validation worksheets offer detailed information on validation and calculation steps for (c) Waiver Measures.

Table 23: C Waiver Performance Measures Validation Scores

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

Performance Improvement Project (PIP) Validation

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

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

PIP Validation Results

For the 2021 review, 7 projects were submitted, and 4 active PIPs were validated, including Assure Consistent Connection to Community Services, TCLI Timeliness Documentation Submission, NC-TOPPS Interview Data Accuracy, and Routine Appointments Kept. Two PIPs showed improvement in their rates and two PIPs had a decline. Recommendations regarding results presentation and interventions were offered. No corrective actions were given. For this year's 2022 EQR, there were 4 actives PIPs submitted, and all four were validated. A review of the documentation and validation was completed.

The Assure Consistent Connection to Community Services for FBC Services and the score was 99% at the previous validation. The most recent quarterly rate for the overall population for Q1 2021/2022 was 56% (121 connected to a community provider out of 216) compared to the Q4 2020/2021 rate of 55% (39 out of 71 members). The goal rate is 70%. The lowest performing provider had a rate of 28% in Q4 2020/2021 which decline to 0% in Q1 2021/2022. The overall rate showed improvement from the previous quarter.

For the Initial NC TOPPs Data Accuracy, the previous review showed a validation score of 94%. The most recent rate was 83.3% with no errors (724 out of 869 consumer interviews) which is an improvement from the Q3 2021/2022 rate of 82.3%. The goal is 85%.

TCLI Timeliness Documentation Submission – This PIP was validated for the 2021 EQR and received a score of 93%. The goal is to reduce the late entry error rate to 0% for care coordination documentation, so lower rates are better for this PIP. The report shows a rate of 1.81% of late entries for Q4 2021/2022 (49 out of 2713). This is a decrease from the Q3 2021/2022 rate of 2.45% (76 out of 3098). Thus, the most recent rate showed improvement.

Routine Appointments Kept – This PIP was validated last year and received a score of 99%. The goal is to increase members with routine appointments that keep their appointment. The goal is 66%. The most recent measure was for Q4 2021/2022 and showed a rate of 19% (7 out of 36 routine appointments that were kept). This was a decline from the Q3 2021/2022 rate of 38% (9 out of 24 appointments). The rate of 19% is the lowest since the start of the PIP.

Table 24: PIP Summary of Validation Scores

Project Type	Project	2021 Validation Score	2022 Validation Score
Non-Clinical	NC-TOPPS Interview Data Accuracy	74/79 = 94% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
	Routine Appointments kept	73/74 = 99% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results
	TCLI Timeliness Documentation Submission	67/72 = 93% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
Clinical	Assure Consistent Connection to Community Services	79/80 = 99% High Confidence in Reported Results	80/80 = 100% High Confidence in Reported Results

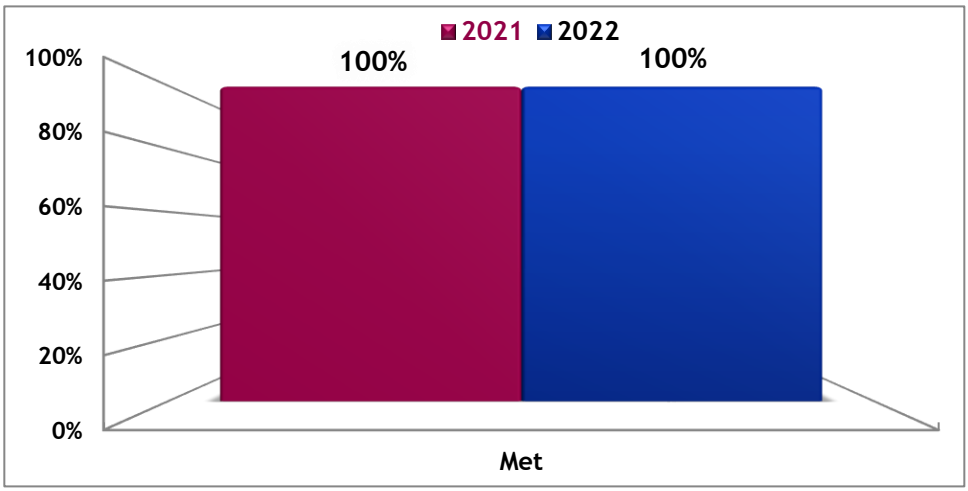
For one of four PIPs, there is a Recommendation regarding the assessment of the interventions to improve rates, which showed a decline in the most recent remeasurement period. The project, section, reason, and Recommendation is displayed in Table 25.

Table 25: Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Routine Appointments kept (Non-Clinical)	Was there any documented, quantitative improvement in processes or outcomes of care?	The goal is 66%. The most recent measure was for Q4 2021/2022 and showed a rate of 19% (7 out of 36 routine appointments that were kept). This was a decline from the Q3 2021/2022 rate of 38% (9 out of 24 appointments). The rate of 19% is the lowest since the start of the PIP.	Assess impact of texts and call reminders and determine if there are methods to obtain evidence that members have received texts and are speaking to staff on phone calls

There were no Corrective actions for any of the four validated PIPs. Details of the validation activities for the PMs and PIPs and specific outcomes related to each activity may be found in *Attachment 3, CCME EQR Validation Worksheets*. As demonstrated in Figure 4, Sandhills met all the Quality Improvement standards in the 2022 EQR.

Figure 4: Quality Improvement Comparative Findings



Strengths

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

Weaknesses

- Measurement rate declined to lowest rate since start of PIP for Routine Appointments Kept PIP.

Recommendations

- Routine Appointments Kept PIP: Assess impact of texts and call reminders and determine if there are methods to obtain evidence that members have received texts and are speaking to staff on phone calls

D. Utilization Management

42 CFR § 438.208

The EQR of Utilization Management (UM) included a review of the Care Coordination and Transition to Community Living (TCLI) programs. CCME reviewed relevant policies and procedures, Sandhills' Organizational Chart, Sandhills' *Member Handbook* and ten files of enrollees participating in Mental Health/Substance Use (MH/SU), Intellectual/Developmental Disability (I/DD), and Transition to Community Living Initiative (TCLI) Care Coordination. Sandhills also submitted for review several tools, reports, and data related to their internal review of Care Coordination documentation.

In the 2021 EQR, Sandhills met 100% of the UM standards and received three Recommendations related to incorrect information in an I/DD procedure, the MH/SU files reviewed, and the I/DD files reviewed. Table 26 outlines the 2021 findings and CCME's follow up in the 2022 EQR regarding Sandhills' implementation of those Recommendations.

Table 26: 2021 EQR Utilization Management Findings

2021 EQR Utilization Management Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Determination of which Behavioral Health Services are medically necessary;	Sandhills' Procedure CC 12a, I/DD Deinstitutionalization Planning, states, "Funding is capped at $135,000 annually. Service costs within the base and non-base budget must not exceed this yearly amount." However, *NC Medicaid Joint Communications Bulletin #J362* allows the enrollees to exceed the Innovations funding cap when: • The individual lives independently. • The individual receives Supported Living Levels III, and • The individual requires 24-hour support. ***Recommendation: Revise Procedure CC 12a, I/DD Deinstitutionalization Planning to include the exclusions to the Waiver cost limits/funding cap as listed in NC Joint Communication Bulletin #J362.***	**Y**
2022 EQR Follow up: Review of Sandhills Procedure 12a, I/DD Deinstitutionalization Planning, now lists the three funding cap exceptions allowed in *Joint Communication Bulletin #J362*.		

2021 EQR Utilization Management Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
3. The PIHP applies the Care Coordination policies and procedures as formulated.	For this EQR, Sandhills showed significant improvement in submitting progress notes and other required Care Coordination documentation in a timely manner. However, the review of I/DD Care Coordination files showed that progress notes did not capture all monitoring, interventions, and supports provided by the Care Coordinator. For example, the review found in two out of three I/DD files that monitoring for service utilization to ensure I/DD providers did not exceed authorization amount or that services were being under-utilized did not occur. Sandhills' Procedure I/DD CC 2a, I/DD Care Coordination Monitoring of Plan Implementation, lists the "review of claims submitted, as a means of monitoring service delivery and identifying potential service deviations" as a monitoring activity. The procedure also states, "All monitoring contacts and attempts to monitor will be documented in enrollees electronic medical record..." Additionally, *NC Medicaid Contract 6.11.3 (h), Section o (6)* lists the monitoring of service utilization as a function of the Innovations Care Coordinator. ***Recommendation: Ensure I/DD progress notes and Monitoring Checklists are complete and concise, capture all monitoring contacts, and follow documentation requirements listed in Sandhills' Procedure I/DD CC 2a, and the NC Medicaid Contract 6.11.3 (h), Section o (6) and Amendments.*** The review of MH/SU files found patterns of inconsistent labeling of Care Coordination levels of care. Sandhills' Procedure CC 22a, MH/SU Care Coordination Levels of Care Coordination Provided to MH/SU Care Coordination Members, outlines the MH/SU tier system used to determine the levels of care provided by the Care Coordinator. Each tier has a list of interventions that must or may be met to determine if the member is ready to step down to a lower level of care or discharge from Care Coordination. The review found that changes in levels of care did not correspond with interventions listed in Procedure CC 22a. For example, in one MH/SU file, the member was stepped down to a "medium" level of care while hospitalized. Additionally, on the same day,	**N**

	the member was referred to community services. During the Onsite, Sandhills stated that this member would not qualify for "medium" level of care and acknowledged issues with fully implementing the Procedure but suggested that more recent progress notes reflect the interventions listed in the Procedure. However, the review found progress notes dated as recently as April 2020 with labeled levels of care that did not correspond with the required interventions provided by the Care Coordinator. ***Recommendation: Ensure MH/SU progress notes are clear and concise and that interventions provided by the Care Coordinator correspond with Sandhills' Procedure CC 22a prior to stepping enrollees down to a lower level of care or discharging from Care Coordination.***	
2022 EQR Follow up: While Sandhills could provide evidence of their efforts to review and improve the completeness, accuracy and timeliness of Care Coordination documentation, evaluation of Sandhills' review methods, tools, and outcome data showed continued patterns of noncompliance.		

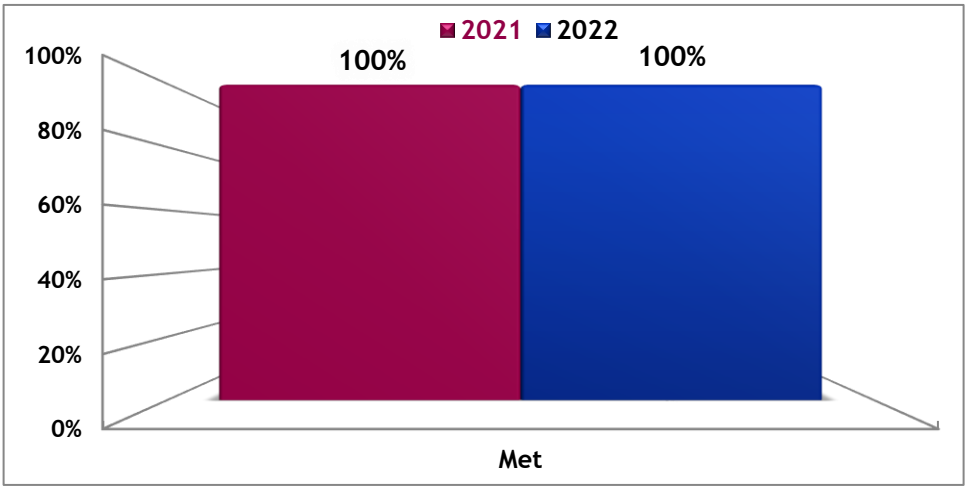
In the 2022 EQR, CCME reviewed Sandhills' processes for internally reviewing Care Coordination documentation for compliance with Sandhills' policies and procedures, as well as the overall quality, completeness, and timeliness of documentation. For this review, Sandhills submitted several reports across all three departments demonstrating performance by Care Coordination in the areas of timely progress notes and completeness and accuracy of documentation within enrollees' files.

Evaluation of these reports along with the review of the MH/SU, I/DD, and TCLI files chosen by Sandhills for this year's EQR showed continued issues. While some areas and departments demonstrated progress (e.g., TCLI timeliness of progress notes), most showed a regression in performance over the past year. Examples of these issues are described in the *Tabular Spreadsheet* (Attachment 3) of this report, in the Care Coordination section of the tabular spreadsheet.

During the Onsite, CCME discussed these findings and explored potential interventions to improve overall documentation performance by Care Coordinators. CCME is again recommending Sandhills continue to enhance their current processes for ensuring all Care Coordination documentation is compliant with Sandhills' procedures and will improve the quality, completeness, and timeliness of documentation.

Figure 5 shows 100% of the Utilization Management standards were scored as "Met" in the 2021 EQR and compares these to the 2022 EQR UM score.

Figure 5: Utilization Management Comparative Findings



Strengths

- In two of the MH/SU files reviewed where the enrollee was new to Care Coordination, contacts by Care Coordinators were compliant with the engagement frequency required in Procedure CC 22a, Levels of Care Coordination, provided to MH/SU Care Coordination Enrollees.
- The files selected and submitted by Sandhills for the EQR provided good examples of the effectiveness of Care Coordinator interventions.

Weaknesses

- Evaluation of Sandhills' documentation review methods, tools, and outcome data showed, overall, efforts are not resulting in a significant improvement in the quality, completeness, and timeliness of Care Coordination documentation and overall compliance with Sandhills' policies and procedures.
- Review of the TCLI files submitted by Sandhills for this year's EQR showed a pattern of late progress notes, missing or late Quality of Life surveys, and late completion of In-Reach tools.

Recommendations

- Enhance the current MH/SU and I/DD documentation monitoring process to ensure continued progress in Care Coordination documentation quality, completeness, and timeliness and overall compliance with Sandhills' policies and procedures.
- Ensure Sandhills' process of monitoring TCLI Care Coordination documentation continues to target not only timeliness of progress notes, but the timeliness, completeness, and accuracy of all documentation (e.g., Quality of Life surveys, In-Reach tools, etc.)

E. Grievances and Appeals

42 CFR § 438, Subpart F

The Grievances and Appeals EQR included a Desk Review of policies and procedures, 10 Grievance and 10 Appeal files, the Grievance and Appeal Logs, the *Medicaid/State Provider Manual* dated November 2, 2021, the *Member Handbook* dated January 25, 2022, and information about Grievances and Appeals available on the Sandhills' website. An Onsite discussion with Grievance and Appeals staff occurred to further clarify the PIHP's documentation and processes.

In the 2021 EQR, Sandhills met 100% of the Grievance and Appeal standards, resulting in no Corrective Actions. CCME issued one Recommendation in Grievances and three Recommendations in Appeals.

In this 2022 EQR, Sandhills met 100% of the Grievance and Appeal standards, resulting in no Corrective Actions. CCME issued one Recommendation in Grievances and two Recommendations in Appeals.

Grievances

In the 2021 EQR, Sandhills received one Recommendation targeting documentation of required notifications in their Grievance monitoring process for extended resolution timeframes. This Recommendation was not incorporated into the written Grievance monitoring process for the 2022 EQR and remains a Recommendation for the 2022 EQR.

Table 27 outlines CCME's review of the 2021 EQR Grievance Recommendation that was not implemented.

Table 27: Follow up to 2021 EQR Grievance Corrective Actions and Recommendations

2021 EQR Grievance Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP applies the Grievance policy and procedure as formulated.	***Recommendation: Enhance the Grievance monitoring process for extended resolution timeframes to include review of notifications required by 42 CFR § 438.408 (c)(2) and by Sandhills' Procedure CORE 35a on page 6 which states, "If the timeframe is extended, the member will receive prompt oral notice. Within 2 calendar days, the member will receive a written notice of the reason to extend the timeframe."***	**N**
2022 EQR Follow up: This Recommendation was not incorporated into the written Grievance monitoring process for the 2022 EQR and remains a Recommendation.		

For the 2022 EQR, CCME reviewed 10 Grievance files. All timeliness requirements were met, including sending an acknowledgement letter within five working days, as per Sandhills' Procedure CORE 35a, Consumer Grievance Process- Medicaid and State-Funded. All Grievances were resolved within 30 days, as per Sandhills' procedure. There were three Grievances that were referred outside of Sandhills. One was a Grievance for DHHS and two were for other PIHPs since those members were not in the Sandhills catchment area. There were also three files where the grievant asked to be anonymous or didn't want to be contacted. Appropriately, these files didn't contain acknowledgement letters or resolution letters and, they were closed or resolved in 30 days. When reviewing the Grievance Log against the file review, CCME noted one file had the wrong resolution date on the Log. During the Onsite interview, Sandhills staff explained that was a typo in transferring data. All other data on the Log were consistent with the file review.

Appeals

In the 2021 Appeals EQR, Sandhills met 100% of the Appeal standards, resulting in no Corrective Actions. CCME issued three Recommendations. The first Appeal Recommendation targeted documentation updates for Appeals initiated orally. An additional written request is not required. This was partially implemented and remains a Recommendation for the 2022 EQR. The second Appeal Recommendation was to ensure all Appeals have a written resolution, even if the Appeal was withdrawn or invalid. This was implemented. CCME's third Appeal Recommendation was for Appeal Coordinators to confirm guardianship and document that in the Appeal file and to add the guardianship verification to the Appeal Monitoring Tool. This was not implemented and remains a Recommendation for the 2022 EQR.

Table 28 outlines CCME's review of the Recommendations and indicates if Sandhills implemented the Recommendations.

Table 28: Follow up to 2021 EQR Appeals Corrective Actions and Recommendations

2021 EQR Appeals Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The procedure for filing an Appeal;	***Recommendation: Update Procedure HUM 34a, Appeals Process (Medicaid), the Member Handbook, and the Medicaid/State Provider Manual to clarify that a written Appeal is no longer required following the submission of an oral Appeal, per 42 CFR § 438.402 (c)(3)(ii) and 438.406 (b)(3).***	**N**
2022 EQR Follow up: Procedure HUM 34a, Appeals Process (Medicaid) and the *Member Handbook* contain this update. The *Medicaid/State Provider Manual* does not contain this update. The Recommendation remains for the 2022 EQR for Sandhills to update the *Medicaid/State Provider Manual* on page 107 to clarify that a written Appeal is no longer required following the submission of an oral Appeal, per *42 CFR § 438.402 (c)(3)(ii) and 438.406 (b)(3).*		

2021 EQR Appeals Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
2. The PIHP applies the Appeal policies and procedures as formulated.	***Recommendation: Revise the Appeal process to include that a written resolution notification is sent to all members/guardians who file an Appeal, including those that are withdrawn or invalid per Attachment M (G) (7).***	**Y**
2022 EQR Follow up: Sandhills has implemented a process to send a resolution notification letter to all members/guardians who file an Appeal.		
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	***Recommendation: Include documentation of the guardianship verification check in the Appeal file and add guardianship verification to the Appeal Audit Tool.***	**N**
2022 EQR Follow up: For the files reviewed in the 2022 EQR, CCME looked for documentation that the Appeals Coordinator confirmed guardianship. Guardianship verification was not documented in any of the files reviewed. Guardianship verification was not added to the Sandhills Appeal Audit Tool. From Onsite discussion, guardianship is checked in Alpha+, but not documented in the Appeal file. CCME has issued the same Recommendation for the 2022 EQR, which is for Sandhills to Include documentation of the guardianship verification check in the Appeal file and add guardianship verification to the *Appeal Audit Tool*.		

In the 2022 EQR of Appeals, CCME issued two Recommendations and no Corrective Actions. The Recommendations target incorrect information in the *Medicaid/State Provider Manual* and a process needed to perform guardianship verification checks within the Appeal file and on Appeal Audit Tool.

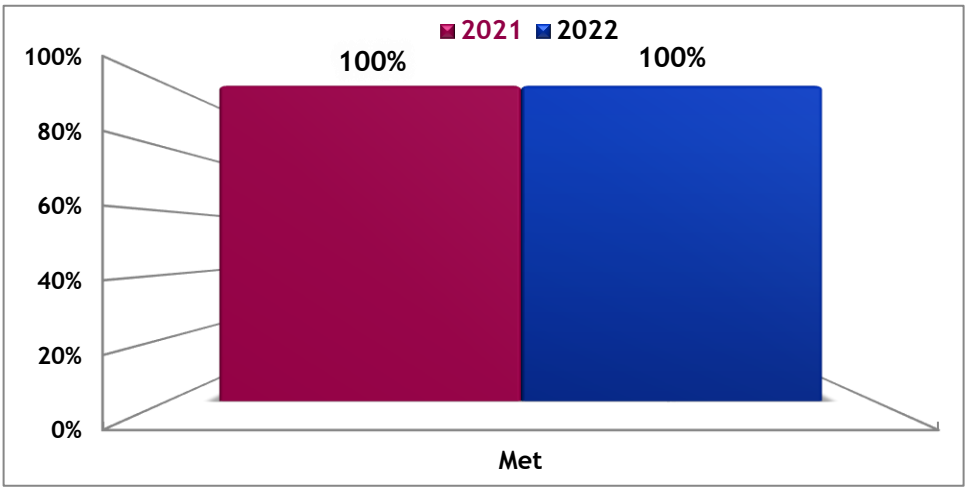
In the 2022 EQR, Appeals file review, one file was missing a resolution letter. This was a withdrawn Appeal and, during the Onsite, Sandhills staff confirmed no Appeal resolution letter was sent to the member. This file was completed prior to last year's EQR feedback explaining the Recommendation to issue a resolution letter for all appeals including withdrawn and invalid Appeals. Sandhills has implemented a process to send a resolution notification letter to all members/guardians who file an Appeal. All files with invalid or withdrawn Appeals that were dated subsequent to the 2021 CCME feedback contained a resolution letter.

In the 2022 EQR Appeal file review, all timeliness metrics were met according to federal regulations and Sandhills' procedure. There was one Appeal Log discrepancy for an expedited Appeal. The Log says 3/24/22 was the date the Appeal was initiated. This

Appeal request was actually faxed on 3/23/22 but logged on 3/24/22. Since an expedited Appeal needs to be resolved in 72 hours per *NC Medicaid Contract Attachment M (H) (5),* it is important to correctly log Appeal dates. This Appeal was resolved in two days, which gave a cushion for the 72-hour timeliness metric. Otherwise, all data in the Log matched the file review.

Figure 6, Grievances and Appeals Comparative Findings, shows that 100% of the standards in the 2022 Grievances and Appeals EQR were scored as "Met". This figure also provides an overview of 2022 scores compared to 2021 scores.

Figure 6: Grievances and Appeals Comparative Findings



Strengths

- Sandhills staff reported additional training is planned for the Care Coordinators to address a weakness identified in the Experience of Care and Health Outcome (ECHO) survey. Training will focus on information that allows Care Coordinators to communicate the Appeals process more effectively.
- Sandhills implemented an internal peer-to-peer process in Appeals after the 2021 EQR to help with training and consistency within the Appeals Department. This process has been received well by staff.

Weaknesses

- The written Grievance monitoring process for extended resolution timeframes does not include monitoring for notifications required by *42 CFR § 438.408 (c)(2)* and by Sandhills' Procedure CORE 35a on page six which states, "If the timeframe is extended, the member will receive prompt oral notice. Within 2 calendar days, the member will receive a written notice of the reason to extend the timeframe."

- The *Medicaid/State Provider Manual* contains incorrect information. A written Appeal is no longer required following the submission of an oral Appeal, per *42 CFR § 438.402 (c)(3)(ii)* and *438.406 (b)(3)*.

- Guardianship verification was not documented in any of the files reviewed and was not included as an element to review on the Sandhills Appeal Audit Tool.

Recommendations

- As in the 2021 EQR, CCME recommends that Sandhills enhance the written Grievance monitoring process for extended resolution timeframes to include review of notifications required by *42 CFR § 438.408 (c)(2)* and by Sandhills' Procedure CORE 35a on page six which states, "If the timeframe is extended, the member will receive prompt oral notice. Within 2 calendar days, the member will receive a written notice of the reason to extend the timeframe."

- As in the 2021 EQR, CCME recommends that Sandhills update the *Medicaid/State Provider Manual* on page 107 to clarify that a written Appeal is no longer required following the submission of an oral Appeal, per *42 CFR § 438.402 (c)(3)(ii)* and *§ 438.406 (b)(3)*.

- As in the 2021 EQR, CCME recommends that Sandhills include documentation of the guardianship verification check in the Appeal file and add guardianship verification to the Appeal Audit Tool.

F. Program Integrity

42 CFR § 438.455 and 1000 through1008, 42 CFR § 1002.3(b)(3), and 42 CFR 438.608 (a)(vii)

The 2022 Program Integrity (PI) EQR for Sandhills encompassed a thorough Desk Review of Sandhills' policies and procedures related to Special Investigative Unit (SIU) investigations, Provider Overpayments, and related aspects of compliance. PI staffing, workflows, reports, training materials, committee minutes, and data mining efforts were also review. Finally, a review of ten investigative case files were also evaluated for compliance with Sandhills' NC Medicaid Contract, federal regulations, and Sandhills' procedures. Discussion with Sandhills Compliance, Program Integrity, Claims, Waiver Programs, Special Investigations staff, and Chief Compliance Officer (CCO) also occurred during the Onsite to obtain additional clarification regarding Sandhills' PI functions.

In the 2021 EQR, Sandhills met 100% of the PI standards. There were two Recommendations and no Corrective Actions issued. Table 29 displays the 2021 findings and evidence presented in the 2022 EQR that Sandhill addressed these findings in the past year.

Table 29: Follow up to 2021 EQR Program Integrity Recommendations

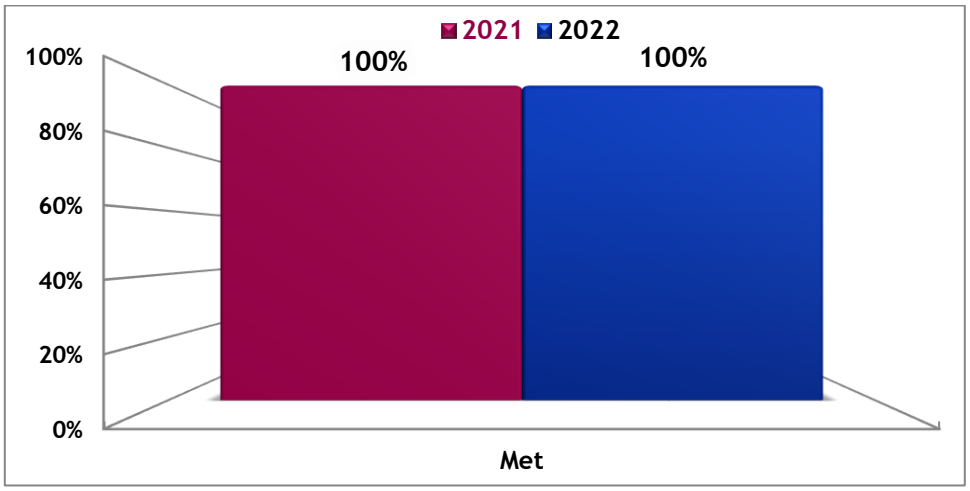
2021 EQR Program Integrity Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
PIHP shall designate, however named, a Compliance Officer who meets the requirements of *42 CFR § 438.608* and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under NC Medicaid Contract in accordance with *42 CFR § 438.608(a)(1)(iv).*	***Recommendation: Define the frequency of the ongoing BOD Compliance training in their Corporate Compliance & Internal Audit Plan to ensure this training is occurring consistently.***	**Y**
2021 EQR Follow up: In the 2022 EQR, Sandhills provided the *Corporate Compliance & Internal Audit Plan FY 2021-2022 & 2022-2023 Addendum.* This addendum showed Sandhills addressed the 2021 Recommendation as the frequency of Board of Directors (BOD) compliance training is now defined within the addendum.		
Standard	**EQR Comments**	**Implemented Y/N/NA**
In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:	***Recommendation: Continue with the PI Department's strategy to eventually eliminate the backlog of older PI cases.***	**Y**
2021 EQR Follow up: In the 2022 EQR, there was evidence Sandhills addressed the 2021 Recommendation and reduced the number of older cases from 23 cases in 2021 to nine cases in 2022.		

In the 2022 EQR, review of the PI cases submitted showed Sandhills initiated all investigations within the timeframe required by Sandhills' procedures, federal regulations, and Sandhills' contract with NC Medicaid. Sandhills has a detailed workflow that outlines the investigative process from taking a complaint to the closing of an investigation. However, a discrepancy was found when comparing the workflow to the files reviewed. In one of the closed PI files reviewed, Sandhills issued a tentative notice of overpayment (TNO) in the amount of $241.20 and a Case Summary was used to report the findings of the investigation. The use of the case summary did not meet the requirements listed in Procedure PI 1a, Investigative Process, which states, "Case summaries should be used in cases where extensive investigation was not required to support or refute the allegation(s) *and* when no adverse action (ex. TNO, referral to DHB, etc.) is to be taken as a result of the investigation." During the Onsite, Sandhills acknowledged the use of the Case Summary did not meet the requirements listed in the procedure. CCME recommends Sandhills ensures PI case findings are reported on the appropriate template as required by Procedure PI 1a, Investigative Process.

Sandhills Procedure PI 7a, Provider Self-Audit, describes the process by which providers can report the results of their self-audit that indicated potential fraud, waste, and abuse. The procedure does not describe how Sandhills' staff handles these reports internally. During the Onsite, Sandhills staff were able to detail their internal process. CCME is recommending Sandhills document this full internal process to ensure consistency in the handling of provider self-audit reports.

Figure 7, Program Integrity Finding, shows that 100% of the standards in the 2022 Program Integrity EQR were scored as "Met", and provides an overview of 2022 scores compared to 2021 scores.

Figure 7: Program Integrity Findings



Strengths

- Sandhills continues to reduce the backlog of older PI cases.
- The *Corporate Compliance & Internal Audit Plan FY 2021-2022 & 2022-2023 Addendum,* details Sandhills methods for preventing and detecting potential fraud, waste, and abuse.

Weaknesses

- Sandhills does not follow the criteria for using the Case Summary as outlined in Procedure PI 1a, Investigative Process.
- Sandhills does not have the process for handling provider self-audits documented.

Recommendations

- Ensure PI case findings are reported on the appropriate template as required by Procedure PI 1a, Investigative Process.
- To ensure continuity in information given to providers when making a self-report of potential fraud, waste and or abuse, develop a desk guide or desk reference outlining the process for handling provider self-audits.

G. Encounter Data Validation

The review, guided by the Centers for Medicare and Medicaid Services (CMS) External Quality Review Protocol, focused on measuring the data quality and completeness of claims paid by Sandhills for the period of January 2021 through December 2021. All claims paid by Sandhills are required to be submitted and accepted as a valid encounter to NC Medicaid. The approach to the review included:

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

Results and Recommendations

Issue: Other Diagnosis

Other Diagnosis codes were often missing, especially on Professional claims. Principal and admitting diagnosis were populated consistently, and Sandhills has made progress in reporting additional Diagnosis codes. However, many Professional claims continue to be missing secondary Diagnosis codes.

Resolution:

Over the past few years, Sandhills made progress in reporting Other Diagnosis codes, especially on Institutional claims. However, there are many providers who do not report more than one Diagnosis code. Aqurate recommends alerting such providers to remind them to ensure that submitted claims are complete and accurate, including secondary Diagnosis codes.

Conclusion

The analyses of Sandhills' encounter data showed that the data submitted to NC Medicaid is complete and accurate. Only one issue was found with Other Diagnosis codes being frequently absent on both Professional and Institutional encounters.

Overall, Sandhills continue to make progress in improving the accuracy of encounter data over the past few years and should continue to be vigilant in resolving issues related to Billing Taxonomy, Rendering Taxonomy, and Procedure codes. Additionally, Sandhills should continue to remind providers of their responsibility to ensure that the coding on claims is accurate, with added emphasis on Other Diagnosis codes. Sandhills should revisit its strategy to address invalid or missing codes, as well as a reconciliation process and make necessary adjustments to further reduce denials. The goal is to avoid denials by improving synchronization of data with NCTracks, in particular the Global Provider File. This improvement would, in turn, reduce the follow-up needed to correct and resubmit encounters.

Missing Other Diagnosis codes on Professional and Institutional claims do not impact the ability to price the claims, and, therefore, do not end up being reported as denials. However, the lack of data may impact NC Medicaid's ability to provide proper oversight, including measurement of quality of care and setting appropriate fees and rates. Sandhills is encouraged to work with its providers to make sure they are documenting and coding all diagnoses.

ATTACHMENTS

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

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

June 27, 2022

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

Dear Ms. Whitt,

At the request of the North Carolina Medicaid (NC Medicaid) this letter serves as notification that the 2022 External Quality Review (EQR) of Sandhills Center (Sandhills) is being initiated. The review will be conducted by us, The Carolinas Center for Medical Excellence (CCME), and is a contractual requirement. The review will include both a Desk Review (at CCME) and a one-day, virtual Onsite that will address contractually required services.

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

The CMS EQR protocols can be found at:

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

Due to COVID-19 and the issuance of the contractual flexibilities issued by the State outlined in Contract Amendment #11, the 2022 EQR will be a focused review. The focus of this review will be on the Sandhills' Corrective Actions from the previous EQR and Sandhills functions that impact enrollee health and safety. Similarly, for the 2022 EQR, the two-day Onsite previously performed at Sandhills' offices will conducted during a one-day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **August 25, 2022**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

In preparation for the Desk Review, the items on the enclosed **Desk Materials List** are to be submitted electronically. **Please note that, to facilitate a timely review, there are three items on the Desk Materials List (items 9, 10, and 19.a) that should be submitted by no later than July 1, 2022,** and the remaining items are due by no later than **August 2, 2022**. Also, as indicated in item 20 of the Desk Materials List, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted with the other Desk Materials on **August 2, 2022**.

All 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

Also, please note that for this year's upload of Encounter Data (item 21), the data should be uploaded into the folder labelled "EDV" within CCME's secure documentation portal along with all other EQR materials.

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

Katherine Niblock, MS, LMFT
CCME Project Manager, External Quality Review
Enclosure(s) – 6

Cc: Comellia Saunders, Sandhills Center Contract Manager
Theresa Clark, Sandhills Center Project Manager/Business Analyst
Tasha Griffin, NC Medicaid Waiver Contract Manager
Deb Goda, NC Medicaid Associate Director, Behavioral Health and IDD
Christean Hunter, NC Medicaid Quality Management Specialist

SANDHILLS

Focused External Quality Review 2022

MATERIALS REQUESTED FOR DESK REVIEW

**** Please note that the lists requested in items 9, 10, and 19.a must be uploaded by no later than July 1, 2022. The remainder of items must be uploaded by no later than August 2, 2022.**

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

2. Organizational Chart of all staff members including names of individuals in each position including their degrees, licensure, and any certifications required for their position. Include any current vacancies. In addition, please include any positions currently filled by outside consultants/vendors.

3. Description of major changes in operations such as expansions, new technology systems implemented, etc. Include any major changes to PIHP functions related to COVID-19.

4. A summary of the status of all Corrective Action items from the previous External Quality Review. Please include evidence of Corrective Action implementation.

5. List of providers credentialed/recredentialed in the last 12 months (June 2021 through May 2022). Include the date of approval of initial credentialing and the date of approval of recredentialing.

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

7. Minutes of committee meetings for the following committees:
   a) Credentialing (for the three most recent committee meetings)
   b) UM (for the three most recent committee meetings)

8. Membership lists and a committee matrix for all committees, including the professional specialty of any non-staff members. Please indicate which members are voting members. Include the required quorum for each committee.

9. **By July 1, 2022, a copy of the complete Appeal log for the months of June 2021 through May 2022. Please indicate on the log: the Appeal type (standard, expedited, extended, withdrawn, or invalid), the service appealed, the date the Appeal was received, and the date of the Appeal resolution notification.

10. **By July 1, 2022, a copy of the complete Grievance log for the months of June 2021 through May 2022. Please indicate on the log: the nature of the Grievance, the date received, and the date of the Grievance resolution notification.

11. Copies of all Appeal notification templates used for expedited, invalid, extended, and withdrawn Appeals.

12. For Appeals and Grievances, please submit a description of your monitoring process that reviews compliance of oral and written notifications, completeness of documentation within the Appeal and Grievance records, accuracy of Appeal and Grievance logs, etc. Provide details regarding frequency of monitoring and any benchmarks, performance metrics, and reporting of monitoring outcomes.

13. Please submit a summary of new provider orientation processes and include a list of materials and training provided to new providers.

14. For MH/SU, I/DD, and TCLI Care Coordination, please submit a description of your monitoring plan that reviews compliance of Care Coordinator documentation. Include in the description the elements reviewed (timeliness of progress notes, timeliness of Innovations monitoring, timeliness of Quality of Life surveys, review of quality, completeness of discharge notes, accuracy of documentation, etc.). Provide details regarding frequency of monitoring, and any benchmarks, performance metrics, and reporting of monitoring outcomes.

15. For Care Coordination enrollee files, please provide:
    a. three MH/SU Care Coordination enrollee files (two active since 2020 and one recently discharged)
    b. three I/DD Care Coordination enrollee files (two active since 2020 and one recently discharged)
    c. four TCLI Care Coordination enrollee files (one active since 2020, one who received In-Reach, one who transitioned to the community and recently discharged).

    NOTE: Care Coordination enrollee files should include all progress notes, monitoring tools, Quality of Life surveys, and any notifications sent to the enrollees.

16. Information regarding the following selected Performance Measures:

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

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

Required information includes the following for each measure:

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

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

c. Reporting frequency and format;

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

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

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

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

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

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

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

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

18. Provide copies of the following files:

a. Credentialing files for the four most recently credentialed practitioners (as listed below)

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

In addition, please include one file for a network provider agency.

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

b. Insurance:
   1. Proof of all required insurance, or a signed and dated statement/waiver/attestation from the practitioner/agency indicating why specific insurance coverage is not required.
   2. For practitioners joining already-contracted agencies, include copies of the proof of insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.
      i. All PSVs conducted during the current process, including current supervision contracts for all LPAs and all provisionally-licensed practitioners (*i.e.*, LCAS-A, LCSW-A).
      ii. Ownership disclosure information/form.

c. Recredentialing files for the four most recently credentialed practitioners (as listed below)
   - One licensed practitioner who is joining an already contracted agency
   - One non-MD, Licensed Independent Practitioner (i.e., clinician who will have their own contract)
   - One physician
   - One practitioner with an associate licensure (e.g., LCSW-A, LMFT-A, etc.)

   In addition, please provide one file for a network provider agency

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

   i. Proof of original credentialing date and all recredentialing dates, including the current recredentialing (this is usually a letter to the provider, indicating the effective date).
   ii. Insurance:
      A. Proof of all required insurance, or a signed and dated statement/waiver/attestation from the practitioner/agency indicating why specific insurance coverage is not required.

B. For practitioners joining already-contracted agencies, include copies of the proof of insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.
    i. All PSVs conducted during the current process, including current supervision contracts for all LPAs and all provisionally-licensed practitioners (*i.e.*, LCAS-A, LCSW-A).
    ii. Site visit/assessment reports if the provider has had a quality issue or a change of address.
    iii. Ownership disclosure information/form.

19. Provide the following for Program Integrity:
    a. ****File Review:** Please produce a listing of all active files during the review period (June 2021 through May 2022) by July 1, 2022. The list should include the following information:
        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. Workflow of process of taking complaint from inception through closure.
    d. All 'Attachment Y' reports collected during the review period.
    e. All 'Attachment Z' reports collected during the review period.
    f. Provider Manual and Provider Application.
    g. Enrollee Handbook.
    h. 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.
    i. 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.
    j. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors, and employees.
    k. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other State or Federal agency.
    l. Code of Ethics and Business Conduct.
    m. Internal and/or external monitoring and auditing materials.
    n. Materials pertaining to how the PIHP captures and tracks complaints.
    o. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
        i. NC Medicaid approved reporting templates.

p. Sample Data Mining Reports.

q. Monthly reports of NCID holders/FAMS-users in PIHP.

r. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.

s. Corrective action plans including any relevant follow-up documentation.

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

a. A completed ISCA.

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

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

c. A copy of the IT Disaster Recovery Plan.

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

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

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

    a. Include all adjudicated claims (paid and denied) from January 1, 2021 – December 31, 2021. Follow the format used to submit encounter data to NC Medicaid (i.e., 837I and 837P). If you archive your outbound files to NC Medicaid, you can forward those to HMS for the specified time period. In addition, please convert each 837I and 837P to a pipe delimited text file or excel sheet using an EDI translator. If your EDI translator does not support this functionality, please reach out immediately to HMS.

    b. Provide a report of all paid claims by service type from January 1, 2021 – December 31, 2021. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

NOTE: EDV information should also be submitted via CCME's SFTP. If you have any questions, please contact Kathy Niblock at kniblock@thecarolinascenter.org.

B. Attachment 2: EQR Validation Worksheets

CCME Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Readmission Rates for Mental Health**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Readmission Rates for Substance Abuse**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Follow-up after Hospitalization for Mental Illness**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Follow-up after Hospitalization for Substance Abuse**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Mental Health Utilization –Inpatient Discharge and Average Length of Stay**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Mental Health Utilization**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Identification of Alcohol and Other Drug Services**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Substance Abuse Penetration Rate**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Mental Health Penetration Rate**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Percentage of Beneficiaries who received appropriate medication**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid PIHP Reporting Schedule- Innovations Measures

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid PIHP Reporting Schedule- Innovations Measures

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Percentage of level 2 and 3 incidents reported within required timeframes**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid PIHP Reporting Schedule- Innovations Measures

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Proportion of beneficiaries reporting they have a choice between providers**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid PIHP Reporting Schedule- Innovations Measures

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available**
Reporting Year:	**2021**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid PIHP Reporting Schedule- Innovations Measures

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with 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 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 Performance Improvement Project Validation Worksheet

PIHP Name:	**Sandhills**
Name of PIP:	**ASSURE CONSISTENT CONNECTION TO COMMUNITY SERVICES FOLLOWING FACILITY BASES CRISIS SERVICES**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to processes of care and functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data are collected are entered into the step down services database.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data are extracted from SHC Managed care system using paid claims data.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data extracted in a systematic manner.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are reported.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed monthly and reported quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	UM staff run the data.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters and interpretation of rate and lowest rate for the measure.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The most recent quarterly rate for the overall population for Q1 2021/2022 was 56% (121 connected to a community provider out of 216). Q4 2020/2021 rate of 55% (39 out of 71 members). The goal rate is 70%. The overall rate showed improvement from the previous quarter.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to have face validity.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Fisher's exact p-value was presented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**80**
Project Possible Score	**80**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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 Performance Improvement Project Validation Worksheet

PIHP Name:	**Sandhills**
Name of PIP:	**DECREASE THE TCLI CARE COORDINATION DOCUMENTATION SUBMISSION LATE ENTRY ERROR RATE TO 0%**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to processes of care and functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data are collected from the CCD entry report.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data are from the CCD report.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data extracted in a systematic manner.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are reported.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed monthly and reported quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	CCD staff run the data.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters and interpretation of rate and lowest rate for the measure.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The most recent rate was 83.3% with no errors (724 out of 869 consumer interviews) which is an improvement from the Q3 2021/2022 rate of 82.3%. The goal is 85%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to have face validity.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No statistical tests used; entire population evaluated.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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 Performance Improvement Project Validation Worksheet

PIHP Name:	**Sandhills**
Name of PIP:	**NC TOPPS INTERVIEW DATA ENTRY**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to processes of care and functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collected are displayed.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data are sourced from NC TOPPS and Alpha systems.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data extracted in a systematic manner.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are reported.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed monthly and reported quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Business Intelligence Department analyzes the data.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters and interpretation of rate and lowest rate for the measure.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The most recent rate was 83.3% with no errors (724 out of 869 consumer interviews) which is an improvement from the Q3 2021/2022 rate of 82.3%. The goal is 85%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to have face validity.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No statistical tests used; entire population evaluated.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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 Performance Improvement Project Validation Worksheet

PIHP Name:	**Sandhills**
Name of PIP:	**ROUTINE APPOINTMENTS KEPT**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to processes of care and functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collection sources are documented as the Alpha slot scheduler.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data are sourced from AlphaMCS system.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data extracted in a systematic manner.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are reported.
6.5 Did the study design prospectively specify a data analysis plan?	**MET**	Data analysis plan is collected and reported quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Care report analysts compute and clinical staff analyze the data.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters and interpretation of rate and lowest rate for the measure.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The goal is 66%. The most recent measure was for Q4 2021/2022 and showed a rate of 19% (7 out of 36 routine appointments that were kept). This was a decline from the Q3 2021/2022 rate of 38% (9 out of 24 appointments). The rate of 19% is the lowest since the start of the PIP. ***Recommendation: Assess impact of texts and call reminders and determine if there are methods to obtain evidence that members have received texts and are speaking to staff on phone calls***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement reported
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No statistical values presented for quarterly trends.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Goal has not been met; thus, sustainment analysis is not relevant.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	73
Project Possible Score	74
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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.*

C. Attachment 3: Tabular Spreadsheet

CCME PIHP Data Collection Tool

PIHP Name:	Sandhills
Collection Date:	2022

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A Management Information Systems						
1. Enrollment Systems						
1.1 The PIHP capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Sandhills had standard processes in place for enrollment data updates. General Dynamics Information Technology (GDIT) uploaded the daily and quarterly GEF files to the Alpha+ enrollment system. Sandhills utilized the monthly 820 capitation file to reconcile the payment received every month to the GEF to determine whether any payments were missing or if overpayments were received. Demographic data was captured and maintained in the Alpha+ system, and enrollment information was maintained indefinitely. Patient IDs were system generated by the Alpha+ system and were unique to members.
1.2 The PIHP is able to identify and review any errors found during, or as a result, of the State enrollment file load process.	X					Sandhills stored error record information in a separate table. If there were issues in the ELIG/TPL/MEDICARE record for a particular row, the results were moved to an error table instead of being parsed. The system first parsed the entire file before distributing it. The file contents were stored separately from the true enrollment data. The data was then parsed from this secondary table into the specific data subsets. No data was removed from the initial table.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 The PIHP's enrollment system member screens store and track enrollment and demographic information.	X					During the Onsite, Sandhills demonstrated the Alpha+ enrollment screens and the systems capability to store the demographic information. Sandhills indicated that a member could not exist under more than one identification number/Patient ID and edits were in place to help prevent multiple records for a member. In the unlikely event that a member has been entered into the Alpha+ system under different Medicaid IDs, the member records could be merged into a single system generated Patient ID.
2. Claims System						
2.1 The PIHP processes provider claims in an accurate and timely fashion.	X					The majority of claims received are electronic on a HIPAA file (82% for Institutional and 79% for Professional) or through the provider web portal (15% for Institutional and 24% for Professional). Very few claims are received via paper (approximately <1%). For claims received in 2021, 91.90% of Institutional and 99.86% of Professional claims were auto adjudicated on a nightly basis. Claims in excess of $5,000, Emergency Department claims, and Professional ED claims with a POS for emergency room were pended for manual review. Pended claims were reviewed daily via the "Manual Review Module" in Alpha+.
2.2 The PIHP has processes and procedures in place to monitor, review and audit claims staff.	X					Sandhills has processes in place to monitor and audit claims staff, routine and non-routine audits are performed. Routine audits: Sandhills performs internal weekly random audits, 3% of claims are audited. Paper claims are audited before and after data entry. Data entry of claims must occur within two business days of receipt. Non-Routine audits: Sandhills performs additional random audits by the Quality Management (QM) Department with assistance from Finance. Additional audits are performed on any provider or service that Utilization Management (UM) reviewers and/or claims processors bring to management's attention after working with providers and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						review of daily denied claims reports. The audits are performed by designated Claims Analysts. No audits were performed by claims processors. Daily denial reports are worked by claim processors to reduce denials and increase timeliness of paid claims.
2.3 The PIHP has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file. The PIHP has the capability of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	X					During the Onsite, Sandhills demonstrated the Alpha+ claims system capabilities to receive and store all ICD-10 Diagnosis codes. Sandhill Center's ISCA responses indicated that ICD-10 Procedure codes, Revenue codes and DRG codes are captured in the Alpha+ system and via the provider web portal. The revenue codes and DRG are also included for encounter data submission reporting. Up to 29 ICD-10 Diagnosis codes are captured for Institutional claims received via the web portal, electronically, and displayed on the claim screens. For Professional encounters, up to 12 ICD-10 Diagnosis codes are captured electronically, via the web portal and displayed on claim screens.
2.4 The PIHP's claim system screens store and track claim information and claim adjudication/payment information.	X					During the ISCA virtual site review, Sandhills demonstrated their provider web portal, claim system screens, and claim adjudication/payment information. Sandhills demonstrated their claim systems' ability to capture all the ICD-10 Diagnosis codes, DRGs, revenue codes, CPT/HCPCS, ICD-10 Procedure codes, and adjudication information.
3. Reporting						
3.1 The PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					ISCA responses indicated that Sandhills captures all required ICD-10 Diagnosis codes and can capture additional procedure, DRG, and revenue codes that are submitted on the claims. Sandhills stored and utilized the ICD-10 Procedure codes for reporting. Data is maintained in the Alpha+ system indefinitely.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.2 The PIHP has processes in place to back up the enrollment and claims data repositories.	X					ISCA responses indicate that Sandhills had processes in place that backup the enrollment and claims data in the Alpha+ system nightly in an AWS cloud environment. The Sandhills' server is replicated between the Primary Data Center (PDC) and Secondary Data Center (SDC) for disaster recovery purposes. Sandhills also maintains a secondary data center (SDC) in the Greensboro, NC office. A copy of the hosted database is exported nightly and restored to a local SQL server. The live data is accessed through the Alpha+ web interface, or for reporting, through queries against our back-end copy. A disaster recovery plan was provided along with the ISCA tool.
4. Encounter Data Submission						
4.1 The PIHP has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	X					ISCA responses indicate that Sandhills submits all secondary ICD-10 Diagnosis codes for Professional encounters and Institutional encounters to NC Medicaid. Sandhills indicated that the DRG and ICD-10 Procedure codes are captured via the Provider Web Portal. Sandhills also indicated that the ICD-10 Procedure codes were captured in their DBMS and are available for reporting in the Alpha+ system and were included for encounter data submissions to NC Medicaid in 2021. Sandhills can capture and submit ICD-10 Procedure codes that are received.
4.2 The PIHP has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					Sandhills has developed a Paid and Denied encounter data application that utilizes the data from the Adam Holtzman paid and denied reports and the 835 response files to identify and reconcile encounter data denials. Denied encounters are worked by the appropriate department for investigation and correction.
4.3 PIHP has policies and procedures in place to reconcile and resubmit encounter data denied by NC Medicaid.	X					Sandhills has sufficient processes in place to address denied encounter submissions. Encounter denial reports were provided and ISCA documentation shows flow charts and procedures for encounter data submissions to NC Medicaid. Sandhills has an encounter acceptance rate of 99.52%.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.4 The PIHP has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to NC Medicaid.	X					Sandhills' Claims and Information Technology (IT) Departments are responsible for working on the denied encounters and resubmitting them to NC Medicaid. Sandhills has three staff dedicated to encounter data. Sandhills' IT Department has internally developed a program based on Adam Holtzman's paid and denied reports. After each check-write, claims that remain in the denied status can be exported for Claims Encounter Staff to review and re-submit. The report contains the denial reason, which assists staff in determining the process needed for follow-up. Weekly 835 files are used for additional information as needed. The encounter data acceptance rate has been consistent with prior year observations. Sandhills staff was able to address all inquiries related to encounter data submission and the associated reconciliation process.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II A. Credentialing and Recredentialing						
1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					Procedure N-CR 01a-19a, N-NM 3a, NRR 04a is identified as the *Practitioner and Facility Credentialing Program Plan*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 Committee meeting minutes indicate which members are "voting" members, which members are present, which member(s) made specific motions, and the outcome of votes cast. The meeting notes contain evidence of the committee discussion and decision-making. Sandhills Center delegated credentialing of employees to Moses Cone and UNC hospital systems. Sandhills retained authority to make the final credentialing determination regarding all providers.
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Credentialing files reviewed for the EQR were organized and contained appropriate information.
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					One of the four practitioner credentialing files did not include evidence of automobile insurance, as indicated on "*Provider Insurance Coverage – Attestations*" form. Sandhills submitted the insurance information in response to CCME's request on the Missing Desk Materials list.
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
3.1.3 Valid DEA certificate; and/or CDS certificate	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); and query of the State Exclusion List;	X					
3.1.10 Query for the System for Awards Management (SAM);	X					
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	X					
3.1.14 Names of hospitals at which the physician has admitting privileges, if any	X					
3.1.15 Ownership Disclosure is addressed.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.16 Criminal background Check	X					For Licensed Independent Practitioners, background checks are conducted via the NC State Bureau of Investigation. Agencies conduct criminal background checks for owners, directors, officers, administrators, and staff, including licensed practitioners. NC Medicaid approved this practice. Sandhills' agency contracts require the agencies to conduct the background checks. Agencies submit their background check policy with their Sandhills Agency Application.
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files reviewed for the EQR were organized and contained appropriate information.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.11 Requery of the Social Security Administration's Death Master File	X					
4.2.12 Requery of the NPPES;	X					
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					
4.2.14 Ownership Disclosure is addressed.	X					All except one of the submitted recredentialing files included the Ownership Disclosure. Sandhills submitted the Ownership Disclosure in response to CCME's request on the Missing Desk Materials list.
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					The Credentialing Committee meeting minutes 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					Procedure N-PM4a, Provider Sanctions, addresses possible provider sanctions. Sandhills has an *External Assessments Grid* to address sanctions "for violations that have been assessed by external monitoring agencies such as DHSR, DMA, DMH/DD?SA or DSS.", and a *Provider Sanctions Grid* to address "violations and available sanctions for areas of risk that are identified by Sandhills Center." The sanctions grids are included in the *Medicaid/State Provider Manual*.
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					

III. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III. Quality Improvement						
III. A Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					All (c) Waiver Measures were above the State benchmark rates. The overall validation scores for all Performance Measures were in the Fully Compliant range, with an average validation score of 100% across the 10 (b) Waiver Measures and the five (c) Waiver Measures. There was one measure with substantial improvement, and two measures with substantial decline, although the rates that declined did not have a large enough sample to consider the rate reliable as only six members were included in the calculation.
III. B Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					Sandhills submitted five active projects for this 2021 EQR. These four were validated: • Assure Consistent Connection to Community Services - Clinical • NC-TOPPS Interview Data Accuracy - Non-Clinical • Routine Appointments Kept- Non-Clinical • TCLI Timeliness Documentation Submission - Non Clinical The remaining active PIP "Increase EBP for Medication Management Care Coordination" was not validated because there are no data available due to monitoring reviews remaining suspended per Deputy Secretary for Behavioral Health & IDD and Deputy Secretary for N.C. Medicaid directives.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					All 4 validated PIPs scored in the High Confidence range. One PIP had a section with concerns that should be addressed by the Recommendation. For the Routine Appointments Kept PIP, the measurement rate declined to lowest rate since start of PIP. ***Recommendation: For the Routine Appointments Kept PIP, assess impact of texts and call reminders, and determine if there are methods to obtain evidence that members have received texts and are speaking to staff on phone calls.***

IV. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. A Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					Sandhills has over a hundred policies and procedures governing the methods and techniques implemented when serving their Mental Health/Substance Use (MH/SU) and Intellectual and Developmental Disability (I/DD) populations through Care Coordination.
2. The care coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					Sandhills' Procedure CC 4a, Access and Availability of Care Coordination Staff, outlines the availability of staff 24 hours per day and seven days per week for telephone assessments and crisis interventions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					
2.5 Quality monitoring and continuous quality improvement;	X					
2.6 Determination of which Behavioral Health Services are medically necessary;	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					
2.10 Ensure privacy for each Enrollee is protected.	X					
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					Sandhills' Procedure I/DD CC 2a, I/DD Care Coordination Monitoring of Plan Implementation, describes the use of the required *State Monitoring Checklist*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					In the 2022 EQR, Sandhills provided evidence of their efforts to review and improve the completeness, accuracy, and timeliness of MH/SU and I/DD Care Coordination documentation. However, evaluation of Sandhills' review methods, review tools, and outcome data showed overall their efforts are not resulting in a significant improvement. For example, MH/SU and I/DD late progress note reports submitted by Sandhills showed a decrease in the past year regarding compliance with timely submission of progress notes. Additionally, performance measure reports submitted by Sandhills this year showed reviews of MH/SU and I/DD enrollee files decreased from the previous EQR in overall regarding quality, completeness, and timeliness. These findings were corroborated by the 2022 EQR MH/SU file reviews. MH/SU files showed a pattern of late progress note entries and lack of compliance with Sandhills' Procedure CC 22a, Levels of Care Coordination provided to MH/SU Care Coordination Members. Two of the three MH/SU files reviewed showed the frequency of Care Coordination contacts was out of compliance with the required frequency for the enrollee's level of care as outlined in Procedure CC 22a. Also, one file showed the enrollee's level of care changed throughout Care Coordination interventions with almost no documented justifications for these changes. It should be noted in two MH/SU files reviewed; staff were compliant with the required frequency of contact (three contacts within the first week) for enrollees new to Care Coordination. Review of the I/DD files submitted for this year's review also demonstrated a pattern of late progress notes. Within these files reviewed, there was evidence that I/DD Care Coordinators were reviewing claims to identify over and under utilization of services, however, this practice was not implemented with consistency. As an example, one file showed claims were reviewed once a year, the other file showed a claims review occurred four times per year. ***Recommendation: Enhance the current MH/SU and I/DD documentation monitoring process to ensure continued progress in Care Coordination documentation quality, completeness, and timeliness and overall compliance with Sandhills' policies and procedures.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. B Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					During the Onsite, Sandhills' staff reported that all Peer Support Specialists are currently certified. This was also verified through the NC Peer Support Specialist Certification Program website.
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					Sandhills has thirty-six policies and procedures governing the Transition to Community Living Initiative (TCLI) Care Coordination unit and the below requirements.
2.1 Care Coordination activities occur, as required.	X					
2.2 Person Centered Plans are developed as required.	X					
2.3 Assertive Community Treatment, Peer Support, Supported Employment, Community Support Team, Psychosocial Rehabilitation, and other services as set forth in the DOJ Settlement are included in the individual's transition, if applicable.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					
2.5 QOL Surveys are administered timely.	X					Sandhills' Procedure CC 38a, Transition to Community Living Initiative (TCLI) Administration of the /Quality of Life (QOL) Surveys, outlines the process and timelines for implementing these surveys.
3. Transition, diversion and discharge processes are in place for TCLI members as outlined in the DOJ Settlement and *DHHS Contract*.	X					
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.	X					NC Medicaid reported no concerns regarding TCLI data and analysis submissions by Sandhills to the State.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					
6. A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	X					Review of the TCLI files submitted by Sandhills for this year's EQR showed a pattern of late progress notes, missing or late Quality of Life surveys, and late completion of In-Reach tools. CCME's evaluation of Sandhills' methods for reviewing compliance of TCLI Care Coordination documentation is not significantly improving the quality, completeness, and timeliness of documentation. It should be noted Sandhills has a current TCLI Performance Improvement Project (PIP) targeting late progress notes for TCLI Care Coordinators. Review of this PIP shows TCLI Care Coordinators are improving the timeliness of their progress note submissions but have not yet achieved the goal of no late submissions. What is not included in this PIP is other TCLI documentation with timeliness requirements such as Quality of Life surveys and In-Reach tools. Additionally, this PIP does not address the completeness and accuracy of TCLI Care Coordination documentation. ***Recommendation: Ensure Sandhills' process of monitoring TCLI Care Coordination documentation continues to target not only timeliness of progress notes, but the timeliness, completeness, and accuracy of all documentation (e.g., Quality of Life surveys, In-Reach tools, etc.)***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee Grievances in a manner consistent with contract requirements, including, but not limited to:	X					Sandhills' Procedure CORE 35a, Consumer Grievance Process- Medicaid and State-Funded, outlines the consistent process used for Grievances throughout the Sandhills organization.
1.1 Definition of a Grievance and who may file a Grievance;	X					
1.2 The procedure for filing and handling a Grievance;	X					
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract;	X					Pages 23-24 of the *Member Handbook* correctly explain the Grievance process including timeliness of notification and resolution and the extension process and notifications that are given when Sandhills or the member extends the Grievance resolution timeframe. Page 167 of the *Medicaid/State Provider Manual* informs the providers of the same timeliness guidelines.
1.4 Review of all Grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					Procedure CORE 35a, Consumer Grievance Process- Medicaid and State-Funded, notes the Chief Clinical Officer/Medical Director's role in the Grievance resolution process, and documentation of this consultation was present within the Grievance files.
1.5 Maintenance of a Grievance log for oral Grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Procedure CORE 35a, Consumer Grievance Process- Medicaid and State-Funded, includes that Grievance files "are maintained for 5 years," as required by *NC Medicaid Contract*, *Attachment M (B). Record Keeping and Reporting*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP applies the Grievance policy and procedure as formulated.	X					There was a Recommendation in the 2021 EQR to enhance the Grievance monitoring process for extended resolution timeframes to include review of notifications required by *42 CFR § 438.408 (c)(2)* and by Sandhills' Procedure CORE 35a on page 6 which states, "If the timeframe is extended, the member will receive prompt oral notice. Within 2 calendar days, the member will receive a written notice of the reason to extend the timeframe." This Recommendation was not incorporated into the written Grievance monitoring process for the 2022 EQR. This remains a Recommendation for the 2022 EQR. ***Recommendation: Enhance the written Grievance monitoring process for extended resolution timeframes to include review of notifications required by 42 CFR § 438.408 (c)(2) and by Sandhills' Procedure CORE 35a on page 6 which states, "If the timeframe is extended, the member will receive prompt oral notice. Within 2 calendar days, the member will receive a written notice of the reason to extend the timeframe."*** For the 2022 EQR Grievance files reviewed, all timeliness requirements were met including sending an acknowledgement letter within 5 working days per Sandhills' Procedure CORE 35a. All files were resolved within 30 days, per Sandhill's procedure. There were three Grievances referred outside of Sandhills. One was a Grievance for DHHS and two for other PIHPs since the members were not in the Sandhills catchment area. There were also three files in which the Grievant asked to be anonymous or didn't want to be contacted. Appropriately, these files didn't contain acknowledgement letters or resolution letters and, they were closed or resolved in 30 days. When reviewing the Log for the file review, CCME noted one file had the wrong resolution date on the Log. During the Onsite interview, Sandhills staff explained that was a typo in transferring data. All other data on the Log were consistent with the file review.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					During the Onsite discussion, Sandhills staff stated they use Grievance data and a Quality Review process for Grievances. Procedure CORE 35a describes the Quarterly Grievance Report and Quarterly Grievances Appeals *Tracking Report*. Reports are reviewed by Customer Service, and Quality Management Committees. A report out is given at Consumer and Family Advisory, Network, and the Client Rights Committees.
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					There were three files reviewed in which the Grievant wanted to remain anonymous or didn't want to be contacted. These files were handled upholding confidentiality practices and the requests from the Grievants.
V. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider Appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					
1.1 The definitions an Appeal and who may file an Appeal;	X					Definitions of an Appeal and who may file an Appeal are outlined for both members and providers in the *Member Handbook* and the *Medicaid/State Provider Manual (11/02/2021)*. Both documents are posted on Sandhills' website.
1.2 The procedure for filing an Appeal;	X					Appeals initiated orally no longer require a written request to follow the oral Appeal. This requirement changed in July 2019 with an amendment to *42 CFR § 438.402 (c)(3)(ii)* and *§ 438.406 (b)(3)*. The *NC Medicaid PIHP Contract Amendment #10* in June of 2020 also changed *NC Medicaid Contract Attachment M* to reflect the change.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						In the 2021 EQR, CCME issued a Recommendation to update Procedure HUM 34a, Appeals Process (Medicaid), the *Member Handbook*, and the *Medicaid/State Provider Manual* to clarify a written Appeal is no longer required following the submission of an oral Appeal, per *42 CFR § 438.402 (c)(3)(ii)* and *438.406 (b)(3)*. For the 2022 EQR, Procedure HUM 34a, Appeals Process (Medicaid) and the *Member Handbook* contain this update. The *Medicaid/State Provider Manual* does not contain this update. ***Recommendation: Update the Medicaid/State Provider Manual on page 107 to clarify a written Appeal is no longer required following the submission of an oral Appeal, per 42 CFR § 438.402 (c)(3)(ii) and § 438.406 (b)(3).***
1.3 Review of any Appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited Appeal where the life or health of the enrollee would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the Appeal as specified in the contract;	X					
1.6 Written notice of the Appeal resolution as required by the contract;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.7 Other requirements as specified in the contract.	X					
2. The PIHP applies the Appeal policies and procedures as formulated.	X					In the 2021 EQR, CCME issued a Recommendation to revise the Appeal process to include a written resolution notification is sent to all members/guardians who file an Appeal, including those Appeals withdrawn or invalid, per *NC Medicaid Contract, Attachment M (G) (7)*. In the 2022 file review there was one file missing a resolution letter. This was a withdrawn Appeal and Sandhills staff confirmed an Appeal resolution letter was not sent to the member. This file was completed prior to last year's EQR feedback explaining this Recommendation to issue a resolution letter to all types of Appeals including withdrawn and invalid Appeals. Sandhills has implemented a process to send a resolution notification letter to all members/guardians who file an Appeal. All files with invalid or withdrawn Appeals were dated subsequent to the 2021 CCME feedback contained a resolution letter. For the 2022 Appeal files reviewed, 2 files were missing the Acknowledgement letter. The 2 Acknowledgement letters were available and uploaded during the Onsite. All acknowledgement letters were sent timely per Procedure HUM 34a. There was one Appeal Log discrepancy for an expedited Appeal. The Log lists 3/24/22 as the Appeal date. This Appeal request was actually faxed on 3/23/22 but logged on 3/24/22. Since an expedited Appeal needs to be resolved in 72 hours per *NC Medicaid Contract Attachment M (H) (5)*, it is important to correctly log the Appeal date. This Appeal was resolved in two days, which gave a cushion for the 72-hour timeliness metric. Otherwise, all data in the Log matched the file review.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					The Appeal monitoring process included a review of the Appeal Log. Both oral and written notifications were provided within the required timeframes. Data is reviewed in Quality Management and Network Committees.
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					In the 2021 EQR, CCME issued a Recommendation to Include documentation of the guardianship verification check in the Appeal file and add guardianship verification to the Appeal Audit Tool. For the files reviewed in the 2022 EQR, CCME looked for Appeals Coordinator documentation confirming guardianship. Guardianship confirmation is needed to ensure HIPAA practices are followed and to help the PIHPs avoid liability. Guardianship verification was not documented in any of the files reviewed. Guardianship verification was also not added to Sandhills' *Appeal Audit Tool*. From Onsite discussion, guardianship is checked in Alpha+, but not documented in the Appeal file. CCME has issued the same Recommendation as in the 2021 EQR. ***Recommendation: Include documentation of the guardianship verification check in the Appeal file and add guardianship verification to the Appeal Audit Tool.***

VI. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI A. General Requirements						
1. PIHP shall be familiar and comply with *Section 1902 (a)(68)* of the *Social Security Act*, *42 CFR § 438.455* and *1000* through *1008*, as applicable, including proper payments to providers and methods for detection of fraud and abuse.	X					
2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents', and subcontractors,' compliance with the requirements of this *Section 14* of the *NC Medicaid Contract*.	X					
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					
VI B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with *42 CFR § 438.608* that is designed to guard against fraud and abuse.	X					The *Corporate Compliance & Internal Audit Plan FY 2020-2021 & FY 2021-2022 Addendum* outlines Sandhills' *Corporate Compliance & Internal Audit Plan*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of *42 CFR § 438.608* and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under NC Medicaid Contract in accordance with *42 CFR § 438.608(a)(1)(iv).*	X					In the 2021 EQR, Sandhills was issued a Recommendation to define the frequency of the ongoing BOD Compliance training in their *Corporate Compliance & Internal Audit Plan* to ensure this training is occurring consistently. This Recommendation was addressed in the *Corporate Compliance & Internal Audit Plan FY 2021-2022 Addendum.* During the Onsite, Sandhills provided the four-part Compliance training that was recently presented to the BOD.
3. PIHP shall establish and implement a special investigation or program integrity unit.	X					
4. PIHP's written Compliance Plan shall, at a minimum include:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in *Section 1902 (a)(66)* of the *Social Security Act;*	X					
4.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing, and development of corrective action initiatives;	X					
4.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					
4.4 The PIHP supplies all data in a uniform format provided by NC Medicaid and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by the Division as provided in *NC Medicaid Contract Section 13.2-Monetary Penalties.*	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. In accordance with *42 CFR § 438.608 (a)(vii),* PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under *NC Medicaid Contract*, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under *NC Medicaid Contract*; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month.	X					Sandhills has an Internal Auditor, and their Internal Auditing Director is also the Contract Manager. Currently, PI has one vacancy due to staff entering retirement. Sandhills' staff stated they are actively recruiting to fill the position.
6. PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					
6.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse.	X					The review for this EQR included 10 PI cases. Six of the investigative cases were in-process, three were closed, and one was pending. The review of investigative cases showed, overall, Sandhills is compliant with PI policies and procedures while conducting SIU investigations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure.	X					Sandhills has a detailed workflow outlining the investigative process from taking a complaint to the closing of an investigation. However, a discrepancy was found when comparing the workflow to the files reviewed. In one of the closed PI files reviewed, Sandhills issued a tentative notice of overpayment (TNO) in the amount of $241.20 and a Case Summary was used to report the findings of the investigation. The use of the case summary did not meet the requirements listed in Procedure PI 1a, Investigative Process, which states, "Case summaries should be used in cases where extensive investigation was not required to support or refute the allegation(s) *and* when no adverse action (ex. TNO, referral to DHB, etc.) is to be taken as a result of the investigation." During the Onsite, Sandhills acknowledged the use of the Case Summary did not meet the requirements listed in the procedure. ***Recommendation: Ensure PI case findings are reported on the appropriate template as required by Procedure PI 1a, Investigative Process.***
6.3 In accordance with Attachment Y - Audits/Self-Audits/investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6.4 Process for tracking overpayments and collections based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on Attachment Y – Audits/Self-Audits/investigations.	X					
6.5 Process for handling self-audits and challenge audits.	X					Sandhills' Procedure PI 7a, Provider Self-Audit, describes the process by which providers can report the results of their self-audits indicating potential fraud, waste, and abuse. However, this procedure does not describe how Sandhills' staff handles these reports internally. During the Onsite, Sandhills' staff were able to detail their internal process. CCME is recommending Sandhills document the full internal process to ensure consistency in the handling of provider self-audit reports. ***Recommendation: To ensure continuity in information given to providers when making a self-report of potential fraud, waste and or abuse, develop a desk guide or desk reference outlining the process for handling provider self-audits.***
6.6 Process for using data mining to determine leads.	X					
6.7 Process for informing PIHP employees, subcontractors, and providers regarding the *False Claims Act.*	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6.8 PIHP shall establish and maintain written policies for all employees, contractors, or agents that detail information about the *False Claims Act* and other federal and state laws as described in the *Social Security Act 1902 (a)(66)*, including information about rights of employees to be protected as whistleblowers.	X					Sandhills' Procedure ADM 11a, Fraud, Waste, and Abuse Monitoring, provides detailed information about the *False Claims Act*.
6.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid-standardized elements or a NC Medicaid-approved template;	X					
6.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available database or other search mechanism.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
7. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements.	X					Sandhills' procedures describe the internal dispute resolution process offered to providers for PI, compliance, and monitoring actions taken by Sandhills. In this EQR, one of the PI cases reviewed showed Sandhills followed the process for a provider dispute resolution as outlined in Procedures N-NM 13a, 14a, 15a, and 16a, Participating Provider Violations and Dispute Resolution (Medicaid & State).
8. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					For this EQR, Sandhills submitted 10 PI cases for review. All investigative cases were initiated within 10 business day of receipt of a potential allegation of fraud.
9. In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						In the 2021 EQR, Sandhills was issued a Recommendation to continue applying the PI Department's strategy(ies) to eliminate the backlog of older PI cases. During the Onsite, Sandhills reported they have closed 60% of their older cases. Nine PI cases are still open for the same review period from the 2021 EQR. This was corroborated by the PI *Attachment Y Report* submitted by Sandhills for this EQR. The *Attachment Y Report* also showed Sandhills submitted to NC Medicaid two new referrals of potential fraud, waste, and abuse and 20 referrals as supplemental information for PI cases already under consideration for potential fraud, waste, and abuse. The NC Medicaid-approved template was used to refer the new cases and to submit the supplemental information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.1 Subject (name, Medicaid provider ID, address, provider type);	X					
9.2 Source/origin of complaint;	X					
9.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					
9.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated; and dates of suspected intentional misconduct;	X					
9.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					
9.6 All communications between PIHP and the Provider concerning the conduct at issue, when available.	X					
9.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					
9.8 Total Sample Amount of Funds Investigated per Service Type	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.8.1 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					
9.8.2 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					
9.8.3 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					
9.8.4 Information on Biller/Owner;	X					
9.8.5 Additional Provider Locations that are related to the allegations;	X					
9.8.6 Legal and Administrative Status of Case	X					
10. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template.	X					Review of the PI Case Log provided by Sandhills for this EQR showed no cases related to suspected enrollee fraud were referred to NC Medicaid for the period under review.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
11. If PIHP uses FAMS, PIHP shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	X					
12. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP.	X					For this EQR, Sandhills submitted all FAMS users reports for the year. These reports showed there were no changes to FAMS users in the past year.
VIII C. Provider Payment Suspensions and Overpayments						
1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, NC Medicaid Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If NC Medicaid determines that a full investigation is warranted, NC Medicaid shall make a referral within five (5) business days of such determination to the MFCU/ MID and will suspend payments in accordance with *42 CFR § 455.23*. At least monthly, NC Medicaid shall provide written notification to PIHP of the status of each such referral. If MFCU/ MID indicates that suspension will not impact their investigation, NC Medicaid may send a payment suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
that payment suspension will impact the investigation, NC Medicaid shall temporarily withhold the suspension notice and notify PIHP. Suspension of payment actions under this *Section 14.3* shall be temporary and shall not continue if either of the following occur: PIHP or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider; or Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.						
1.1 In the circumstances described in *Section 14.3 (c)* above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.	X					
2. Upon receipt of a payment suspension notice from NC Medicaid Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of NC Medicaid Program Integrity's suspension and lasting until PIHP is notified by NC Medicaid Program Integrity in writing that the suspension has been lifted.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. PIHP shall provide to NC Medicaid all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid Program Integrity due to allegations of suspected fraud without prior written approval from NC Medicaid Program Integrity or the MFCU/MID.	X					

D. Attachment 4: Encounter Data Validation Report

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Background

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

To use the encounter data as intended and provide proper oversight, NC Medicaid must be able to confirm the data is complete and accurate.

Overview

The review, guided by the Centers for Medicare and Medicaid Services (CMS) External Quality Review Protocol, focused on measuring the data quality and completeness of claims paid by Sandhills for the period of January 2021 through December 2021. All claims paid by Sandhills are required to be submitted and accepted as a valid encounter to NC Medicaid. The approach to the review included:

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

Review of Sandhills' ISCA response

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

The 837 files are transmitted securely to NCTracks and parsed using an EDI validator to check for errors and produce a 999 response to confirm receipt and any compliance errors. The encounter claims are then validated by applying a list of edits provided by the State (See Appendix 1) and adjudicated accordingly by NCTracks. Using existing Medicaid pricing methodology and the billing, or rendering provider accordingly, the appropriate Medicaid allowed amount is calculated for each encounter claim in order to assess and recreate what was paid by the PIHP.

Once NCTracks processes the 837 files, it produces 835 files detailing the results of adjudication and pricing of encounter submissions. The PIHP is required to resubmit encounter records that were denied upon triggering one or more of NC Medicaid's edits marked as "DENY" in Appendix 1. Additionally, Sandhills extensively utilized NC Medicaid's "Adam Holtzman" reports to identify the encounter records that were denied, research issues and decide whether provider outreach was needed to correct the issue(s) that caused the denials.

In 2021, it took Sandhills five days, on average, between completing their front-end adjudication and submitting paid encounters to NCTracks. During 2021, it took Sandhills approximately 24 days, on average, to correct and resubmit encounters that were denied by NCTracks. These figures were comparable to what was documented for 2020 encounters, indicating that Sandhills did not experience disruptions in its encounter data reporting despite the public health emergency brought on by the COVID-19 pandemic or changes in the North Carolina Medicaid managed care model. During 2021, Sandhills submitted 1,462,685 unique encounters to NC Medicaid. Similar to the prior year, less than 1% of all encounters submitted in 2021 have not been corrected and accepted by NC Medicaid. The overall acceptance rate, including resubmissions, was nearly identical to the prior year.

2021	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	32,383	26,932	5,229	222	0.69%
Professional	1,430,302	1,242,347	181,146	6,809	0.48%
Total	1,462,685	1,269,279	186,375	7,031	0.48%

There was a noticeable increase in Professional encounters during specific weeks that were denied by NCTracks. Much of this increase was isolated to a handful of 837 batches where the time of submission was past 11:59 p.m. which was impacting the submission of encounters. The vast majority of these were subsequently resubmitted and accepted by NCTracks, and this issue did not impact the overall quality of encounter submissions in 2021.

Overall, 19% of all denials were related to procedure codes/revenue codes invalid for place of service, while 18.7% of the denials were related to procedure invalid for the diagnosis. Given the overall denial rate of 0.48% has held steady despite denials due to the timing issue described above, Sandhills continues to do a good job of reconciling and mitigating denials. Sandhills' strategy for correcting encounter denials includes the following steps:

- Three staff dedicated only to encounter data. Two staff primarily to review weekly check write denials utilizing the Pay and Deny application based on the Adam Holtzman report
- Provider education guidelines
- Internal database and reporting tools
- Rebilling corrected encounter denials

Analysis of Encounters

The encounter data analyses evaluated whether Sandhills submitted complete, accurate, and valid data to NC Medicaid for all claims paid between January 1, 2021, through December 31, 2021. Sandhills worked with their EDI vendor to convert each 837I and 837P file submitted to NC Medicaid during the requested audit period to an excel spreadsheet and submitted to CCME and Aqurate. This included 1,216,166 Professional claim line items and 87,026 Institutional claim line items. These figures include line level detail, as well as voids and resubmissions for previously denied claims, including denials prior to 2021. Therefore, these numbers may not match the metrics reported in Sandhills' ISCA response for 2021.

In order to evaluate the data, Aqurate pre-processed all batch encounter files and loaded them to a consolidated database. After completing data onboarding, Aqurate applied proprietary data analytics to review each data element, with special focus on the required data elements as defined. These analytics tools evaluated the presence of data in each field within a record as well as whether the value for the field was within accepted standards. Results of these checks were compared with general expectations for each data field and to the CMS standards for encounter data. The table below depicts the specific data expectations and validity criteria applied. Professional and Institutional files reviewed included older dates of service that were resubmitted to NC Medicaid during 2021.

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. Medicaid IDs are 9 numeric long followed by 1 alpha.
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 may vary, but there should be at least some last names of >8 digits and some first names of < 8 digits, validating that fields have not been truncated.
Recipient Date of Birth	Should not be missing and should be a valid date.	Existence of a valid date
PIHP ID	Critical Data Element	100% valid for PIHP
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	10 digits

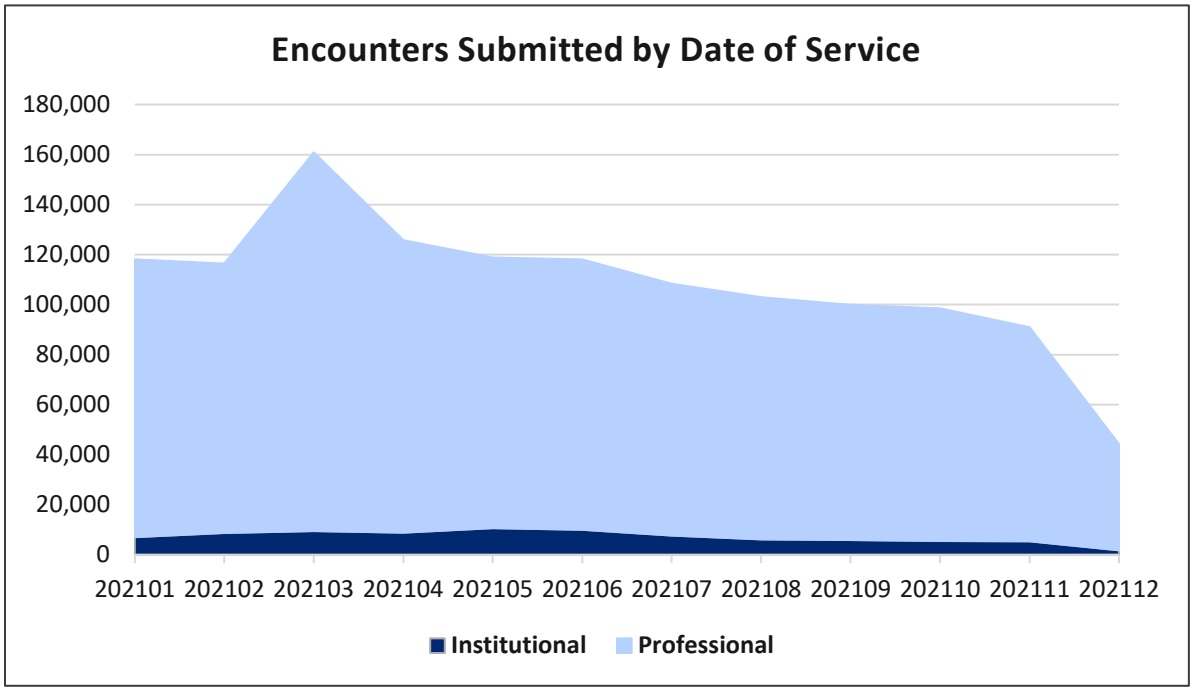
Data Quality Standards for Evaluation of Submitted Encounter Data Fields
Adapted and revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
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. 10 digits
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 Standard UB POS
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% non-missing and valid on physician or other applicable provider type claims (e.g., other practitioners). This is the taxonomy code and is a standard code set.
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid ICD codes for practitioner providers. Codes should be within standard ICD 9 and 10 code sets. ICD-9s have generally stopped appearing on files for current records.
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. Codes should be within standard ICD 9 and 10 code sets. ICD-9s have generally stopped appearing on files for current records.
Dates of Service	Dates should be evenly distributed across time.	Valid date Dates spread throughout reporting year.

Data Quality Standards for Evaluation of Submitted Encounter Data Fields
Adapted and revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Unit of Service (Quantity)	The number should be routinely coded.	The number should be routinely coded. Current Procedural Terminology (CPT) code is in 99200–99215 or 99241–99291 range.
Procedure Code	Critical Data Element	There should be a wide range of procedures appropriate for the services covered by the PIHP
Procedure Code Modifier	Important to separate out surgical procedures/ anesthesia/assistant surgeon, not applicable for all procedure codes.	Expect a variety of modifiers both numeric (CPT) and Alpha (Healthcare Common Procedure Coding System [HCPCS])
Patient Discharge Status Code (Hospital)	Should be valid codes for inpatient claims, with the most common code being “Discharged to Home.” For outpatient claims, the code can be “not applicable.”	Expect a variety of values, with "Discharge to Home" being most common, and includes "Still-in" and transfers
Revenue Code	If the facility uses a UB04 claim form, this should always be present	Valid code is present

Encounter Accuracy and Completeness



The table that follows outlines the key fields 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 the complete data set and validated all data values were reviewed, the fields identified are key to properly shadow price 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	1,407,705	100%	1,407,705	100%	1,407,705	100%	1,407,705	100%
Recipient Name	1,407,705	100%	1,407,705	100%	1,407,705	100%	1,407,705	100%
Recipient Date of Birth	1,407,705	100%	1,407,705	100%	1,407,705	100%	1,407,705	100%
PIHP ID	1,407,705	100%	1,407,705	100%	1,407,705	100%	1,407,705	100%
Provider ID	1,407,705	100%	1,407,705	100%	1,407,705	100%	1,407,705	100%
Attending/Rendering Provider ID	1,407,705	100%	1,407,705	100%	1,407,705	100%	1,407,705	100%
Provider Location	1,407,705	100 %	1,407,705	100%	1,407,705	100%	1,407,705	100%

Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
Place of Service	1,407,705	100%	1,407,705	100%	1,407,705	100%	1,407,705	100%
Specialty Code / Taxonomy - Billing	1,407,705	100%	1,407,705	100%	1,407,705	100%	1,407,705	100%
Specialty Code / Taxonomy - Rendering / Attending	1,407,705	100%	1,407,705	100%	1,407,705	100 %	1,407,705	100%
Principal Diagnosis	1,407,682	100%	1,407,682	100%	1,407,682	100 %	1,407,682	100%
Other Diagnosis	233,444	16.58%	233,444	16.58%	233,444	16.58%	233,444	16.58%
Dates of Service	1,407,705	100%	1,407,705	100%	1,407,705	100%	1,407,705	100%
Unit of Service (Quantity)	1,383,794	98.30%	1,383,794	98.30%	1,383,794	98.30%	1,383,794	98.30%
Procedure Code	1,366,248	97.06%	1,366,248	97.06%	1,366,248	97.06%	1,366,248	97.06%
Procedure Code Modifier	560,950	39.85%	560,950	39.85%	560,950	39.85%	560,950	39.85%
Patient Discharge Status Code Inpatient	97,125	100 %	97,125	100%	97,125	100.00%	97,125	100%
Revenue Code	97,125	100.00%	97,125	100.00%	97,125	100.00%	97,125	100.00%

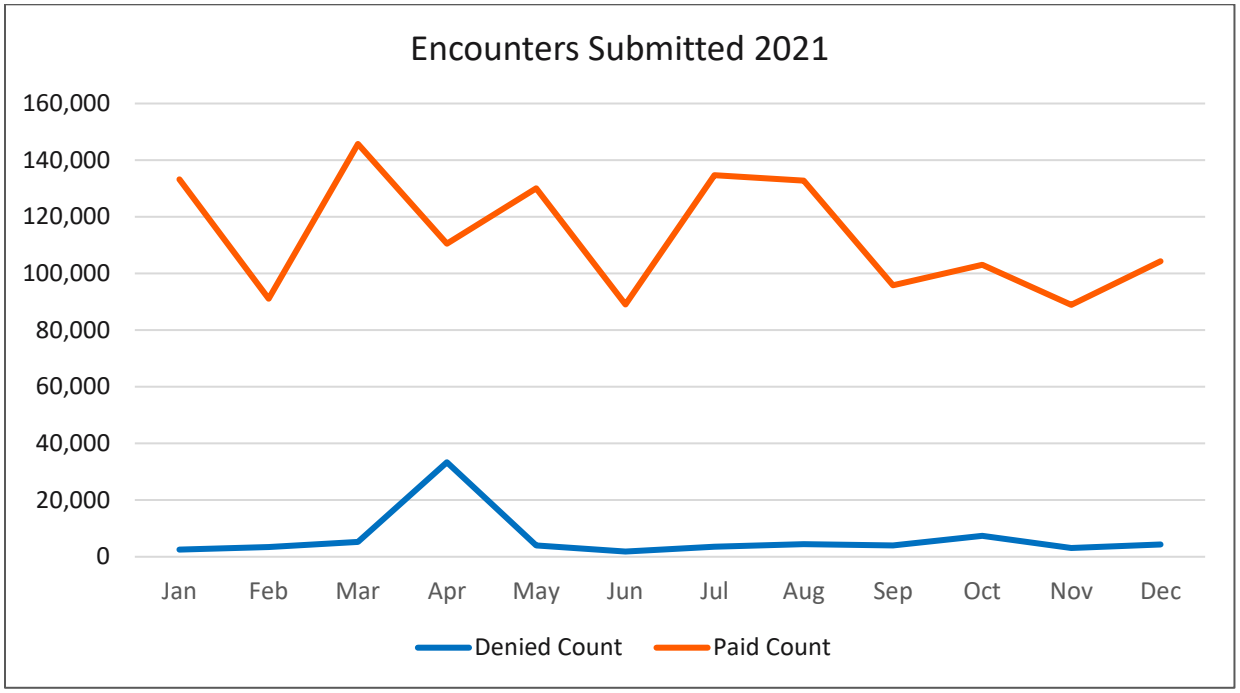
There were very few inconsistencies in the data other than the denial issues highlighted in Sandhills' ISCA response and NC Medicaid's encounter acceptance report. Institutional claims contained complete and valid data in 13 of the 18 key fields (72%) with noted issues to Other Diagnosis codes not populated. Some of the fields however may be appropriately blank for certain types of claims.

Overall, there has been improvement in the accuracy of Institutional encounter data elements over the past couple of years. In particular, deficiencies related to Taxonomy code, Procedure code and Diagnosis code mapping issues have reduced, and any denied encounters are being corrected timely using the resolution process in place at Sandhills.

Professional encounter claims submitted contained complete and valid data in 13 of the 15 key Professional fields (87%). The primary issue is the infrequent reporting of Other Diagnosis on Professional services. The principal Diagnosis code was populated 100% of the time, however, there is some inconsistency in Other Diagnosis codes being present. Specifically, some providers never reported Other Diagnosis codes. There were also a high number of records without a procedure code modifier, but a review of the files indicated this might be appropriate for certain types of claims.

Encounter Acceptance Report

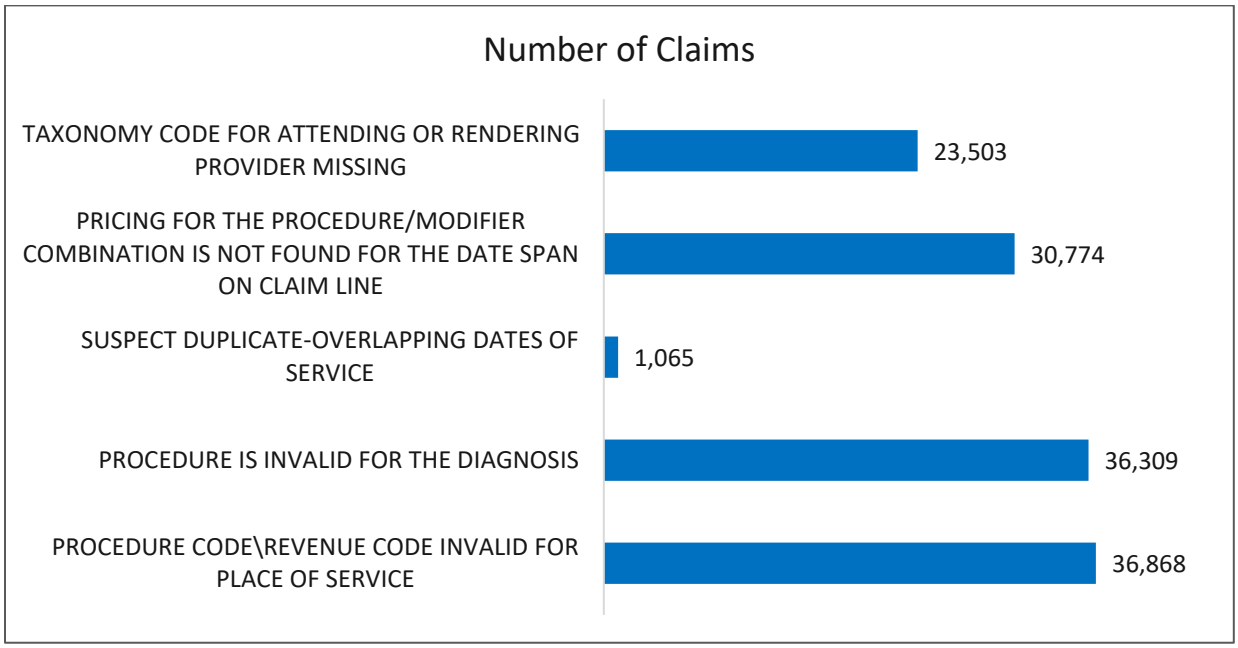
In addition to evaluating the encounter data submitted, Aqurate analysts reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. Since this report is tracked by check write, it was not easy to tie back the metrics to the ISCA response and the converted encounter files submitted since only the Date of Service for each is available. During the 2021 weekly check write schedule, Sandhills submitted a total of 1,462,685 encounters to NC Medicaid. On average, 99.52% of all encounters submitted were accepted by NC Medicaid.

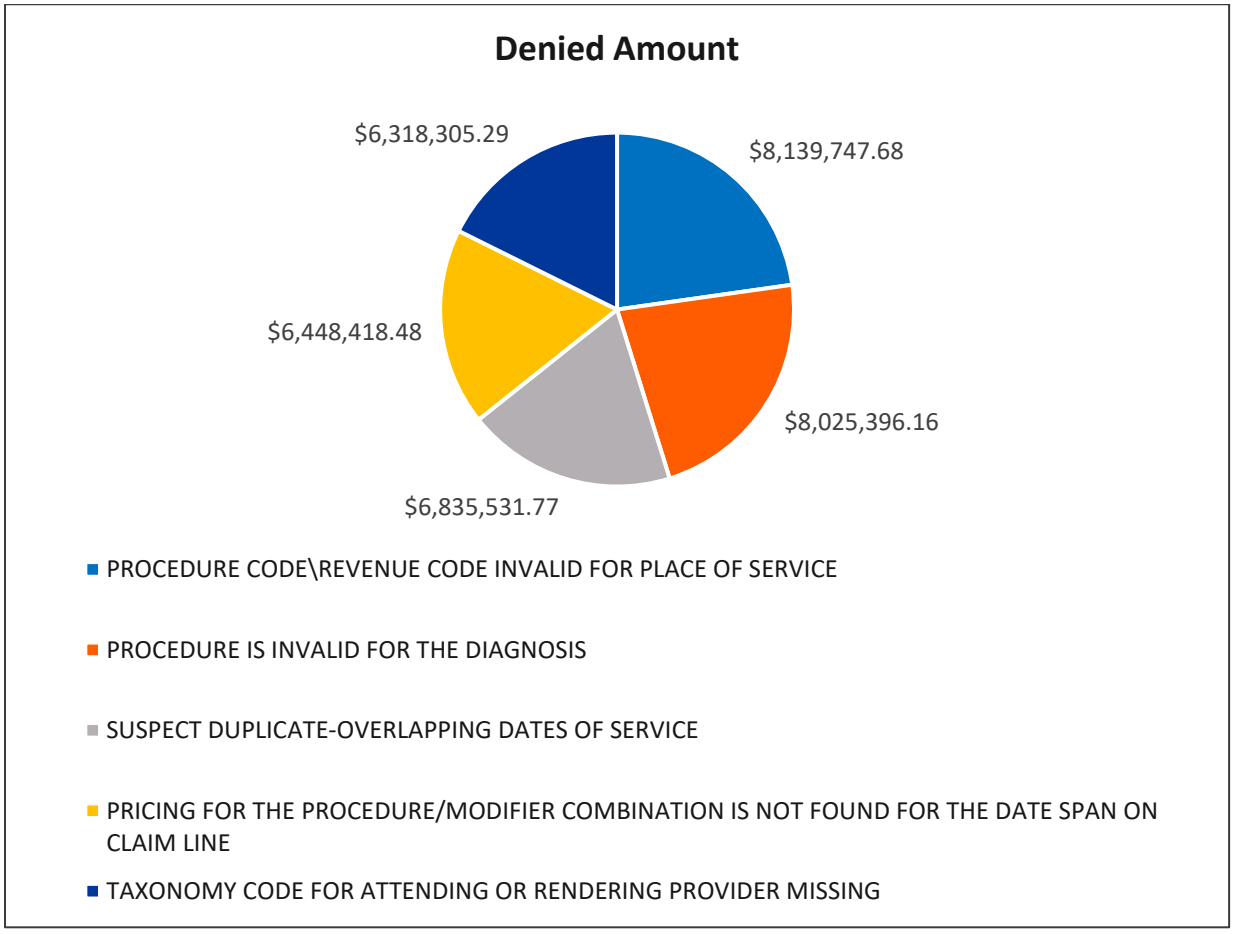


Evaluation of the top denials for Sandhills' encounters correlates with the data deficiencies identified in the Key Field analysis described previously. The top denials in 2021 were similar to the denial reasons for the dates of service reviewed in last year's report. Encounters were denied primarily for:

- Suspect duplicate-overlapping dates of services
- Procedure code/Revenue code invalid for Place of Service
- Procedure is invalid for the diagnosis
- Pricing for the procedure/modifier combination is not found for the date span on claim line
- Taxonomy code for attending or rendering provider missing

The charts that follow reflect the top 5 denials by paid amount.





Results and Recommendations

Issue: Other Diagnosis

Other Diagnosis codes were often missing, especially on Professional claims. Principal and admitting diagnosis were populated consistently, and Sandhills has made progress in reporting additional Diagnosis codes. However, many Professional claims continue to be missing secondary Diagnosis codes.

Resolution:

Over the past few years, Sandhills made progress in reporting Other Diagnosis codes, especially on Institutional claims. However, there are many providers who do not report more than one Diagnosis code. Aqurate recommends alerting such providers to remind them to ensure submitted claims are complete and accurate, including secondary Diagnosis codes.

Conclusion

The analyses of Sandhills' encounter data showed the data submitted to NC Medicaid is complete and accurate. Only one issue was found with Other Diagnosis codes being frequently absent on both Professional and Institutional encounters.

Overall, Sandhills continue to make progress in improving the accuracy of encounter data over the past few years and should continue to be vigilant in resolving issues related to Billing Taxonomy, Rendering Taxonomy, and Procedure codes. Additionally, Sandhills should continue to remind providers of their responsibility to ensure that the coding on claims is accurate, with added emphasis on Other Diagnosis codes. Sandhills should revisit its strategy to address invalid or missing codes, as well as a reconciliation process and make necessary adjustments to further reduce denials. The goal is to avoid denials by improving synchronization of data with NCTracks, in particular the Global Provider File. This improvement would, in turn, reduce the follow-up needed to correct and resubmit encounters.

Missing Other Diagnosis codes on Professional and Institutional claims do not impact the ability to price the claims, and, therefore, do not end up being reported as denials. However, the lack of data may impact NC Medicaid's ability to provide proper oversight, including measurement of quality of care and setting appropriate fees and rates. Sandhills is encouraged to work with its providers to make sure they are documenting and coding all diagnoses.

Appendix 1

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
00001	HDR BEG DOS INVLD/ > TCN DATE	DENY
00002	ADMISSION DATE INVALID	DENY
00003	HDR END DOS INVLD/ > TCN DATE	DENY
00006	DISCHARGE DATE INVALID	PAY AND REPORT
00007	TOT DAYS CLM GTR THAN BILL PER	PAY AND REPORT
00023	SICK VISIT BILLED ON HC CLAIM	IGNORE
00030	ADMIT SRC CD INVALID	PAY AND REPORT
00031	VALUE CODE/AMT MISS OR INVLD	PAY AND REPORT
00036	HEALTH CHECK IMMUNIZATION EDIT	IGNORE
00038	MULTI DOS ON HEALTH CHECK CLM	IGNORE
00040	TO DOS INVALID	DENY
00041	INVALID FIRST TREATMENT DATE	IGNORE
00044	REQ DIAG FOR VITROCERT	IGNORE
00051	PATIENT STATUS CODE INVALID	PAY AND REPORT
00055	TOTAL BILLED INVALID	PAY AND REPORT
00062	REVIEW LAB PATHOLOGY	IGNORE
00073	PROC CODE/MOD END-DTE ON FILE	PAY AND REPORT
00076	OCC DTE INVLD FOR SUB OCC CODE	PAY AND REPORT
00097	INCARCERATED - INPAT SVCS ONLY	DENY
00100	LINE FDOS/HDR FDOS INVALID	DENY
00101	LN TDOS BEFORE FDOS	IGNORE
00105	INVLD TOOTH SURF ON RSTR PROC	IGNORE
00106	UNABLE TO DETERMINE MEDICARE	PAY AND REPORT
00117	ONLY ONE DOS ALLOWED/LINE	PAY AND REPORT
00126	TOOTH SURFACE MISSING/INVALID	IGNORE
00127	QUAD CODE MISSING/INVALID	IGNORE
00128	PROC CDE DOESNT MATCH TOOTH #	IGNORE
00132	HCPCS CODE REQ FOR REV CODE	IGNORE
00133	HCPCS CODE REQ BILLING RC 0636	IGNORE
00135	INVL POS INDEP MENT HLTH PROV	PAY AND REPORT
00136	INVLD POS FOR IDTF PROV	PAY AND REPORT

00140	BILL TYPE/ADMIT DATE/FDOS	DENY
00141	MEDICAID DAYS CONFLICT	IGNORE
00142	UNITS NOT EQUAL TO DOS	PAY AND REPORT
00143	REVIEW FOR MEDICAL NECESSITY	IGNORE
00144	FDOS AND TDOS MUST BE THE SAME	IGNORE
00146	PROC INVLD - BILL PROV TAXON	PAY AND REPORT
00148	PROC\REV CODE INVLD FOR POS	PAY AND REPORT
00149	PROC\REV CD INVLD FOR AGE	IGNORE
00150	PROC CODE INVLD FOR RECIP SEX	IGNORE
00151	PROC CD/RATE INVALID FOR DOS	PAY AND REPORT
00152	M/I ACC/ANC PROC CD	PAY AND REPORT
00153	PROC INVLD FOR DIAG	PAY AND REPORT
00154	REIMB RATE NOT ON FILE	PAY AND REPORT
00157	VIS FLD EXAM REQ MED JUST	IGNORE
00158	CPT LAB CODE REQ FOR REV CD	IGNORE
00164	IMMUNIZATION REVIEW	IGNORE
00166	INVALID VISUAL PROC CODE	IGNORE
00174	VACCINE FOR AGE 00-18	IGNORE
00175	CPT CODE REQUIRED FOR RC 0391	IGNORE
00176	MULT LINES SAME PROC, SAME TCN	IGNORE
00177	HCPCS CODE REQ W/ RC 0250	IGNORE
00179	MULT LINES SAME PROC, SAME TCN	IGNORE
00180	INVALID DIAGNOSIS FOR LAB CODE	IGNORE
00184	REV CODE NOT ALLOW OUTPAT CLM	IGNORE
00190	DIAGNOSIS NOT VALID	DENY
00192	DIAG INVALID RECIP AGE	IGNORE
00194	DIAG INVLD FOR RECIP SEX	IGNORE
00202	HEALTH CHECK SHADOW BILLING	IGNORE
00205	SPECIAL ANESTHESIA SERVICE	IGNORE
00217	ADMISSION TYPE CODE INVALID	PAY AND REPORT
00250	RECIP NOT ON ELIG DATABASE	DENY
00252	RECIPIENT NAME/NUMBER MISMATCH	PAY AND REPORT
00253	RECIP DECEASED BEFORE HDR TDOS	DENY
00254	PART ELIG FOR HEADER DOS	PAY AND REPORT

00259	TPL SUSPECT	PAY AND REPORT
00260	M/I RECIPIENT ID NUMBER	DENY
00261	RECIP DECEASED BEFORE TDOS	DENY
00262	RECIP NOT ELIG ON DOS	DENY
00263	PART ELIG FOR LINE DOS	PAY AND REPORT
00267	DOS PRIOR TO RECIP BIRTH	DENY
00295	ENC PRV NOT ENRL TAX	IGNORE
00296	ENC PRV INV FOR DOS	IGNORE
00297	ENC PRV NOT ON FILE	IGNORE
00298	RECIP NOT ENRL W/ THIS ENC PRV	IGNORE
00299	ENCOUNTER HMO ENROLLMENT CHECK	PAY AND REPORT
00300	BILL PROV INVALID/ NOT ON FILE	DENY
00301	ATTEND PROV M/I	PAY AND REPORT
00308	BILLING PROV INVALID FOR DOS	DENY
00313	M/I TYPE BILL	PAY AND REPORT
00320	VENT CARE NO PAY TO PRV TAXON	IGNORE
00322	REND PROV NUM CHECK	IGNORE
00326	REND PROV NUM CHECK	PAY AND REPORT
00328	PEND PER NC MEDICAID REQ FOR FIN REV	IGNORE
00334	ENCOUNTER TAXON M/I	PAY AND REPORT
00335	ENCOUNTER PROV NUM MISSING	DENY
00337	ENC PROC CODE NOT ON FILE	PAY AND REPORT
00339	PRCNG REC NOT FND FOR ENC CLM	PAY AND REPORT
00349	SERV DENIED FOR BEHAV HLTH LM	IGNORE
00353	NO FEE ON FILE	PAY AND REPORT
00355	MANUAL PRICING REQUIRED	PAY AND REPORT
00358	FACTOR CD IND PROC NON-CVRD	PAY AND REPORT
00359	PROV CHRGS ON PER DIEM	PAY AND REPORT
00361	NO CHARGES BILLED	DENY
00365	DRG - DIAG CANT BE PRIN DIAG	DENY
00366	DRG - DOES NOT MEET MCE CRIT.	PAY AND REPORT
00370	DRG - ILLOGICAL PRIN DIAG	PAY AND REPORT
00371	DRG - INVLD ICD-9-CM PRIN DIAG	DENY
00374	DRG PAY ON FIRST ACCOM LINE	DENY

00375	DRG CODE NOT ON PRICING FILE	PAY AND REPORT
00378	DRG RCC CODE NOT ON FILE DOS	PAY AND REPORT
00439	PROC\REV CD INVLD FOR AGE	IGNORE
00441	PROC INVLD FOR DIAG	IGNORE
00442	PROC INVLD FOR DIAG	IGNORE
00613	PRIM DIAG MISSING	DENY
00628	BILLING PROV ID REQUIRED	IGNORE
00686	ADJ/VOID REPLC TCN INVALID	DENY
00689	UNDEFINED CLAIM TYPE	IGNORE
00701	MISSING BILL PROV TAXON CODE	DENY
00800	PROC CODE/TAXON REQ PSYCH DX	PAY AND REPORT
00810	PRICING DTE INVALID	IGNORE
00811	PRICING CODE MOD REC M/I	IGNORE
00812	PRICING FACTOR CODE SEG M/I	IGNORE
00813	PRICING MOD PROC CODE DTE M/I	IGNORE
00814	SEC FACT CDE X & % SEG DTE M/I	IGNORE
00815	SEC FCT CDE Y PSTOP SEG DT M/I	IGNORE
01005	ANTHES PROC REQ ANTHES MODS	IGNORE
01060	ADMISSION HOUR INVALID	IGNORE
01061	ONLY ONE DOS PER CLAIM	IGNORE
01102	PRV TAXON CHCK - RAD PROF SRV	IGNORE
01200	INPAT CLM BILL ACCOM REV CDE	DENY
01201	MCE - ADMIT DTE = DISCH DTE	DENY
01202	M/I ADMIT AND DISCH HRS	DENY
01205	MCE: PAT STAT INVLD FOR TOB	DENY
01207	MCE - INVALID AGE	PAY AND REPORT
01208	MCE - INVALID SEX	PAY AND REPORT
01209	MCE - INVALID PATIENT STATUS	DENY
01705	PA REQD FOR CAPCH/DA/CO RECIP	PAY AND REPORT
01792	DME SUPPLIES INCLD IN PR DIEM	DENY
02101	INVALID MODIFIER COMB	IGNORE
02102	INVALID MODIFIERS	PAY AND REPORT
02104	TAXON NOT ALLOWED WITH MOD	PAY AND REPORT
02105	POST-OP DATES M/I WITH MOD 55	IGNORE

02106	LN W/ MOD 55 MST BE SAME DOS	IGNORE
02107	XOVER CLAIM FOR CAP PROVIDER	IGNORE
02111	MODIFIER CC INTERNAL USE ONLY	IGNORE
02143	CIRCUMCISION REQ MED RECS	IGNORE
03001	REV/HCPCS CD M/I COMBO	IGNORE
03010	M/I MOD FOR PROF XOVER	IGNORE
03012	HOME HLTH RECIP NOT ELG MCARE	IGNORE
03100	CARDIO CODE REQ LC LD LM RC RI	IGNORE
03101	MODIFIER Q7, Q8 OR Q9 REQ	IGNORE
03200	MCE - INVALID ICD-9 CM PROC	DENY
03201	MCE INVLD FOR SEX PRIN PROC	PAY AND REPORT
03224	MCE-PROC INCONSISTENT WITH LOS	PAY AND REPORT
03405	HIST CLM CANNOT BE ADJ/VOIDED	DENY
03406	HIST REC NOT FND FOR ADJ/VOID	DENY
03407	ADJ/VOID - PRV NOT ON HIST REC	DENY
04200	MCE - ADMITTING DIAG MISSING	DENY
04201	MCE - PRIN DIAG CODE MISSING	DENY
04202	MCE DIAG CD - ADMIT DIAG	DENY
04203	MCE DIAG CODE INVLD RECIP SEX	PAY AND REPORT
04206	MCE MANIFEST CODE AS PRIN DIAG	DENY
04207	MCE E-CODE AS PRIN DIAG	DENY
04208	MCE - UNACCEPTABLE PRIN DIAG	DENY
04209	MCE - PRIN DIAG REQ SEC DIAG	PAY AND REPORT
04210	MCE - DUPE OF PRIN DIAG	DENY
04506	PROC INVLD FOR DIAG	IGNORE
04507	PROC INVLD FOR DIAG	IGNORE
04508	PROC INVLD FOR DIAG	IGNORE
04509	PROC INVLD FOR DIAG	IGNORE
04510	PROC INVLD FOR DIAG	IGNORE
04511	PROC INVLD FOR DIAG	IGNORE
07001	TAXON FOR ATTND/REND PROV M/I	DENY
07011	INVLD BILLING PROV TAXON CODE	DENY
07012	INVLD REND PROV TAXONOMY CODE	DENY
07013	INVLD ATTEND PROV TAXON CODE	PAY AND REPORT

07100	ANESTH MUST BILL BY APPR PROV	IGNORE
07101	ASC MODIFIER REQUIREMENTS	IGNORE
13320	DUP-SAME PROV/AMT/DOS/PX	DENY
13420	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
13460	POSSIBLE DUP-SAME PROV/PX/DOS	PAY AND REPORT
13470	LESS SEV DUPLICATE OUTPATIENT	PAY AND REPORT
13480	POSSIBLE DUP SAME PROV/OVRLAP	PAY AND REPORT
13490	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13500	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13510	POSSIBLE DUP/SME PRV/OVRLP DOS	PAY AND REPORT
13580	DUPLICATE SAME PROV/AMT/DOS	PAY AND REPORT
13590	DUPLICATE-SAME PROV/AMT/DOS	PAY AND REPORT
25980	EXACT DUPE. SAME DOS/ADMT/NDC	PAY AND REPORT
34420	EXACT DUP SAME DOS/PX/MOD/AMT	PAY AND REPORT
34460	SEV DUP-SAME PX/PRV/IM/DOS/MOD	DENY
34490	DUP-PX/IM/DOS/MOD/$$/PRV/TCN	PAY AND REPORT
34550	SEV DUP-SAME PX/IM/MOD/DOS/TCN	PAY AND REPORT
39360	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
39380	EXACT/LESS SEVERE DUPLICATE	PAY AND REPORT
49450	PROCDURE CODE UNIT LIMIT	PAY AND REPORT
53800	DUPE SERVICE OR PROCEDURE	PAY AND REPORT
53810	DUPE SERVICE OR PROCEDURE	PAY AND REPORT
53820	DUPE SERVICE OR PROCEDURE	PAY AND REPORT
53830	DUPE SERVICE OR PROCEDURE	PAY AND REPORT
53840	LIMIT OF ONE UNIT PER DAY	PAY AND REPORT
53850	LIMIT OF ONE UNIT PER DAY	PAY AND REPORT
53860	LIMIT OF ONE UNIT PER MONTH	PAY AND REPORT
53870	LIMIT OF ONE UNIT PER DAY	PAY AND REPORT
53880	LIMIT OF 24 UNITS PER DAY	DENY
53890	LIMIT OF 96 UNITS PER DAY	DENY
53900	LIMIT OF 96 UNITS PER DAY	DENY