2021 External Quality Review

SANDHILLS CENTER

Submitted: October 8, 2021

Prepared on behalf of the
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 the Sandhills Center (Sandhills). This report contains a description of the process and the results of the 2021 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of 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 State's issuance 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 a comprehensive review of the PIHP's health systems capabilities and provider credentialing, as well as recredentialing documentation and processes. The review included validation of the PIHP's PIPs, PMs, and Encounter data. Lastly, a thorough review of the PIHP's Utilization Management, Grievances, and Appeals processes were conducted. The focused review did not include the PIHP's network adequacy, availability of services, subcontractual relationships, or Clinical Practice Guidelines (*42 CFR § 438.206, § 438.207, § 438.230, and § 438.236,* respectively*)*.

To assess the health plan's compliance with federal regulations and the *NC Medicaid 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.

The following provides a global or high-level summary of the status of the Recommendations and Corrective Action items from the 2020 EQR and the findings of the 2021 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 2020 EQR, Sandhills met 100% of the Administrative standards and received one Recommendation. In 2020, Sandhills did not have the ability to submit ICD-10 Procedure codes on encounter data extracts to NC Medicaid. In the 2021 EQR, Sandhills reported on their ISCA they now can capture and submit the ICD-10 Procedure codes to NC Medicaid. Sandhills met 100% of the Administrative standards in the 2021 EQR.

Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

In Sandhills' 2020 EQR of Credentialing/Recredentialing, CCME issued no Corrective Actions or Recommendations. In the current EQR, Sandhills met 100% of the Provider Services standards and received two Recommendations. The first Recommendation is to ensure the accuracy of Credentialing Committee meeting minutes. The second Recommendation is to ensure the credentialing and recredentialing files include Ownership Disclosure information, including by the agency for the employee.

Quality Improvement

42 CFR § 438.330

In the 2020 EQR, Sandhills met 100% of the Quality standards and received five Recommendations related to the four PIPs validated. Four Recommendations were implemented, and one was not applicable this EQR.

For the 2021 EQR, all standards were met with no Corrective Actions and five Recommendations. All PIPs were validated in the High Confidence range but were issued four Recommendations. The four PIP Recommendations target revisions in interventions and initiation of additional interventions to improve rates. CCCME also issued Recommendations related to the presentation of PIP results to offer more clarity with the data findings.

In the 2021 EQR, Sandhills was Fully Compliant for (b) Waiver and (c) Waiver Performance Measures, but several (b) Waiver PMs showed a decline in rate from the previous measurement year. CCME Recommended monitoring to determine if rates with substantial improvement or decline represent a trend or an anomaly in the PMs.

Utilization Management

42 CFR § 438.208

In the 2020 EQR, Sandhills met 100% of Utilization Management (UM) standards and received no Corrective Actions. CCME issued one Recommendation to add an explanation of Home and Community Based Services (HCBS) and the use of the required *State Monitoring Checklist* to a procedure, relevant I/DD Care Coordination manual, or I/DD document. Sandhills addressed the Recommendation.

For this EQR, Sandhills has met 100% of the UM standards. CCME has issued three Recommendations. The first Recommendation addresses enhancements to policies and procedures concerning the Innovations Waiver funding cap. The remaining two Recommendations target inconsistent documentation patterns in Care Coordination progress notes.

Grievances and Appeals

42 CFR § 438, Subpart F, 42 CFR 483.430

In the 2020 EQR, Sandhills met 90% of the Grievance and Appeal standards, resulting in two Corrective Actions and five Recommendations. CCME's primary concern was that Grievance files did not always reflect all steps Sandhills took to resolve the Grievance. Additionally, the review of the submitted Appeals files showed staff were not starting the Appeal resolution timeframe when an oral appeal was submitted by the enrollee. All Corrective Actions and Recommendations were implemented in this 2021 EQR.

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

- The Grievance section Recommendation addresses the need to provide oral and written notification when the resolution timeframe is extended.

The first Appeal Recommendation targets documentation updates for Appeals initiated orally. A written request is not required in addition. The second Appeal Recommendation aims to ensure all Appeals have a written resolution, even if the Appeal was withdrawn or invalid. CCME's third Appeal Recommendation is for Appeal coordinators to confirm guardianship and document that in the Appeal file and to add the guardianship verification to the Appeal Monitoring Tool.

Program Integrity

42 CFR § 455, 42 CFR § 438.455 and *1000* through*1008, 42 CFR § 1002.3(b)(3), 42 CFR 438.608 (a)(vii)*

In the 2020 EQR, Sandhills met 100% of the Program Integrity (PI) standards, and no Corrective Actions or Recommendations were issued. In the 2021 EQR, Sandhills again met 100% of the PI standards. CCME issued one Recommendation to improve the timeliness and consistency of Compliance trainings given to Sandhills' Board of Directors. A second Recommendation issued supports Sandhills' efforts to address the backlog of older PI cases.

Encounter Data Validation

Based on the analyses of Sandhills' encounter data, CCME concluded that the data submitted to NC Medicaid was complete and accurate. Only one notable issue was found, where Other Diagnosis codes are frequently absent on both professional and institutional encounters.

Overall, Sandhills has made 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. Denials related to Taxonomy codes and Procedure codes still account for the bulk of denials. Sandhills should revisit its strategy to address invalid or missing Taxonomy codes, as well as a reconciliation process and make necessary adjustments to further reduce Taxonomy code-related denials. The goal of these process improvements would be to avoid denials by improving synchronization of data with NCTracks, in particular the Global Provider File. In turn, this change would reduce the follow-up needed to correct and resubmit encounters.

While missing Other Diagnosis codes on Professional and Institutional claims are not reported as denials, the lack of information may impact to NC Medicaid's ability to provide proper oversight, including measurement of quality of care and setting appropriate fees and rates. CCME encourages Sandhills to work with its providers to make sure they are documenting and coding all diagnoses.

2020 Corrective Actions

In Sandhills' 2020 EQR, there were two standards scored as "Partially Met," and no standards scored as "Not Met." Following the 2020 EQR, Sandhills submitted a Corrective Action Plan to address the identified deficiencies. CCME reviewed and accepted Sandhills' Corrective Action Plan on March 15, 2021. The following is a high-level summary of those deficiencies:

- Sandhills' Appeal policies and procedures did not describe the right of the enrollee to file a Grievance if Sandhills denied a request to expedite an Appeal
- Sandhills' compliance monitoring of Appeals was not adequately capturing compliance issues, especially those appeals initiated orally

During the 2021 EQR, CCME assessed the degree to which the PIHP implemented the actions to address these deficiencies and found the Corrective Action Plan was implemented.

Additional details regarding the PIHP's 2020 Corrective Actions Plan, the PIHP's response, and evidence, or lack thereof, of PIHP implementation of the 2020 Corrective Actions are detailed in the sections of this report.

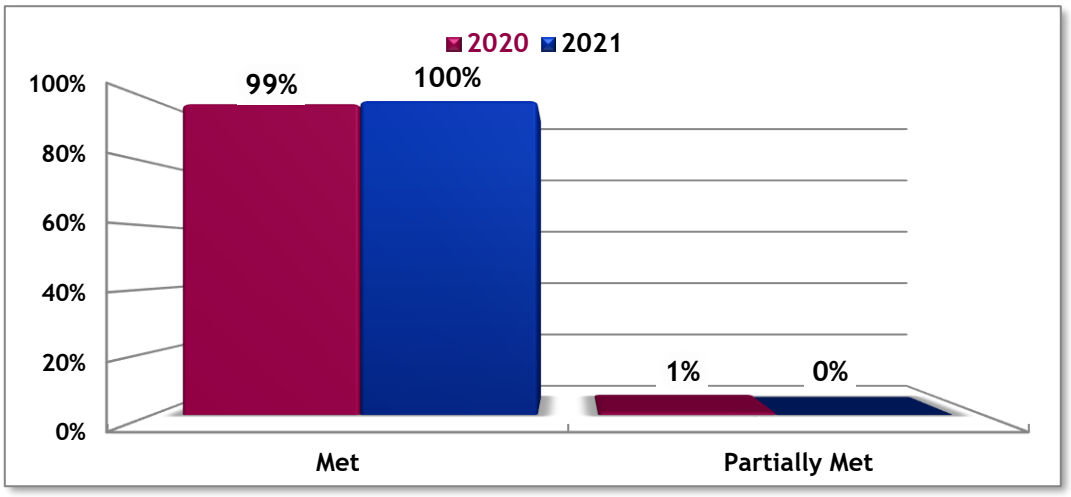
Conclusions

Overall, Sandhills has met the requirements set forth in their contract with NC Medicaid. The 2021 Annual EQR shows that Sandhills has achieved a "Met" score for 100% of the standards reviewed.

B. Overall Score

Figure 1: Annual EQR Comparative Results shows Sandhills' EQR scores in the 2020 and 2021 focused EQRs.

Figure 1: Annual EQR Comparative Results



The following is a summary of key findings in the 2021 EQR and Recommendations or opportunities for improvement. Specific details of strengths, weaknesses, and Recommendations can be found in the sections that follow.

Table 1: Sandhills' 2021 Overall Strengths, Weaknesses, and Recommendations

	Strengths	Weaknesses	Recommendations
Quality	Sandhills Center can capture of up to 29 ICD-10 Diagnosis codes on Institutional claims and 12 ICD-10 Diagnosis codes on Professional claims.	Credentialing Committee meeting minutes for the April, May, and June 2021 meetings include some inaccuracies, as outlined elsewhere in this report.	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.
	Sandhills Center has the ability to submit all ICD-10 Diagnosis codes submitted by the provider on the encounter data extracts to NC Medicaid.	Assure Consistent Connection to Community Services Rate PIP: declined from 65% to 55% for percentage of providers connecting members to community services.	Determine if provider has adequate staff and adequately trained staff to ensure referrals to follow-up and recipients are connected to services.

	Strengths	Weaknesses	Recommendations
	(b) Waiver Measures included all necessary documentation, and measures were reported according to specifications.	TCLI Timeliness Documentation Submission PIP: Results are presented using bar charts for quarterly rates. Graph on page 6 has a 1% rate that is not explained in the narrative, and the other bar says 8% although the rate is reported as 8.13%.	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.
	(c) Waiver Measures met or exceeded State benchmark rates.	NC-TOPPS Interview Data Accuracy PIP: Results are presented using bar charts for the baseline year and then a 2021 Q4 quarterly rate. Results are confusing—Table has 2 decimals and graphs are rounded to the nearest number. The 82% is labeled as “measure” and should be measured with a timepoint (Q4 2021) to be consistent with the other labels in the bar graph. One period is a full year and the other is a quarterly rate.	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.
	All PIPs were in the High Confidence range.	Routine Appointments kept PIP: Rate decreased from 35% to 21%. Goal rate is 66%.	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.
	Interdepartmental coordination was evident in the Grievance and Appeal files reviewed.		
	Sandhills fully implemented the Grievance and Appeal Corrective Actions and Recommendations issued in the 2020 EQR.		

	Strengths	Weaknesses	Recommendations
	Sandhills' Compliance Plan provides a thorough overview of PI accomplishments of prior goals and a list of initiatives to be implemented in the current year.		
	Sandhills' PI case files contained thorough documentation of the investigation.		
Timeliness	Sandhills Center's current NC Medicaid encounter data acceptance rate is approximately 99.5% for the combined Professional and Institutional extracts.	Sandhills has no documentation defining the frequency of BOD PI training, and there was no evidence that BOD Compliance training has occurred since 2018.	Define the frequency of the ongoing BOD Compliance training in their Corporate Compliance Plan to ensure this training is occurring consistently and timely.
	Care Coordination and TCLI documentation (i.e., progress notes, I/DD Monitoring Note, State Required Monitoring Checklist, In-Reach Transition Tools and QOL Surveys) were completed timely.	Several PI case files showed investigations have been open for as many as four years.	Continue with the PI Department's strategy to eventually eliminate the backlog of older PI cases.
Access to Care	Sandhills Credentialing staff developed a training manual for credentialing processes.	Two of the four submitted initial credentialing files (one practitioner and one agency) and two of the four submitted recredentialing files (one practitioner and one agency) did not include the Ownership Disclosure regarding "managing employees, persons with an ownership and control interest in the Provider" or EFT authorized individuals, officers, or directors.	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.

	Strengths	Weaknesses	Recommendations
	Credentialing and recredentialing files contain checklists to help guide the process.	Sandhills' Procedure CC 12a, I/DD Deinstitutionalization Planning did not include the exclusions listed in *NC Joint Communication Bulletin #J362.*	Revise Procedure I-DD/CC 12a, IDD Deinstitutionalization Planning, to include the exclusion to the Waiver cost limits/funding cap as listed in *NC Joint Communication Bulletin #J362.*
	Sandhills has a Provider Help Desk with a dedicated toll-free phone number and email address to assist providers with any issues. Sandhills posts Provider Help Desk Questions and Answers on its website.	I/DD progress notes and *I/DD Monitoring Notes* did not capture all the monitoring activities as stated in Sandhills Procedure I/DD CC 2a.	Implement a process that ensures I/DD progress notes and *I/DD Monitoring Notes* are complete, concise, reflect engagement and interventions provided to or on behalf of the enrollee, and are compliant with Sandhills' procedures and the *NC Medicaid Contract 6.11.3 (h), Section O (6) and Amendments*.
	The cover email sent to new providers with contracts includes a list of links to numerous items on the Sandhills website, including provider orientation materials and other materials that would be helpful to providers.	MH/SU levels of care labeled on progress notes did not correspond with required Care Coordinator intervention listed in Sandhills' Procedure CC 22a.	Implement a process that ensures MH/SU progress notes are clear and concise and that interventions provided by the Care Coordinator correspond with Sandhills Procedure CC 22a prior to step-down to a lower level of care or discharge from Care Coordination.
	TCLI collaborated with the Quality Management Department to develop a TCLI Provider Monitoring tool to assist with monitoring service delivery.	The file reviewed in which Sandhills extended the resolution timeframe did not include an oral or written notification to the grievant informing them of the extension. These notifications are required by *42 CFR § 438.408 (c)(2)(i)(ii)* and by Sandhills Procedure Core 35a.	Enhance the Grievance monitoring process for extended resolution timeframes to include review of notifications required by *42 CFR § 438.408 (c)(2)(i)(ii)* and by Sandhills Procedure Core 35a on page 6 that 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	Recommendations
	Sandhills has maintained their very high acceptance rate of encounter data submissions this review year.	Appeals initiated orally no longer require a written request to follow the oral Appeal as was once required. Sandhills Procedure HUM 34a, Appeals Process (Medicaid), the Member Handbook, and the *Medicaid/State Provider Manual* need to be updated to reflect this change.	Update Procedure HUM 34a, Appeals Process (Medicaid), the *Member Handbook*, and the *Medicaid/State Provider Manual* with documentation that Appeals initiated orally do not require a written request to follow the oral Appeal as was once required (*42 CFR § 438.402 (c)(3)(ii)* and *438.406 (b)(3).*
		One Appeal file that was withdrawn by the member's representative did not have a resolution letter sent to the member/guardian. The *NC Medicaid Contract* requires that all Appeals are resolved with written notification provided in *Attachment M (G) (7).*	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).*
		CCME looked at Appeal files for documentation that the Appeals Coordinator confirmed guardianship. From Onsite discussion, guardianship is checked in Alpha, but not documented in the Appeal file.	Include documentation of the guardianship verification check in the Appeal file and add guardianship verification to the *Appeal Audit Tool.*

METHODOLOGY

The process used for the EQR was based on the CMS protocols for EQR of MCOs and PIHPs. This review focused on the three federally mandated EQR activities: compliance determination, validation of Performance Measures, and validation of Performance Improvement Projects, as well as optional activity in the area of Encounter Data Validation, conducted by CCME's subcontractor, HMS. Additionally, as required by CCME's contract with NC Medicaid, an Internal Systems Capability Assessment (ISCA) and Medicaid program integrity review of the PIHP was conducted by CCME's subcontractor, IPRO.

On July 26, 2021, 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 to allow 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 17, 2021, 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 Quality Improvement 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 September 9, 2021. This Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the onsite visit, see *Attachment 2*. CCME's onsite activities included:

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

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

FINDINGS

The findings of the EQR are summarized in the following pages of this report and are based on the regulations set forth in *42 CFR § 438.358* and the *NC Medicaid Contract* requirements between 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. Information Systems Capabilities Assessment (ISCA)

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 Information Technology (IT) staffing patterns. This system analysis was completed as specified in the Centers for Medicaid and Medicare Services (CMS) protocol. During the Onsite, staff presented a member and claims systems review. Questions regarding the ISCA tool were discussed with Sandhills staff.

In the 2020 EQR, Sandhills met all of the administrative standards and received one Recommendation related to Encounter Data submissions.

Table 2: 2020 EQR Grievance Findings

2020 EQR Grievance Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The MCO has the capabilities in place to submit the State required data elements to NC MEDICAID on the encounter data submission	***Recommendation: Continue to work with providers and the State to increase the number of ICD-10 Procedure codes submitted into NCTracks.***	**Y**
2021 EQR Follow up: Last year's weakness where Sandhills did not have the ability to submit ICD-10 Procedure codes on encounter data extracts to NC Medicaid has been resolved. Sandhills is now able to capture and submit ICD-10 Procedure codes that are received.		

Sandhills, like many other PIHPs in North Carolina, used the AlphaMCS transactional, a hosted system environment produced by WellSky, their vendor. During second quarter 2021, Sandhills transitioned from AlphaMCS to the Alpha+ platform, noting that there were no major changes in processes or functionality of the platform. Hosting of the Alpha+ system has been brought in-house, and Sandhills has eliminated WellSky. The Alpha+ system is used to process member enrollment and claims, submit encounters, and generate reports.

The ISCA tool and supporting documentation for enrollment systems loading processes clearly define the process for enrollment data updates in the Alpha enrollment system. During the ISCA Onsite, Sandhills provided a demonstration of the Alpha enrollment system. The system maintains a member's enrollment history. The Global Eligibility File (GEF) file is imported daily into the Alpha system by Sandhills staff.

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

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

During the Onsite system demonstration, staff displayed the enrollment information that is viewable and captured within Alpha. The Alpha system captures demographic data like 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

2018	2019	2020
188,683	188,722	206,437

Sandhills' claims and authorizations are 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 ISCA Onsite, including Institutional and Professional claim screens.

Sandhills receives claims from three methods, 837 electronic file, provider web portal, and paper claims. During the ISCA Onsite, Sandhills stated that they receive claims from out-of-network providers on paper. Table 4 details the percentage of 2020 claims received via each of the three methods.

Table 4: Percent of claims with 2020 dates of service that were received via Electronic (HIPAA, Provider Web Portal) or Paper forms.

Source	HIPAA File	Paper	Provider Web Portal
Institutional	82%	>1%	17%
Professional	63%	>1%	36%

Sandhills adjudicates claims on a nightly basis. Data shows that 99.75% of Professional claims and 88.02% of Institutional claims are auto adjudicated.

On the Alpha system, Sandhills captures up to 25 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. During the ISCA Onsite, Sandhills confirmed they can capture and submit Telehealth modifier codes during the ongoing COVID-19 pandemic.

Sandhills pends claims that have a claim header amount of $5,000 or more. Emergency Department (ED) claims and Professional ED claims that have a place of service of ER are also pended. The pended claims are manually reviewed and completed daily.

Sandhills utilizes the Alpha system to generate reports with real-time data. A local reporting database is also used to create reports. The enrollment, provider, claims, and authorization information that is captured in the Alpha is 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 ISCA 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 ISCA Onsite, Sandhills indicated that reporting database is backed up on a nightly basis. Sandhills has 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 ISCA Onsite, Sandhills demonstrated their encounter reconciliation system to NC Medicaid.

The breakdown of encounter data acceptance/denial rates by claim service detail counts was provided for encounters submitted in 2020. Table 5 provides a comparison of 2019 and 2020.

Table 5: Volume of 2019 and 2020 Submitted Encounter Data

2020	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	23,070	415	86	23,571
Professional	1,196,973	48,927	6,988	1,252,888
2019	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	30,537	239	1,830	32,606
Professional	1,216,008	12,697	2,573	1,231,278

Sandhills has a 99.5% acceptance rate for both Professional and Institutional encounters with dates of service in 2020. Sandhills reported that the top three denial reason for encounters submitted in 2020 were:

- Provider Taxonomy mismatches
- End date associated with provider Re-credentialing
- Duplicates due to submission timing of voided encounters

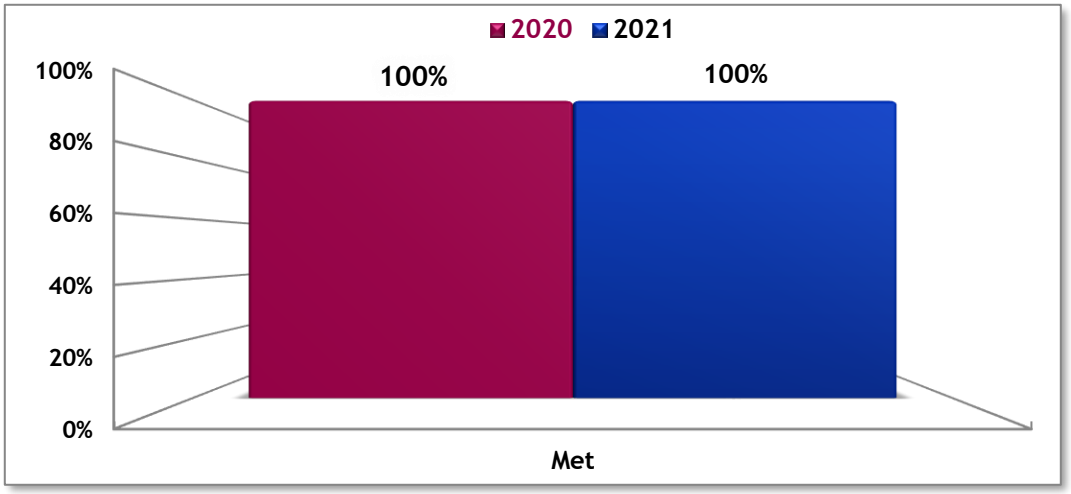
On average, Sandhills submits an encounter within five days from the time of adjudication to NC Medicaid. It takes approximately 24 days to correct and resubmit an encounter to NC Medicaid. Sandhills uses the Adam Holtzman's paid and denied report and the weekly 835 file to identify encounters that were denied. As stated in the ISCA, Sandhills has 317 Institutional and 6,572 Professional encounters still awaiting resubmission as of July 23, 2021.

During the ISCA Onsite, Sandhills demonstrated an encounter data Pay and Deny application that Sandhills developed a Pay and Deny encounter reconciliation application that is based on the Adam Holtzman's paid and denied report. Sandhills' application is 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 has addressed the corrective action from last year's EQR review and is now able to submit all ICD-10 Diagnosis codes received on Institutional claims to NC Medicaid.

Figure 2 demonstrates that Sandhills met all of the Standards in the 2020 and 2021 ISCA EQRs.

Figure 2: ISCA Comparative 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 99.5% 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 2020 EQR. No Corrective Actions or Recommendations were issued.

Procedures N-CR 01a-19a, N-NM 03a, and NRR 04a comprise the *Sandhills Center Provider Credentialing Program Plan,* which guides the credentialing and recredentialing processes. Procedure NCR 02a indicates the Chief Medical Officer/Chief Clinical Officer (CMO/CCO) is "responsible for oversight of the clinical aspects of the credentialing program." Dr. Anthony Carraway, a Board-Certified Psychiatrist and Sandhills' CMO/CCO, chairs the Credentialing Committee. Approval of "clean" applications is delegated to Dr. Carraway. Sandhills delegates credentialing to UNC and Moses Cone hospital systems for their employees. The two hospital systems submit to Sandhills a monthly credentialing roster. The individual practitioners are entered as "delegates" in the Alpha system and are not available for direct referrals.

Procedure NCR 03a, Credentialing Committee, defines the "Scope of Responsibilities and Duties" of the Credentialing Committee. Voting members of the committee are "practitioners participating in the (Sandhills) network, limited to active practicing licensed clinicians who have no other role in Sandhills Center's management and that mirror the network composition." 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.

During the Onsite, CCME discussed with Sandhills staff issues regarding documentation in the submitted April 27, 2021, May 25, 2021, and June 29, 2021 Credentialing Committee meeting minutes. A table titled "*Re-Credentialing Request: LP's (Clean) Affiliated with an Agency with QOC concerns (See Agencies in Report)***" in the meeting minutes lists practitioner numbers, the number of the agency with which they are affiliated, and includes a column titled "QM Concerns." That column has "See QM Issues Below" entered for every agency; however, during Onsite discussion, Sandhills staff confirmed there is no information in the minutes regarding most of the agencies whose numbers are listed in that section, and no information was provided to committee members regarding the agency Quality of Care (QOC) concerns.

An additional issue is that the table name references "LP's" (*sic*), but the relevant column heading is labeled "LIP Number." During Onsite discussion, Sandhills staff confirmed the table is about LPs, not Licensed Independent Practitioners (LIPs).

In the referenced table regarding LPs with clean applications applying for recredentialing at agencies with QOC issues, the "QM Concerns" column in the June 2021 minutes states "QM concerns are available upon request" for every agency. During the Onsite, Sandhills staff indicated there was no additional information provided regarding the referenced QOC issues for the agencies for which the LPs were applying to be recredentialed, but confirmed that Credentialing Committee members could request information.

CCME's review of the credentialing and recredentialing files showed they were organized and contained appropriate information. Two of the four submitted practitioner credentialing files and two of the four submitted practitioner recredentialing 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*. In response to CCME's request on the Missing Desk Materials list, Sandhills submitted the Ownership Disclosures.

During Onsite discussion, Sandhills staff reported the credentialing staff has developed a training manual for credentialing processes. Staff also reported they have instituted DocuSign for contracts, which has created efficiencies and streamlined the process. Sandhills is developing a similar DocuSign process for credentialing and recredentialing.

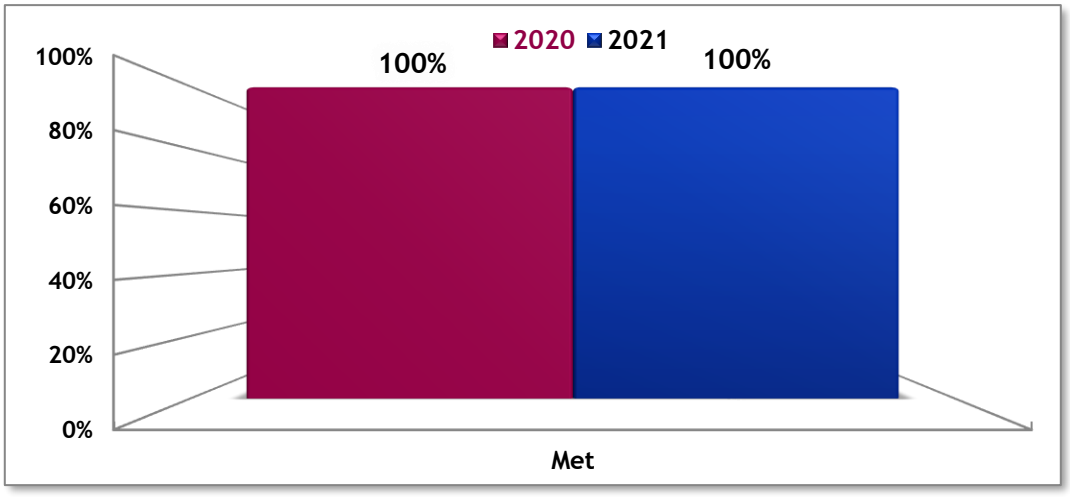
Orientation materials, training opportunities and events, the *Medicaid/State Provider Manual*, and provider forms and documents are posted on the Sandhills website. With their contracts, new providers receive communications directing them to the materials.

Sandhills' Annual Provider Orientation was offered electronically in May 2021 due to the pandemic. The Annual Provider Orientation, which is posted on the Sandhills website, included information from Network Operations, Quality Management, Customer Services, Care Management/Utilization Management, Finance, Care Coordination, and Program Integrity, including information on fraud, waste, and abuse. The Orientation included information on navigating the Sandhills website, as well as a presentation on results of the *2020 Consumer Perception of Care Survey* and the *2020 Experience of Care and Health Outcomes (ECHO) Survey*.

During the Onsite for the current EQR, Sandhills staff reported they run quarterly geo-mapping reports and analyze the reports to determine the need to add providers. Staff reported continued progress regarding services for which Sandhills had submitted Exception Requests. For example, Sandhills added to their network the Partial Hospital program at Moses Cone and a Facility-Based Crisis provider in Asheboro. Sandhills has issued several RFPs, with providers selected for Facility-Based Crisis, Child and Adolescent, and Child and Adolescent Day Treatment. Though providers were 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." RFPs were recently posted for High Fidelity Wrap Around and In-Home Skill Building services.

Figure 3, Provider Services Comparative Findings, shows that 100% of the standards in the 2021 Credentialing/Recredentialing EQR were scored as "Met", and provides an overview of 2021 scores compared to 2020 scores.

Figure 3: Provider Services Comparative Findings



Strengths

- Sandhills Credentialing staff developed a training manual for credentialing processes.
- Credentialing and recredentialing files contain checklists to help guide the process.
- Network Management uses a two-tiered review process in which a Credentialing Specialist processes the credentialing/recredentialing applications, followed by a review by another Credentialing Specialist.
- Sandhills has a Provider Help Desk with a dedicated toll-free phone number and email address to assist providers with any issues. Sandhills posts Provider Help Desk Questions and Answers on its website.
- The cover email sent to new providers with contracts includes a list of links to numerous items on the Sandhills website, including provider orientation materials and other materials that would be helpful to providers.

Weaknesses

- Credentialing Committee meeting minutes for the April, May, and June 2021 meetings included some inaccuracies, as outlined elsewhere in this report.
- Two of the four submitted initial credentialing files (one practitioner and one agency) and two of the four submitted recredentialing files (one practitioner and one agency)

did not include the Ownership Disclosure regarding "managing employees, persons with an ownership and control interest in the Provider", or EFT authorized individuals, officers, or directors.

Recommendations

- 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.

- 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.

C. Quality Improvement

42 CFR § 438.330

The 2021 Quality Improvement (QI) EQR included Performance Measures (PMs) and Performance Improvement Projects (PIPs) validation. CCME conducted a Desk Review of the submitted (b) and (c) Waiver Performance Measures and a review of each PIP's *Quality Improvement Project (QIP) report* for validation, using CMS standard validation protocols. An Onsite discussion occurred to clarify measurement rates for each of the areas.

In the 2020 EQR, Sandhills Met 100% of the Quality standards and received five Recommendations related to the four PIPs validated. The 2020 Recommendations and whether Sandhills implemented the Recommendations are presented in Table 6.

Table 6: 2020 PIP Recommendations

Project(s)	Recommendations	Recommendation Implemented in 2021 (Y/N/NA)
Increase EBP for Medication Management	Add a chi square or Fisher's exact test to compare rates and report the p-value.	N/A: There is no data available for this QIP due to pause on data audits.

Project(s)	Recommendations	Recommendation Implemented in 2021 (Y/N/NA)
Assure Consistent Connection to Community Services Following FBC Services	Add a chi square or Fisher's exact test to compare rates and report the p-value	Y
Access to Routine BH Assessments	Omit the Fisher's exact test as a method for validating the sample and use a random function in Excel as an alternative to generate random selection.	Y
Access to Routine BH Assessments	Add information in the Data Collection section on how the caller enters the data and the database system used for data collection.	Y
TCLI Transition Days	Continue interventions and determine if specific interventions are more beneficial as the COVID-19 crisis continues to limit contact with consumers.	Y

Performance Measure Validation

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

Table 7: (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 8: (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 the FY2019 to FY2020 rates, there was one measure with substantial improvement, and a few measures with substantial decline. The 30-Day Readmission Rate for Mental Health, Inpatient State Hospital increased from 0% to 12.5%, indicating a decline, since lower is better for readmissions.

The 7- and 30-Day Follow Up After Hospitalization for Substance Abuse declined for Detox and FBC, at a rate of 57.9% for 7-Day and 46.8% for 30-Day.

The Engagement of AODD Treatment for 13-17-year-olds declined 10.6% and for 18-20-year-olds, there was a 10.0% decline for Initiation and a 13.2% decline for Engagement.

The 65+ age group had a decline for Initiation of 10%. The 30-Day Follow Up After Hospitalization for Mental Illness improved substantially for FBC (18.2% improvement) and PRTF (15.5% improvement). 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 9 through 18.

Table 9: A.1. Readmission Rates for Mental Health

30-day Readmission Rates for Mental Health	FY 2019	FY 2020	Change
Inpatient (Community Hospital Only)	8.4%	10.8%	2.40%
Inpatient (State Hospital Only)	0.0%	12.5%	12.50%
Inpatient (Community and State Hospital Combined)	8.4%	10.8%	2.40%
Facility Based Crisis	11.4%	6.7%	-4.70%
Psychiatric Residential Treatment Facility (PRTF)	14.3%	14.3%	0.00%
Combined (includes cross-overs between services)	8.8%	11.0%	2.20%

Table 10: A.2. Readmission Rate for Substance Abuse

30-day Readmission Rates for Substance Abuse	FY 2019	FY 2020	Change
Inpatient (Community Hospital Only)	4.7%	8.9%	4.20%
Inpatient (State Hospital Only)	2.0%	0.0%	-2.00%
Inpatient (Community and State Hospital Combined)	4.3%	7.0%	2.70%
Detox/Facility Based Crisis	10.9%	7.9%	-3.00%
Combined (includes cross-overs between services)	5.9%	7.2%	1.30%

Table 11: A.3. Follow-Up after Hospitalization for Mental Illness

Follow-up after Hospitalization for Mental Illness	FY 2019	FY 2020	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	40.0%	40.4%	0.40%
Percent Received Outpatient Visit Within 30 Days	58.2%	59.6%	1.40%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	81.8%	83.3%	1.50%
Percent Received Outpatient Visit Within 30 Days	81.8%	100.0%	18.20%
PRTF			
Percent Received Outpatient Visit Within 7 Days	23.1%	30.0%	6.90%
Percent Received Outpatient Visit Within 30 Days	46.2%	61.7%	15.50%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	40.04%	40.2%	0.16%
Percent Received Outpatient Visit Within 30 Days	58.2%	59.8%	1.60%

Table 12: A.4. Follow-Up After Hospitalization for Substance Abuse

Follow-up after Hospitalization for Substance Abuse	FY 2019	FY 2020	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	21.3%	17.5%	-3.80%
Percent Received Outpatient Visit Within 30 Days	34.1%	30.2%	-3.90%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	5.0%	5.6%	0.60%
Percent Received Outpatient Visit Within 7 Days	69.0%	11.1%	-57.90%
Percent Received Outpatient Visit Within 30 Days	69.0%	22.2%	-46.80%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	26.0%	17.1%	-8.90%
Percent Received Outpatient Visit Within 30 Days	37.5%	29.7%	-7.80%

*NR = Denominator is equal to zero.

Table 13: B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2019	FY 2020	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	49.2%	45.3%	-3.90%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	40.8%	30.2%	-10.60%
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	53.8%	43.8%	-10.00%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	38.6%	25.4%	-13.20%
Ages 21–34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	57.1%	52.5%	-4.60%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	44.4%	40.9%	-3.50%
Ages 35–64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	54.8%	50.4%	-4.40%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	43.3%	35.8%	-7.50%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	60.0%	50.0%	-10.00%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	48.3%	44.2%	-4.10%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	55.3%	50.3%	-5.00%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	43.4%	36.6%	-6.80%

Table 14: D.1. Mental Health Utilization-Inpatient Discharges and Average Length of Stay

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
3–12	Male	0.2	0.2	0.0	44.3	40.3	-4.0
	Female	0.2	0.3	0.1	28.4	26.9	-1.5
	Total	0.2	0.2	0.0	36.9	32.4	-4.5
13–17	Male	1.0	0.8	-0.2	49.5	46.6	-2.9
	Female	2.0	1.7	-0.3	23.1	24.2	1.1
	Total	1.5	1.3	-0.2	31.8	31.4	-0.4
18–20	Male	1.3	1.3	0.0	7.9	10.6	2.7
	Female	1.2	1.3	0.1	9.4	8.0	-1.4
	Total	1.2	1.3	0.1	8.7	9.3	0.6
21–34	Male	3.5	3.9	0.4	7.6	8.9	1.3
	Female	1.3	1.4	0.1	5.7	6.3	0.6
	Total	1.8	1.9	0.1	6.5	7.5	1.0
35–64	Male	2.5	2.7	0.2	8.4	7.8	-0.6
	Female	1.6	1.7	0.1	7.5	7.6	0.1
	Total	2.0	2.1	0.1	7.9	7.7	-0.2
65+	Male	0.2	0.3	0.1	21.9	12.5	-9.4
	Female	0.2	0.2	0.0	16.2	11.7	-4.5
	Total	0.2	0.3	0.1	18.3	12.0	-6.3
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**	**1.0**	**0.0**	**19.5**	**17.0**	**-2.5**
	Female	**1.0**	**1.0**	**0.0**	**13.4**	**13.3**	**-0.1**
	Total	**1.0**	**1.0**	**0.0**	**16.0**	**14.9**	**-1.1**

Table 15: D.2. Mental Health Utilization -% of Members that Received at Least 1 Mental Health Service in the Category Indicated during the Measurement Period

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
3-12	Male	11.34%	10.57%	-0.77%	0.03%	0.04%	0.01%	0.23%	0.19%	-0.04%	11.30%	10.52%	-0.78%
	Female	8.73%	8.01%	-0.72%	0.03%	0.02%	-0.01%	0.11%	0.06%	-0.05%	8.71%	8.00%	-0.71%
	Total	10.07%	9.33%	-0.74%	0.03%	0.03%	0.00%	0.17%	0.13%	-0.04%	10.05%	9.30%	-0.75%
13-17	Male	14.15%	13.27%	-0.88%	0.26%	0.19%	-0.07%	0.33%	0.30%	-0.03%	14.02%	13.17%	-0.85%
	Female	16.10%	16.00%	-0.10%	0.26%	0.24%	-0.02%	0.21%	0.16%	-0.05%	16.06%	15.92%	-0.14%
	Total	15.12%	14.62%	-0.50%	0.26%	0.21%	-0.05%	0.27%	0.23%	-0.04%	15.02%	14.53%	-0.49%
18-20	Male	8.56%	8.00%	-0.56%	0.00%	0.04%	0.04%	0.05%	0.01%	-0.04%	8.55%	7.99%	-0.56%
	Female	11.41%	10.68%	-0.73%	0.07%	0.01%	-0.06%	0.03%	0.01%	-0.02%	11.39%	10.68%	-0.71%
	Total	10.04%	9.39%	-0.65%	0.04%	0.03%	-0.01%	0.04%	0.01%	-0.03%	10.02%	9.38%	-0.64%
21-34	Male	24.70%	23.61%	-1.09%	0.00%	0.00%	0.00%	0.00%	0.06%	0.06%	24.70%	23.61%	-1.09%
	Female	19.05%	17.88%	-1.17%	0.03%	0.01%	-0.02%	0.03%	0.02%	-0.01%	19.05%	17.87%	-1.18%
	Total	20.30%	19.16%	-1.14%	0.02%	0.00%	-0.02%	0.02%	0.03%	0.01%	20.30%	19.15%	-1.15%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
35-64	Male	22.00%	21.70%	-0.30%	0.02%	0.00%	-0.02%	0.01%	0.00%	-0.01%	22.00%	21.70%	-0.30%
	Female	23.70%	22.49%	-1.21%	0.03%	0.01%	-0.02%	0.03%	0.00%	-0.03%	23.70%	22.49%	-1.21%
	Total	23.06%	22.20%	-0.86%	0.02%	0.01%	-0.01%	0.02%	0.00%	-0.02%	23.06%	22.20%	-0.86%
65+	Male	5.30%	9.28%	3.98%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.30%	4.71%	-0.59%
	Female	5.48%	7.32%	1.84%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.48%	4.86%	-0.62%
	Total	5.42%	8.00%	2.58%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.42%	4.81%	-0.61%
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**	**13.75%**	**13.33%**	**-0.42%**	**0.07%**	**0.06%**	**-0.01%**	**0.17%**	**0.15%**	**-0.02%**	**13.70%**	**12.99%**	**-0.71%**
	Female	**14.37%**	**13.84%**	**-0.53%**	**0.06%**	**0.05%**	**-0.01%**	**0.08%**	**0.05%**	**-0.03%**	**14.36%**	**13.59%**	**-0.77%**
	Total	**14.10%**	**13.62%**	**-0.48%**	**0.06%**	**0.05%**	**-0.01%**	**0.12%**	**0.09%**	**-0.03%**	**14.07%**	**13.33%**	**-0.74%**

Table 16: D.3. Identification of Alcohol and Other Drug Services

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
3–12	Male	0.01%	0.02%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.02%	0.01%
	Female	0.01%	0.01%	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	0.89%	0.87%	-0.02%	0.02%	0.01%	-0.01%	0.19%	0.16%	-0.03%	0.79%	0.75%	-0.04%
	Female	0.78%	0.58%	-0.20%	0.03%	0.00%	-0.03%	0.23%	0.10%	-0.13%	0.63%	0.50%	-0.13%
	Total	0.84%	0.73%	-0.11%	0.03%	0.00%	-0.03%	0.21%	0.13%	-0.08%	0.71%	0.62%	-0.09%
18–20	Male	2.02%	1.70%	-0.32%	0.05%	0.03%	-0.02%	0.26%	0.16%	-0.10%	1.96%	1.62%	-0.34%
	Female	2.34%	1.98%	-0.36%	0.01%	0.00%	-0.01%	0.43%	0.32%	-0.11%	2.20%	1.83%	-0.37%
	Total	2.18%	1.84%	-0.34%	0.03%	0.01%	-0.02%	0.35%	0.24%	-0.11%	2.08%	1.73%	-0.35%
21–34	Male	8.24%	7.22%	-1.02%	0.21%	0.21%	0.00%	1.19%	0.86%	-0.33%	7.95%	6.99%	-0.96%
	Female	7.60%	6.93%	-0.67%	0.14%	0.14%	0.00%	1.27%	0.80%	-0.47%	7.40%	6.71%	-0.69%
	Total	7.74%	6.99%	-0.75%	0.16%	0.16%	0.00%	1.25%	0.81%	-0.44%	7.52%	6.77%	-0.75%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
35–64	Male	8.80%	8.90%	0.10%	0.13%	0.15%	0.02%	1.19%	1.07%	-0.12%	8.46%	8.54%	0.08%
	Female	6.51%	6.12%	-0.39%	0.07%	0.07%	0.00%	1.08%	1.02%	-0.06%	6.31%	5.79%	-0.52%
	Total	7.37%	7.16%	-0.21%	0.09%	0.10%	0.01%	1.12%	1.04%	-0.08%	7.11%	6.82%	-0.29%
65+	Male	1.74%	1.49%	-0.25%	0.02%	0.02%	0.00%	0.19%	0.30%	0.11%	1.66%	1.41%	-0.25%
	Female	0.51%	0.34%	-0.17%	0.00%	0.00%	0.00%	0.07%	0.07%	0.00%	0.48%	0.30%	-0.18%
	Total	0.92%	0.74%	-0.18%	0.01%	0.01%	0.00%	0.11%	0.15%	0.04%	0.88%	0.68%	-0.20%
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**	**2.32%**	**2.23%**	**-0.09%**	**0.04%**	**0.04%**	**0.00%**	**0.33%**	**0.28%**	**-0.05%**	**2.22%**	**2.13%**	**-0.09%**
	Female	**2.90%**	**2.64%**	**-0.26%**	**0.04%**	**0.04%**	**0.00%**	**0.50%**	**0.38%**	**-0.12%**	**2.79%**	**2.51%**	**-0.28%**
	Total	**2.65%**	**2.46%**	**-0.19%**	**0.04%**	**0.04%**	**0.00%**	**0.42%**	**0.34%**	**-0.08%**	**2.54%**	**2.34%**	**-0.20%**

Table 17: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
	3-12			13-17			18-20			21-34		
Anson	0.00%	0.00%	0.00%	2.06%	1.03%	-1.03%	3.05%	0.98%	-2.07%	5.16%	5.16%	0.00%
Guilford	0.03%	0.02%	-0.01%	0.95%	0.60%	-0.35%	2.28%	1.53%	-0.75%	5.59%	4.34%	-1.25%
Harnett	0.01%	0.04%	0.03%	0.79%	0.90%	0.11%	1.24%	1.50%	0.26%	3.80%	4.46%	0.66%
Hoke	0.00%	0.02%	0.02%	0.78%	1.30%	0.52%	1.93%	2.13%	0.20%	3.18%	3.49%	0.31%
Lee	0.02%	0.00%	-0.02%	0.74%	0.99%	0.25%	1.20%	2.01%	0.81%	6.21%	5.95%	-0.26%
Montgomery	0.04%	0.00%	-0.04%	1.37%	0.70%	-0.67%	2.58%	2.86%	0.28%	9.39%	8.08%	-1.31%
Moore	0.02%	0.00%	-0.02%	0.90%	0.49%	-0.41%	1.67%	1.61%	-0.06%	11.34%	11.29%	-0.05%
Randolph	0.03%	0.01%	-0.02%	0.71%	0.58%	-0.13%	1.50%	1.06%	-0.44%	6.47%	5.37%	-1.10%
Richmond	0.02%	0.02%	0.00%	1.32%	1.45%	0.13%	2.63%	3.32%	0.69%	9.70%	11.24%	1.54%
	35-64			65+			Unknown			Total		
Anson	7.52%	6.72%	-0.80%	1.75%	0.30%	-1.45%	0.00%	0.00%	0.00%	3.07%	2.42%	-0.65%
Guilford	7.98%	6.84%	-1.14%	1.50%	1.20%	-0.30%	0.00%	0.00%	0.00%	2.62%	2.10%	-0.52%
Harnett	3.83%	4.96%	1.13%	0.42%	0.52%	0.10%	0.00%	0.00%	0.00%	1.50%	1.83%	0.33%
Hoke	5.72%	5.48%	-0.24%	0.64%	0.74%	0.10%	0.00%	0.00%	0.00%	1.79%	1.90%	0.11%
Lee	6.57%	8.08%	1.51%	0.21%	0.98%	0.77%	0.00%	0.00%	0.00%	2.20%	2.53%	0.33%
Montgomery	9.25%	10.07%	0.82%	0.78%	0.91%	0.13%	0.00%	0.00%	0.00%	3.43%	3.26%	-0.17%
Moore	8.55%	10.03%	1.48%	0.58%	0.53%	-0.05%	0.00%	0.00%	0.00%	3.61%	3.74%	0.13%
Randolph	6.14%	5.72%	-0.42%	0.36%	0.40%	0.04%	0.00%	0.00%	0.00%	2.27%	2.00%	-0.27%
Richmond	8.63%	11.19%	2.56%	1.77%	1.31%	-0.46%	0.00%	0.00%	0.00%	3.94%	4.81%	0.87%

Table 18: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
	3-12			13-17			18-20			21-34		
Anson	6.76%	6.35%	-0.41%	13.18%	11.15%	-2.03%	7.17%	5.89%	0.00%	13.06%	12.07%	-0.99%
Guilford	7.94%	7.52%	-0.42%	14.87%	14.82%	-0.05%	9.53%	9.16%	0.00%	13.10%	12.07%	-1.03%
Harnett	9.25%	8.23%	-1.02%	14.63%	13.68%	-0.95%	9.27%	9.91%	0.00%	11.74%	11.45%	-0.29%
Hoke	9.01%	8.18%	-0.83%	13.28%	13.39%	0.11%	8.71%	10.81%	0.00%	11.55%	10.98%	-0.57%
Lee	6.95%	6.73%	-0.22%	11.24%	11.02%	-0.22%	6.89%	8.54%	0.00%	11.63%	12.00%	0.37%
Montgomery	7.23%	6.08%	-1.15%	13.32%	13.31%	-0.01%	8.15%	7.57%	0.00%	12.27%	11.94%	-0.33%
Moore	8.32%	8.28%	-0.04%	14.57%	14.95%	0.38%	9.39%	9.25%	0.00%	14.51%	15.78%	1.27%
Randolph	7.14%	6.88%	-0.26%	13.84%	12.91%	-0.93%	8.53%	8.57%	0.00%	11.28%	11.25%	-0.03%
Richmond	10.68%	10.89%	0.21%	17.34%	16.89%	-0.45%	9.30%	11.21%	0.00%	14.76%	17.12%	2.36%
	35-64			65+			Unknown			Total		
Anson	18.08%	17.21%	-0.87%	10.09%	6.50%	-3.59%	0.00%	0.00%	0.00%	11.36%	10.17%	-1.19%
Guilford	19.78%	18.10%	-1.68%	5.24%	3.91%	-1.33%	0.00%	0.00%	0.00%	11.73%	10.99%	-0.74%
Harnett	15.25%	15.54%	0.29%	6.79%	6.76%	-0.03%	0.00%	0.00%	0.00%	11.34%	10.88%	-0.46%
Hoke	15.83%	17.60%	1.77%	3.83%	5.15%	1.32%	0.00%	0.00%	0.00%	10.92%	11.07%	0.15%
Lee	14.77%	16.77%	2.00%	4.06%	4.23%	0.17%	0.00%	0.00%	0.00%	9.37%	9.77%	0.40%
Montgomery	17.66%	19.17%	1.51%	8.70%	8.33%	-0.37%	0.00%	0.00%	0.00%	10.91%	10.63%	-0.28%
Moore	19.77%	20.71%	0.94%	6.92%	8.90%	1.98%	0.00%	0.00%	0.00%	12.30%	12.87%	0.57%
Randolph	17.02%	16.53%	-0.49%	5.68%	2.92%	-2.76%	0.00%	0.00%	0.00%	10.54%	10.03%	-0.51%
Richmond	20.20%	21.66%	1.46%	5.73%	7.36%	1.63%	0.00%	0.00%	0.00%	13.81%	14.86%	1.05%

(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 19 contains validation scores for each of the 10 (b) Waiver Performance Measures.

Table 19: (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 20: (c) Waiver Measures Reported Results 2020 - 2021*. 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 20: (c) Waiver Measures Reported Results 2020-2021

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	1281/1281 = 100%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	1281/1281 = 100%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	452/467 = 96.79%	85%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	1303/1304 = 99.92%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	83/83 = 100%	85%

* Latest reported rates are shown in table from Excel files: *SHC Innovations Waiver Reporting 05012021 (Quarterly)* and *SHC Innovations Waiver Reporting 11012020 (Annual)*.

(c) Waiver Validation

All (c) Waiver Measures met the validation requirements and were Fully Compliant as shown in *Table 21: (c) Waiver Performance Measure Validation Scores*. The validation worksheets offer detailed information on validation and calculation steps for (c) Waiver Measures.

Table 21: 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 2020 EQR, there were seven active PIPs submitted. Of those seven, four were validated. The validated PIPs include: Access to BH Assessment (Non-Clinical), TCLI Transition Days (Non-Clinical), Increase EBP for Medication Management (clinical), and Assure Consistent Connection to Community Services following FBC services (clinical). All PIPs scored in the high confidence range in the 2020 EQR.

In the 2021 EQR, there were nine PIPs submitted, two of which are considered as monitoring only PIPs and seven that are considered active. Of the seven active PIPs, four were validated: TCLI Timeliness Documentation Submission, Assure Consistent Connection to Community Services Following FBC Services, Routine Appointments Kept, and Maximize Benefit of Level III. Only the Assure Consistent Connection to Community Services PIP was validated last year. Three new PIPs were chosen to be validated based on the availability of data and the status of the other PIPs. PIP validation is presented in *Table 22: PIP Summary of Validation Scores*. The validation was conducted using the *CMS Protocol 1: Validating Performance Improvement Projects*.

Table 22: PIP Summary of Validation Scores

Project Type	Project	2020 Validation Score	2021 Validation Score
Clinical	Assure Consistent Connection to Community Services	79/80 = 99% High Confidence in Reported Results	79/80 = 99% High Confidence in Reported Results
Non-Clinical	NC-TOPPS Interview Data Accuracy	Not Validated	74/79 = 94% High Confidence in Reported Results
	Routine Appointments kept	Not Validated	73/74 = 99% High Confidence in Reported Results
	TCLI Timeliness Documentation Submission	Not Validated	67/72 = 93% High Confidence in Reported Results

Table 23 displays the PIP project title and the interventions reported by Sandhills for the current review year aimed at improving PIP outcomes.

Table 23: 2021 Review PIP Interventions

Project(s)	Interventions
Assure Consistent Connection to Community Services - Clinical	Make referrals to Care Coordination to facilitate referrals to follow-up services when appropriate; Continue technical assistance to providers with emphasis on follow up to community services
TCLI Timeliness of Documentation Submission- Non-Clinical	TCLI staff are encouraged to complete and submit documentation immediately after each contact; When documentation isn't entered, it is recommended that staff complete and submit all documentation the morning of the following day; Staff are encouraged to not respond to calls or emails or schedule meetings until all notes have been entered
NC-TOPPS Interview Data Accuracy- Non-Clinical	NCTOPPS training Presentation
Routine Appointments kept- Non-Clinical	Continue sending reminder texts and reminder calls; 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; Research how to improve appointments kept for consumers being released from prison

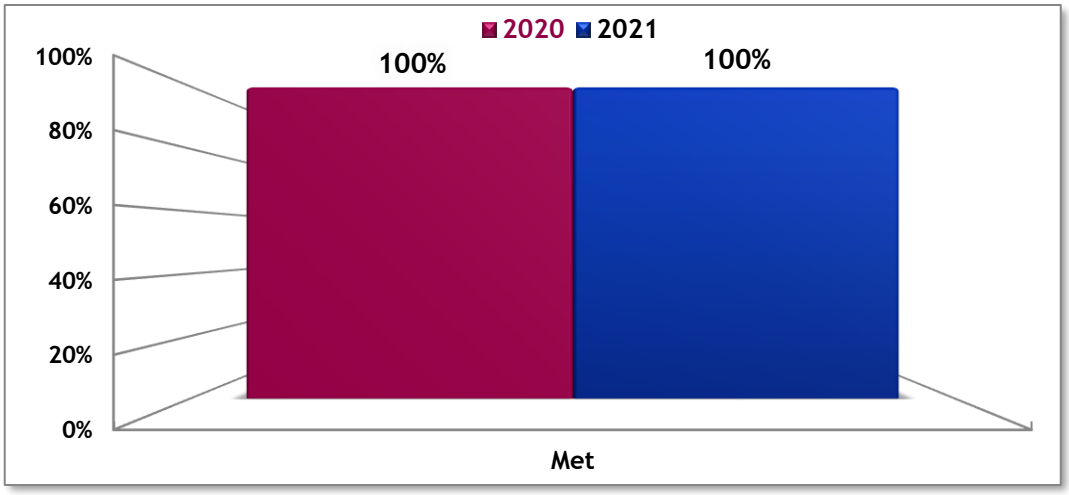
There are no Corrective Actions for the validated PIPs. For four of four PIPs, there are Recommendations regarding the revision of interventions and initiation of additional interventions to improve rates due to lack of rate improvement, and revisions on presentation of the results to offer more clarity in the presented findings. The project, section, reason, and Recommendations are displayed in Table 24 that follows.

Table 24: 2021 Performance Improvement Project Recommendations

Project(s)	Section	Reason	Recommendations
Assure Consistent Connection to Community Services (Clinical)	Was there any documented, quantitative improvement in processes or outcomes of care?	Rate declined from 65% to 55% for percentage of providers connecting members to community services.	Determine if provider has adequate staff and adequately trained staff to ensure referrals to follow-up are made and recipients are connected to services.
TCLI Timeliness Documentation Submission (Non-Clinical)	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results are presented using bar charts for quarterly rates. Graph on page 6 has a 1% rate that is not explained in the narrative; and the other bar says 8% although the rate is reported as 8.13%.	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.
NC-TOPPS Interview Data Accuracy (Non-Clinical)	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results are presented using bar charts for the baseline year and then a 2021 Q4 quarterly rate. Results are confusing; Table has 2 decimals and graphs are rounded to the nearest number. The 82% is labeled as “measure” and should be measured with a timepoint (Q4 2021) to be consistent with the other labels in the bar graph. One period is a full year and the other is a quarterly rate.	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.
Routine Appointments kept (Non-Clinical)	Was there any documented, quantitative improvement in processes or outcomes of care?	Rate decreased from 35% to 21%. Goal rate is 66%.	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.

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 2021 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 were in the High Confidence range.

Weaknesses

- PIP rates did not improve for two of the validated PIPs.
- Results are not presented clearly for two of the four PIPs.
- Several (b) waiver performance measures showed a decline in rate from the previous measurement year.

Recommendations

- Assure Consistent Connection to Community Services: Determine if provider has adequate staff and adequately trained staff to ensure referrals to follow up are made and recipients are connected to services.

- TCLI Timeliness Documentation Submission: To ensure each element of each indicator rate is easily identified, present the results using a table with the numerator, denominator, and rate instead of bar charts.

- NC-TOPPS Interview Data Accuracy: 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.

- Routine Appointments Kept: 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.

- Continue to monitor rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the performance measures.

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, the *Member Handbook*, and 11 files of enrollees participating in mental health/substance use (MH/SU), Intellectual/Developmental Disability (I/DD), and TCLI Care Coordination.

In the 2020 EQR, Sandhills met 100% of UM standards. CCME issued no Corrective Actions and one Recommendation for Sandhills to add an explanation of Home and Community Based Services (HCBS) and the use of the required State Monitoring Checklist to a procedure, relevant I/DD Care Coordination manual, or I/DD document. This Recommendation was addressed.

Table 25: 2020 Grievance Findings

2020 EQR Grievance Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	***Recommendation: Add an explanation of Home and Community Based Services (HCBS) and the use of the required State Monitoring Checklist to a procedure, relevant I/DD Care Coordination manual, or I/DD document.***	**Y**
2021 EQR Follow up: In this 2021 EQR, Sandhills addressed the Recommendation and updated Procedure I/DD CC2, I/DD Care Coordination Monitoring of Plan Implementation.		

For this EQR, there are no Corrective Actions and three Recommendations. Sandhills' Procedure CC12a, I/DD Deinstitutionalization Planning, lists the Innovations Waiver funding cap as $135,000 for base and non-base budget services. The procedure does not list the exclusions to the Waiver funding cap as stated in *NC Medicaid Joint Communications Bulletin #J362* that allows Innovations Waiver enrollees to exceed the Waiver funding cap when one of three criteria is met. CCME recommends that Sandhills update Procedure CC12a to include the exclusion criteria.

The review of Care Coordination files showed that Sandhills continues to make significant improvements in submitting progress notes and other required Care Coordination documentation in a timely manner. However, the review of I/DD files found that progress notes did not capture all monitoring, treatment, and supports provided by the Care Coordinator. For example, in two out of three I/DD files, the review or monitoring of claims data for over-utilization and or under-utilization was not documented in progress notes. 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 that "All monitoring contacts and attempts to monitor will be documented in enrollee's electronic medical record." CCME recommends that Sandhills ensure I/DD progress notes and I/DD Monitoring Notes 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. 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 labeled as "medium" level of care while hospitalized. On the same day, 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. CCME recommends that Sandhills 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.

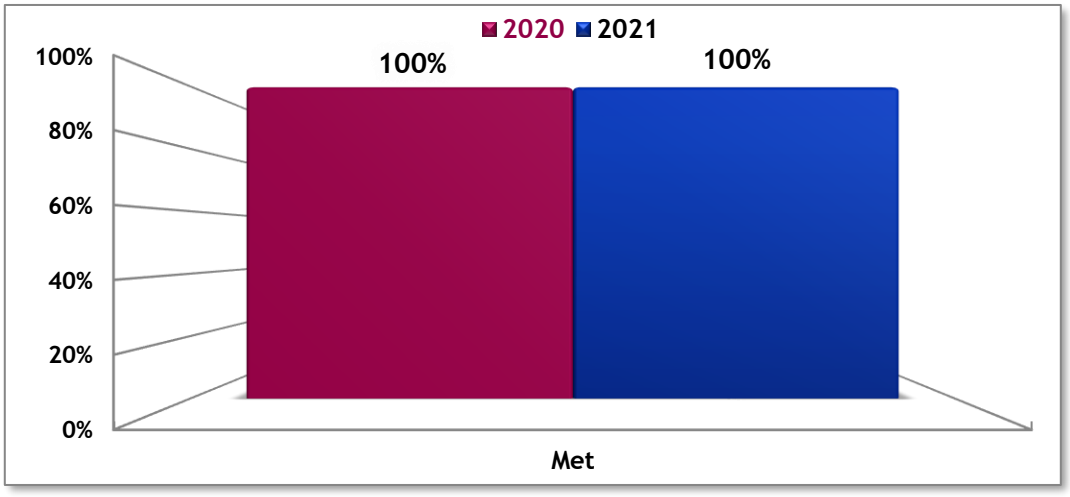
During the initial review of NC's Certified Peer Support Specialist Program website, CCME found that one In-Reach Specialist's certification had lapsed, and two In-Reach Specialists could not be located on the website due to the spelling of their names. During

the Onsite, Sandhills was able to provide documentation showing that all In-Reach staff are Certified Peer Support Specialists.

The review of TCLI files included one enrollee who was discharged from TCLI after securing employment and earning more than $2,000 monthly. The reason for discharge did not correspond with a Sandhills' procedure. During the Onsite, Sandhills' staff clarified that they followed the *NC Transition to Community Living (TCLI) Housing Fund Guidelines*, which states that "the maximum expenditure of $2000 shall not be exceeded for any individual". Furthermore, emails between NC Medicaid representatives and Sandhills, explained that "exceeding the expenditure amount disqualifies the member from receiving subsidies, thus disqualifying the member from the TCLI programs." Sandhills followed *NC TCLI Manuals* when discharging the member from TCLI.

Figure 5 Utilization Management Comparative Findings shows that 100% of the UM standards were scored as "Met" and provides an overview of 2021 scores compared to the 2020 EQR UM scores.

Figure 5: Utilization Management Comparative Findings



Strengths

- Care Coordination and TCLI documentation (i.e., progress notes, I/DD Monitoring Note, *State Required Monitoring Checklist*, *In-Reach Transition Tools* and *QOL Surveys*) were completed in a timely manner.

- TCLI collaborated with the Quality Management Department to develop a TCLI Provider Monitoring tool to assist with monitoring service delivery.

Weaknesses

- Sandhills' Procedure CC 12a, I/DD Deinstitutionalization Planning, did not include the exclusions listed in NC Joint Communication Bulletin #J362.
- I/DD progress notes and I/DD Monitoring Notes did not capture all the monitoring activities as stated in Sandhills' Procedure I/DD CC 2a.
- MH/SU levels of care labeled on progress notes did not correspond with required Care Coordinator interventions listed in Sandhills' Procedure CC 22a.

Recommendations

- Revise Procedure I-DD/CC 12a, IDD Deinstitutionalization Planning, to include the exclusions to the Waiver cost limits/funding cap as listed in *NC Joint Communication Bulletin #J362*.
- Implement a process that ensures I/DD progress notes and I/DD Monitoring Notes are complete and concise and reflect engagement and interventions provided to or on behalf of the enrollee. Ensure notes comply with Sandhills' procedures and *NC Medicaid Contract 6.11.3 (h), Section O (6) and Amendments*.
- Implement a process that ensures MH/SU progress notes are clear and concise and that interventions provided by the Care Coordinator correspond with Sandhills' procedure CC 22a prior to step-down to a lower level of care or discharge from Care Coordination.

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*, the *Member Handbook*, 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 2020 EQR, Sandhills met 90% of the Grievance and Appeal standards, resulting in two Corrective Actions and five Recommendations. Follow up to the 2020 EQR Grievance and Appeal Corrective Actions and Recommendations are detailed in the following, respective sections.

In this 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.

Grievances

In the 2020 EQR, two Recommendations were issued primarily targeting missing or inconsistent information within Sandhills' Medicaid/State Provider Manual. In the 2021 EQR, there was evidence that Sandhills addressed all Grievance Recommendations issued in the 2020 EQR.

Table 26 outlines CCME's review to ensure those Recommendations were implemented by Sandhills.

Table 26: Follow up to 2020 EQR Grievance Corrective Actions and Recommendations

2020 EQR Grievance findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements.	***Recommendation: Revise the Medicaid/State Provider Manual to consistently use the term "Grievance."***	**Y**
2021 EQR Follow up: In this 2021 EQR, it was noted there is consistent use of the term Grievance throughout the *Medicaid/State Provider Manual* updated November 4, 2020.		
Timeliness guidelines for resolution of the Grievance as specified in the contract;	***Recommendation: Add information to the Member Handbook regarding the process followed when Sandhills extends the Grievance resolution timeframe. Include the notifications required by 42 CFR § 438.408 (c)(1) and (c)(2).***	**Y**
2021 EQR Follow up: Page 24 of the *Member Handbook* (May 18, 2021) explains the extension process and notifications that are given when Sandhills or the member extends the Grievance resolution timeframe.		

In the 2021 EQR, 10 Grievance files were reviewed. Seven files were standard and straightforward Grievances. Two of the files were extended resolutions beyond the 30 days in which Sandhills resolves Grievances per Procedure Core 35a. Of the files with extensions, one was extended by the Grievant and the other by Sandhills. Both were resolved within the 14-calendar-day extension period. When Sandhills extended the resolution date, it was in the best interest of the Grievant, but there was not an oral or written notification sent to the Grievant informing them of this extension. These notifications are required by *42 CFR § 438.408 (c)(2)* and by Sandhills' Procedure Core 35a on page six. CCME issued a Recommendation 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 that 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." Lastly, one of the files was a Grievance that was resolved as unsubstantiated and appealed by the Grievant. Sandhills followed the Appeal process required in Procedure Core 35a when resolving the appealed Grievance.

Appeals

In the 2020 EQR of Appeals, Sandhills received two Corrective Actions and two Recommendations. Corrective Actions and Recommendations were aimed at language missing from Sandhills' policies and procedures, errors found within the Appeal files and data reviewed, and concerns related to Sandhills' delay in updating and correcting information within the *Member Handbook* and *Medicaid/State Provider Manual*.

Table 27 outlines Sandhills' responses to those findings and CCME's follow up to ensure Corrective Actions and Recommendations were implemented by Sandhills.

Table 27: Follow up to 2020 EQR Appeal Corrective Actions and Recommendations

2020 EQR Appeal findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	***Corrective Action: Revise Sandhills' policies and procedures to state the requirement that Sandhills notify the enrollee of his or her right to file a Grievance if Sandhills denied a request to expedite an Appeal. See NC Medicaid Contract, Attachment M, Section H.1.***	**Y**
Sandhills' 2020 CAP Response: "A sentence was added to Procedures HUM 33a, pg. 8; HUM 34a, pg. 8; HUM 38a, pg. 4. The sentence reads, 'The written notification will inform the member of his/her right to file a Grievance if he/she disagrees with the decision to deny an expedited Appeal.' The sentence has been highlighted for your convenience."		
CCME 2020 Corrective Action follow up: In the 2021 EQR, there was evidence that Sandhills revised and published Sandhills' Appeal procedures to consistently detail the enrollee's right to file a Grievance if Sandhills denies a request to expedite an Appeal.		
The PIHP applies the appeal policies and procedures as formulated.	***Corrective Action: Enhance the current Appeals monitoring process to ensure compliance of Appeal processes and notifications, especially those Appeals initiated orally.***	**Y**
Sandhills' 2020 CAP Response: "Fields have been added to the tool to capture acknowledgement standards required by the *NC Medicaid Contract* – See highlighted rows on attached Appeal Audit Tool – Revised."		
CCME 2020 Corrective Action follow up: The 2021 EQR Appeal file review found 100% of the Appeal files reviewed were acknowledged and resolved in a timely manner, including those appeals submitted orally.		

The definitions an appeal and who may file an appeal;	***Recommendation: Define a "reasonable timeframe" for correcting errors identified in Member Handbook and Medicaid/State Provider Manual and publishing them on Sandhills' website. Add this timeframe to an applicable procedure.***	**Y**
2021 EQR Follow up: Sandhills corrected this for the 2021 EQR and both the *Member Handbook* (published May 18, 2021) and *Medicaid/State Provider Manual* (published November 13, 2020) are current on the Sandhills' website.		
Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	***Recommendation: In the enhanced Appeals monitoring process, include routine review of the Appeals Log to ensure data and documentation within the log are complete and accurate.***	**Y**
2021 EQR Follow up: In this 2021 EQR of Appeals, it was noted the monitoring process includes a review of the Appeals Log. Further, for the 10 Appeal files reviewed, dates of acknowledgements, notifications, resolutions, and decisions were accurately captured on the Appeal Log.		

The 2021 EQR Appeal file review found 100% of the 10 files reviewed were acknowledged and resolved in a timely manner. In addition, all required notifications were sent on time. The Sandhills' Appeal Log was accurate for all 10 files. For the files reviewed for this 2021 EQR, seven were standard Appeals with two of the seven having an oral Appeal request as opposed to a written request. One file each was expedited, extended, and withdrawn. Appeals initiated orally no longer require a written request to follow the oral Appeal. This change was made 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 *Attachment M* to reflect the change. CCME issued a Recommendation for Sandhills to update Procedure HUM 34a, Appeals Process (Medicaid), the *Member Handbook*, and the *Medicaid/State Provider Manual* to reflect this change.

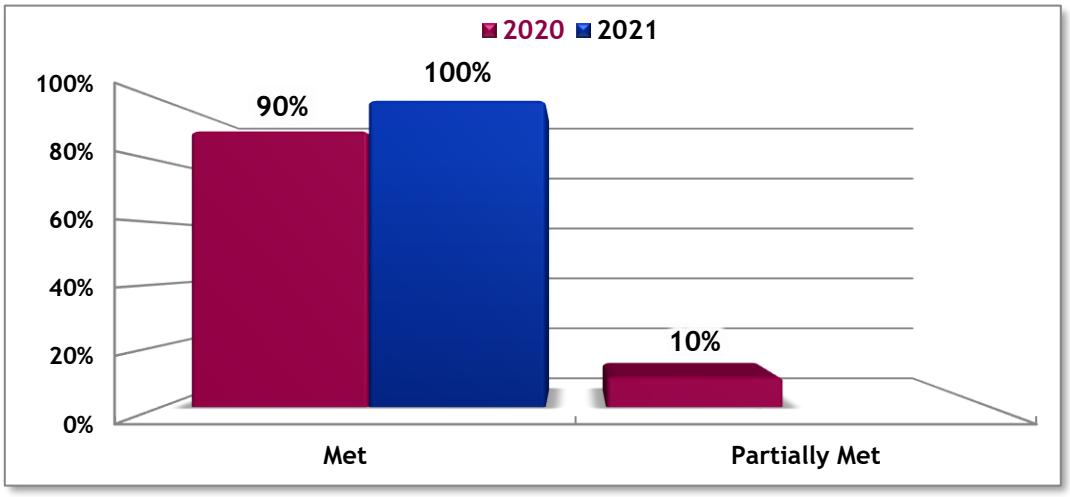
For the file reviewed that included an Appeal that was withdrawn, the member's representative had withdrawn the Appeal, and a resolution letter was not sent to the member/guardian. The *NC Medicaid Contract, Attachment M (G) (7)* requires that all Appeals are resolved with written notification provided. CCME issued a Recommendation to revise the Appeal process to include that a written resolution notification is sent to all members/guardians who file an Appeal, including Appeals that are withdrawn or invalid.

For all the Appeal files reviewed, CCME looked for documentation that the Appeals Coordinator confirmed guardianship. Guardianship is checked to ensure HIPAA practices are followed and to help the PIHPs avoid liability. From discussion with Sandhills' staff, guardianship is checked in the Alpha+ system but not documented in the Appeal file. CCME issued a Recommendation to include documentation of the guardianship verification check in the Appeal file and to add guardianship verification on the *Appeal*

Monitoring Tool. Sandhills improved the Appeals monitoring process since the 2020 EQR and made enhancements to the *Appeal Audit Tool* for monitoring notifications required for expedited and extended Appeals.

Figure 6, Grievances and Appeals Comparative Findings, shows that 100% of the standards in the 2021 Grievances and Appeals EQR were scored as "Met". This figure also provides an overview of 2021 scores compared to 2020 scores.

Figure 6: Grievances and Appeals Comparative Findings



Strengths

- The Grievance and Appeal files reviewed showed evidence of interdepartmental coordination.
- Sandhills fully implemented the Grievance and Appeal Corrective Actions and Recommendations issued in the 2020 EQR.

Weaknesses

- The file reviewed in which Sandhills extended the resolution timeframe did not include an oral or written notification to the Grievant informing them of the extension. These notifications are required by *42 CFR § 438.408 (c)(2)* and by Sandhills' Procedure Core 35a.
- Appeals initiated orally no longer require a written request to follow the oral Appeal. Sandhills' Procedure HUM 34a, Appeals Process (Medicaid), the *Member Handbook*, and the *Medicaid/State Provider Manual* need to be updated to reflect this change.
- One Appeal file that was withdrawn by the member's representative did not have a resolution letter sent to the member/guardian. The *NC Medicaid Contract* requires

that all Appeals are resolved with written notification provided in *Attachment M (G) (7)*.

- CCME reviewed Appeal files for documentation that the Appeals Coordinator confirmed guardianship. From the Onsite discussion, guardianship is checked in Alpha+ but not documented in the Appeal file.

Recommendations

- 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."

- 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)*.

- 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)*.

- 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 § 455, 42 CFR § 438.455 and 1000 through 1008, 42 CFR § 1002.3(b)(3), and 42 CFR § 438.608 (a)(vii)

The Program Integrity (PI) EQR included a thorough review of Sandhills' PI policies and procedures, staffing, workflows, reports, training materials, committee minutes, data mining initiatives, and investigation files. During the Onsite, PI staff were interviewed to further clarify PI functions.

In the 2020 EQR, Sandhills met 100% of the PI standards, and no Corrective Actions or Recommendations were issued.

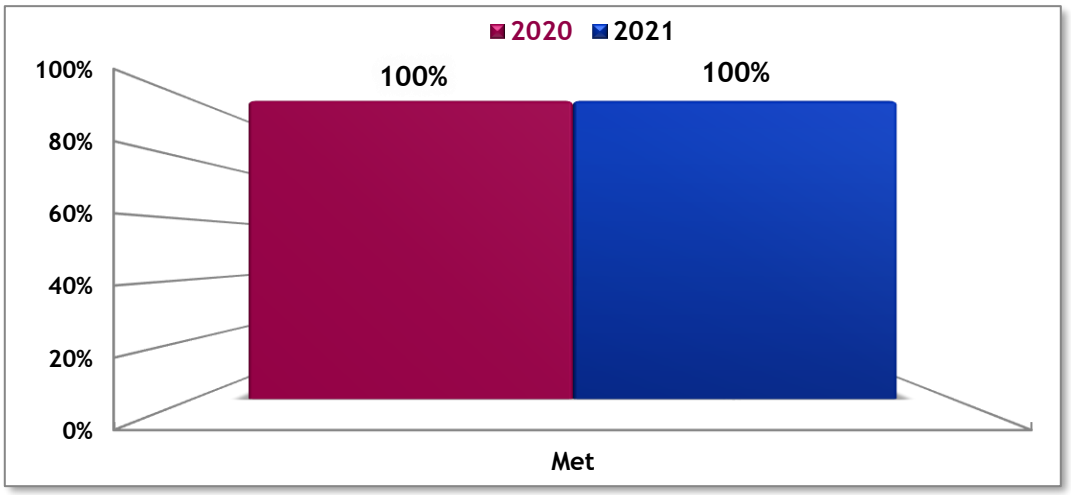
Program Integrity requirements are broken into the following sections: General Requirements, Fraud and Abuse, and Provider Payment Suspensions and Overpayments. The Fraud and Abuse review ensures PIHPs are adequately training PIHP staff, network providers and the PIHP Board of Directors (BOD) on the identification and reporting of potential fraud, waste, and abuse of Medicaid funds. Sandhills' *Corporate Compliance Plan* states the BOD training is an "ongoing review of compliance laws, standards,

policies/procedures, and updates of rules and regulations." In the 2021 EQR, Sandhills provided curriculum for training of staff, providers, and the BOD. However, Sandhills was not able to provide evidence that the BOD had received any Compliance training since 2018. During the Onsite discussion, Sandhills reported training of the BOD was scheduled in the next few months. In this 2021 EQR, CCME recommends Sandhills define the frequency of the ongoing BOD Compliance training in their *Corporate Compliance Plan*.

Fifteen PI files were selected and reviewed for the 2021 EQR. Sandhills' case files contained thorough documentation and showed investigations were initiated within 10 days. Final reports were well written and organized and referrals to NC Medicaid, where applicable, were complete and concise. There was detailed discussion on Sandhills' PI caseload, which included several investigations open for as many as four years. The PI Director described a strategy that was recently implemented to address the backlog of older cases. CCME recommends Sandhills continue with this strategy to eventually eliminate the backlog of older cases.

Figure 7 demonstrates Sandhills met 100% of the PI standards in the 2020 and 2021 EQRs.

Figure 7: Program Integrity Comparative Findings



Strengths

- Sandhills' *Corporate Compliance Plan* provides a thorough overview of PI accomplishments of prior goals and a list of initiatives to be implemented in the current year.
- Sandhills' PI case files contained thorough documentation of each investigation.

Weaknesses

- Sandhills has no documentation defining the frequency of BOD PI training, and there was no evidence that BOD Compliance training has occurred since 2018.
- Several PI case files showed investigations have been open for as many as four years.

Recommendations

- Define the frequency of the ongoing BOD Compliance training in the *Corporate Compliance Plan* to ensure this training is occurring consistently.
- Continue with the PI Department's strategy to eliminate the backlog of older PI cases.

G. Encounter Data Validation

The review, guided by the CMS Encounter Data Validation Protocol, focused on measuring the data quality and completeness of claims paid by Sandhills for the period of January 2020 through December 2020. All claims paid by Sandhills should 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. The review showed that principal and admitting diagnoses were populated consistently and that Sandhills has made notable progress in reporting additional Diagnosis codes. However, secondary Diagnosis codes are still missing from too many Professional claims.

Resolution:

Over the past few years, Sandhills made progress in reporting Other Diagnosis codes, especially on Institutional claims. However, there are many providers who never report more than one Diagnosis code. We recommend alerting such providers to remind them to ensure that submitted claims are complete and accurate, including secondary Diagnosis codes. We also shared a frequency distribution report showing which providers are not reporting secondary Diagnosis codes.

Conclusion

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

Overall, Sandhills has made great 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 emphasis on Other Diagnosis codes. Denials related to Taxonomy codes and Procedure codes still account for the bulk of denials. Sandhills should revisit its strategy to address issues with invalid or missing Taxonomy codes as well its reconciliation process and make necessary adjustments to further reduce Taxonomy code-related denials. The goal is to avoid denials by improving synchronization of data with NCTracks, in particular the Global Provider File. These improvements would, in turn, reduce the follow-up needed to correct and resubmit encounters.

While the missing Other Diagnosis codes on Professional and Institutional claims are not reported as denials, the omissions 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: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet
- Attachment 5: Encounter Data Validation Report

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

July 26, 2021

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 2021 External Quality Review (EQR) of 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 #9, the 2021 EQR will be a focused review. The focus of this review will be on the PIHP's Corrective Actions from the previous EQR and PIHP functions that impact enrollee health and safety. Similarly, for the 2021 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 **Thursday, September 9, 2021**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

In preparation for the Desk Review, the items on the enclosed **Desk Materials List** are to be submitted electronically. **Please note that, to facilitate a timely review, there are three items on the Desk Materials List (items 9, 10, and 19a) that should be submitted by no later Friday July 30, 2021,** and the remaining items are due by no later than **Tuesday**, **August 17, 2021**. Also, as indicated in item 40 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 **Tuesday**, **August 17, 2021**.

Further, as indicated on item 21 of the Desk Materials List, Encounter Data Validation (EDV) will also be part of this review. Our subcontractor, Health Management Systems (HMS) will be evaluating this component. Please read the documentation requirements for this section carefully and make note of the submission instructions, as they differ from the other requested materials.

All other materials should be submitted to CCME electronically through our secure file transfer website. The location for the file transfer site is: https://eqro.thecarolinascenter.org

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 5

Cc: Comellia Saunders, Sandhills Contract Manager
Tasha Griffin, NC Medicaid Waiver Contract Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager
Hope Newsome, NC Medicaid Quality Specialist

Sandhills

Focused External Quality Review 2021

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 30, 2021. The remainder of items must be uploaded by no later than August 17, 2021.**

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 (July 2020 through June 2021). Include the date of approval of initial credentialing and the date of approval of recredentialing.

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

7. Minutes of committee meetings for the following committees:

   a) Credentialing (for the three most recent committee meetings)
   b) UM (for the three most recent committee meetings)
   c) Any clinical committee meeting minutes showing discussion of Clinical Practice Guidelines impacted by COVID-19.

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

9. ****By July 30, 2021**, a copy of the complete Appeal log for the months of July 2020 through June 2021. Please indicate on the log: the appeal type (standard, expedited, extended, withdrawn, or invalid), the service appealed, the date the appeal was received, and the date of appeal resolution notification.

10. **By July 20, 2021, a copy of the complete Grievances log for the months of July 2020 through June 2021. Please indicate on the log: the nature of the grievance, the date received, and the date of grievance resolution.

11. Copies of all appeal notification templates used for expedited, invalid, extended, and withdrawn appeals.

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

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

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

15. For Care Coordination enrollees files, please provide:
    a. three MH/SU Care Coordination enrollee files (two active since 2019 and one recently discharged)
    b. three I/DD Care Coordination enrollee files (two active since 2019 and one recently discharged)
    c. four TCLI Care Coordination enrollee files (one active since 2019, 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:

i. 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.

ii. 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).

iii. 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 include 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.

iii. 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).

iv. Site visit/assessment reports if the provider has had a quality issue or a change of address.

v. Ownership disclosure information/form.

NOTE: Appeals, Grievances, and Program Integrity files will be selected from the logs submitted on July 30, 2021. A request will then be sent to the plan to send electronic copies of the files to CCME. The entire file will be needed.

19. Provide the following for Program Integrity:

a. ****File Review: By July 30, 2021**, Please produce a listing of all active files during the review period (July 2020 through June 2021). 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. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.

d. Workflow of process of taking complaint from inception through closure.

e. All 'Attachment Y' reports collected during the review period.

f. All 'Attachment Z' reports collected during the review period.

g. Provider Manual and Provider Application.

h. Enrollee Handbook.

i. Subcontractor Agreement/Contract Template.

j. Training and educational materials for the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse and the False Claims Act.

k. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse.
l. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors, and employees.
m. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other State or Federal agency.
n. Code of Ethics and Business Conduct.
o. Internal and/or external monitoring and auditing materials.
p. Materials pertaining to how the PIHP captures and tracks complaints.
q. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
    i. NC Medicaid approved reporting templates.
r. Sample Data Mining Reports.
s. NC Medicaid Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
t. Monthly reports of NCID holders/FAMS-users in PIHP.
u. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
v. Corrective action plans including any relevant follow-up documentation.
w. Policies/Procedures for:
    i. Program Integrity
    ii. HIPAA and Compliance
    iii. Internal and external monitoring and auditing
    iv. Annual ownership and financial disclosures
    v. Investigative Process
    vi. Detecting and preventing fraud
    vii. Employee Training
    viii. Collecting overpayments
    ix. Corrective Actions
    x. Reporting Requirements
    xi. Credentialing and Recredentialing Policies
    xii. Disciplinary Guidelines

20. Provide the following for the Information Systems Capabilities Assessment (ISCA):
    b. 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, 2020 – December 31, 2020. 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, 2020 – December 31, 2020. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

NOTE: EDV information should be submitted via the secure FTP to HMS. This site was previously set up during the first round of Semi-Annual audits with HMS. If you have any questions, please contact Kyung Lee of HMS at (978) 902-0031.

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2021

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Program Integrity: Please upload into file 19.a the MCO referral to DHB form for Case #240.

2. Appeals: Please upload into file 9 the Appeal audit tool that was referenced in the cover letter uploaded into file #12.

3. Provider Services: Please review and have available during the Onsite the Credentialing Committee Meeting Minutes that were uploaded for Desk Review: (meeting dates of 04/27/21, 05/25/21 and 06/29/21).

4. Grievances and Appeals: Please review and be able to discuss during the Onsite Grievance #3125 and Appeal #531894.

C. Attachment 3: EQR Validation Worksheets

- Mental Health (b Waiver) Performance Measures Validation Worksheet
  - Readmission Rates for Mental Health
  - Readmission Rates for Substance Abuse
  - Follow-up after Hospitalization for Mental Illness
  - Follow-up after Hospitalization for Substance Abuse
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
  - Mental Health Utilization –Inpatient Discharge and Average Length of Stay
  - Mental Health Utilization
  - Identification of Alcohol and Other Drug Services
  - Substance Abuse Penetration Rate
  - Mental Health Penetration Rate
- Innovations (c Waiver) Performance Measures Validation Worksheet
  - Proportion of 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
- Performance Improvement Project Validation Worksheet
  - Assure Consistent Connection to Community Services Following Facility Based Crisis Services
  - TCLI Transition Days
  - NC-TOPPS Interview Data Accuracy
  - Access to Routine Behavioral Health Assessments

CCME EQR PM Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Readmission Rates for Mental Health**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using 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 State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Readmission Rates for Substance Abuse**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using 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 State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Follow-up After Hospitalization for Mental Illness**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Follow-up After Hospitalization for Substance Abuse**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**Met**	Denominator sources were accurate.
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NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using 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 State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Mental Health Utilization- Inpatient Discharged and Average Length of Stay**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using 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 State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Mental Health Utilization**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using 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 State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Identification of Alcohol and Other Drug Services**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using 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 State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Substance Abuse Penetration Rate**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using 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 State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Mental Health Penetration Rate**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using 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%**

UDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

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

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

CCME EQR PM Validation Worksheet

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

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

CCME EQR PM Validation Worksheet

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

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

CCME EQR PM Validation Worksheet

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

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

CCME EQR PM Validation Worksheet

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

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Sandhills**
Name of PIP:	**ASSURE CONSISTENT CONNECTION TO COMMUNITY SERVICES FOLLOWING FACILITY BASES CRISIS SERVICES**
Reporting Year:	2021-2021
Review Performed:	09/2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale 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 PIHP 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)**	**NOT MET**	Rate declined from 65% to 55% for percentage of providers connecting members 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.***
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**	Only one measurement has been above the goal rate of 70% so 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	0
9.2	5	5
9.3	1	1
9.4	NA	NA

Project Score	**79**
Project Possible Score	**80**
Validation Findings	**98.8%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Sandhills**
Name of PIP:	**DECREASE THE TCLI CARE COORDINATION DOCUMENTATION SUBMISSION LATE ENTRY ERROR RATE TO 0%**
Reporting Year:	2021-2021
Review Performed:	09/2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale 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 PIHP 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 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)**	**PARTIALLY MET**	Results are presented using bar charts for quarterly rates. Graph on page 6 has a 1% rate that is not explained in the narrative; and the other bar says 8% although the rate is reported as 8.13%. ***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.***
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)**	**N/A**	Baseline only is reported.
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 and interpretation of rate for the baseline rate.
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)**	**N/A**	Rate for baseline is 8.13%. Goal is 0%. Baseline only reported.
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)**	**N/A**	Baseline only is reported.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**N/A**	Baseline only is reported.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**N/A**	Baseline only is reported.

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	5	10
7.3	NA	NA
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	**67**
Project Possible Score	**72**
Validation Findings	**93%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Sandhills**
Name of PIP:	**NC TOPPS INTERVIEW DATA ENTRY**
Reporting Year:	2021-2021
Review Performed:	09/2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale 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 PIHP 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**	Baseline yearly rate and quarterly rates are reported. Report mentions quarterly rates as the standard for evaluation.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**PARTIALLY MET**	Results are presented using bar charts for the baseline year and then a 2021 Q4 quarterly rate. Results are confusing—Table has 2 decimals, and graphs are rounded to the nearest number. The 82% is labeled as "measure" and should be measured with a timepoint (Q4 2021) to be consistent with the other labels in the bar graph. One period is a full year and the other is a quarterly rate. ***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.***
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.

Component / Standard (Total Points)	Score	Comments
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**	Rate improved from 78% to 82% for percentage of non-errors.
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 values presented as one data point is quarterly and the other is annual.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Not enough data collected yet.

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	5
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	**74**
Project Possible Score	**79**
Validation Findings	**94%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Sandhills**
Name of PIP:	**ROUTINE APPOINTMENTS KEPT**
Reporting Year:	2021-2021
Review Performed:	09/2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale 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 PIHP 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.

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 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**	Baseline and 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 charts.
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.
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**	Rate decreased from 35% to 21%. Goal rate is 66%. ***Recommendations: 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.***
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 PIHP reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	PIHP deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

D. Attachment 4: Tabular Spreadsheet

I. Information Systems Capabilities Assessment (ISCA)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I A. Management Information Systems						
1. Enrollment Systems						
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Sandhills has standard processes in place for enrollment data updates. General Dynamics Information Technology (GDIT) uploads the daily and quarterly GEF files to the Alpha enrollment system. Sandhills utilizes the monthly 820 capitation file to reconcile the payment received every month to the GEF to determine if any payments were missing or if overpayments were received. Demographic data is captured and maintained in the Alpha system, and enrollment information is maintained indefinitely. Patient IDs are unique to members.
1.2 The MCO is able to identify and review any errors identified during, or as a result of, the State enrollment file load process.	X					Sandhills stores error record information in a separate table. If there are mistakes in the ELIG/TPL/MEDICARE record for that row, the results are pushed into the error table instead of being parsed. The system first parses in the entire file before distributing it. The file contents are stored separately from the true enrollment data. The data is then parsed from this secondary table into the specific data subsets. No data is removed from the initial table.
1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.	X					During the ISCA Onsite, Sandhills demonstrated the Alpha enrollment screens and their capability to store the demographic information. On the ISCA Onsite, Sandhills indicated that a member should not exist under more than one identification number and edits are in place to help prevent multiple records for a member. In the unlikely event that a consumer has been entered into the Alpha system under different identification numbers due to a lack of information needed to cross reference to the original number, the records can be merged into a single ID.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Claims System						
2.1 The MCO 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 63% for Professional) or through the provider web portal (17% for Institutional and 36% for Professional). Very few claims are received via paper (approximately 1%). For claims received in 2020, 88.02% of Institutional and 99.75% 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 are pended for manual review. Pended claims are reviewed daily via the "Manual Review Module" in Alpha.
2.2 The MCO 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 – 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 – Sandhills performs external 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 our attention after working with providers and their daily denied claims reports. Designated Claims Analyst performs audits; no audits are performed by claims processors. Daily denial reports are worked by claim processors to reduce denials and increase timeliness of paid claims.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.3 The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	X					During the ISCA Onsite, Sandhills demonstrated the Alpha+ claims system and 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 MCO's claim system screens store and track claim information and claim adjudication/payment information.	X					During the ISCA Onsite, 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 MCO's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					ISCA responses indicated Sandhills captures all required ICD-10 Diagnosis codes and can capture additional procedure, DRG, and revenue codes that are submitted on the claims. Sandhills stores and utilizes 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 MCO has processes in place to back up the enrollment and claims data repositories.	X					ISCA responses indicate Sandhills has processes in place that backup the enrollment and claims data in the Alpha system on a nightly basis. 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 MCO has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	X					ISCA responses indicate Sandhills submits all secondary ICD-10 Diagnosis codes for Professional encounters. Sandhills submits all secondary ICD-10 Diagnosis codes on Institutional encounters to NC Medicaid. Sandhills indicated that the DRG and ICD-10 Procedure codes are captured via the Provider Web Portal. Sandhills has also indicated that the ICD-10 Procedure codes are captured in their DBMS and are available for reporting in the Alpha system and were included for encounter data submissions to NC Medicaid as of January 2021. Last year's weakness where Sandhills did not have the ability to submit ICD-10 Procedure codes on encounter data extracts to NC Medicaid has been resolved, and Sandhills is able to capture and submit ICD-10 Procedure codes that are received.
4.2 The MCO has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					Sandhills has created an internally developed Pay and Deny encounter data application that utilizes the data from the Adam Holtzman's paid and denied reports and the 835 response files to identify and reconcile encounter data denials. Denied encounters are worked on by appropriate department for investigation and correction.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.3 MCO has policies and procedures in place to reconcile and resubmit encounter data denied by NC Medicaid.	X					Sandhills has clear 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 99.5%.
4.4 The MCO 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 rebill. The report contains the denial reason, which assists staff in determining the process needed for follow-up. Weekly 835 is utilized for additional information as needed. The encounter data acceptance rate has been consistent with last year's observations. Sandhills' staff was able to speak to encounter data submissions and 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*.
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. An issue was identified regarding the minutes section listing the provider number of Licensed Practitioners (LPs) who are applying to join contracted agencies when the LP application is clean, but the agency has "QM concerns." The minutes from the 04/27/21 and 05/25/21 meetings had "See QM Issues Below" in the minutes section titled "Re-Credentialing Request: LP's (Clean) Affiliated with QOC concerns (See Agencies in Report)**." However, there is no information in the minutes regarding most of the agencies whose numbers are listed in that section. Onsite discussion revealed that no additional information was provided to committee members. The statement in the "QM Concerns" column in the referenced section in the 06/29/21 meeting minutes was changed to "QM concerns are available upon request." An additional issue in the submitted Credentialing Committee meeting minutes is that the column heading on the table is "LIP Number", but, during Onsite discussion, Sandhills' staff confirmed the table is about LPs, not LIPs. Meeting minutes should accurately reflect information, including what information is provided within

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						the minutes. If the minutes do not include information regarding "QM Issues" for the agencies, the minutes should not state, "See QM Issues Below." Also, as the practitioner number column is about LPs joining agencies, the heading should be revised from "LIP" to "LP." ***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.***
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Credentialing files reviewed for the EQR were organized and contained appropriate information. CCME identified the following issues in the file review:
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
3.1.3 Valid DEA certificate; and/or CDS certificate	X					
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					
3.1.5 Work History	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.6 Malpractice claims history;	X					
3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.8 Query of the National Practitioner Data Bank (NPDB) ;	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); and query of the State Exclusion List;	X					
3.1.10 Query for the System for Awards Management (SAM);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Two of the four submitted initial credentialing files (one practitioner and one agency) did not include the Ownership Disclosure regarding "managing employees, persons with an ownership and control interest in the Provider", or EFT authorized individuals, officers, or directors. Upon CCME's follow up request, Sandhills submitted the Ownership Disclosure information. ***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.***

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. During the Onsite discussion, Sandhills' staff verified agencies conduct criminal background checks for owners, directors, officers, administrators, and staff. This practice was approved by NC Medicaid. Sandhills' agency contracts require the agency conduct the background checks. Agencies submit their background check policy with their Sandhills' Agency Application. Sandhills conducts the PSVs outlined in the NC Medicaid Contract.
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files reviewed for the EQR were organized and contained appropriate information. CCME identified the following issues in the file review:
4.1 Recredentialing every three years;	X					
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					
4.2.3 Valid DEA certificate; and/or CDS certificate	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
4.2.11 Requery of the Social Security Administration's Death Master File	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Two of the four submitted recredentialing files (one practitioner and one agency) did not include the Ownership Disclosure regarding "managing employees, persons with an ownership and control interest in the Provider", or EFT authorized individuals, officers, or directors. Upon CCME's follow up request, Sandhills submitted the Ownership Disclosure information. ***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.***
4.3 Site reassessment if the provider has had quality issues.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.4 Review of provider profiling activities.	X					During Onsite discussion, Sandhills' staff reported their process includes verifying through the Quality Management Department whether the provider has had any adverse actions at Sandhills. The Credentialing Committee meeting notes reflect consideration of quality of care concerns and other items for recredentialing candidates.
5. The PIHP formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the PIHP for serious quality of care or service issues.	X					Procedure N-PM4a, Provider Sanctions, addresses possible provider sanctions. Though the procedure reference the External Assessments Grid and the Provider Sanctions Grid, these items are not included in the procedure. Sandhills submitted the grids in response to CCME's request.
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 were several (b) Waiver Measures with substantial declines and one measure with substantial improvement. ***Recommendation: Continue to monitor rates to determine if rates with substantial improvement or decline represent a continued trend or an anomaly in the performance measures.***
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 7 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

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, although four PIPs had sections with concerns that should be addressed by the recommendations. See Recommendations in Table 24. ***Recommendations:*** • ***Assure Consistent Connection to Community Services: Determine if provider has adequate staff and adequately trained staff to ensure referrals to follow-up and recipients are connected to services.*** • ***TCLI Timeliness Documentation Submission: 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.*** • ***NC-TOPPS Interview Data Accuracy: 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.*** • ***Routine Appointments Kept: 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.***

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					
2. The case coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					
2.5 Quality monitoring and continuous quality improvement;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.6 Determination of which Behavioral Health Services are medically necessary;	X					Sandhills' Procedure CC 12a, I/DD Deinstitutionalization Planning, states that, "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.***
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					During the 2020 EQR, CCME issued a Recommendation to add an explanation of Home and Community Based Services (HCBS) and the use of the required *State Monitoring Checklist* to a Procedure, a relevant I/DD Care Coordination manual, or I/DD document. Sandhills addressed the Recommendation and updated Procedure I/DD CC2 I/DD Care Coordination Monitoring of Plan Implementation.
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					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 that "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.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						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, 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.***
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 initial review of NC's Certified Peer Support Specialist Program website, CCME found that one In-Reach Specialist's certification had lapsed, and two In-Reach Specialists could not be located on the website due to the spelling of their names. During the Onsite, Sandhills was able to provide documentation showing that all In-Reach staff are Certified Peer Support Specialists.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.						
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					
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					
2.5 QOL Surveys are administered timely.	X					All Quality of Life (QOL) surveys were completed in a timely manner by TCLI staff and enrollees.
3. Transition, diversion and discharge processes are in place for TCLI enrollees as outlined in the DOJ Settlement and *DHHS Contract*.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.	X					
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					
6. A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	X					The review of TCLI files for this EQR included one enrollee who was discharged. According to progress notes, discharge was due to the enrollee gaining employment and earning more than $2,000 monthly. Gainful employment was not listed as a reason for discharge in Sandhills' Procedure. During the Onsite, Sandhills' staff stated that they followed the *NC Transition to Community Living (TCLI) Housing Fund Guidelines*, that states that "the maximum expenditure of $2000 shall not be exceeded for any individual." Additionally, emails between NC Medicaid representatives and Sandhills explained that "exceeding the expenditure amount disqualifies the member from receiving subsidies, thus disqualifying the member from the TCLI programs." The review of TCLI files found that Sandhills is following all Procedures and NC TCLI manuals.

V. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					In the 2020 EQR, the *Medicaid/State Provider Manual* effective included a more consistent use of "Grievance." However, the term "complaint" was still evident in two areas of the manual. It was a Recommendation to consistently use the term Grievance. In this 2021 EQR, there is consistent use of the term Grievance throughout the *Medicaid/State Provider Manual* updated November 4, 2020.
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					It was a Recommendation in the 2020 EQR to "Add information to the *Member Handbook* regarding the process followed when Sandhills extends the Grievance resolution timeframe, including the notifications required by *42 CFR § 438.408 (c)(1) and (c)(2).*" Page 24 of the *Member Handbook* (May 18, 2021) correctly explains the extension process and notifications that are given when Sandhills or the member extends the Grievance resolution timeframe.
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, 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.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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, includes that Grievance files "are maintained for 5 years," per *NC Medicaid Contract, Attachment M, B. Record Keeping and Reporting*.
2. The PIHP applies the grievance policy and procedure as formulated.	X					There was a Recommendation in the 2020 EQR to routinely review the Grievance resolution notifications to identify opportunities to provide more details regarding the internal steps Sandhills took to resolve the Grievance. In the 2021 EQR, the Sandhills' team was asked how they implemented this Recommendation. The Sandhills' team explained that they have been providing more information in the Grievance resolution notifications as a result of regular meetings to discuss what steps to include and word it in an understandable way. The Grievance team talks as a group to discuss each resolution notification for the more complicated files, then sends an email to group for approval before finalizing the resolution notice. This process was Initiated soon after the last EQR. One of the 10 files reviewed was a file in which Sandhills extended the resolution timeframe. There was not an oral or written notification sent to the grievant informing them of this extension. These notifications are required by *42 CFR § 438.408 (c)(2)* and by Sandhills' Procedure Core 35a on page 6. ***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 that 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."***

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 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, Quality Management, Consumer and Family Advisory, and the Client Rights Committees, and the Board of Directors.
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					
V. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 The definitions an appeal and who may file an appeal;	X					The 2020 EQR Recommendation asked Sandhills to "Define a 'reasonable timeframe' for correcting errors identified in Member Handbook and Provider Manual and publishing them on Sandhills' website. Add this timeframe to an applicable procedure." The 2020 EQR found that the *Member Handbook* was not finalized and published on Sandhills' website until September 2020 and the *Medicaid/State Provider Manual* was not finalized and published on Sandhills' website until December 2020. As a result, misinformation, such as who can file an Appeal, within the *Member Handbook* was publicly available for a year, and misinformation within the *Medicaid/State Provider Manual* was publicly available for two years. Sandhills corrected this for the 2021 EQR, and both the *Member Handbook* (May 18, 2021) and *Medicaid/State Provider Manual* (November 13, 2020) are current on the website and match the Desk Material versions or are more current than the uploaded Desk Materials.
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 *Attachment M* to reflect the change. Sandhills' Procedure HUM 34a, Appeals Process (Medicaid), The *Member Handbook*, and the *Medicaid/State Provider Manual* need to be updated to reflect this change. ***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).***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					In the 2020 EQR, Sandhills was issued a Corrective Action to revise policies and procedures to state the requirement that Sandhills notify the enrollee of his or her right to file a Grievance if Sandhills denied a request to expedite an Appeal. This 2021 EQR revealed this Corrective Action was implemented in Procedure HUM 38a, Expedited Appeal Process Timeframe in section G, "Notification and Tracking."
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					The 2020 EQR included a Corrective Action to enhance the Appeals monitoring process to ensure compliance of Appeal processes and notifications, especially those appeals initiated orally. The 2021 EQR Appeal file review found 100% of the 10 files reviewed were acknowledged and resolved in a timely manner. In addition, all required notifications were sent on time. The Sandhills' Appeal Log was accurate for all 10 files. The current Appeals monitoring process has improved with enhancements made to the *Appeal Audit Tool* for monitoring notifications that are required for expedited and extended Appeals. One Appeal file that was withdrawn by the member's representative did not have a resolution letter sent to the member/guardian. The *NC Medicaid Contract* requires that all Appeals are resolved with written notification provided in *Attachment M (G) (7)*. ***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).***

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					In the 2020 EQR, there was a Recommendation for the enhanced Appeal monitoring process to include routine review of the Appeals Log to ensure data and documentation within the log are complete and accurate. This 2021 EQR found the Appeal monitoring process included a review of the Appeal Log. All dates recoded for acknowledgements, notifications, resolutions, and decisions were accurate. 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					For the files reviewed, CCME looked for documentation that the Appeals Coordinator confirmed guardianship. Confirmation is needed to ensure HIPAA practices are followed and to help the PIHPs avoid liability. From Onsite discussion, guardianship is checked in Alpha+, but not documented in the Appeal file. ***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					
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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. The Compliance Plan shall be submitted to the NC Medicaid Contract Administrator on an annual basis.	X					
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					Sandhills' *Corporate Compliance Plan* states the Board of Directors' (BOD) training is an "ongoing review of compliance laws, standards, policies/procedures, and updates of rules and regulations." Sandhills provided curriculum for training of staff, providers, and the BOD. However, Sandhills was not able to provide evidence that the BOD had received any Compliance training since 2018. During the Onsite discussion, Sandhills reported training of the BOD was scheduled in the next few months. CCME recommends Sandhills define the frequency of the ongoing BOD Compliance training in their *Corporate Compliance Plan* to ensure this training is occurring consistently. ***Recommendation: Define the frequency of the ongoing BOD Compliance training in their Corporate Compliance Plan to ensure this training is occurring consistently.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. PIHP shall establish and implement a special investigations or program integrity unit, however named, that is responsible for PIHP program integrity activities, including identification, detection, and prevention of fraud, waste, and abuse in the PIHP Closed Provider Network. PIHP shall identify an appropriately qualified contact for Program Integrity and Regulatory Compliance issues as mutually agreed upon by PIHP and NC Medicaid. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator. In addition, PIHP shall identify a primary point of contact within the Special Investigations Unit to receive and respond to data requests from MFCU/MID. The MFCU/ MID will copy the PIHP Contract Administrator on all such requests.	X					Sandhills' PI investigation unit is described in the Sandhills' *Corporate Compliance* and *Internal Audit Plan FY 2020-2021.*
4. PIHP shall participate in quarterly Program Integrity meetings with NC Medicaid Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the NC Department of Justice ("MFCU/ MID').	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. PIHP shall send staff to participate in monthly meetings with NC Medicaid Program Integrity staff either telephonically or in person, at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.	X					
6. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information	X					
7. Within seven (7) business days of a request by the Division, PIHP shall also make portions of the PIHP's Regulatory Compliance and Program Integrity minutes relating to Program Integrity issues available for review, but the PIHP may, redact other portions of the minutes not relating to Regulatory Compliance or Program Integrity issues.	X					
8. PIHP's written Compliance Plan shall, at a minimum include:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
8.1 A plan for training, communicating with and providing detailed information to PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in *Section 1902 (a)(66)* of the *Social Security Act;*	X					Sandhills' PI training of staff, providers, and contractors is described in the Sandhills' *Corporate Compliance and Internal Audit Plan FY 2020-2021*. The required PIHP training plan is found Core 27a, Staff Training Program.
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing, and development of corrective action initiatives;	X					
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					
8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including NC Medicaid or MFCU/MID, and including supplying all data in a uniform format provided by NC Medicaid and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by 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	
9. In accordance with *42 CFR § 438.608 (a)(vii),* PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under *NC Medicaid Contract*, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under *NC Medicaid Contract*; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month. PIHP shall be penalized One Hundred Dollars ($100) for each overpayment that is not specified in an Attachment Y Report within the applicable month. In addition, PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse.	X					The procedures for detecting fraud and abuse are outlined in ADM 11A, Fraud, Waste and Abuse.
10.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure. This process shall include procedures for logging the complaint, determining if the complaint is valid, assigning the complaint, investigating, appeal, recoupment, and closure. The detailed workflow needs to differentiate the steps taken for fraud versus abuse; PIHP shall establish and implement policies for treatment of recoveries of all overpayments from PIHP to Providers and contracted agencies, specifically including retention policies for treatment of recoveries of overpayments due to fraud, waste, or abuse. The retention policies shall include processes, timeframes, and required documentation for payment of recoveries of overpayments to the State in situations where PIHP is not permitted to retain some or all of the recoveries of overpayments. This provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.3 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					
10.4 Process for tracking overpayments and collections based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on Attachment Y – Audits/Self-Audits/investigations.	X					
10.5 Process for handling self-audits and challenge audits.	X					
10.6 Process for using data mining to determine leads.	X					
10.7 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	
10.8 If PIHP makes or receives annual payments of at least $5,000,000, PIHP shall establish and maintain written policies for all employees, contractors or agents that detail information about the *False Claims Act* and other federal and state laws as described in the *Social Security Act 1902 (a)(66)*, including information about rights of employees to be protected as whistleblowers.	X					
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid-standardized elements or a NC Medicaid-approved template;	X					
10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available database or other search mechanism.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.	X					
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					The case initiation timing requirement is addressed in Sandhills' Procedure ADM 11a, Fraud, Waste and Abuse Monitoring.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13. In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						The process for documenting provider investigations is addressed in Procedure ADM 11A, Fraud, Waste and Abuse Monitoring. The fifteen files reviewed for this year's EQR showed all required information was present on the NC Medicaid-approved template. Fifteen PI files were selected and reviewed for this 2020 EQR. Sandhills' case files contained thorough documentation and showed investigations were initiated within 10 days. Final reports were well written and organized, and referrals to NC Medicaid, where applicable, were complete and concise. There was detailed discussion on Sandhills' PI caseload, which included several investigations open for as many as four years. The PI Director described a strategy that was recently implemented and designed to address the backlog of those older cases. CCME recommends Sandhills continue with this strategy to eventually eliminate the backlog of older cases. ***Recommendation: Continue with the PI Department's strategy to eventually eliminate the backlog of older PI cases.***
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					
13.2 Source/origin of complaint;	X					
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated; and dates of suspected intentional misconduct;	X					
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					
13.6 All communications between PIHP and the Provider concerning the conduct at issue, when available.	X					
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					
13.8 Total Sample Amount of Funds Investigated per Service Type	X					
14. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						The process for documenting investigations of potential enrollee fraud is addressed ADM 11A, Fraud, Waste and Abuse Monitoring. No PI case files reviewed for this year's EQR were initiated by concerns of enrollee fraud.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.1 The Enrollee's name, birth date, and Medicaid number;	X					
14.2 The source of the allegation;	X					
14.3 The nature of the allegation, including the timeframe of the allegation in question;	X					
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	X					
14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;	X					
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and	X					
14.7 The legal and administrative status of the case.	X					
14.8 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					
14.9 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.10 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					
14.11 Information on Biller/Owner;	X					
14.12 Additional Provider Locations that are related to the allegations;	X					
14.13 Legal and Administrative Status of Case.	X					
15. PIHP and NC Medicaid shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of State and Federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.	X					
16. PIHP shall use the NC Medicaid Fraud and Abuse Management System (FAMS) or a NC Medicaid approved alternative data mining technology solution to detect and prevent fraud, waste, and abuse in managed care.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
17. If PIHP uses FAMS, PIHP shall work with the NC Medicaid designated Administrator to submit appropriate claims data to load into the NC Medicaid Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	X					Sandhills' Organizational Chart showed no staff changes in the past year, and staff reported to changes in FAMS users in that same timeframe.
18. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month or the next business day if the 10th day is a non-business day (i.e., weekend or State or PIHP holiday). In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to NC Medicaid Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59 p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to NC Medicaid Program Integrity all Network Provider contract terminations	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.						
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						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
notify PIHP. If the MFCU/ MID indicates that payment suspension will impact the investigation, NC Medicaid shall temporarily withhold the suspension notice and notify PIHP. Suspension of payment actions under this *Section 14.3* shall be temporary and shall not continue if either of the following occur: PIHP or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider; or Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.						
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					The information and access requirement is addressed in Sandhills' Procedure ADM 11a, Fraud, Waste and Abuse Monitoring.
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid Program Integrity due to allegations of suspected fraud without prior written approval from NC Medicaid Program Integrity or the MFCU/MID. If PIHP takes administrative action, including issuing a Notice of Overpayment based on such fraud that precedes the submission date of a Division referral, the State will adjust the PIHP capitated payment in the amount of the original overpayment identified or One Thousand Dollars ($1,000) per case, whichever amount is greater.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. Notwithstanding the foregoing, nothing herein shall be construed as prohibiting PIHP from taking any action against a Network Provider in accordance with the terms and conditions of any written agreement with a Network Provider, including but not limited to prepayment review, identification and collection of overpayments, suspension of referrals, de-credentialing, contract nonrenewal, suspension or termination or other sanction, remedial or preventive efforts necessary to ensure continuous, quality care to Enrollees, regardless of any ongoing investigation being conducted by NC Medicaid, MFCU/MID or other oversight agency, to the extent that such action shall not interfere with Enrollee access to care or with any such ongoing investigation being conducted by NC Medicaid, MFCU/MID or other oversight agency.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with *NCGS 108C-5*, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.	X					

E. Attachment 5: Encounter Data Validation Report

Sandhills Center

Encounter Data Validation Report

performed on behalf of

North Carolina Medicaid

September 22, 2021

Prepared By:

hms

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

Table of Contents

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Background

Health Management Systems (HMS) has completed a review of the encounter data submitted by 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 HMS to perform encounter data validation for each PIHP. North Carolina Senate Bill 371 requires that each PIHP submit encounter data "for payments made to providers for Medicaid and State-funded mental health, intellectual and developmental disabilities, and substance abuse disorder services. NC Medicaid may use encounter data for purposes including, but not limited to, setting PIHP capitation rates, measuring the quality of services managed by 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 that the data is complete and accurate.

Overview

The review, guided by the CMS Encounter Data Validation Protocol, focused on measuring the data quality and completeness of claims paid by Sandhills for the period of January 2020 through December 2020. All claims paid by Sandhills should 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 on a weekly basis 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 “shadow price” what was paid by the PIHP.

Once NCTracks processes the 837 files, it produces 835 files detailing the results of adjudication and "shadow 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 utilizes NC Medicaid's "Adam Holtzman" reports to identify the encounter records that were denied and whether provider outreach is needed to correct the issue(s) that caused the denials.

In 2020, it took Sandhills five days, on average, between completing their front-end adjudication and submitting paid encounters to NCTracks. During the same time period, Sandhills took approximately 24 days, on average, to correct and resubmit encounters that were denied by NCTracks. These figures were comparable to what was documented in 2019, indicating that Sandhills did not experience disruptions in its encounter data reporting despite the public health emergency brought on by the COVID-19 pandemic. During 2020, Sandhills submitted 1,158,028 unique encounters to NC Medicaid. Similar to the prior year, less than 1% of all encounters submitted in 2020 have not been corrected and accepted by NC Medicaid. The overall acceptance rate, including resubmissions, was nearly identical to the prior year.

2020	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	23,571	23,070	415	86	0.36%
Professional	1,252,888	1,196,973	48,927	6,988	0.56%
Total	1,276,459	1,220,043	49,342	7,074	0.55%

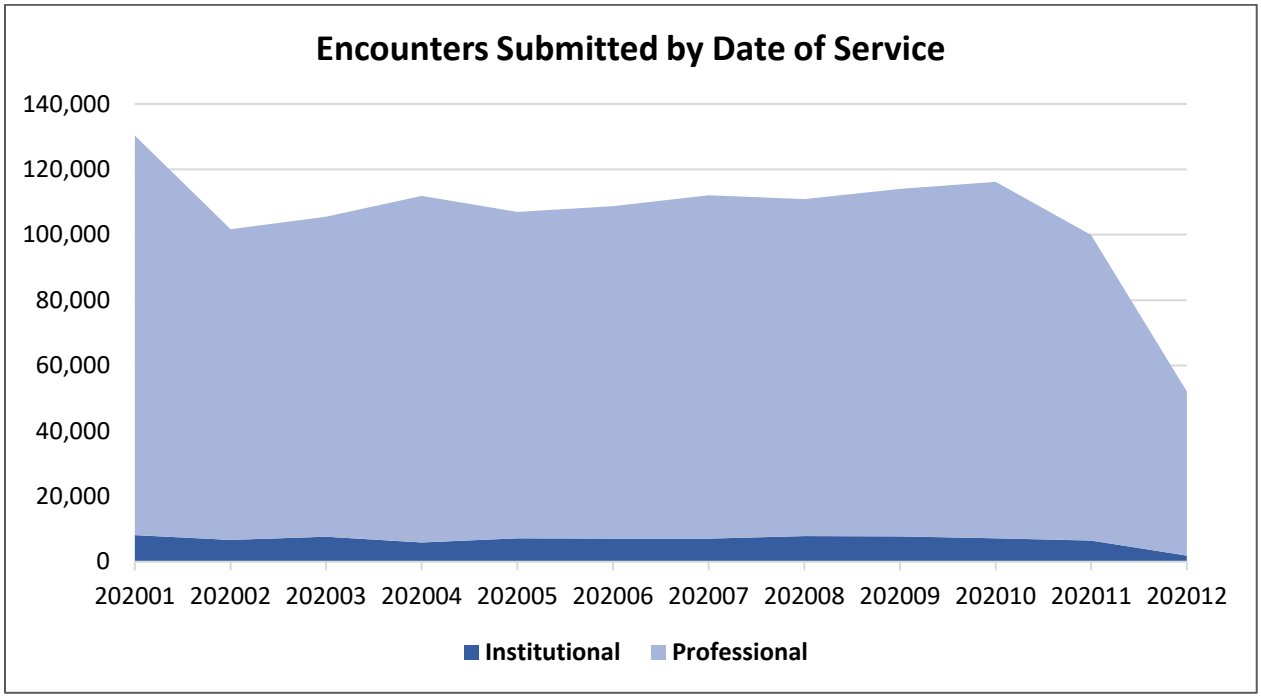
There was, however, a noticeable increase in Professional encounters that were initially denied by NCTracks. Much of this increase was isolated to a handful of 837 batches where Sandhills was attempting to submit adjustments to prior encounter reports. Due to a timing issue, void transactions had not been processed by NCTracks prior to Sandhills resubmitting updated 837s, which triggered edits within NCTracks to reject effected encounters as "duplicate" claims/payments. 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 2020.

Overall, 21% of all denials were related to duplicate claims/payments, while 26% of the denials were related to Taxonomy codes. Given that the overall denial rate of 0.55% has held steady despite an uptick in "duplicate" 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:

- Provider upload files (PUFs) to update essential provider taxonomy and address information
- 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, 2020 through December 31, 2020. 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 HMS. This included 1,249,520 Professional claim line items and 90,014 Institutional claim line items. These figures include line level detail as well as voids and resubmissions for previously denied claims, including denials prior to 2020. Therefore, these numbers may not match the metrics reported in Sandhills' ISCA response.



In order to evaluate the data, HMS pre-processed all batch encounter files and loaded them to a consolidated database. After completing data onboarding, HMS applied proprietary, internally designed data analysis tools to review each data element, focusing on the data elements defined as required. These tools evaluate the presence of data in each field within a record as well as whether the value for the field is within accepted standards. Results of these checks were compared with general expectations for each data field and to the CMS standards adopted for encounter data. The table below depicts the specific data expectations and validity criteria applied. Professional and Institutional files included older dates of service that were resubmitted to NC Medicaid during 2020.

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

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

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

Data Element	*Expectation*	*Validity Criteria*
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid codes (using International Statistical Classifications of Diseases, Ninth Revision, Clinical Modification [ICD-9-CM] lookup tables) for practitioner providers (not including transportation, lab, and other ancillary providers)
Other Diagnosis	This is not expected to be coded on all claims even with applicable provider types, but should be coded with a fairly high frequency.	90% valid when present
Dates of Service	Dates should be evenly distributed across time.	If looking at a full year of data, 5%–7% of the records should be distributed across each month.
Unit of Service (Quantity)	The number should be routinely coded.	98% nonzero <70% should have one if Current Procedural Terminology (CPT) code is in 99200–99215 or 99241–99291 range.
Procedure Code	Critical Data Element	99% present (not zero, blank, or 8- or 9-filled). 100% should be valid, State-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.
Procedure Code Modifier	Important to separate out surgical procedures/ anesthesia/assistant surgeon, not applicable for all procedure codes.	> 20% non-missing. Expect a variety of modifiers both numeric (CPT) and Alpha (Healthcare Common Procedure Coding System [HCPCS]).
Patient Discharge Status Code (Hospital)	Should be valid codes for inpatient claims, with the most common code being “Discharged to Home.” For outpatient claims, the code can be “not applicable.”	For inpatient claims, expect >90% “Discharged to Home.” Expect 1%–5% for all other values (except “not applicable” or “unknown”).
Revenue Code	If the facility uses a UB04 claim form, this should always be present	100% valid

Encounter Accuracy and Completeness

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

Table: Evaluation of Key Fields

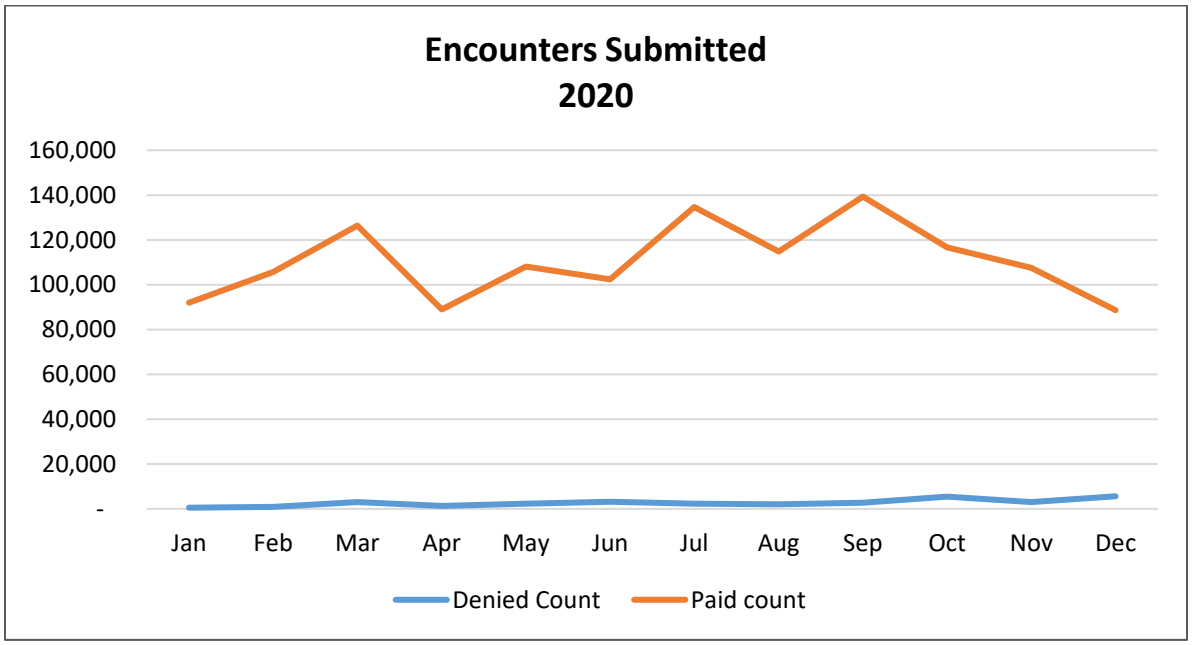
Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	1,339,534	100.00%	1,339,528	100.00%	1,339,528	100.00%	1,339,528	100.00%
Recipient Name	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%
Recipient Date of Birth	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%
PIHP ID	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%
Provider ID	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%
Attending/Rendering Provider ID	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%
Provider Location	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%
Place of Service	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%
Specialty Code / Taxonomy - Billing	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%
Specialty Code / Taxonomy - Rendering / Attending	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%
Principal Diagnosis	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%
Other Diagnosis	230,912	17.24%	230,912	17.24%	230,912	17.24%	230,912	17.24%
Dates of Service	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%
Unit of Service (Quantity)	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%	1,339,534	100.00%
Procedure Code	1,324,477	98.88%	1,324,477	98.88%	1,324,477	98.88%	1,324,477	98.88%
Procedure Code Modifier	562,565	42.00%	562,565	42.00%	562,565	42.00%	562,565	42.00%
Patient Discharge Status Code Inpatient	90,014	100.00%	90,014	100.00%	90,014	100.00%	90,014	100.00%
Revenue Code	90,014	100.00%	90,014	100.00%	90,014	100.00%	90,014	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 17 of the 18 key fields (94%) with noted issues to Other Diagnosis codes.

Overall, there has been a great deal of 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 dropped significantly and those that are denied now are being corrected timely following the process that Sandhills and Alpha have put in place to resolve. Professional encounter claims submitted contained complete and valid data in 14 of the 15 key Professional fields (93%). 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.

Encounter Acceptance Report

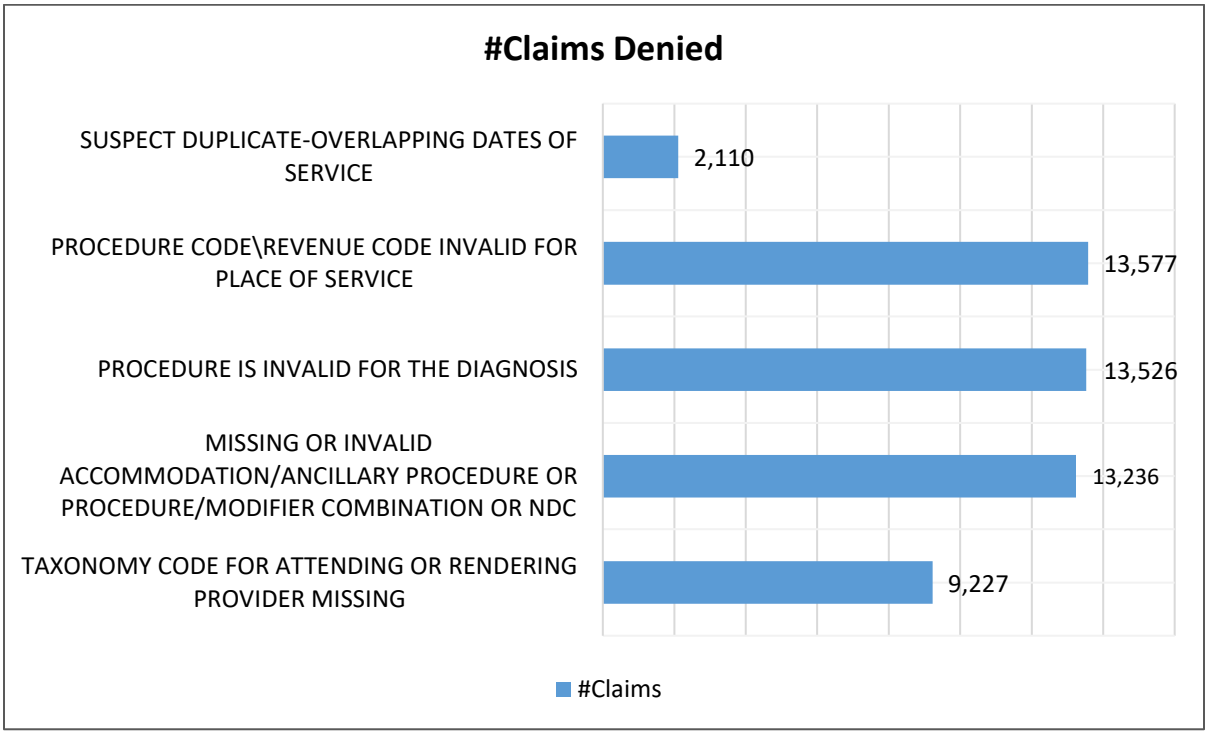
In addition to evaluating the encounter data submitted, analysts reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write, which made it difficult to tie back to the ISCA response and converted encounter files since only the Date of Service for each is available. During the 2020 weekly check write schedule, Sandhills submitted a total of 1,158,028 encounters to NC Medicaid. On average, 99.45% of all encounters submitted were accepted by NC Medicaid.

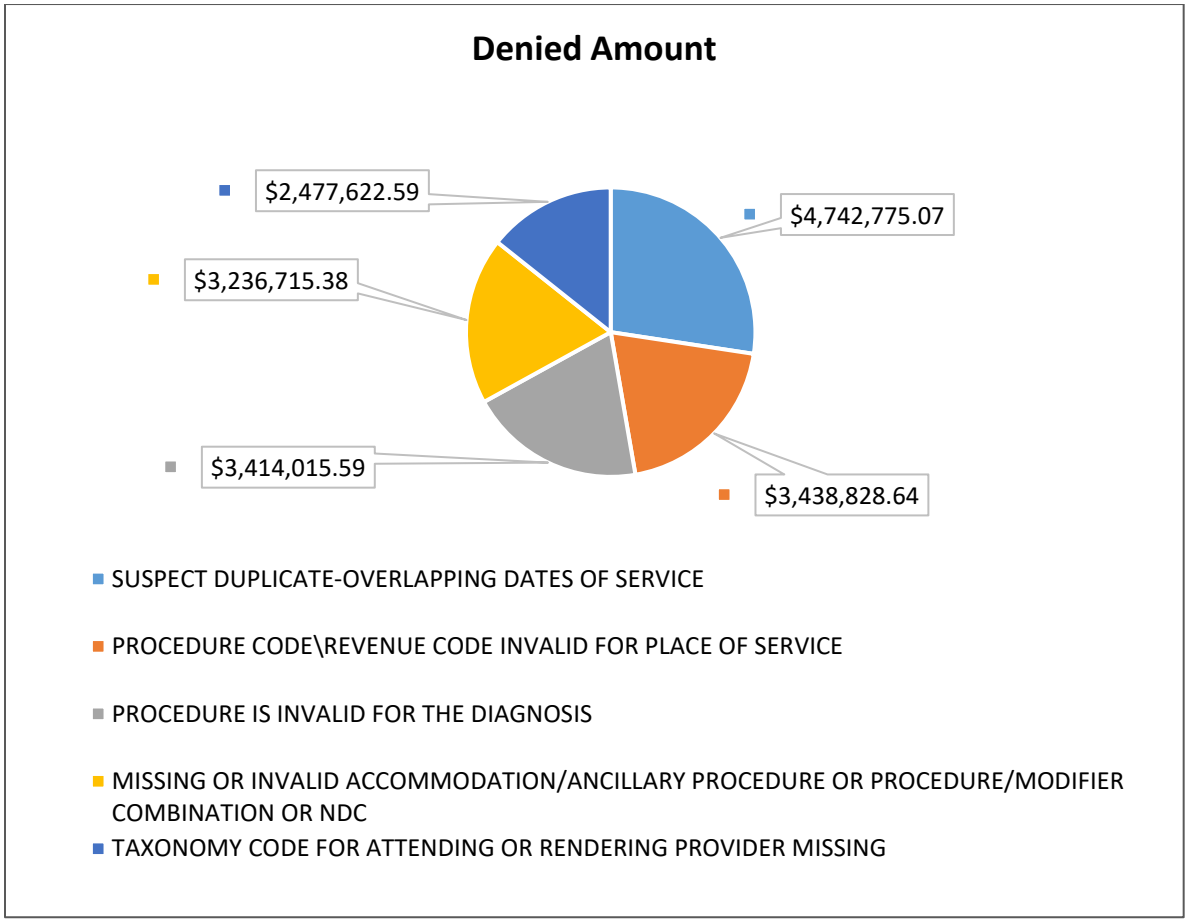


Evaluation of the top denials for Sandhills' encounters correlates with the data deficiencies identified in the Key Field analysis described previously. The top denials in 2020 were similar to the denial reasons for the dates of service reviewed in last year's report. Encounters were denied primarily for:

- Suspect duplicate-overlapping dates of services
- Procedure code/Revenue code invalid for Place of Service
- Procedure is invalid for the diagnosis
- Missing or invalid accommodation/ancillary procedure or procedure/modifier combination or National Drug Code (NDC)
- 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 notable progress in reporting additional Diagnosis codes. However, too 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 never report more than one Diagnosis code. HMS recommends alerting such providers to remind them to ensure that submitted claims are complete and accurate, including secondary Diagnosis codes. HMS also shared a frequency distribution report showing which providers are not reporting secondary Diagnosis codes.

Conclusion

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

Overall, Sandhills has made great 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. Taxonomy code and Procedure code-related denials still account for the bulk of denials. Sandhills should revisit its strategy to address invalid or missing Taxonomy codes, as well as a reconciliation process and make necessary adjustments to further reduce Taxonomy code-related 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.

Lastly, 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 CAN'T 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