2019 External Quality Review

SANDHILLS CENTER

Submitted: September 27, 2019

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

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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 2019 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:

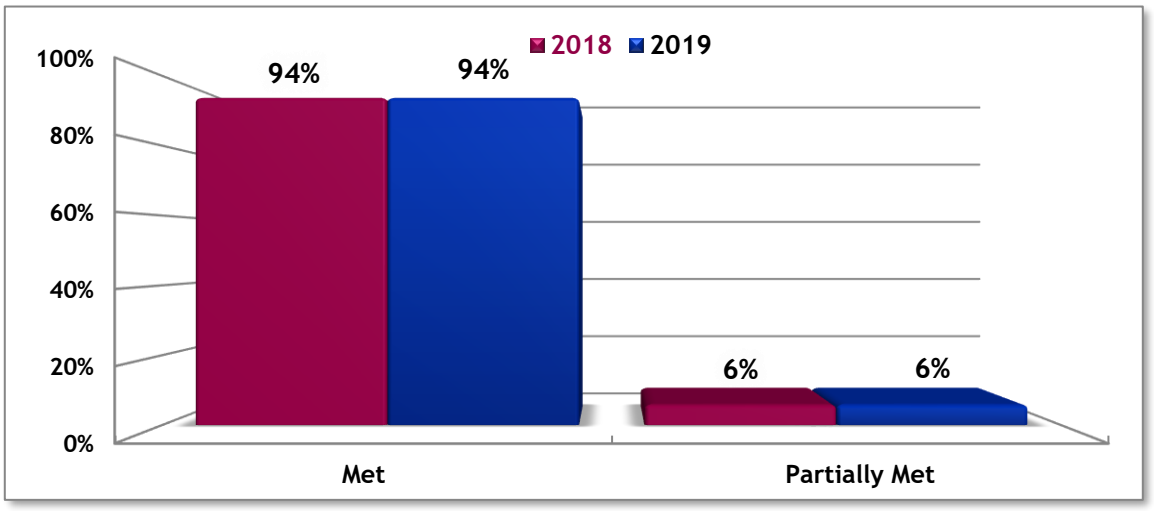
- Determine if Sandhills complies with service delivery as mandated by their *NC Medicaid Contract*
- Provide feedback for potential areas of further improvement
- Verify the delivery and determine the quality of contracted health care services

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

A. Overall Findings

The 2019 Annual EQR reflects that Sandhills achieved a "Met" score for 94% of the standards reviewed. As *Figure 1* indicates, 6% of the standards were scored as "Partially Met." None of the standards were scored as "Not Met." *Figure 1* provides a comparison of Sandhills' 2018 review results to 2019 results.

Figure 1: Annual EQR Comparative Results



B. Overall Recommendations

Recommendations that address each of the review findings are addressed in detail under each respectively labeled section of this report. The following global Recommendations were identified for improvement and should be implemented in conjunction with the detailed Recommendations in each section.

Administration

Sandhills met all of the standards relating to organizational staffing and structure, confidentiality policies and processes, and policies and procedure management. However, CCME provided Recommendations for three areas. Sandhills still struggles with their large policy and procedure set. Sandhills has 741 policies and procedures that are duplicative and, at times, contradictory. CCME recommends that Sandhills develop a comprehensive, interdepartmental plan to streamline their policies and procedures and retire those policies and procedures that are no longer relevant to Sandhills' functions. Additionally, Sandhills' policies and procedures should include a process for retiring policies and procedures. Another Recommendation is ensuring that the departmental involvement and oversight provided by the Associate Medical Director, Dr. Kenneth Marks, is better demonstrated on the Organizational Chart.

In the ISCA portion of this year's EQR, Sandhills met all but two EQR standards. Sandhills resolved the Corrective Action from last year's review and can now capture all diagnosis codes for Institutional and Professional claims. Sandhills has partially resolved the Corrective Action from last year's review and can now submit up to 12 diagnosis codes on Professional encounter data files to NCTracks. Even though Sandhills is capturing up to 29 diagnosis codes on an Institutional claim in AlphaMCS, Sandhills is only submitting up to 12 diagnosis codes to NCTracks on Institutional encounter data files. Sandhills is working

with WellSky to update their system to submit all ICD-10 diagnosis codes on Institutional encounter data files. Sandhills is also working with WellSky to update their system to capture and use ICD-10 procedure codes for reporting and include ICD-10 procedure codes on the encounter data extracts to NCTracks.

Provider Services

Sandhills met 97% of the Provider Services standards in the current EQR. One Corrective Action item and one Recommendation item apply to both credentialing and recredentialing processes. The three additional Recommendations include two items in the Adequacy of the Provider Network section, and one Recommendation related to communication about Clinical Practice Guidelines.

Enrollee Services

Sandhills "Met" 100% of the Enrollee Services standards. Two weaknesses within this area center around providing members the locations of Emergency services and procedures for obtaining out-of-state coverage. Two corresponding Recommendations were made for the Weaknesses.

Quality Improvement

Sandhills "Met" 94% of the Quality Improvement standards. The standard pertaining to validation of PIPs was scored as a "Partially Met" resulting in one Corrective Action. Four Recommendations were given in the areas of the *QM Work Plan FY 2018-2019,* Quality Management Committee (QMC) and Global Continuous Quality Improvement (GCQI) Committee meeting discussions and minutes, and one reviewed but not validated PIP.

Utilization Management

Sandhills met 96% of the Utilization Management (UM) standards in the current EQR. There are two Corrective Actions and three Recommendations targeting concerns noted in the timeliness of progress notes within the intellectual and developmental disabilities (I/DD) and TCLI Departments. One additional Recommendation addresses the lack of information in the *Member Handbook* explaining to enrollees the availability and eligibility for Care Coordination services.

Grievances and Appeals

Sandhills met 75% of the grievance and appeal standards for this year's EQR and six Recommendations were made. Two Recommendations were made to assist Sandhills' efforts to consistently use of the term "grievance" (i.e., versus "complaint") in their policies, procedures and all written materials. Three additional Recommendations were made to enhance or clarify details within *Procedure CORE 35a., Consumer Grievance Process-Medicaid.* Lastly, CCME recommends Sandhills maximize their use of grievance

data to develop a more in-depth analysis of grievance trends to identify potential quality improvement opportunities.

In the previous year's EQR of appeals, Sandhills received 10 Corrective Actions and 11 Recommendations, most of which were aimed at missing or incorrect information within Sandhills' 18 policies and procedures, the *Medicaid Provider Manual*, *Member Handbook*, Sandhills' website, appeal file documentation, and analysis of appeals data. Sandhills partially addressed the Corrective Actions and Recommendations and, as a result, much of the feedback from this year's EQR is the same as last year. It should be noted that, outside of these documentation concerns, the appeal file review showed staff processed appeals timely and captured steps taken to process the appeals within each appeal file.

Delegation

Sandhills met 50% of the Delegation standards in the current EQR. The Corrective Action item is to monitor the Credentialing Delegates to ensure they are conducting the required queries of the *State Exclusion List*. CCME also made a Recommendation regarding the *Annual Monitoring Summary* reports.

Program Integrity

Sandhills met 97% of the Program Integrity (PI) standards in this year's EQR. Sandhills' PI files showed eight reviewed files were missing required elements. Corrective Action is needed to ensure Sandhills captures all of the required elements within each PI file. It is also recommended that Sandhills create a standardized cover sheet for each PI file to summarize required elements within each file. In addition, training staff on elements required in each file would improve consistency of quality across PI files and improve compliance.

Financial Services

Sandhills met 100% of the Financial Services standards in the current EQR. CCME made two Recommendations on ways to bolster information within finance policies and procedures.

Encounter Data Validation

Based on the analysis of Sandhills' encounter data, we have concluded that the data submitted to NC Medicaid is complete and accurate as defined by NC Medicaid standards.

Their biggest issue was noted with the number of diagnosis codes being reported to NC Medicaid for both Professional and Institutional claims. Although the additional diagnosis codes do not impact adjudication, the codes are key for reporting, evaluating member health, and factors that will be used in a value based payment model. Sandhills should review and revise their 837 mapping immediately.

METHODOLOGY

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

On July 9, 2019, CCME sent notification to Sandhills that the annual EQR was being initiated (see *Attachment 1*). This notification included:

- Materials Requested for Desk Review
- ISCA Survey
- Draft Onsite agenda
- PIHP EQR standards

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

The review consisted of two segments. The first was a Desk Review of materials and documents received from Sandhills on July 31, 2019 and reviewed in the offices of 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, case management, and appeal files.

The second segment was a two-day, Onsite review conducted on August 28, 2019 and August 29, 2019, at Sandhills' corporate office in West End, North Carolina. CCME's Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's Onsite activities included:

- Entrance and exit conferences
- Interviews with Sandhills administration and staff

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

FINDINGS

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

A. Administration

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

Policies & Procedures

Sandhills' policies and procedures are accounted for on the *Master List of Policies and Procedures*. The list submitted for this year's EQR indicates Sandhills has 741 active policies and procedures. In the previous year's EQR, CCME recommended that Sandhills streamline their policy and procedure set, as many of the policies and procedures overlap and/or contradict one another. As an example, a description of who can file a service authorization appeal varies across the 18 policies and procedures governing appeals. It is also evident that a large number of policies and procedures are no longer relevant to Sandhills' functions. Sandhills did not follow this Recommendation and, instead, added another four policies and three procedures to their set in the past year.

Per a list submitted during the Onsite, 25 policies and procedures were retired in the past three years, but Sandhills added almost 50 new policies and procedures during that same timeframe. CCME is again recommending that Sandhills develop a plan to streamline their policy and procedure set with an emphasis on an interdepartmental, vigorous and active process of retiring those policies and procedures that are no longer relevant to Sandhills' functions. It is also recommended that Sandhills add to *Policy and Procedure Core 3, Policy, Procedure and Program Description Maintenance, Review and Approval,* the only procedure governing policy and procedure management, the process for retiring policies and procedures as this procedure does not document this process.

Organizational Staffing/Management

Dr. Anthony Carraway serves as Chief Clinical Officer/Medical Director (CCO). In the past year, Dr. Carraway's job description was updated to more accurately reflect his current duties and oversight. This was a Recommendation in the previous year's EQR as some NC

Medicaid contractual obligations of the Medical Director were not present in his CCO job description.

Dr. Kenneth Marks continues in his role as a part-time Associate Medical Director (AMD) and his availability to Sandhills has increased since the retirement of the previous AMD. During the Onsite, his responsibilities were described, and these functions aligned with the written description of his "responsibilities and duties". He is only denoted on the Organizational Chart as reporting to Dr. Carraway despite departmental responsibilities such as Transition to Community Living Initiative support and involvement in quality of care and Utilization Management functions. CCME recommends that Sandhills denote on the Organizational Chart Dr. Marks' routine departmental involvement to better show this additional medical support of Sandhills' functions.

Prest & Associates is the delegated Peer Reviewer for both service authorizations and appeals. In the previous year's EQR it was noted that their contract states they also provide "consultation, supervision and oversight" to the UM Committee and further, to "serve as back up to the Sandhills Centre Medical Director when volume necessitates or when the Medical Director is not available". Concern was expressed by CCME that this contractual language, while not currently a function of Prest & Associates, creates a liability of conflicts of interest, real or perceived. The contract has since been amended and no longer reflects a possible dual relationship within Prest & Associates.

Confidentiality

Sandhills has in excess of 40 policies and procedures governing their confidentiality practices. Among them are the following:

- *Information Management*
- *Provider Specific Confidentiality*
- *Information Confidentiality, Integrity and Availability-Annual Risk Assessment*
- *Access to Individually-Identifiable Health Information*
- *Information Confidentiality and Security-Prevention of Confidentiality and Security Breaches*
- *Accounting of Disclosures*
- *Information Confidentiality and Security-Detection, Containment and Correction for Breach*
- *Confidentiality of Individually-Identifiable Health Information*
- *Health Insurance Portability & Accountability Act (HIPAA)*
- *Authorization for Use and Disclosure of Protected Health Information*

- *De-Identification of Protected Health Information*
- *HIPAA Security Risk Analysis*
- *HIPAA Workforce*
- *Minimum Necessary Disclosures*
- *Use and Disclosure of Protected Health Information*
- *Notice of Privacy Practices*
- *Privacy Complaints*
- *Requests for Privacy Protection of Protected Health Information*
- *Revoking Authorizations*
- *Retention of Member Records*
- *Subpoena for Records*

These policies and procedures sufficiently address state and federal regulations regarding health and information privacy requirements.

Policy and Procedure Core 27, Staff Training Program explains that new staff are trained in confidentiality specific to their new position within the first two days of employment. Additional training to new staff is provided during the new employee orientation that is completed within the new staff's first month of employment.

Information Systems Capabilities Assessment

As required by its contract with the CCME, IPRO conducted a review of Sandhills' information system capabilities using the Information Systems Capabilities Assessment (ISCA), as specified in the Centers for Medicaid and Medicare Services (CMS) protocol.

The completed ISCA tool and supporting documentation submitted from Sandhills were reviewed and followed up on through Onsite interview. Additionally, staff presented a member and claims system overview and clarified existing processes and reports.

Sandhills' transactional, hosted system environment is produced by WellSky (formerly known as Mediware). The AlphaMCS system is used to process member enrollment, claims, submit encounters and generate reports. WellSky modifies the user interface and conducts backend programming updates to the system.

Enrollment Systems

Sandhills has experienced steady growth in enrollment over the past three years. *Table 1* demonstrates Sandhills' year-end enrollment from 2016 to 2018.

Table 1: Enrollment Counts

2016	2017	2018
192,862	197,583	198,629

The ISCA tool and supporting documentation clearly define the process for enrollment data updates in the AlphaMCS enrollment system. The system maintains a member's enrollment history. The Global Eligibility File (GEF) file is imported daily into the AlphaMCS. The daily eligibility file is compared to existing eligibility in the AlphaMCS. The member enrollment records are processed and checked against the existing data in the database. An edit code that identifies if the member record needs to be added, changed or deleted is applied.

During the Onsite, Sandhills mentioned that their vendor, WellSky, has a process in place to generate error reports and notify Sandhills when errors are encountered during the Global Eligibility File (GEF) load process. Sandhills indicated that they have not encountered any errors while uploading the daily and quarterly GEF files.

Enrollees are identified by unique system generated patient IDs. 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 stores the Medicaid identification number received on the GEF. During the Onsite, Sandhills indicated that they rarely see members with multiple identification numbers (IDs), but are able to research and merge the information into one Member ID. The historical claims for the member are also merged into one Member ID. Sandhills maintains only one internal patient ID per member and the patient ID does not change when there are Medicaid eligibility changes.

Member deaths are captured through the GEF file and through notifications from providers. Sandhills' providers have the capability to confirm a member's eligibility in the AlphaMCS Provider Portal.

Monthly, Sandhills uses the 820 Capitation file to reconcile with their payments to determine missing payments or overpayments.

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

Claims Systems

Sandhills' claims payments occur within the accounting system, Great Plains Dynamic Accounting system. A review of Sandhills' processes for collecting, adjudicating and reporting claims was conducted through a review of its ISCA response and supporting documentation provided. The demonstration of Sandhills' Provider web claims entry portal and the AlphaMCS claims processing system along with claims process workflows, daily denial reports and sample audit reports provided a clear overview of Sandhills' claims processing and reporting.

Sandhills receives claims from three methods, 837 electronic file, provider web portal and paper claims. Sandhills receives claims from out-of-network providers on paper. *Table 2* details the percentage of 2018 claims received via the three methods.

Table 2: Percent of claims with 2018 dates of service that were received via Electronic HIPAA, Provider Web Portal or Paper forms.

Source	HIPAA File	Paper	Provider Web Portal
Institutional	85.1%	.2%	14.7%
Professional	56.1%	<.01%	43.9%

Sandhills processes claims within 18 days of receipt of a claim and if approved, claims are paid within 30 days of receipt. If a required field is missing from a claim, the provider portal rejects the claim. If the claim is being submitted electronically via an electronic 837 file and one or more required fields are missing, the claim is rejected, and the provider receives a 999 response file advising the provider of the claim submission failure. Sandhills uses exception reports to identify the missing information on the Institutional and Professional claims. Edits and checks that are in place for Institutional and Professional encounters include validation of Procedure codes, diagnosis, age and physician assistant on file. Sandhills' Claims Processors do not change any information on the claims.

Sandhills adjudicates claims nightly. Approximately 99.76% of Professional claims and 87.15% of Institutional claims are auto adjudicated. On an average, 99% of Professional claims and 98% of Institutional claims are paid within three months of date of service.

Sandhills conducts audits of claims processed weekly and monthly. Sandhills' staff conducts random audits on 3% of all claims processed for a week. Audits are conducted on all claims received via paper both prior to and after being manually entered into the AlphaMCS. Random audits are also conducted by Sandhills' Quality Management Department with assistance from Sandhills' Finance Department. A sample *Daily Claims*

Audit Report and *Claims Exception Report* was submitted in the Desk Materials to show monitoring and oversight of claims processing in the AlphaMCS. During the Onsite, Sandhills indicated that the paid and denied claims with top five paid amounts are audited. Sandhills discussed the process of auditing paper claims and also shared an audit report of the paper claims.

As recently as March 2019, Sandhills addressed last year's Corrective Action to allow for up to 25 ICD-10 diagnosis codes to be captured in their claims system for Institutional claims. Within the AlphaMCS claim system, Sandhills captures up to 25 ICD-10 diagnosis codes via the web portal and up to 29 ICD-10 diagnosis codes via HIPAA files for Institutional claims. For Professional encounters, the PIHP has the ability to receive and store up to 12 diagnosis codes. Sandhills captures ICD-10 Procedure codes and Diagnosis-Related Groups (DRGs) if they are submitted on the claim. During the Onsite, Sandhills indicated that though they capture the ICD-10 Procedure codes on the claim, the service line containing the ICD-10 Procedure code would deny the Sandhills' claims adjudication process for invalid code. Sandhills is working with their vendor to update AlphaMCS to resolve this issue and process the ICD-10 Procedure codes.

As discussed, Onsite, Sandhills has the capability to capture and submit Healthcare Common Procedure Coding System (HCPCS) codes along with required revenue codes for specific claims regarding lab, drug or radiology services.

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 emergency room are also pended. The pended claims are manually reviewed daily.

Reporting

Sandhills' uses the AlphaMCS to generate reports with real-time data. A local reporting database and data warehouse are also used to create reports. The enrollment, provider claims, and authorization information captured in the AlphaMCS is available in the local reporting database. Sandhills maintains an internal database that is a copy of the AlphaMCS database and is refreshed daily through a backup copy of the database from WellSky. If there are any errors while restoring the copy of the AlphaMCS database to the internal database, the backup restore process is aborted and Sandhills is notified.

Full enrollment and claims history are maintained in the AlphaMCS system. During the Onsite, Sandhills indicated that the reporting database and data warehouse are backed up nightly and also replicated in real time in the primary and secondary data centers. The replicated data in the data centers will be used during disaster recovery.

WellSky generates data extracts and reports for Sandhills within the AlphaMCS system. Sandhills also uses Structured Query Language (SQL) and Structured Query Language Server Reporting Services (SSRS) to create reports internally from the reporting database.

Internal claims reports were provided as supplemental documentation for the ISCA review. A sample *Claims Exception Report*, the *Claims Lag Report*, and the sample *Claims Audit Reports* indicate Sandhills has oversight and monitoring of its claims processes.

Encounter Data Submissions

Sandhills has a defined process in place for their encounter data submission, with 837 files submitted to NC Medicaid, and 835 files received back from NC Medicaid through the NCTracks system. Sandhills-approved encounters are submitted to NCTracks. Sandhills has the ability to track claims from the adjudication process to their encounter submissions status. Sandhills uses the 835 file from NCTracks to review denials. The extraction, submission and reconciliation of encounter data are fully automated. During the Onsite, Sandhills mentioned that they developed an encounter reconciliation database that tracks all Institutional and Professional encounters through their extraction, submission, and reconciliation process.

The breakdown of encounter data acceptance/denial rates was provided for the 2018 year, with a 2017 year comparison. This comparison is provided in *Table 3*.

Table 3: Volume of 2017 and 2018 Submitted Encounter Data

2018	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	29,855	743	136	30,734
Professional	1,140,606	22,648	5,336	1,168,590
2017	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	30,075	1,095	58	31,228
Professional	1,055,136	115,348	29,470	1,199,954

Sandhills has 99.5% acceptance rate for both Professional and Institutional encounters with dates of service in 2018. During the Onsite, Sandhills mentioned that they are working with their providers to keep the provider credentialing current and avoid encounter data denials. Sandhills indicated that the three top denial reason codes were:

1. Provider Taxonomy denials
2. Provider terminated
3. Provider site related issues

On average, Sandhills submits an encounter within five days from the time of adjudication to NCTracks. It takes approximately 24 days to correct and resubmit an encounter to NCTracks. Sandhills uses the *Adam Holtzman's Paid and Denied Report* and the weekly 835 file to identify denied encounters.

As stated in the ISCA, Sandhills has 136 Institutional and 5,336 Professional encounters still awaiting resubmission as of June 30, 2019. During the Onsite, Sandhills mentioned that they developed a Paid and Denied encounter reconciliation database that is based on the Adam Holtzman's Paid and Denied Report. This database 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 0.5% denial rate of their encounter data submissions.

Sandhills followed up after the ISCA Onsite and advised the number of ICD-10 diagnosis codes submitted on Institutional and Professional encounters to NC Medicaid. For Institutional and Professional encounters, Sandhills is submitting up to 12 ICD-10 diagnosis codes. Twenty-five ICD-10 diagnosis codes for Institutional encounters and 12 ICD-10 diagnosis codes for Professional encounters are the maximum number of diagnosis codes that may be submitted on an 837I and 837P, respectively and the maximum number that NCTracks captures. Sandhills has updated their system in March 2019 to submit all 12 ICD-10 diagnosis codes on 837P. As identified in 2018 ISCA Corrective Action findings, Sandhills does not have the capability to submit to NCTracks all the possible 837I diagnosis codes. Sandhills indicated that they are working with WellSky to increase the number of ICD-10 diagnosis codes submitted on Institutional extracts to 29.

During the Onsite, Sandhills mentioned that they can submit lab, drug or radiologic services that have revenue codes along with the HCPCS Procedure code on the encounter data extracts.

Figure 2 demonstrates the percentage of "Met" scores in this year's administrative EQR and compares those scores to the previous year's EQR.

Figure 2: Administration Comparative Findings

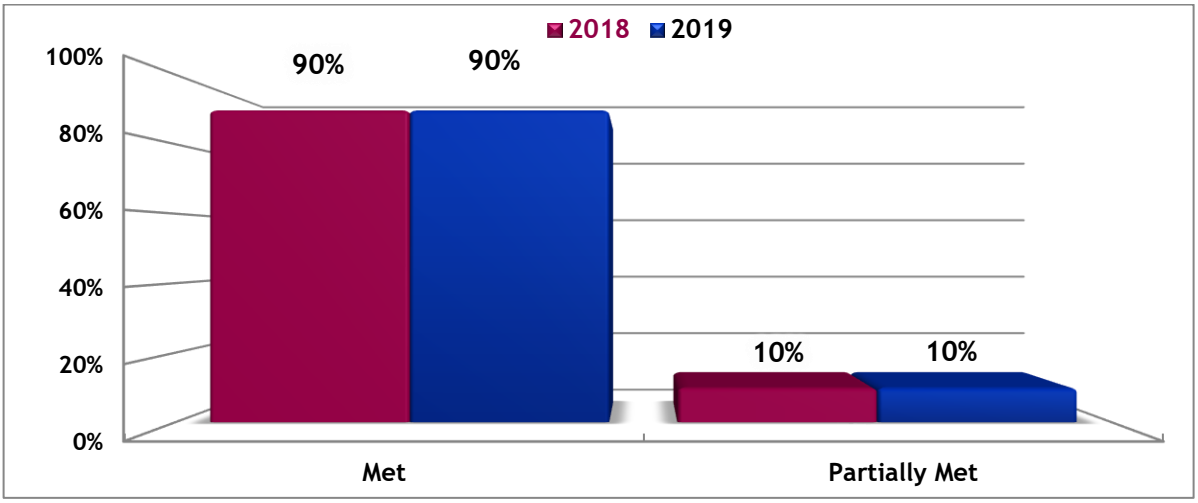


Table 4: Administration

Section	Standard	2019 Review
Management Information Systems	3.1 The PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.	Partially Met
	4.1 The MCO has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data.	Partially Met

Strengths

- Sandhills reconciles the monthly per member per month (PMPM) payment with the 820 Capitation file, which helps Sandhills determine missing payments and overpayments received.
- Sandhills auto-adjudicates clean claims; 87.15% of Institutional claims and 99.76% of Professional claims.
- Sandhills' current NCTracks encounter data acceptance rate is approximately 99.5%. Sandhills has made significant improvements in the acceptance rate of encounter data submissions.

Weaknesses

- Many of Sandhills' 741 policies and procedures overlap and/or contradict one another or are no longer relevant to Sandhills' functions. The policy and procedure set

continues to grow each year with no evidence of an effort to retire or streamline the set.

- Sandhills' only procedure governing policy and procedure management, *Policy and Procedure Core 3, Policy, Procedure and Program Description Maintenance, Review and Approval,* does not describe a process for retiring policies and procedures.
- Sandhills' AMD, Dr. Kenneth Marks, is only denoted on the Organizational Chart as reporting to Dr. Carraway despite departmental responsibilities such as, TCLI support and involvement in quality of care and UM functions.
- Sandhills does not store and use ICD-10 Procedure codes for reporting.
- Sandhills submits only up to 12 ICD-10 diagnosis codes on Institutional encounter data extracts to NCTracks, even though Sandhills is able to capture up to 29 ICD-10 diagnosis codes in their claims processing system.
- Sandhills does not have the ability to submit ICD-10 Procedure codes on encounter data extracts to NCTracks.

Corrective Action

- Update Sandhills' system and reporting database to be able to store and report on the ICD-10 Procedure codes.
- Update Sandhills' encounter data submission process to allow all ICD-10 diagnosis codes submitted on an Institutional claim to be submitted to NCTracks. Twenty-five ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837I and the maximum number that is captured by NCTracks.
- Update Sandhills' encounter data submission process to allow ICD-10 Procedure codes to be submitted on an encounter data extract.

Recommendations

- Develop an interdepartmental, vigorous and active process for retiring Sandhills' policies and procedures that are no longer relevant to Sandhills' functions.
- Describe in detail the process for retiring policies and procedures in *Policy and Procedure Core 3, Policy, Procedure and Program Description Maintenance, Review and Approval*.
- Denote on the Organizational Chart Dr. Marks routine departmental involvement to better show this medical support of Sandhills' functions.

B. Provider Services

The Provider Services review is comprised of Credentialing and Recredentialing, Network Adequacy, Provider Accessibility, Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, and Practitioner Medical Records. CCME reviewed relevant policies and procedures, the *Medicaid Provider Manual*, Clinical Advisory Committee (CAC) and Credentialing Subcommittee (CS) meeting minutes and documents, provider network information, credentialing/recredentialing files, practice guidelines, provider orientation materials, the *Sandhills 2018 Community Mental Health Substance Use and Developmental Disabilities Services Network Adequacy and Accessibility Report* ("Gaps Analysis"), and the Sandhills' website. An Onsite interview included personnel from Sandhills' Network Operations Department and the External and Quality Programs Department.

There were two items requiring Corrective Action in the Provider Services area at the last EQR. Both items were because Sandhills did not complete the *State Exclusion List* query as part of the credentialing and recredentialing process until June 2018. This was corrected, and the date of the query of the *State Exclusion List* is listed on the *Websites for Primary Source Verification* form in all files submitted for the current EQR.

At the last EQR, there were eight Recommendations in the Provider Services area. Changes were made and retained in two of the three Recommendations in the Credentialing/Recredentialing section. The third Recommendation was partially resolved, and now requires Corrective Action. Of the five Recommendations in the Network Adequacy section, Sandhills resolved three, and partially resolved the other two. The unresolved Recommendations are discussed later in this report section.

The *Credentialing Program Description* and several procedures, including the *Provider Credentialing Plan Procedure* (*N-CR 1a-19a, N-NM 3a*), address the credentialing process. Dr. Anthony Carraway, a Board-Certified Psychiatrist and Sandhills' Chief Clinical Officer (CCO)/Medical Director, chairs the Clinical Advisory Committee (CAC) and the Credentialing Subcommittee (CS). *Policy N-CR3, Credentialing Committee* defines the "Scope of Responsibilities & Duties" of the Sandhills CAC, including the CS. Per this policy, the CS is composed "ONLY of non-Sandhills members of the CAC who hold active and unrestricted licensure in their field and these members are the only ones casting votes on credentialing/re-credentialing matters. In the case of a tie vote, the Sandhills Center Chief Clinical Officer/Medical Director casts the deciding vote." A quorum is defined as "a majority of more than ½ of non-Sandhills Center staff voting members."

There were 11 CS meetings from July 31, 2018 through June 27, 2019, with one additional email vote. The CS included seven voting members for five of the meetings, and six voting members for five of the meetings and for the email vote.

A quorum was present at all meetings, with voting member attendance ranging from between 25% (one member) to 100% (two members) of the meetings at which they were members. Another person was only a member for two meetings, and attended one of the two. Three voting members attended between 75% and 92% of the meetings at which they were members. The member who attended 25% of the meetings is the same member who did not attend any meetings during the previous review period. That member also did not submit a written vote during either review period.

The credentialing and recredentialing file review showed the files are well-organized and contain appropriate information, with some exceptions, as outlined in the following "Weaknesses" section and in the *Attachment 4: Tabular Spreadsheet*. As was the case at the last EQR, many of the submitted files did not contain proof of Worker's Compensation/Employer's Liability (WC/EL) insurance coverage. On the Onsite materials request, CCME specifically requested the missing proof of WC/EL insurance (or the verification obtained from the practitioner that they had fewer than three employees). Sandhills did not provide either of these items for the files which lacked the documentation for the current EQR.

As required by NC Medicaid, Sandhills conducts the annual *Network Adequacy and Accessibility Analysis (Gaps Analysis)*, which includes obtaining feedback from members, providers, and other stakeholders, as well as Geo Access studies. Sandhills submitted an *Exception Request* for three services but has not yet received approval from NC Medicaid.

At the Onsite Review, Sandhills provided an update on three specific large projects. The adult Facility-Based Crisis Center is in the same location as the Walk-In Clinic at Daymark in Asheboro. The original plan was to open in the Spring of 2018, but there have been several delays. The most recent delay is due to an elevator issue in the building. Anticipated opening is now fall 2019 or early 2020.

Construction has started on a Facility-Based Crisis Center (FBC) for Children in Richmond County. The FBC for Children will serve enrollees in the entire Sandhills' catchment area. Anticipated opening is early 2020.

A 23-hour observation unit and outpatient services for adults in Guilford County is tied to Moses Cone Hospital system and is in the planning process. A similar program for adolescents will go out to bid.

Quarterly *Managed Care Accessibility Analysis* reports are presented in the Health Network Committee meetings and in the Quality Management Committee (QMC) meetings. The reports include Geo Access maps and charts with data regarding the percentage of enrollees who have access to at least two providers within 30 miles, broken down by service. There is no accompanying analysis of the reports, and the committee meeting minutes include little to no discussion of the reports. Though

Sandhills consistently did not meet the access standard for Multisystemic Therapy (MST), there is no evidence of any efforts to increase enrollee access by recruiting providers. At the Onsite, Sandhills staff reported they would add MST providers if they applied, though the website does not list MST providers among those who are invited to apply to be credentialed.

The following chart shows Sandhills received a score of "Met" for 97% of the standards during the Provider Services review. The score of "Partially Met" in both Credentialing and Recredentialing is due to Sandhills not obtaining documentation regarding WC/EL insurance.

Figure 3, Provider Services Comparative Findings, provides a comparison of the 2018 scores versus the 2019 scores.

Figure 3: Provider Services Comparative Findings

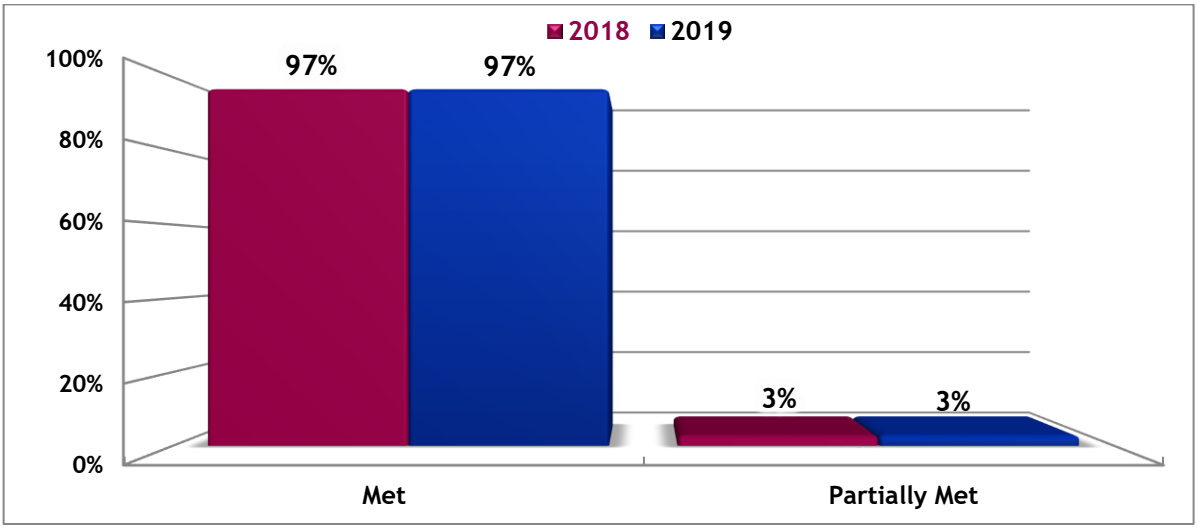


Table 5: Provider Services

Section	Standard	2018 Review
Credentialing and Recredentialing	Credentialing: Verification of information on the applicant, including: Insurance Requirements	**Partially Met**
	Recredentialing: Verification of information on the applicant, including: Insurance Requirements	**Partially Met**

Strengths

- Credentialing and recredentialing files contain checklists to help guide the process.
- Sandhills has a Provider Help Desk with a dedicated phone number and email address to assist providers with any issues.
- Sandhills posts Provider Help Desk Questions and Answers on its website.
- The Sandhills website includes Provider Orientation and other materials that would be helpful to providers.
- Sandhills conducts an annual provider orientation in two locations, for the convenience of providers.

Weaknesses

- *Procedure NCR 1a-19a, NM 3a Provider Cred Plan*, states, "Licensed Practitioners who do not employ any staff shall not be required to obtain Worker's Compensation or Employer's Liability insurance." The procedure does not address how Sandhills will verify whether practitioners have three or more employees.
- Five of the submitted initial credentialing files and eight of the submitted recredentialing files did not contain evidence of WC/EL insurance, or confirmation from the practitioner that they did not have three or more employees (in which case WC/EL insurance would not be required). This was also an issue at the last EQR. At that Onsite Review, Sandhills reported they had developed a new form for practitioners to complete, to address auto insurance and WC/EL insurance. That form was not in the files for the current EQR.
- Sandhills did not complete Primary Source Verification (PSV) of education for one Physician Assistant credentialing applicant who is not certified, or PSV of certification for one certified Physician Assistant recredentialing applicant. A North Carolina Medical License is not PSV of education, but PSV of certification by the National Commission on Certification of Physician Assistants serves as PSV of education.
- There is no evidence the quarterly *Managed Care Accessibility Analysis* reports are routinely analyzed to identify gaps, nor that strategies are developed to address identified gaps. This was also an issue at the last EQR.
- The *Member Handbook* does not clearly indicate that the member may use an out-of-network specialist with no benefit penalty if a network specialist is not available.
- Page 18 of the *Medicaid Provider Manual* contains a link to the Clinical Practice Guidelines on the Sandhills website that did not work during the Desk Review and at the beginning of the Onsite Review. This was also an issue at the last EQR, resulting in a Recommendation at that time. During the Onsite Review of the current EQR, Sandhills indicated they corrected the link.

Corrective Action

- Verify credentialing and recredentialing files contain proof of all required insurance coverage, including WC/El (or the relevant statement from the provider about why it is not required). For providers joining already-contracted agencies, include (in the files uploaded for Desk Review) copies of the insurance coverage for the agency, and verification the provider is covered under the plans. See *NC Medicaid Contract, Attachment B, Section 7.7.*

Recommendations

- Revise *Procedure NCR 1a-19a, NM 3a Provider Cred Plan*, and any other documents that include the credentialing/recredentialing process, to address how Sandhills will verify whether practitioners have three or more employees (and, therefore, need to provide proof of WC/EL insurance). Obtain and retain proof of WC/EL insurance coverage or the statement confirming practitioner does not have three or more employees (in which case WC/EL insurance would not be required). *See NC Medicaid Contract, Attachment B, Section 7.7.*
- Conduct PSV of education (or certification, if applicable) of physician assistants. Revise the *Provider Credentialing Plan Procedure, N-CR 1a-19a, N-NM 3a*, and any other documents containing the list of required materials, to indicate Sandhills will conduct PSV of education or certification of physician assistants. See *NC Medicaid Contract, Attachment O.*
- Analyze reports such as the quarterly *Managed Care Accessibility Analysis* reports to determine gaps and develop strategies to address identified gaps. This was also a Recommendation at the last EQR.
- Revise the *Member Handbook* to clearly indicate that member may use an out-of-network specialist with no benefit penalty, if a network specialist is not available. See *42 CFR § 438.206* and *NC Medicaid Contract, Attachment B, Section 6.4.5.*
- Sandhills indicated during the Onsite Review of the current EQR that they had corrected the link in the *Medicaid Provider Manual* to the Clinical Practice Guidelines. As recommended at previous EQRs, Sandhills should have a staff member periodically check links to ensure they work.

C. Enrollee Services

The Enrollee Services External Quality Review (EQR) includes review of the Enrollee Rights and Responsibilities, enrollee program education, behavioral health and chronic disease management education materials, and Call Center policies and procedures and monitoring reports. Enrollee Services was assessed through the review of policies and procedures, the *Member Handbook*, the *Medicaid Provider Directory*, staff training

documentation, Call Center monitoring, and the Sandhills website. One Corrective Action and three Recommendations were implemented and maintained from the 2018 EQR.

All required enrollee rights and responsibilities were documented in *Policy and Procedure Core 37, Consumer Rights and Responsibilities* and includes both member rights and the procedure for informing enrollees of these rights. The member rights are documented in the *Member Handbook* for easy access by the members.

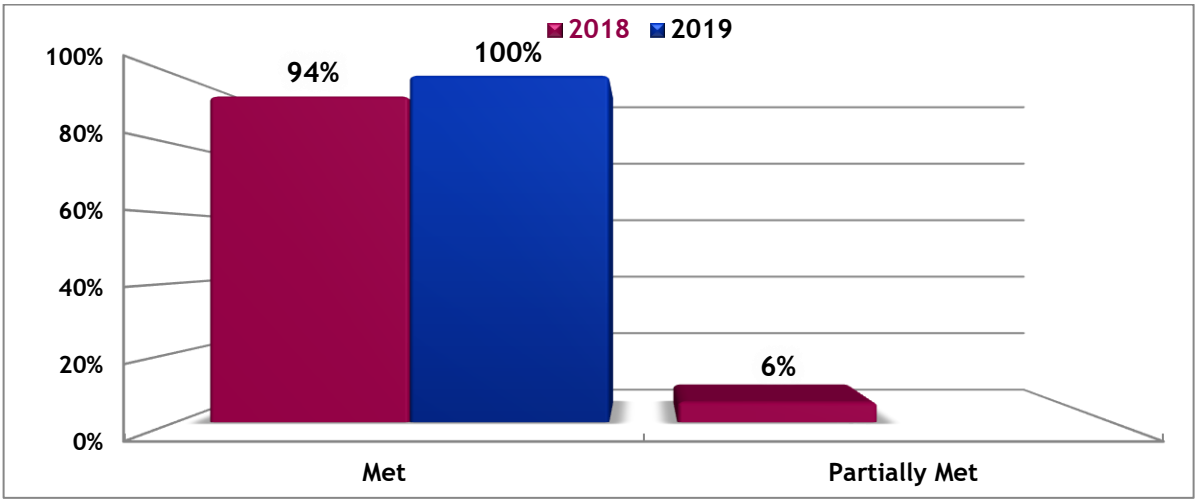
The *Welcome to Sandhills Center* letter is sent to members within 14 days of requesting service and explains how to access the Sandhills website, highlighting important information that can be found on the website. The website contains the *Member Handbook*, the main document for providing the new enrollee with written information on the Medicaid Waiver Managed Care Program. The letter also explains a website link for NC Innovations services, the toll-free phone number for a mailed copy of the *Member Handbook* which is the same number to call if you have a crisis or question. There were two Weaknesses within this area of the review centering around providing members locations of Emergency Services and procedures for obtaining out-of-state coverage. Two corresponding Recommendations were made for the Weaknesses.

Member educational opportunities are displayed on the Sandhills website under the Calendar tab and are all displayed in green. Sandhills contracts with NC Families United to deliver the educational training to enrollees, families, and the community. Data on member participation is prepared monthly by NC Families United, and kept with the Sandhills Care Coordination team.

Call Center staff use triage questions to determine the level of urgency for each call. The Call Center Clinicians use mobile crisis, when needed. They will dispatch mobile crisis, law enforcement, or emergency medical services (EMS) depending on which need is determined. Call Center staff stay on the line with the caller until services arrive. Sandhills uses the Language Line service for members when translation service is needed for all non-English speaking callers. Call Performance statistics for the period of July 2018 through June 2019 are within NC Medicaid parameters.

Figure 4 provides a comparison of the 2018 scores versus the 2019 scores. The 2019 review shows 100% of the standards in the Enrollee Services section were scored as "Met." There were no "Partially Met" or "Not Met" scores.

Figure 4: Enrollee Services Comparative Findings



Strengths

- The new soft-phone system in the Call Center allows staff to access their phone through any computer by carrying their identifying information with them and inserting that hardware that contains their data into any computer. This enables Call Center staff to work remotely in the event of an emergency or weather event.

Weaknesses

- Specific locations where Emergency services are offered are not mentioned in the *Member Handbook* or searchable within the *Medicaid Provider Directory*. The locations where Post Stabilization services are offered are listed in the *Member Handbook*.
- Page 13 of the *Member Handbook* states, "If you are out of the Sandhills area and need services, have the provider contact our Network Department at 1-855-777-4652." There is no documentation of the procedures for obtaining out-of-state coverage.

Recommendations

- In the *Member Handbook*, *Medicaid Provider Directory*, or both places, add locations Emergency services are provided, in addition to Post Stabilization services. Sandhills may choose to add this in the *Medicaid Provider Directory* as a search criterion, in a new Service Category for Emergency and Post-Stabilization Services.
- In the *Member Handbook*, add member procedures for obtaining out-of-state coverage of services.

D. Quality Improvement

The Quality Improvement (QI) section covers the QI Program, QI Committees, provider participation in QI, the QI Annual Evaluation, performance measures (PMs), and performance improvement projects (PIPs). Desk Material review was completed prior to the Onsite interview.

Since the last External Quality Review (EQR), the Quality Management (QM) Department has reorganized under the External and Quality Programs Department. The Quality Management Director and one Administrative Support staff make up the quality area of the organization chart with a "dotted line" to Dr. Anthony Carraway, CCO. The *Quality Management Program/Plan FY 2018-2019* provides structure and accountability for the QM Program.

Procedure NPM-7a, Monitoring the Provision of Evidence-Based Best Practice Services, describes the process for monitoring provider compliance with Evidenced Based Practice (EBP) guidelines. Onsite interview reveals this procedure is followed and Sandhills is offering a provider training biannually called, "Training for Excellence in Clinical Practice."

The ECHO Survey Tracking.xlsx document tracks question results that scored lower than the state average on the *Child and Adult ECHO Survey* for years 2016, 2017, and 2018. The scores are compared from year to year. Of the 39 items tracked over 3 years, only one item scored lower the following year when comparisons were completed.

The *QM Work Plan FY 2018-2019* includes seven identified tasks. Tasks from the *QM Work Plan 2017-2018* that were on-going did not carry over. CCME recommends Sandhills update the *QM Work Plan FY 2018-2019* to track all QM activities including tasks that carry over from FY 2017-2018.

The Quality Management Committee (QMC) oversees the QM Program at Sandhills. Global Continuous Quality Improvement Committee (GCQI) is the provider representation subcommittee for QMC. The role of the GCQI is defined in the *Quality Management Program/Plan FY 2018-2019* as "…a committee to provide feedback to the QMC regarding QIPs, quality of care concerns, and results of monitoring activities as they relate to QOC issues." However, there was no feedback or discussion from committee members in these areas documented on the GCQI minutes. The GCQI minutes need to document this discussion. There was no documentation in QMC minutes pertaining to updates from the GCQI meetings. There are Sandhills staff that attend both GCQI and QMC. CCME recommends staff members report back to QMC on the updates from GCQI.

The Quality Management Program/Plan FY 2018-2019 explains the process of the *Quality Management Program Evaluation* including what is evaluated and how the evaluation is

documented. *The Quality Management Program Evaluation* reviews the QM Program including the program goals with rating, outcome, barriers, and recommendations for each goal. Overviews of the enrollee and provider survey results are also included.

Performance Measure Validation

CCME conducted a validation review of the NC Medicaid-selected (b) and (c) Waiver performance measures following the CMS-developed protocol, *EQR Protocol 2: Validation of Performance Measures Reported by the Managed Care Organization (MCO) Version 2.0* (September 2012) which requires a review of the following for each measure:

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

This process assesses the production of these measures by the Prepaid Inpatient Health Plan (PIHP) to verify that what is submitted to NC Medicaid complies with the measure specifications as defined in the North Carolina Local Management Entity/Managed Care Organization (*LME/MCO) Performance Measurement and Reporting Guide*.

The measures selected for validation are listed in the *Tables 6* and *7*.

Table 6: (b) Waiver Measures

(b) WAIVER MEASURES	
A.1. Readmission Rates for Mental Health	D.1. Mental Health Utilization - Inpatient Discharges and Average Length of Stay
A.2. Readmission Rates for Substance Abuse	D.2. Mental Health Utilization
A.3. Follow-up After Hospitalization for Mental Illness	D.3. Identification of Alcohol and other Drug Services

(b) WAIVER MEASURES	
A.4. Follow-up After Hospitalization for Substance Abuse	D.4. Substance Abuse Penetration Rates
B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	D.5. Mental Health Penetration Rates

Table 7: (c) Waiver Measures

(c) WAIVER MEASURES	
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals. IW D1 ISP	Percentage of level 2 and 3 incidents reported within required timeframes. IW G2
Proportion of Individual Support Plans that address identified health and safety risk factors. IW D2 ISP	Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required. IW G3
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need	Percentage of medication errors resulting in medical treatment
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available	Percentage of beneficiaries who received appropriate medication
Proportion of beneficiaries reporting they have a choice between providers	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required

(b) Waiver Measures Reported Results

Ten (b) Waiver measures were reviewed and validated in accordance with the October 2015 protocol developed by NC Medicaid and the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

Most of the (b) Waiver measure rates have improved or remained about the same as the last EQR. There was a substantial increase,12.5%, in psychiatric residential treatment facility (PRTF) for follow up within 30 days. There was a substantial decrease in follow-up after hospitalization for SA in the category of Detox and Facility Based Crisis (FBC). The decrease was over 44% for 3 and 7 days, and over 58% for 30 days. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment for ages 18-20 decreased

over 20% for initiation and over 10% for engagement. The MH Utilization unknown age group had an incorrect percentage reported in the Desk Materials. This was resolved during the Onsite, and post-Onsite documents were uploaded to reflect the accurate rate. Validation worksheets based on the Centers for Medicaid and Medicare Services (CMS) protocol for validating PMs for each of the (b) waiver measures are included in *Attachment 3*. (b) Waiver measures' rates as reported by Sandhills are included in the *Table 8* through *Table 17*.

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

30-day Readmission Rates for Mental Health	FY 2017	FY 2018	Change
Inpatient (Community Hospital Only)	7.4%	8.0%	0.6%
Inpatient (State Hospital Only)	0.0%	0.0%	0.0%
Inpatient (Community and State Hospital Combined)	7.4%	8.1%	0.7%
Facility Based Crisis	0.0%	7.7%	7.7%
PRTF	6.7%	11.2%	4.5%
Combined (includes cross-overs between services)	8.0%	9.3%	1.3%

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

30-day Readmission Rates for Substance Abuse	FY 2017	FY 2018	Change
Inpatient (Community Hospital Only)	8.7%	7.7%	-1.0%
Inpatient (State Hospital Only)	0.0%	0.0%	0.0%
Inpatient (Community and State Hospital Combined)	8.6%	8.0%	-0.6%
Detox/Facility Based Crisis	7.5%	2.4%	-5.1%
Combined (includes cross-overs between services)	9.6%	7.8%	-1.8%

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

Follow-up after Hospitalization for Mental Illness	FY 2018	FY 2019	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	38.8%	40.7%	1.9%
Percent Received Outpatient Visit Within 30 Days	58.1%	59.9%	1.8%

Follow-up after Hospitalization for Mental Illness	FY 2018	FY 2019	Change
Inpatient (Hospital)			
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	NA	60%	NA
Percent Received Outpatient Visit Within 30 Days	NA	80%	NA
PRTF			
Percent Received Outpatient Visit Within 7 Days	22.2%	22.4%	0.2%
Percent Received Outpatient Visit Within 30 Days	46.7%	59.2%	**12.5%**
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	38.4%	40.2%	1.8%
Percent Received Outpatient Visit Within 30 Days	57.8%	59.9%	2.1%

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

Follow-up after Hospitalization for Substance Abuse	FY 2017	FY 2018	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NR
Percent Received Outpatient Visit Within 7 Days	18.2%	18.1%	-0.1%
Percent Received Outpatient Visit Within 30 Days	32.6%	29.7%	-2.9%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	71.4%	27.3%	-44.1%
Percent Received Outpatient Visit Within 7 Days	71.4%	27.3%	-44.1%
Percent Received Outpatient Visit Within 30 Days	85.7%	27.3%	-58.4%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NR
Percent Received Outpatient Visit Within 7 Days	19.6%	18.5%	-1.1%
Percent Received Outpatient Visit Within 30 Days	34.0%	29.6%	-4.4%

*NR = Denominator is equal to zero.

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2017	FY 2018	Change
Ages 13–17			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	52.7%	44.0%	-8.7%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	39.5%	40.9%	1.4%
Ages 18–20			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	59.9%	39.4%	-20.5%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	40.1%	29.8%	-10.3%
Ages 21–34			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	53.3%	53.7%	0.4%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	37.5%	44.0%	6.5%
Ages 35–64			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	56.0%	52.5%	-3.5%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	41.9%	43.7%	1.8%
Ages 65+			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	56.6%	53.3%	-3.3%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	42.4%	47.7%	5.3%
Total (13+)			
Percent With 2nd Service Or Visit Within 14 Days (Initiation)	55.2%	51.6%	-3.6%
Percent With 2 Or More Services Or Visits Within 30 Days After Initiation (Engagement)	40.1%	42.9%	2.8%

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

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		2017	2018	Change	2017	2018	Change
3–12	Male	0.2	0.2	0.0	24.5	26.9	2.4
	Female	0.2	0.2	0.0	9.0	15.1	6.1
	Total	0.2	0.2	0.0	18.7	20.9	2.2
13–17	Male	1.1	0.9	-0.2	42.1	33.5	-8.6
	Female	1.9	1.8	-0.1	24.1	24.5	0.4
	Total	1.5	1.3	-0.2	30.8	27.7	-3.1
18–20	Male	1.0	1.3	0.3	15.4	10.7	-4.7
	Female	1.1	1.2	0.1	11.4	5.7	-5.7
	Total	1.1	1.2	0.1	13.1	8.1	-5.0
21–34	Male	3.8	4.3	0.5	7.8	7.1	-0.7
	Female	1.3	1.3	0.0	5.6	7.0	1.4
	Total	1.8	1.9	0.1	6.6	7.1	0.5
35–64	Male	1.7	2.1	0.4	11.9	7.6	-4.3
	Female	2.4	1.8	-0.6	6.5	7.6	1.1
	Total	2.5	1.9	-0.6	8.6	7.6	-1.0
65+	Male	0.4	0.3	-0.1	13.5	18.5	5.0
	Female	0.4	0.2	-0.2	15.4	12.7	-2.7
	Total	0.4	0.3	-0.1	14.8	15.1	0.3
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**	1.1	1.0	-0.1	18.4	14.4	-4.0
	Female	1.1	1.0	-0.1	11.2	12.1	0.9
	Total	1.1	1.0	-0.1	14.2	13.1	-1.1

Table 14: 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		
		2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
3-12	Male	11.68%	11.23%	-0.45%	0.22%	0.18%	-0.04%	0.37%	0.38%	0.01%	11.54%	11.13%	-0.41%
	Female	8.26%	8.19%	-0.07%	0.17%	0.20%	0.03%	0.17%	0.20%	0.03%	8.17%	8.14%	-0.03%
	Total	10.02%	9.76%	-0.26%	0.19%	0.19%	0.00%	0.27%	0.29%	0.02%	9.89%	9.68%	-0.21%
13-17	Male	14.15%	13.42%	-0.73%	1.05%	0.91%	-0.14%	0.71%	0.65%	-0.06%	13.75%	13.19%	-0.56%
	Female	16.00%	15.08%	-0.92%	1.73%	1.63%	-0.10%	0.30%	0.29%	-0.01%	15.68%	14.79%	-0.89%
	Total	15.06%	14.23%	-0.83%	1.38%	1.27%	-0.11%	0.51%	0.47%	-0.04%	14.70%	13.98%	-0.72%
18-20	Male	9.05%	8.73%	-0.32%	0.95%	1.11%	0.16%	0.11%	0.02%	-0.09%	8.76%	8.51%	-0.25%
	Female	11.80%	10.98%	-0.82%	1.01%	1.27%	0.26%	0.08%	0.04%	-0.04%	11.46%	10.65%	-0.81%
	Total	10.51%	9.91%	-0.60%	0.98%	1.20%	0.22%	0.10%	0.03%	-0.07%	10.20%	9.63%	-0.57%
21-34	Male	24.70%	24.48%	-0.22%	2.81%	2.90%	0.09%	0.00%	0.06%	0.06%	24.36%	23.95%	-0.41%
	Female	18.28%	18.33%	0.05%	1.13%	1.10%	-0.03%	0.04%	0.06%	0.02%	18.17%	18.18%	0.01%
	Total	19.65%	19.67%	0.02%	1.49%	1.49%	0.00%	0.03%	0.06%	0.03%	19.49%	19.43%	-0.06%
35-64	Male	22.58%	22.61%	0.03%	2.34%	1.50%	-0.84%	0.02%	0.01%	-0.01%	22.27%	22.41%	0.14%
	Female	24.75%	23.82%	-0.93%	1.89%	1.45%	-0.44%	0.04%	0.03%	-0.01%	24.49%	23.62%	-0.87%

	Total	23.94%	23.37%	-0.57%	2.06%	1.47%	-0.59%	0.03%	0.02%	-0.01%	23.67%	23.17%	-0.50%
65+	Male	6.03%	6.11%	0.08%	0.45%	0.32%	-0.13%	0.00%	0.02%	0.02%	5.79%	5.91%	0.12%
	Female	5.48%	5.76%	0.28%	0.38%	0.14%	-0.24%	0.00%	0.00%	0.00%	5.32%	5.73%	0.41%
	Total	5.65%	5.87%	0.22%	0.40%	0.20%	-0.20%	0.00%	0.01%	0.01%	5.47%	5.79%	0.32%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**Male**	**14.17%**	**13.75%**	**-0.42%**	**0.95%**	**0.78%**	**-0.17%**	**0.32%**	**0.30%**	**-0.02%**	**13.93%**	**13.57%**	**-0.36%**
	Female	**14.37%**	**14.02%**	**-0.35%**	**0.97%**	**0.88%**	**-0.09%**	**0.12%**	**0.13%**	**0.01%**	**14.19%**	**13.87%**	**-0.32%**
	Total	**14.29%**	**13.90%**	**-0.39%**	**0.96%**	**0.84%**	**-0.12%**	**0.20%**	**0.20%**	**0.00%**	**14.07%**	**13.74%**	**-0.33%**

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

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
3–12	Male	0.03%	0.02%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.02%	0.00%
	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	0.02%	0.01%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.01%	-0.01%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
13–17	Male	0.95%	0.91%	-0.04%	0.04%	0.01%	-0.03%	0.32%	0.23%	-0.09%	0.74%	0.76%	0.02%
	Female	0.97%	0.71%	-0.26%	0.07%	0.04%	-0.03%	0.37%	0.28%	-0.09%	0.78%	0.54%	-0.24%
	Total	0.96%	0.81%	-0.15%	0.05%	0.02%	-0.03%	0.35%	0.25%	-0.10%	0.76%	0.65%	-0.11%
18–20	Male	2.28%	2.10%	-0.18%	0.24%	0.27%	0.03%	0.58%	0.30%	-0.28%	1.92%	1.88%	-0.04%
	Female	2.38%	2.16%	-0.22%	0.18%	0.22%	0.04%	0.70%	0.48%	-0.22%	2.04%	1.88%	-0.16%
	Total	2.33%	2.13%	-0.20%	0.21%	0.24%	0.03%	0.64%	0.39%	-0.25%	1.99%	1.88%	-0.11%
21–34	Male	7.72%	8.26%	0.54%	0.70%	0.81%	0.11%	1.28%	1.26%	-0.02%	7.19%	7.77%	0.58%
	Female	6.66%	7.28%	0.62%	0.45%	0.40%	-0.05%	1.18%	1.30%	0.12%	6.32%	6.99%	0.67%
	Total	6.89%	7.50%	0.61%	0.50%	0.49%	-0.01%	1.20%	1.29%	0.09%	6.50%	7.16%	0.66%
35–64	Male	8.64%	8.70%	0.06%	0.90%	0.85%	-0.05%	1.53%	1.36%	-0.17%	7.88%	7.96%	0.08%
	Female	5.43%	5.93%	0.50%	0.44%	0.40%	-0.04%	1.09%	1.02%	-0.07%	4.99%	5.54%	0.55%
	Total	6.62%	6.96%	0.34%	0.61%	0.57%	-0.04%	1.25%	1.15%	-0.10%	6.07%	6.44%	0.37%
65+	Male	1.87%	1.79%	-0.08%	0.17%	0.12%	-0.05%	0.45%	0.45%	0.00%	1.60%	1.52%	-0.08%
	Female	0.34%	0.42%	0.08%	0.04%	0.00%	-0.04%	0.05%	0.05%	0.00%	0.33%	0.40%	0.07%
	Total	0.82%	0.86%	0.04%	0.08%	0.04%	-0.04%	0.17%	0.18%	0.01%	0.73%	0.76%	0.03%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
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%**	**2.33%**	**0.01%**	**0.22%**	**0.21%**	**-0.01%**	**0.45%**	**0.39%**	**-0.06%**	**2.09%**	**2.13%**	**0.04%**
	Female	**2.60%**	**2.75%**	**0.15%**	**0.19%**	**0.17%**	**-0.02%**	**0.53%**	**0.51%**	**-0.02%**	**2.40%**	**2.57%**	**0.17%**
	Total	**2.48%**	**2.57%**	**0.09%**	**0.20%**	**0.19%**	**-0.01%**	**0.50%**	**0.45%**	**-0.05%**	**2.27%**	**2.38%**	**0.11%**

Table 16: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Anson	0.04%	0.00%	-0.04%	3.73%	1.94%	-1.79%	2.53%	4.17%	1.64%	4.48%	5.15%	0.67%
Guilford	0.02%	0.02%	0.00%	0.88%	0.95%	0.07%	2.26%	2.00%	-0.26%	4.40%	4.95%	0.55%
Harnett	0.02%	0.03%	0.01%	0.55%	0.50%	-0.05%	1.11%	1.22%	0.11%	3.31%	3.37%	0.06%
Hoke	0.08%	0.00%	-0.08%	0.66%	0.54%	-0.12%	1.06%	1.77%	0.71%	5.31%	5.25%	-0.06%

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		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
Lee	0.00%	0.00%	0.00%	0.71%	0.61%	-0.10%	1.53%	0.79%	-0.74%	5.89%	5.58%	-0.31%
Montgomery	0.00%	0.00%	0.00%	1.17%	1.08%	-0.09%	2.58%	2.37%	-0.21%	7.05%	8.46%	1.41%
Moore	0.00%	0.04%	0.04%	1.68%	1.06%	-0.62%	2.95%	1.79%	-1.16%	10.64%	10.78%	0.14%
Randolph	0.03%	0.00%	-0.03%	1.13%	0.79%	-0.34%	1.76%	1.89%	0.13%	6.55%	6.85%	0.30%
Richmond	0.00%	0.04%	0.04%	0.76%	0.50%	-0.26%	2.70%	2.58%	-0.12%	9.07%	8.89%	-0.18%
	35-64			65+			Unknown			Total		
Anson	6.63%	7.82%	1.19%	0.77%	0.45%	-0.32%	0.00%	0.00%	0.00%	2.89%	3.07%	0.18%
Guilford	6.88%	7.12%	0.24%	1.25%	1.40%	0.15%	0.00%	0.00%	0.00%	2.24%	2.38%	0.14%
Harnett	3.80%	3.80%	0.00%	0.23%	0.49%	0.26%	0.00%	0.00%	0.00%	1.38%	1.40%	0.02%
Hoke	7.86%	7.54%	-0.32%	0.94%	1.15%	0.21%	0.00%	0.00%	0.00%	2.42%	2.37%	-0.05%
Lee	5.35%	5.58%	0.23%	0.51%	0.21%	-0.30%	0.00%	0.00%	0.00%	1.98%	1.89%	-0.09%
Montgomery	7.05%	9.52%	2.47%	0.90%	1.09%	0.19%	0.00%	0.00%	0.00%	2.64%	3.28%	0.64%
Moore	7.99%	7.65%	-0.34%	0.81%	0.45%	-0.36%	0.00%	0.00%	0.00%	3.60%	3.41%	-0.19%
Randolph	5.82%	6.41%	0.59%	0.31%	0.36%	0.05%	0.00%	0.00%	0.00%	2.32%	2.42%	0.10%
Richmond	8.50%	7.21%	-1.29%	1.43%	1.12%	-0.31%	0.00%	0.00%	0.00%	3.77%	3.40%	-0.37%

Table 17: 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		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Anson	9.80%	7.74%	-2.06%	15.78%	14.02%	-1.76%	10.74%	6.45%	-4.29%	12.29%	13.35%	1.06%
Guilford	7.77%	7.60%	-0.17%	14.45%	13.62%	-0.83%	9.52%	9.19%	-0.33%	12.98%	12.71%	-0.27%
Harnett	8.66%	8.42%	-0.24%	13.93%	13.68%	-0.25%	9.46%	10.14%	0.68%	11.07%	10.95%	-0.12%
Hoke	8.54%	8.58%	0.04%	14.58%	13.28%	-1.30%	7.42%	7.33%	-0.09%	12.21%	9.98%	-2.23%
Lee	8.10%	8.20%	0.10%	12.99%	12.69%	-0.30%	8.77%	8.27%	-0.50%	12.32%	11.67%	-0.65%
Montgomery	7.14%	7.22%	0.08%	9.98%	10.61%	0.63%	7.74%	7.11%	-0.63%	12.07%	9.20%	-2.87%
Moore	9.18%	8.27%	-0.91%	14.20%	12.29%	-1.91%	9.56%	9.03%	-0.53%	16.00%	13.36%	-2.64%
Randolph	6.27%	6.26%	-0.01%	11.96%	12.55%	0.59%	9.23%	8.78%	-0.45%	12.87%	12.28%	-0.59%
Richmond	11.81%	11.73%	-0.08%	15.52%	15.70%	0.18%	9.79%	8.56%	-1.23%	13.81%	12.76%	-1.05%
	35-64			65+			Unknown			Total		
Anson	19.55%	19.32%	-0.23%	6.65%	8.43%	1.78%	0.00%	0.00%	0.00%	12.88%	11.89%	-0.99%
Guilford	20.83%	20.24%	-0.59%	5.95%	6.16%	0.21%	0.00%	0.00%	0.00%	11.84%	11.50%	-0.34%
Harnett	16.46%	16.22%	-0.24%	5.80%	6.14%	0.34%	0.00%	0.00%	0.00%	11.09%	10.96%	-0.13%
Hoke	18.87%	15.85%	-3.02%	3.90%	4.60%	0.70%	0.00%	0.00%	0.00%	11.47%	10.44%	-1.03%

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		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Lee	17.08%	16.33%	-0.75%	3.50%	4.11%	0.61%	0.00%	0.00%	0.00%	10.64%	10.42%	-0.22%
Montgomery	17.66%	17.50%	-0.16%	5.97%	5.76%	-0.21%	0.00%	0.00%	0.00%	9.99%	9.64%	-0.35%
Moore	22.15%	17.74%	-4.41%	5.99%	5.11%	-0.88%	0.00%	0.00%	0.00%	13.08%	11.21%	-1.87%
Randolph	19.04%	18.38%	-0.66%	7.72%	7.25%	-0.47%	0.00%	0.00%	0.00%	10.73%	10.56%	-0.17%
Richmond	19.26%	17.55%	-1.71%	4.37%	5.08%	0.71%	0.00%	0.00%	0.00%	13.54%	12.93%	-0.61%

(b) Waiver Validation Results

The overall validation scores are "Fully Compliant" with an average validation score of 100% across the 10 measures. The stored procedures have been updated to address NC Medicaid's most recent changes to the measures.

Table 18 contains validation scores for each of the 10 (b) Waiver Performance Measures.

Table 18: (b) Waiver Performance Measure Validation Scores 2018

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

For reviews of 2018 (c) Waiver measures, there were changes made to validated measures. Seven new measures were chosen, and three previously validated measures were retained. Documentation was included for all ten (c) Waiver measures. The rates reported by Sandhills are displayed in *Table 19*.

Table 19: (c) Waiver Measures: Reported Results 2017-2018

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	Annual	1315/1315=100%	**85%**
Proportion of Individual Support Plans that address identified health and safety risk factors	Semi Annually	661/661=100%	**85%**
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need	Annually	1315/1315=100%	**85%**
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available	Annually	1315/1315=100%	**85%**
Proportion of beneficiaries reporting they have a choice between providers	Annually	1315/1315=100%	**85%**
Percentage of level 2 and 3 incidents reported within required timeframes	Quarterly	72/90=80%#	**85%**
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required	Quarterly	6/6=100%	**85%**
Percentage of medication errors resulting in medical treatment	Quarterly	0/0=NA	**15%**
Percentage of beneficiaries who received appropriate medication	Quarterly	1254/1254=100%	**85%**
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required	Quarterly	27/27=100%	**85%**

Note. Annual rates reported using SHC 11/2018 Excel file; Semiannual and quarterly rates reported using SHC Annual May 2019.

= below benchmark

(c) Waiver Validation

Validation scores are "Fully Compliant" with an average validation score of 100% across the ten measures. The validation scores are shown in *Table 20*, (c) Waiver Performance Measure Validation Scores. Documentation on data sources, data validation, source code, and calculated rate for the ten (c) Waiver measures was provided. As well, all rates met or exceeded state performance benchmarks. The validation worksheets offer detailed information on point deduction when validating each (c) Waiver measure.

Table 20: (c) Waiver Performance Measure Validation Scores

Measure	Validation Score Received
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	**100%**
Proportion of Individual Support Plans that address identified health and safety risk factors	**100%**
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need	**100%**
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available	**100%**
Proportion of beneficiaries reporting they have a choice between providers	**100%**
Percentage of level 2 and 3 incidents reported within required timeframes	**100%**
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required	**100%**
Percentage of medication errors resulting in medical treatment	**100%**
Percentage of beneficiaries who received appropriate medication	**100%**
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required	**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 CMS-developed protocol titled, *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0 (September 2012)*. 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

Sandhills submitted five Performance Improvement Projects (PIPs) for validation. Topics included: Maximizing the Benefit of Child Mental Health Level III, EBP Specialty, Shaping the Network, Access to Routine BH Assessments, and TCLI Transition Days. *Table 21: Performance Improvement Project Validation Scores* provides an overview of the validation results.

Table 21: Performance Improvement Project Validation Scores

Project Type	Project	2018 Validation Score	2019 Validation Score
Clinical	Maximizing the Benefit of Child Mental Health Level III	79/85=93% High Confidence in Reported Results	90/90=100% High Confidence in Reported Results
	EBP Specialty	84/85=99% High Confidence in Reported Results	Not validated
Non-Clinical	Shaping the Network	Not validated	80/90=89% Confidence in Reported Results

Project Type	Project	2018 Validation Score	2019 Validation Score
	Access to Routine BH Assessments	105/111=95% High Confidence in Reported Results	105/111=95% High Confidence in Reported Results
	TCLI Transition Days	78/85=92% High Confidence in Reported Results	79/85=93% High Confidence in Reported Results

Three of the four PIPs (75%) received a score of "High Confidence in Reported Results" in reported results. The PIP Shaping the Network received a score of "Confidence in Reported Results." Additionally, The EBP Specialty PIP was discussed during the Onsite. This PIP was not validated for 2019 due to a change in PIP status. Sandhills indicated a new PIP will be initiated and will include all EBP Specialty diagnoses.

Table 22 provides an overview of the Corrective Actions needed for the Shaping the Network Pip. *Table 23* provides the recommendations for the other PIPs validated.

Table 22: Performance Improvement Project Errors and Corrective Actions

Project	Section	Reason	Corrective Action
Shaping the Network	Was/were the study question(s) stated clearly in writing?	Research question is stated on page 2 but does not include a goal number or statement about types of interventions.	Reformulate study question to include the goal number and types of interventions that will be implemented to shape the network and decrease inactive providers.

Table 23: Performance Improvement Project Errors and Recommendations

Project	Section	Reason	Recommendation
Access to Routine BH Assessments in a Timely and Appropriate Manner	Were qualified staff and personnel used to collect the data?	Personnel involved in calls and data entry were not listed in the report.	Clarify role and title of individuals that are making the mystery shopper calls.
	Is there any statistical evidence that any observed performance improvement is true improvement?	Statistical analyses were not conducted	Because sampling is utilized, a statistical test (z test or Fisher's exact) should be conducted and reported.
TCLI Transition Days	Did the study design prospectively specify a data analysis plan?	Data analysis plan is not specified.	Include documentation on how data will be analyzed quarterly and the formula for the analysis.
	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Interventions have been initiated based on results and issues with the database, but the barriers that are linked to each intervention are not clear in the report.	Revise the report to display the specific barriers that are being addressed by the interventions.

Details of the validation of the PMs and PIPs are found in the *CCME EQR Validation Worksheets, Attachment 3.*

Figure 5 provides a comparison of the 2018 scores versus the 2019 scores. The 2019 review shows 94% of the standards were scored as "Met," and 6% of the standards were scored as "Partially Met." None of the standards were scored "Not Met."

Figure 5: Quality Improvement Comparative Findings

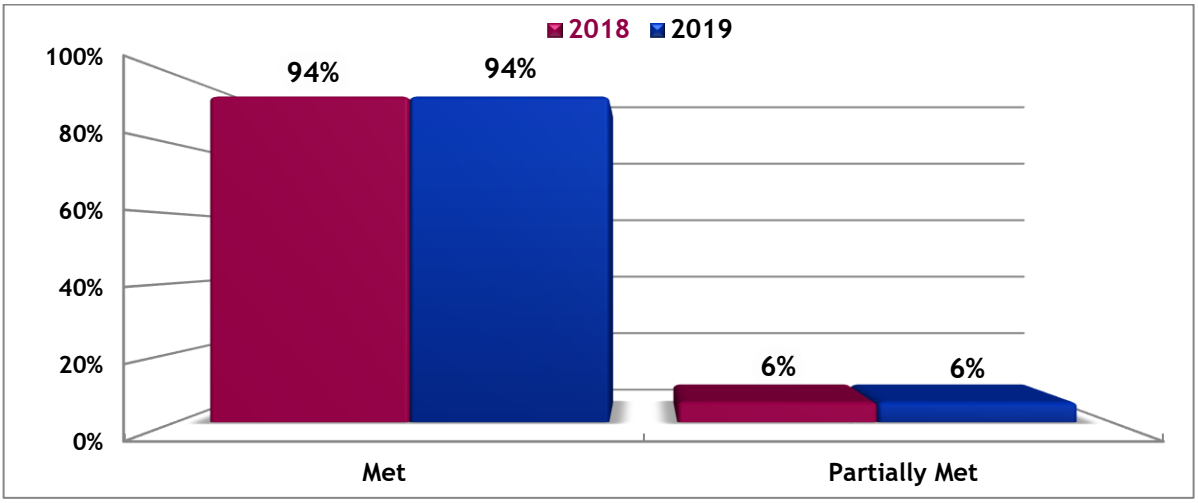


Table 24: Quality Improvement

Section	Standard	2019 Review
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects."	Partially Met

Strengths

- Sandhills has an 18-hour, in-person, experiential training over three days to promote best clinical practices in the outpatient setting. Training was launched in March of 2019 and will be offered biannually.
- Sandhills has *The ECHO Survey Tracking* document. All lower scoring *ECHO Survey* items are on the document. Thirty-nine items are tracked from the 2016, 2017, and 2018 surveys. Only one item scored lower the following year when comparisons were made year-to-year.

Weaknesses

- The *QM Work Plan FY 2018-2019* includes 7 identified tasks. On-going tasks from the *QM Work Plan 2017-2018* did not carry over.
- The role of the GCQI committee is defined in the *Quality Management Program/Plan FY 2018-2019* as "…a committee to provide feedback to the QMC regarding QIPs, quality of care concerns, and results of monitoring activities as they relate to QOC

issues." However, there was no feedback or discussion in GCQI minutes on these topics.

- There was no report documented in QMC minutes pertaining to updates from the GCQI. Sandhills' staff attend both GCQI and QMC. Those staff members should report back to QMC on the updates from GCQI.
- The PIP, "Shaping the Network to improve provider choice and ensure members access to quality services", scored in the "Confidence" range and has Corrective Action associated.
- Two PIPs have Recommendations.
- The EBP Specialty PIP was discussed during the Onsite, but not validated for 2019 due to a change in PIP status. The initial EBP Specialty PIP focused on Bipolar and PTSD patient populations. In January 2019 the patient population changed to include all EBP Specialty diagnosis.

Corrective Action

- Make corrections to the PIP, "Shaping the Network to improve provider choice and ensure members access to quality services", as outlined in *Table 22*.

Recommendations

- Update the *QM Work Plan FY 2018-2019* to track all QM activities including tasks that carry over from *FY 2017-2018*.
- Facilitate GCQI meetings so that feedback is captured in meeting minutes for QIPs, quality of care concerns, and results of monitoring activities as they relate to quality of care (QOC) issues.
- Begin reporting the GCQI meeting summary at QMC meetings and documenting the update in the QMC meeting minutes.
- Address the PIP Recommendations listed in *Table 23*.
- Close the current EBP Specialty PIP and initiate a new EBP Specialty PIP that includes all EBP Specialty diagnoses.

E. Utilization Management

The Utilization Management (UM) EQR includes review of the Utilization Management, Care Coordination and Transition to Community Living Initiative (TCLI) functions for the Intellectual/Developmental Disability (I/DD) and Mental Health/Substance Abuse (MH/SA) enrollees. Included in the review process are a Desk Review of policies and procedures, the *UM Executive Summary 2019-2020*, the *Utilization Management Program Description SY 2019-2020*, the *TCLI Quality Oversight of TCLI Initiative 2019,* the *Medicaid Provider Manual*, the *Member Handbook,* and respective departmental files.

There were four issues that required Corrective Action in 2018. Three of these were aimed at improving information available in the *Medicaid Provider Manual*, the *Member Handbook*, and UM and Care Coordination policies and procedures. The fourth issue was intended to address concerns regarding the quality and timeliness of Care Coordination progress notes. This year's file review showed that, while the quality of the progress notes improved over the past year, issues with the timeliness of progress notes persist.

Sandhills' UM policies and procedures require progress notes to be entered by MH/SA Care Coordinators within five business days (*Policy and Procedure CC-8, MH/SA Care Coordination Documentation Requirements)*, and by I/DD Care Coordinators (*Policy and Procedure I/DD CC 6, Documentation Requirements for Care Coordination*) within seven calendar days. Staff reported that TCLI staff have a required timeframe of five business days to submit progress notes, but this is not outlined in TCLI policy or procedure. Of the 473 Care Coordination notes reviewed, around 20% were entered late into the progress note portal. Further review revealed that MH/SA entered less than 2% of their progress notes late, whereas over 17% of the TCLI progress notes and 30% of the I/DD Care Coordination notes were submitted late. The average timeframe for progress notes entry in the TCLI and I/DD Care Coordination files was 14 days, which is double the timeframe required by and of Sandhills' policies and procedures.

Sandhills provided reports that capture the timeframes of progress note submission per enrollee and per Care Coordinator. These reports are used in supervision with individual Care Coordinators, along with a small sample of progress notes. These reports could be used to measure individual Care Coordinator adherence to timeliness requirements of progress notes, develop a departmental dashboard, drive a quality improvement project, or quantify employee performance. A more enhanced and data driven monitoring process is needed using these reports to bring the I/DD and TCLI department into compliance with the required timeframe for submitting progress notes. This enhanced monitoring process should be outlined in each distinct Care Coordination unit's policies and procedures.

A review of the *Member Handbook* shows that information describing the TCLI program is available, and eligibility for that program is explained. This was a Recommendation from

the previous EQR and was addressed by Sandhills. However, no general information about Care Coordination was added to the manual. CCME recommends that information about MH/SA Care Coordination, I/DD Care Coordination, and eligibility for those programs is included in the *Member Handbook*.

In reviewing the 13 policies and 13 procedures governing TCLI, it was noted that TCLI has policies and procedures separate from those in Care Coordination, as it is considered a distinct unit. These policies and procedures describe very specific TCLI functions and processes such as, Root Cause Analysis, Quality of Life surveys, and Transition Year Stability Resources. but do not capture overarching responsibilities of TCLI Care Coordinators such as participation in treatment planning, documentation requirements for progress notes, monitoring, and supervision of TCLI staff. CCME recommends Sandhills revise the existing TCLI policies and procedures to include references to Care Coordination policies and procedures that outline basic but primary responsibilities for TCLI staff. These references will prevent the addition of policies and procedures that duplicate those already available.

Figure 6, Utilization Management Findings, provides a comparison of Sandhills' 2019 EQR Utilization Management results to the 2018 review results.

Figure 6: Utilization Management Comparative Findings

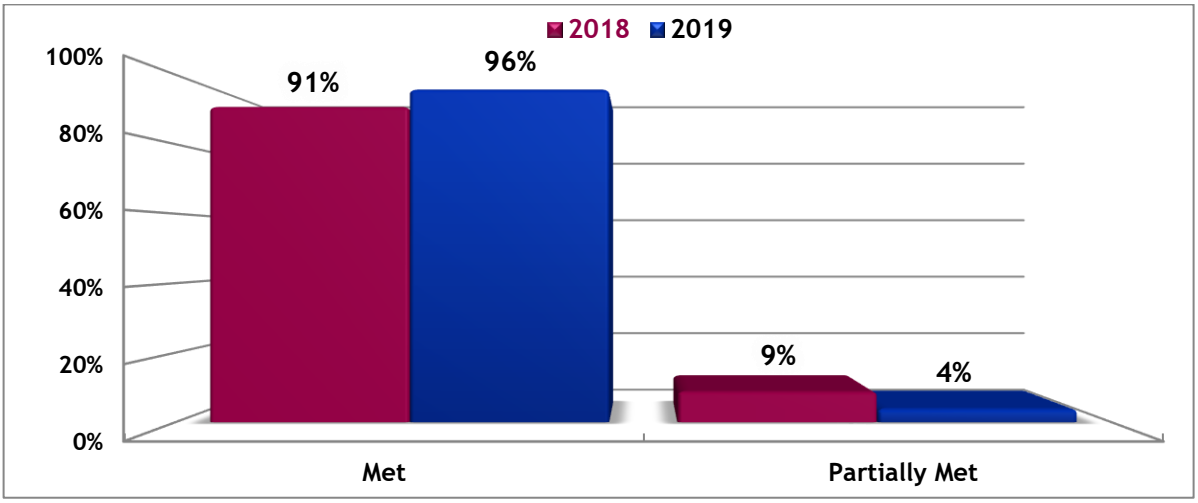


Table 25: Utilization Management

Section	Standard	2019 Review
Care Coordination	The PIHP applies the Care Coordination policies and procedures as formulated.	Partially Met

Section	Standard	2019 Review
Transition to Community Living	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.	**Partially Met**

Strengths

- The quality of Care Coordination notes has improved since the last EQR.

Weaknesses

- 17% of the TCLI progress notes and 30% of the I/DD Care Coordination progress notes were out of compliance with the submission timeframes required by Sandhills' policies and procedures. This issue was identified as needing Corrective Action in last year's EQR.
- Sandhills has data and reports that are used in individual care coordinator's supervision, but does not use this data to identify and address quality issues within the Care Coordination Department as a whole.
- The *Member Handbook* lacks information about the availability of and eligibility for Care Coordination services.
- TCLI policies and procedures do not capture overarching responsibilities of the TCLI program such as, participation in treatment planning, documentation requirements for progress notes, and supervision of TCLI staff.

Corrective Action

- Enhance the current monitoring process using a data driven approach to bring the I/DD and TCLI progress notes into compliance with the required timeframe for submission. This enhanced monitoring process should be outlined in each distinct Care Coordination unit's policies and procedures.

Recommendations

- Use available data to analyze and target issues with progress note timeliness, or any other issues within the I/DD and TCLI Care Coordination Units. This data could be used to measure individual care coordinator adherence, develop a departmental dashboard, drive a quality improvement project, or quantify employee performance.
- Describe the availability of and eligibility for MH/SA and I/DD Care Coordination services in the *Member Handbook*.
- Either add to TCLI policies and procedures the overarching responsibilities of the TCLI program such as, participation in treatment planning, documentation requirements for progress notes, and supervision of TCLI staff, or reference existing Care Coordination policies and procedures that already outline these responsibilities.

F. Grievances and Appeals

Grievances

The Grievance External Quality Review (EQR) includes a Desk Review of policies and procedures, grievance files, and the *Grievance Log*, *Medicaid Provider Manual* and *Member Handbook,* as well as an Onsite discussion with Grievance and Call Center staff to further clarify Sandhills' grievance process. The 2018 EQR Review included four Recommendations in the grievance section, these four Recommendations were implemented.

Sandhills processes grievances within the Customer Services Center. Staff are trained to receive, and document grievances within the electronic grievance form. Customer Center staff are able access the Chief Medical Officer for consultation on quality of care and health and safety grievances.

Sandhills has adopted the use of the one term "grievance" for the grievances process as recommended in the 2018 EQR. This was a Recommendation in the previous year's EQR. The change to the use of one term "grievance" was reflected in the edit of *Policy and Procedure Core 35, Consumer Grievance Process-Medicaid*, but two references to the term "complaint" remain in that procedure. The term "complaint" is also used interchangeably with the term "grievance" within the *Medicaid Provider Manual*. Sandhills should review all printed materials discussing grievances to align these materials with their policies and procedures.

Within *Procedure Core 35a-Consumer Grievance Process-Medicaid,* the acknowledgment of a grievance occurs "within 5 working days of the receipt of the grievance". This timeframe is included in the "Low Risk Grievances", however the timeframe is not included in the "High Risk Grievance" section. The Onsite interview clarified that the grievant is notified within five days of the receipt of the grievance for both Low and

High-Risk grievances. Adding the timeframe, "within 5 working days of receipt of the grievance" to the "High-Risk Grievance" section will provide clarification of all the steps within the "High-Risk" process.

In Procedure *CORE 35a, Consumer Grievance Process-Medicaid*, the details for an Extension of a grievance are missing in section "Time Extension for all grievances". The missing details for all grievances include a "prompt" phone call and written notification "within 2 days". It is advised to edit the sentence to read, "If the timeframe is extended: The member will be notified with a prompt phone call and the member will notified in writing within 2 calendar days, per *42 CFR § 438.408*."

The final item to consider within *Procedure, CORE 35a, Consumer Grievance Process-Medicaid* is the timeframe requirement to maintain grievance records. This element is not within the procedure and needs to be included, Per *Attachment M of the NC Medicaid Contract*, *Section* "B. Record Keeping and Reporting:1. PIHP shall maintain records of each relevance...PIHP shall provide for the retention of the records… for 5 years following the final decision or close of the grievance…The record must be maintained in a manner accessible to the State and available upon request to CMS." Ensure that the timeframe to maintain a grievance record is included within the procedure.

The review of the *Grievance Log* verified data is available and used for basic analysis, however, trending analysis and advanced analytics is not evident in committee minutes or reports. A more in-depth analysis would help Sandhills maximize the use of data and identify potential quality improvement opportunities.

Appeals

EQR of the appeals functions at Sandhills involves review of 20 first level appeal files, five second level appeal files, appeals data, the appeals tracking sheet, the *Member Handbook*, the *Medicaid Provider Manual*, and appeal information available on Sandhills' website. An extensive policy and procedure review was also completed for compliance with the *NC Medicaid Contract* and federal regulations governing the Medicaid appeals process.

In the previous year's EQR of appeals, Sandhills received 10 Corrective Actions and 11 Recommendations, most of which were aimed at bringing Sandhills' nine appeal policies and nine procedures into compliance with the *NC Medicaid Contract* and federal regulations around Medicaid appeals. In response to the Corrective Actions aimed at appeals policies and procedures, Sandhills revised one appeal policy and one appeal procedure. As a result, the policies and procedures governing appeals still contain incorrect and contradictory information. Areas of contractual noncompliance within Sandhills' appeal policies and procedures are detailed in *Attachment 4, Tabular Spreadsheet*.

During the Onsite, Sandhills discussed a plan to revise one appeal policy and procedure (*HUM 33 and 33a Non Certification Appeal Process*) and retire the remaining 16 policies and procedures. CCME encouraged Sandhills to develop a comprehensive and cross departmental plan to ensure all documentation addressing appeals, such as the *Utilization Management Plan*, the *Medicaid Provider Manual*, the *Member Handbook*, Sandhills' website and appeals brochure, etc. are aligned and in compliance with the *NC Medicaid Contract*. This approach would help prevent contradiction across Sandhills' appeal documentation.

Three areas also highlighted in this year's EQR are related to missing information or misinformation within the *Medicaid Provider Manual*, *Member Handbook* and Sandhills' website. These areas were also noted in last year's EQR.

The appeal file review showed Sandhills' staff processed the appeals correctly and within the required timeframes. Within the appeal record, staff are now detailing interactions with appellants including efforts to obtain additional appeal information and oral notifications related to expedited appeals. As a result, each file reviewed clearly demonstrated the steps taken by staff in assisting appellants and processing appeals.

When additional information was submitted by appellants for appeal consideration, staff labelled this as simply "additional documentation" or "reconsideration documentation" and did not specify what was received or reviewed by the appeal Reviewers. This was discussed last year and, while documents are now specified in the Peer Reviewers' reports, documents listed on the appeal resolution notice remain ambiguous and do not assure the enrollee that all submitted information was reviewed. Therefore, this Recommendation continues again this year.

Also discussed last year was the need for analysis and trending of appeals data. This is required by *NC Medicaid Contract, Section 7.5.2* for the purpose of identifying potential quality improvement or program integrity opportunities. Sandhills' appeal data are reported to the Quality Management Committee and the Utilization Management (UM) Committee monthly. Appeal data are reported by type (disability, service type, age group, appeal level, appeal outcome, etc.) and across months, but there is no evidence of committee analysis, discussion or identification of potential improvement opportunities appeals data may offer.

The *UM/CM Plan* states appeals are analyzed "by provider" and reported to UM and Quality Management Committees. The appeals policies and procedures (*HUM 33 and HUM 40*) state the timeliness of appeals will be reviewed by committee. However, there is no evidence in UM and QM committees that either of these data elements were gathered, analyzed, or reviewed in committee.

Figure 7, Grievances and Appeals Comparative Findings indicates the scoring for Grievances and Appeals for 2019 compared to the scores received in the 2018 EQR.

Figure 7: Grievances and Appeals Comparative Findings

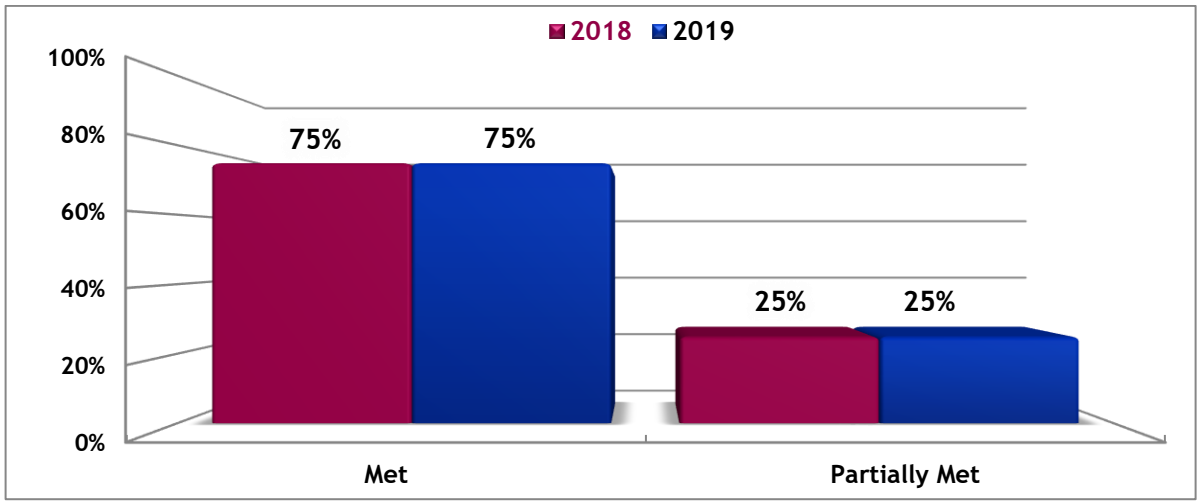


Table 26: Grievances and Appeals

Section	Standard	2019 Review
Appeals	The definitions an appeal and who may file an appeal;	Partially Met
	The procedure for filing an appeal;	Partially Met
	A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	Partially Met
	Timeliness guidelines for resolution of the appeal as specified in the contract;	Partially Met
	Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	Partially Met

Strengths

- The grievance process is documented within one policy and procedure.
- The Chief Medical Officer (CMO) is involvement in the grievance process is well documented.
- The Recommendations from the 2018 EQR were fully implemented by Sandhills.
- Within the appeal files reviewed, staff detailed interactions with appellants, including efforts to obtain additional appeal information.

Weaknesses

- Sandhills has adopted the use of the term "grievance" and has edited *Policy and Procedure CORE 35, Consumer Grievance Process-Medicaid*, to reflect the use of the single term "grievances" but three references to the term "complaint" still remain in this procedure.
- The term "complaint" is also used interchangeably with "grievance" in the *Medicaid Provider Manual*.
- In *Procedure CORE 35a, Consumer Grievance Process-Medicaid* a member is notified "within 5 working days of the receipt of the grievance". The timeframe is included in the "Low Risk Grievances" section; however, the timeframe a member is notified of the receipt of a grievance is not included in the "High Risk Grievance" section.
- Procedure *CORE 35a, Consumer Grievance Process-Medicaid*, is missing two details related to notification requirements in the, "Time Extension for all grievances", section when Sandhills extends a grievance resolution timeframe.
- The timeframe to maintain grievance records in not included within Procedure, *CORE 35a, Consumer Grievance Process-Medicaid*. Include within the procedure that grievance records are maintain for 5 years per *NC Medicaid Contract*, Attachment M.
- The review of the *Grievances Log* verified that data is available and used of basic analysis is present data of grievances reported in committee; however, the use of the data for in-depth analysis or trending is not evident in committee minutes or grievance reports.
- Appeals policies and procedures are duplicative in title yet contradicting in information. None of the 18 policies and procedures provide consistent and accurate information regarding NC Medicaid contractual requirements.
- Only one of Sandhills' 18 policies and procedures correctly states the requirement of signed consent by the enrollee or legal guardian when anyone other than the enrollee or legal guardian files an appeal.

- Sandhills' website and *Member Handbook* also do not provide clear information regarding who can file an appeal.
- Only two of Sandhills' 18 policies and procedures correctly defines an appeal.
- Only one of Sandhills' policies or procedures indicate that the first level appeal process must be exhausted prior to an appellant requesting a second level appeal at the Office of Administrative Hearings. The *Member Handbook* also does not clarify this for members.
- Only one of Sandhills' appeals procedures accurately define the allowable timeframe for filing an appeal.
- There are two sections within the *Member Handbook*; an "Appeals" section on page 102 of the manual and a "Reconsiderations/Appeals" section on page 129 of the manual. Information in these two sections differs.
- Within the appeal files reviewed, the documents submitted to the Peer Reviewer were not clearly identified on the appeal resolution notice that is sent to the enrollee. The documents are named ambiguously (e.g., "additional documentation") and do not assure the enrollee that all submitted information (e.g., "letter from physician") was reviewed and considered as a part of the Peer Reviewer's decision.
- Only one of Sandhills' policies and procedures contains the correct criteria by which expedited appeal requests should be reviewed and either accepted or denied by Sandhills.
- Sandhills' appeal policies and procedures do not provide clear information regarding the process Sandhills follows when deciding whether to accept a request to expedite an appeal.
- None of Sandhills' policies and procedures contain the requirement that Sandhills provide "prompt" oral notification when a request to expedite an appeal is denied by Sandhills.
- Sandhills added information about extending appeal timeframes to some of their policies and procedures but omitted the requirement that, when Sandhills extends the appeal timeframe, the extension has to be "to the satisfaction" of NC Medicaid.
- Sandhills is required to provide "prompt" oral notification to an enrollee when Sandhills extends the appeal resolution timeframe. This information is either missing or incorrect in all but one procedure.
- No information is available in the *Medicaid Provider Manual* that explains to providers when standard appeals are resolved and notifications are sent.
- Sandhills reports general appeal numbers to the committees by type, but there is no evidence of committee analysis, discussion or identification of potential areas of improvement.

- The *UM/CM Plan* states appeals are analyzed "by provider" and reported to UM and Quality Management Committees. The appeals policies and procedures (*HUM 33 and HUM 40*) state the timeliness of appeals will be reviewed by committee. However, there is no evidence in UM and QM committees that either of these data elements were gathered, analyzed, or reviewed in committee.

Corrective Action

- Add to all of Sandhills' policies and procedures the requirement of signed consent by the enrollee or legal guardian when anyone other than the enrollee or legal guardian files an appeal.
- Correct the Sandhills' website and *Member Handbook* to reflect that signed consent by the enrollee, when anyone other than the enrollee or legal guardian files an appeal, is required.
- Correct the definition of an appeal in all of Sandhills' policies and procedures to remove the word "administrative" from the definition.
- Add information to all of Sandhills' policies and procedures and the *Member Handbook* to indicate that the first level appeal process with Sandhills must be exhausted prior to an appellant requesting a second level appeal at the Office of Administrative Hearings.
- Add to all of Sandhills' policies or procedures that the timeframe for filing an appeal is within 60 days of the mailing date of the UM denial notification.
- Within the *Medicaid Provider Manual*, combine the two sections addressing "Appeals" and "Reconsiderations/Appeals" into one section that accurately explains Sandhills' Medicaid appeal process.
- Add the correct criteria for expedited appeals to Sandhills' policies and procedures, to include "that taking the time for a standard resolution could seriously jeopardize an Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function."
- Clarify in all of Sandhills' policies and procedures how requests for expedited appeals are processed. Include detail regarding how the decision to deny a request to expedite an appeal is made, by whom, and where consideration of expedited criteria is documented.
- Ensure appeal policies and procedures consistently state that Sandhills will provide "prompt" oral notice if Sandhills denies a request to expedite an appeal.
- Add to all of Sandhills' appeal policies and procedures that Sandhills extends appeal resolution timeframes "to the satisfaction" of NC Medicaid. Ensure staff document in the appeal record the reason the decision is in the best interest of the enrollee when Sandhills extends an appeal resolution timeframe.

- Add to all of Sandhills' appeal policies and procedures that Sandhills provides "prompt" oral notification to enrollees when Sandhills extends the appeal resolution timeframe. Ensure this is also explained in any policy or procedure that describes extensions of expedited appeals.
- Analyze appeals data to identify potential quality improvement or program integrity activities. Analysis and discussion of appeals data would be evident in committee minutes.
- Revise the *UM/CM Plan* and appeals policies and procedures to accurately and consistently describe this new appeals analysis process and the data elements that will be gathered, analyzed and discussed in committee.

Recommendations

- Ensure edits within *Procedure CORE 35a, Consumer Grievance Process-Medicaid* consistently reflects the use by Sandhills of the term "grievance".
- Ensure the use of the term "grievance" is consistent across all print materials, including *Medicaid Provider Manual*.
- Add to Procedure Core 35a that and acknowledgement of a grievance is sent "within 5 working days of the receipt of the grievance" to the "High Risk Grievances" section.
- Add the details to the extension timeframe to Procedure *CORE 35a Consumer Grievance Process-Medicaid* regarding the notification requirements when Sandhills extends the grievance resolution timeframe to include that Sandhills will make reasonable efforts to give the enrollee "prompt oral notice" of the delay and "within 2 calendars give the enrollee written notice of the reason to extend the timeframe, per *42 CFR § 438.408.*"
- Include within Procedure *CORE 35a, Consumer Grievance Process-Medicaid*, that grievance records are maintain for 5 years per *NC Medicaid Contract, Attachment M, Section B 2.*
- Maximize the use of the grievance data to include more in-depth analysis of trends and identifying potential quality improvement opportunities.
- Develop an inter departmental, comprehensive plan to bring Sandhills' appeals policies and procedures into compliance with *Attachment M* of the *NC Medicaid Contract* and in *42 CFR § 438 Subpart F*. Ensure this plan includes review and revision of any other documentation addressing appeals (such as the UM/CM Plan, Sandhills' website, appeals brochure, etc.) Retire unnecessary appeal policies and procedures.
- Ensure staff specify the documents submitted for the appeal review and include the names of the documents in the appeal resolution notification.
- Clarify in the *Medicaid Provider Manual* the timeframe by which an enrollee and/or provider can expect an appeal resolution notification for a standard appeal.

G. Delegation

CCME's External Quality Review (EQR) of the Delegation section included a review of the relevant policies and procedures, the Delegate List, the Delegation Contracts/Letters of Agreement, and the Delegation Monitoring Tools. An Onsite interview included personnel from the Sandhills Clinical Operations, Network Operations, and the External and Quality Programs Departments.

At the last EQR, there was one Corrective Action item and one Recommendation. Sandhills resolved the Corrective Action item and partially implemented CCME's Recommendation.

Sandhills reported four delegated entities, as evidenced in *Table 27, Delegated Entities*.

Table 27: Delegated Entities

Delegated Entities	Service
PREST & Associates	Peer Review
UNC Health System	Credentialing
Moses Cone Hospital	Credentialing
Cardinal Innovations	Roll-Over Calls

Several policies and procedures (*Core 6, 7, 6a, 7a Delegation Review Criteria and Review, Core 8, 8a Delegation Contracts*, and *Core 9, 9a Delegation Oversight*) direct the delegation processes. Sandhills delegates credentialing of employees at Moses Cone Hospital and UNC Health System to those organizations. *Policy N-CR17 Credentialing Delegation*, confirms "Sandhills Center retains authority to make the final credentialing determination regarding any provider."

Quarterly performance reviews and a formal annual assessment of each delegated entity are referenced in Sandhills *Procedure Core 8a, Delegation Contracts* and in *Core 9, 9a Delegation Oversight*. Sandhills submitted evidence of the quarterly reviews and annual assessment of each delegate listed in *Table 27* above.

At the last EQR, the *Delegation Checklists* for UNC Faculty/Physicians and Cone Health did not include the required query of the *State Exclusion List*. This resulted in the Recommendation to "Add the query of the *State Exclusion List* to the *Pre-Delegation*

Checklists and to monitoring tools for the annual assessment of entities to whom credentialing has been delegated, to ensure the required queries are being conducted."

Though the *State Exclusion List (SEL) query* was added to the *Annual Delegated Assessment Tool* for UNC and Moses Cone, neither organization completed the query during this EQR period. In August 2019, Sandhills communicated with both delegates about the requirement to conduct the query of the *SEL*.

The *Cardinal Innovations Annual Monitoring Review* summary was essentially a narrative of what Cardinal does, including the call standards. The summary read more like a Pre-Delegation Assessment and appears to have been copied from year to year. One sentence stated, "During our eight years of working together", and the next paragraph stated, "During the nine years Cardinal Innovations Healthcare has provided rollover call services to Sandhills Center….". It was neither dated nor signed and did not indicate the time period covered by the summary.

Sandhills submitted the *Cardinal Telephone Performance 2018-2019*, which documents Cardinal's performance by month, including call "Volume, Time to answer (seconds), Abandoned calls, and Calls answered within 30 seconds." In six of twelve months, Cardinal Innovations did not meet Performance Standards for "Call Abandonment Rate" or for "Calls Answered within 30 Seconds." Cardinal submitted a *Corrective Action Plan* for these items, and Sandhills monitors monthly reports for adherence to access standards. However, due to the extremely small number of calls answered by Cardinal, it is often difficult for them to meet the Performance Standards.

The following chart indicates Sandhills received a score of "Partially Met" for 50% of the standards during the Delegation review. The score of "Partially Met" is because neither UNC nor Moses Cone conducted the required query of the *State Exclusion List* during the credentialing/recredentialing process.

Figure 8, Provider Services Comparative Findings, provides a comparison of the 2018 scores versus the 2019 scores.

Figure 8: Delegation Comparative Findings

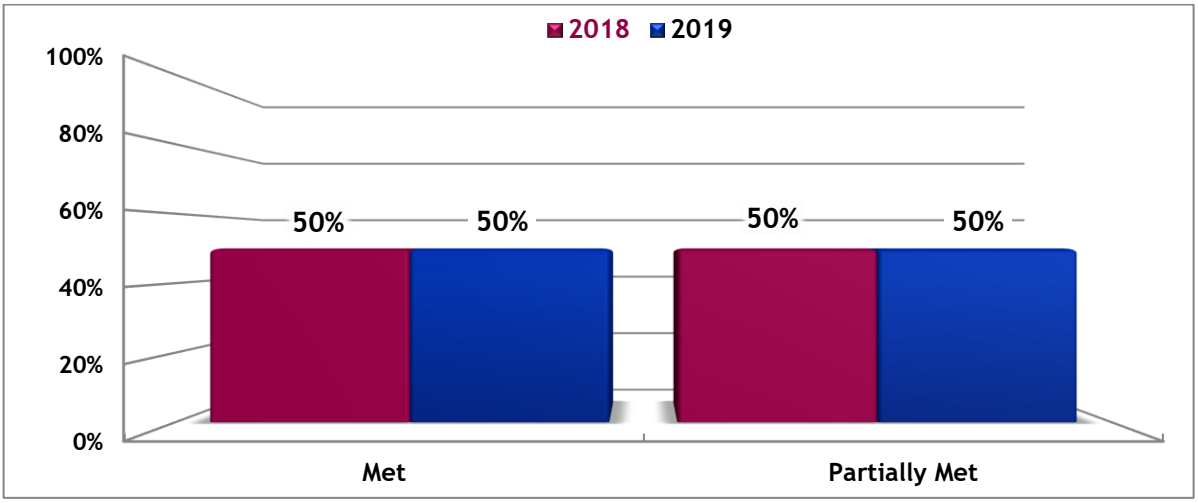


Table 28: Delegation

Section	Standard	2019 Review
Delegation	The PIHP conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the PIHP if the PIHP were directly performing the delegated functions.	Partially Met

Strengths

- Sandhills has an executed contract with its four delegates, including Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreements (BAA) with delegates with access to Protected Health Information (PHI).
- Sandhills conducted quarterly performance reviews and annual monitoring for the four delegates.
- Sandhills made and retained the changes from the one Corrective Action item from the previous EQR.

Weaknesses

- Though Sandhills added the *State Exclusion List* query to the *Annual Delegation Assessment Tool* for the Credentialing Delegates (UNC and Moses Cone), neither delegate conducted the required query of the *State Exclusion List*.
- The *Cardinal Innovations Annual Monitoring Review* summary was essentially a narrative of what Cardinal does, read like a Pre-Delegation Assessment, was neither dated nor signed, and did not indicate the time period covered by the summary.

Corrective Action

- Monitor the Credentialing Delegates to ensure they are conducting the required queries of the *State Exclusion List*.

Recommendation

- Ensure the *Annual Monitoring Summary* reports include the timeframe covered by the report, comply with procedure *CORE 9a, Delegation Oversight and Delegation Contracts*, including information about any Corrective Actions, and are signed and dated.

H. Program Integrity

A Desk Review of Sandhills policies, procedures, training materials, organizational charts, job descriptions, committee meeting minutes and reports, provider agreements, enrollment application, workflows, *Medicaid Provider Manual*, *Employee Handbook*, newsletters, conflict of interest forms and the *Compliance Plan* was implemented. Onsite interviews provided additional clarification of the Desk Review findings.

IPRO requested the universe of program integrity (PI) files from Sandhills for the April 1, 2018 through March 31, 2019 review period and from there, selected a random sample of 15 files with a two-file oversample for a total of 17 files. These files were thoroughly reviewed to ensure Sandhills investigates a credible allegation of fraud and provides NC Medicaid PI with the information required on a NC Medicaid-approved template.

The file review showed that seven of 15 files contained all of the required information. Seven of the files reviewed did not show evidence that the investigation was initiated within 10 days as required. Four investigations were not initiated within 10 days of referral and investigation initiation information could not be found in three of the files reviewed. One reviewed file did not contain the total sample amount of funds investigated per service type, as is required.

Increased monitoring of the PI files is needed to ensure required elements are captured in each PI file. It is also recommended that Sandhills develop a standardized coversheet for each file. This would help monitor PI files to ensure key elements of the investigation (e.g., timeline of actions taken, subject, provider name, Medicaid provider ID, address, provider type, source/origin of complaint, date reported to PIHP, date PIHP initiated the investigation, contact information for PIHP staff persons, an estimated or actual dollar value of funds exposed, etc.) are captured.

Discrepancies in the quality of documentation between PI files were discussed during Onsite interviews. Although Sandhills has a detailed PI Workflow, it was discussed that this workflow should be reviewed with the PI team.

Figure 9 demonstrates that Sandhills met 97% of the EQR standards.

Figure 9: Program Integrity Findings

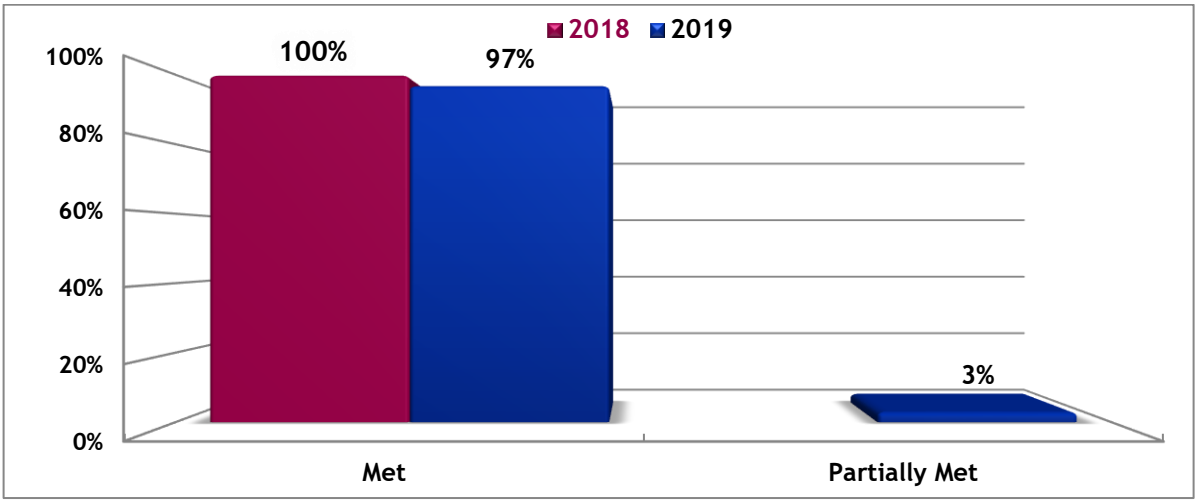


Table 29: Program Integrity

Section	Standard	2019 Review
Fraud and Abuse	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.	Partially Met
	Total Sample Amount of Funds Investigated per Service Type.	Partially Met

Strengths

- Sandhills increased PI referrals and MID acceptance rates this year.
- Sandhills reduced its backlog of open investigations (some since 2017) from 17 to 9, bringing its caseload more current.

Weaknesses

- Seven of the PI files were either not initiated within the required timeframe of 10 days from referral, or this information was not documented in the file.
- One reviewed file did not contain the total sample amount of funds investigated per service type, as is required.

- Discrepancies in the quality of documentation between PI files were identified in the case file review.

Corrective Actions

- Increase the monitoring of PI files to ensure all required elements are captured within the file documentation.

Recommendation

- Develop a standardized coversheet for each PI file to help monitor PI files and ensure key elements of the investigation (e.g., timeline of actions taken, subject, provider name, Medicaid provider ID, address, provider type, source/origin of complaint, date reported to PIHP, date PIHP initiated the investigation, contact information for PIHP staff persons, an estimated or actual dollar value of funds exposed, etc.) are captured within each file.
- Retrain PI staff on the procedures of the PI Workflow for investigating allegations of Fraud, Waste, and Abuse to address discrepancies in the quality of documentation across PI files.

I. Financial Services

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

- Financial policies and procedures
- Audited financial statements, compliance reports and footnotes dated June 30, 2018
- Balance sheet and income statements dated May 31, 2019, and June 30, 2019
- Medicaid monthly financial reports for May and June 2019
- Claims processing aging reports and claims processing procedures
- Finance Department staffing structure
- Fiscal year budget ordinance for 2018-2019
- Budget to Actual Expenses Report for Medicaid for May and June 2019
- Administrative Cost Allocation Plan FY 2019
- Medicaid risk reserve bank statements for May and June 2019

After reviewing Sandhills' Desk Materials, CCME conducted an Onsite visit and interview on August 29, 2019. In reviewing Sandhills' financial operations, CCME used a standardized EQR Finance Desk Review and Onsite administrative interview guide. CCME also reviewed deficiencies from prior EQRs to determine whether they were corrected.

In addition to the standardized Desk Review inquiries, CCME asked additional interview questions in the following areas:

- Policies and procedures development and staff communication
- Staffing changes in finance
- Accounting system and upgrade
- Risk reserve payments
- Reinvestment spending and plans

Sandhills demonstrates ongoing financial stability; however, is operating at a loss for both Medicaid and non-Medicaid activities for the current fiscal year. Sandhills' Audit Report, as of June 30, 2018, has no audit findings with an unqualified opinion, and no findings or questioned costs for the Auditor's Compliance Report for the same period. During fiscal year 2018, Sandhills' total net position decreased by $5.3 million, primarily due to major reductions in state funding, increased expenses due to community expansion projects and increased rates to enhance services.

Sandhills exceeded the contract benchmark for current ratio and Medical Loss Ratio (MLR). Sandhills' Medicaid current ratio is 6.38 with a total current ratio of 6.38 for May 2019. The Medicaid current ratio is 6.36 with a total current ratio of 6.33 for June 2019 (benchmark is 1.00). Sandhills' Medicaid year-to-date medical loss ratio (MLR) is 91.6% before Health Care Quality Indicators (HCQI) spending, and 97.7% after for May 2019. The MLR is 91.6% before HCQI, and 97.8% after for June 2019 (benchmark is 85%). Sandhills' Medicaid total assets on May 31, 2019 are $137,531,222 and overall total assets are $153,888,393. As of June 30, 2019, Medicaid total assets are $136,379,350 and total assets are $151,232,029.

Sandhills is compliant with *42 CFR § 433.32(a)* for maintaining an appropriate accounting system (Great Plains). Sandhills uses the following Great Plains modules: general ledger, accounts payable, fixed assets, purchasing, payroll, timekeeping, human resources and cash management. Sandhills is currently using version 2018. They use AlphaMCS for claims processing.

Sandhills met the ten-year record retention standard required by the *NC Medicaid Contract*. It retains financial records for a minimum of ten years in their physical storage rental unit. Medical records are stored in Charlotte. Within the Great Plains financial accounting system, records are not purged and remain accessible. Sandhills keeps records longer if any unresolved audit findings exist. Sandhills' *Maintenance of Financial Records 32a* procedure addresses compliance with Medicaid requirements for record retention for all financial records, and this policy had been updated to reflect the ten-year retention required by *NC Medicaid Contract, Section 8.3.2*.

Sandhills reviews and updates, if necessary, all policies and procedures annually. All finance policies and procedures CCME reviewed reflect an annual review date of February 2019. Sandhills has adequate policies and procedures documenting its Medicaid procedures. CCME recommends enhancing the procedures to cite *NC Medicaid Contract* and/or federal regulation requirements. Additionally, CCME recommends that *Procedure 400-09, Financial Risk Management* be modified to add the five-business day deadline.

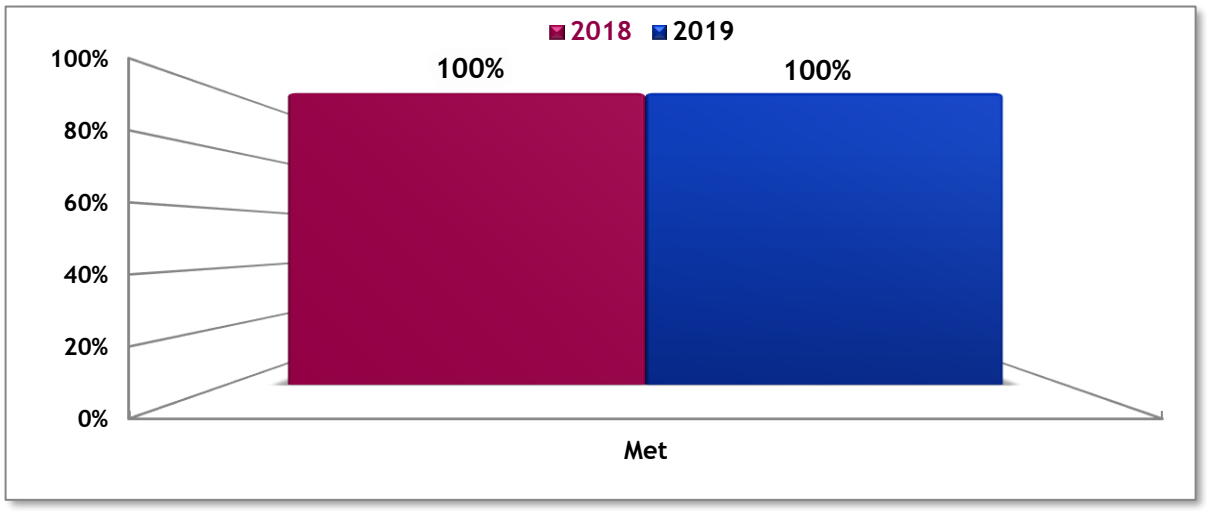
Sandhills' *Cost Allocation Plan* meets the requirements for allocating the administrative costs between federal, state, and local based on revenue as required by *42 CFR § 433.34*. Sandhills had no disallowed costs per the audit report and Onsite interview. Annually, Sandhills submits a cost allocation plan to Medicaid to determine the percentage of Medicaid's share of administrative costs. Currently this percentage is 87.5%. The administrative expenses are recorded by expense type in the general ledger and are then allocated to the different funding sources based on a percentage of total revenues received (except county funding). Medicaid funds are properly segregated through the chart of accounts in the Great Plains general ledger.

Sandhills' Medicaid Risk Reserve account meets the minimum requirement of 2% of the capitation payment per month required by *NC Medicaid Contract, Section 1.9*. Sandhills reached 13.2% of its required percentage of annualized capitation maximum (15%) as of June 30, 2019, with a balance of $35,510,378. Once Sandhills receives the capitation payment, the Accounting Manager calculates the risk reserve payment and the pays the risk reserve contribution to the risk reserve account at First Bank within five business days by check. All deposits were made timely, and CCME did not find any unauthorized withdrawals. Sandhills provided CCME with bank statements demonstrating the risk reserve deposit and balance.

Sandhills is compliant with *42 CFR § 438.8* and *NC Medicaid Contract* standard of meeting or exceeding 85% of the Medical Loss Ratio (MLR) ratio. Sandhills' staff indicated in the Onsite interview that their MLR ratio ranged from 97% to 118%, and that they had no issues meeting the 85%.

Sandhills met all standards in the Financial Services area as indicated in *Figure 10*.

Figure 10: Financial Services Comparative Findings



Strengths

- Sandhills is properly segregating Medicaid funding from non-Medicaid funding.
- All claims in the Claims Aging Report were between one and 30 days.

Weaknesses

- Not all policies and procedures detail who is responsible for duties, *NC Medicaid Contract* requirements, or contractual reporting due dates.

Recommendations

- Enhance policies and procedures by adding details about who is responsible for duties and citing contract requirements.
- Add to procedures *14b Financial Reports to the DHB* and *32b, Financial Reports Certification* the due dates of monthly reports to NC Medicaid (i.e. the 20th of each month).

J. Encounter Data Validation

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

The scope of our review, guided by the Centers for Medicaid and Medicare Services (CMS) Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid by Sandhills for the period of January 2018 through

December 2018. All claims paid by Sandhills should be submitted and accepted as a valid encounter to NC Medicaid. Our approach to the review included:

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

Results and Recommendations

Issue: Other Diagnosis

Other Diagnosis was only populated 6% of the time for Institutional and Professional claims. Principal and admitting diagnosis was populated consistently where appropriate, however, no more than one additional diagnosis was received for any claim. This issue was present in the 2017 review. Sandhills should be capturing up to the maximum allowed.

Resolution:

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

Conclusion

Based on the analysis of Sandhills' encounter data, we have concluded that the data submitted to NC Medicaid is complete and accurate as defined by NC Medicaid standards.

Their biggest issue was noted with the number of diagnosis codes being reported to NC Medicaid for both Professional and Institutional claims. Although the additional diagnosis codes do not impact adjudication, the codes are key for reporting, evaluating member health, and factors that will be used in a value based payment model. Sandhills should review and revise their 837 mapping immediately.

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

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

The Carolinas Center *for* Medical Excellence
12040 Regency Parkway, Suite 100, Cary, NC 27518-8597 • 919.461.5500 • 800.682.2650 • www.thecarolinascenter.org

July 9, 2019

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 2019 External Quality Review (EQR) of Sandhills Center is being initiated. The review will be conducted by us, The Carolinas Center for Medical Excellence (CCME), and is a contractual requirement. The review will include both a Desk Review (at CCME) and a two-day Onsite visit at Sandhills Center's office in West End, NC that will address all contractually required services.

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

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

CCME's review team plans to conduct the Onsite visit at Sandhills Center on **August 28, 2019** through **August 29, 2019**. For your convenience, a tentative agenda for the two-day review is enclosed.

In preparation for the Desk Review, the items on the enclosed Desk Materials List are to be submitted electronically, and are due no later than **July 31, 2019**. As indicated in item 40 of the review list, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted by the aforementioned deadline.

Further, as indicated on item 42 of the list, Encounter Data Validation (EDV) will also be part of this review. Our subcontractor, Health Management Systems (HMS) will be evaluating this component. Please read the documentation requirements for this section carefully and make note of the submission instructions as they differ from the other requested materials.

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

The location for the file transfer site is:

https://eqro.thecarolinascenter.org

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

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

An opportunity for a pre-Onsite conference call with your management staff, in conjunction with 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
EQR Project Manager

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

External Quality Review 2019

MATERIALS REQUESTED FOR DESK REVIEW

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. *(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/temporary staff. Further, please indicate staffing structure for Transitions Community Living Initiative (TCLI) program.

3. Current Medical Director and Medical Staff job descriptions.

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

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

6. A summary of the status of all best practice Recommendations and Corrective Action items from the previous External Quality Review.

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

8. List of new services added to the provider network in the past 12 months (July 2018 through June 2019) by provider.

9. Network turnover rate for the past 12 months (July 2018 through June 2019) including a list of providers that were terminated for cause and list of providers that did not have their contracts renewed. For five providers termed in the last 12 months (July 2018 through June 2019), who were providing service to enrollees at the time of the termination notice, submit the termination letter sent to or from the provider, and the notification (of provider termination) letters sent to three consumers who were seeing the provider at the time of the provider termination notice.

10. List of providers credentialed/recredentialed in the last 12 months (July 2018 through June 2019). Include the date of approval of initial credentialing and the date of approval of recredentialing.

11. A current provider manual and provider directory.

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

13. The Quality Improvement work plans for 2018 and 2019.

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

15. Minutes of committee meetings for the months of July 2018 through June 2019 for all committees reviewing or taking action on enrollee-related activities. For example, quality committees, quality subcommittees, credentialing committees, compliance committee, etc.

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

16. 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.

17. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

18. Copies of the most recent provider profiling activities conducted to measure contracted provider performance (for example, provider report cards, dashboards, etc.).

19. A copy of staff handbooks/training manuals, orientation and educational materials, and scripts used by Call Center personnel, if applicable.

20. A copy of the enrollee handbook and any statement of the enrollee bill of rights and responsibilities if not included in the handbook.

21. A copy of any enrollee and provider newsletters, educational materials and/or other mailings, including the packet of materials sent to new enrollees and the materials sent to enrollees annually.

22. A copy of the complete Appeal log for the months of July 2018 through June 2019. Please indicate on the log appeal type (standard or expedited), the service appealed, the date the appeal was received, the resolution date, and if the resolution timeframe was extended, who requested the extension. Also include on the log those appeals that were withdrawn or deemed invalid.

23. A copy of the complete Grievances log for the months of July 2018 through June 2019. Please indicate on the log the nature of the grievance, the date received, and the date resolved. If the grievance resolution timeframe was extended, please include who requested the extension.

24. Copies of all letter templates used for Utilization Management, Grievances, and Appeals. This includes all acknowledgement, adverse benefit determination, resolution, extension, invalid, expedited, etc. notifications.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal PIHP compliance with these standards.

26. Clinical Practice Guidelines developed for use by practitioners, including references used in their development, when they were last updated and how they are disseminated. Also, policies and procedures for researching, selecting, adopting, reviewing, updating, and disseminating practice guidelines. Results of the most recent monitoring of provider compliance with Clinical Practices Guidelines.

27. All information supplied at orientation to new providers, including, for example, the Welcome letter and any orientation materials. If the new provider orientation is provided via the PIHP website, provide a link to the location of the orientation materials. Please also provide the location of ongoing provider training materials and/or calendar of training events.

28. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the PIHP, and any reports of activities submitted by the subcontractor to the PIHP. Include pre-delegation assessments conducted for any delegates added/contracted during the timeframe covered by the current EQR.

29. Contracts and relevant amendments for all delegated entities, including Business Associate Agreements for delegates handling PHI.

30. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used. Include annual evaluations, if applicable, and indicate to which committees delegate monitoring is reported.

31. Please provide an excel spreadsheet with a list of enrollees that have been placed in care coordination since April 2016. Please indicate the disability type (MH/SU, I/DD).

32. Please provide an excel spreadsheet with a list of enrollees that have been placed in the TCLI program since April 2016. Please indicate on that list the individuals transitioned to the community, the individuals currently receiving Care Coordination, the individuals connected to services and list the services they are receiving, the individuals choosing to remain in ACH and the services they are receiving.

33. Information regarding the following selected Performance Measures:

1. 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
2. C WAIVER MEASURES	
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals
Proportion of beneficiaries reporting they have a choice between providers.	Proportion of Individual Support Plans that address identified health and safety risk factors
Percentage of level 2 and 3 incidents reported within required timeframes.	Percentage of participants reporting that their Individual Support Plan has the services that they need
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.	Percentage of beneficiaries who received appropriate medication.
Percentage of medication errors resulting in medical treatment.	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.

34. 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.)

35. Summary description of quality oversight of the Transition to Community Living Initiative, including monitoring activities, performance metrics, and results.

36. Data, Dashboards and/or reports for the Transition to Community Living Initiative (e.g., numbers of in-reach completed, housing slots filled, completed transitions, numbers of enrollees in supported employment, numbers of enrollees receiving ACT, Supported Employment, Peer Support Services, Community Support Team, Psychosocial Rehabilitation, etc. for the period July 2018 through June 2019.

37. Call performance statistics for the period of July 2018 through June 2019, including average speed of answer, abandoned calls, and average call/handle time for customer service representatives (CSRs).

38. Provide copies of the following files:

    a. Credentialing files for the 12 most recently credentialed practitioners (should include 6 licensed practitioners who work at agencies and 6 Licensed Independent Practitioners; include at least two physicians). Please also include 4 files for network provider agencies and/or hospitals and/or psychiatric facilities, in any combination.
    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, the 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.

b. Recredentialing files for the 12 most recently recredentialed practitioners (should include 6 licensed practitioners who work at agencies and 6 Licensed Independent Practitioners, include the files of at least two MDs). Also, please include 4 files of network provider agencies and/or hospitals and/or psychiatric facilities, in any combination.
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, the 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.

c. Ten MH/SU, ten I/DD and five TCLI files medical necessity approvals made from July 2018 through June 2019, including any medical information and approval criteria used in the decision. Please select MEDICAID ONLY files and submit the entire file.

d. Ten MH/SU, ten I/DD and five TCLI files medical necessity denial files for any denial decisions made from July 2018 through June 2019. Include any medical information and physician review documentations used in making the denial determination. Please include all correspondence or notifications sent to

providers and enrollees. Please select MEDICAID ONLY files and submit the entire file.

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

39. Provide the following for Program Integrity:
    a. File Review: Please produce a listing of all active files during the review period (July 2018 through June 2019) including:
        i. Date case opened
        ii. Source of referral
        iii. Category of case (enrollee, provider, subcontractor)
        iv. Current status of the case (opened, closed)
    b. Program Integrity Plan and/or Compliance Plan.
    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.
    e. All 'Attachment Y' reports collected during the review period.
    f. 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

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

a. A completed ISCA.

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

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

c. A copy of the IT Disaster Recovery Plan.

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

41. Provide the following for Financial Reporting:
    a. Most recent annual audited financial statements.
    b. Most recent annual compliance report
    c. Most recent two months' State-required NC Medicaid financial reports.
    d. Most recent two months' balance sheets and income statements including associated balance sheet and income statement reconciliations.
    e. Most recent months' capitation/revenue reconciliations.
    f. Most recent reconciliation of claims processing system, general ledger, and the reports data warehouse. Provide full year reconciliation if completed.
    g. Most recent incurred but not reported claims medical expense and liability estimation. Include the process, work papers, and any supporting schedules.
    h. Any other most recent month-end financial/operational management reports used by PIHP to monitor its business. Most recent two months' claims aging reports.
    i. Most recent two months' receivable/payable balances by provider. Include a detailed list of all receivables/payables that ties to the two monthly balance sheets.
    j. Any P&Ps for finance that were changed during the review period.
    k. PIHP approved annual budget for fiscal year in review.
    l. P&Ps regarding program integrity (fraud, waste, and abuse) including a copy of PIHP's compliance plan and work plan for the last twelve months.
    m. Copy of the last two program integrity reports sent to NC Medicaid's Program Integrity Department.
    n. An Excel spreadsheet listing all of the internal and external fraud, waste, and abuse referrals, referral agent, case activity, case status, case outcome (such as provider education, termination, recoupment and recoupment amount, recoupment reason) for the last twelve months.
    o. A copy of PIHP's Special Investigation Unit or Program Integrity Unit Organization chart, each staff member's role, and each staff member's credentials.
    p. List of the internal and external program integrity trainings delivered by PIHP in the past year.
    q. Description and procedures used to allocate direct and overhead expenses to Medicaid and State funded programs, if changed during the review period.
    r. Claims still pending after 30 days.
    s. Bank statements for the restricted reserve account for the most recent two months.
    t. A copy of the most recent administrative cost allocation plan.
    u. A copy of the PIHP's accounting manual.
    v. A copy of the PIHP's general ledger chart of accounts.
    w. Any finance Corrective Action Plan

x. Detailed medical loss ratio calculation, including the following requirements under *42 CFR § 438.8*:
    i. Total incurred claims
    ii. Expenditures on quality improvement activities
    iii. Expenditures related to PI requirements under §438.608
    iv. Non-claims costs
    v. Premium revenue
    vi. Federal, state and local taxes, and licensing and regulatory fees
    vii. Methodology for allocation of expenditures
    viii. Any credibility adjustment applied
    ix. The calculated MLR
    x. Any remittance owed to State, if applicable
    xi. A comparison of the information reported with the audited financial report required under §438.3 (m)
    xii. The number of member months
y. A copy of the PIHP's annual MLR report.

42. Provide the following for Encounter Data Validation (EDV):
    a. Include all adjudicated claims (paid and denied) from January 1, 2018 through December 31, 2018. 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, 2018 through December 31, 2018. 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 Nathan Burgess of HMS at (919) 714-8476.

B. Attachment 2: Materials Requested for Onsite Review

Sandhills

External Quality Review 2019

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were uploaded. Please upload into folder 15.

2. Documentation of Medical Director approval (at the time of the approval- not obtained now) of all "clean" credentialing and recredentialing files submitted in Desk Materials. Examples of evidence are a form showing applicants' information with the Medical Director's dated signature giving approval, or a dated email sent from the Medical Director. Please upload into folder 38 (into appropriate subfolder for Credentialing or Recredentialing).

3. Annual (delegated credentialing) monitoring completed in 2019 for Moses Cone Hospital. Please upload into folder 30.

4. Associate Medical Director's job description.

5. Clinical Leadership meeting minutes for June 11, 2019 meeting into folder 15 (subfolder CLC Minutes 2019 06).

6. Complete List of retired policies and procedures in folder 1.

Please upload to the aforementioned folders using this link :

https://eqro.thecarolinascenter.org

Also, please title documents and folder within a minimum of 20 letters/characters to allow for easy transmission.

C. Attachment 3: EQR Validation Worksheets

- MH/SU (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 Individual Support Plans in which the services and supports reflect participant assessed needs and life goals
    - Proportion of Individual Support Plans that address identified health and safety risk factors
    - Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need
    - 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
    - Number and Percentage of deaths where required PIHP follow-up interventions were completed as required
    - Percentage of medication errors resulting in medical treatment
    - 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
    - Maximizing the Benefit of Child Mental Health Residential Level III
    - Shaping the Network to Improve Provider Choice and Ensure Members Access to Quality Services
    - Access to Routine Behavioral Health Assessments
    - Transition to Community Living Transition Days

CCME EQR PM Validation Worksheet

PIHP Name:	**SANDHILLS CENTER**
Name of PM:	**READMISSION RATES FOR MENTAL HEALTH**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	08/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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**	Complete documentation for calculations was in place.

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**	Data sources used to calculate denominator values are complete.
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 the performance measure denominator adhered to all 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**	Data sources used to calculate the numerator are complete.
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 the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**SANDHILLS CENTER**
Name of PM:	**READMISSION RATES FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	08/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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**	Complete documentation for calculation was in place.

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**	Data sources used to calculate denominator values are complete.
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 the performance measure denominator adhered to all 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**	Data sources used to calculate the numerator are complete.
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 the performance measure numerator adhered to all numerator specifications.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**SANDHILLS CENTER**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	08/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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**	Complete documentation for calculations was in place.

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**	Data sources used to calculate denominator values are complete.
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 the performance measure denominator adhered to all 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**	Data sources used to calculate the numerator are complete.
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 the performance measure numerator adhered to all numerator specifications.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**SANDHILLS CENTER**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	08/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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**	Complete documentation for calculations was in place.

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**	Data sources used to calculate denominator values are complete.
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 the performance measure denominator adhered to all 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**	Data sources used to calculate the numerator are complete.
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N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**SANDHILLS CENTER**
Name of PM:	**INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	08/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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**	Complete documentation for calculations was in place.

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**	Data sources used to calculate denominator values are complete.
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 the performance measure denominator adhered to all 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**	Data sources used to calculate the numerator are complete.
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 the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**SANDHILLS CENTER**
Name of PM:	**MENTAL HEALTH UTILIZATION- INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	08/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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**	Complete documentation for calculations was in place.

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**	Data sources used to calculate denominator values are complete.
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 the performance measure denominator adhered to all 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**	Data sources used to calculate the numerator are complete.
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 the performance measure numerator adhered to all numerator specifications.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**SANDHILLS CENTER**
Name of PM:	**MENTAL HEALTH UTILIZATION**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	08/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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**	Complete documentation for calculations was in place.

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**	Data sources used to calculate denominator values are complete.
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 the performance measure denominator adhered to all 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**	Data sources used to calculate the numerator are complete.
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 the performance measure numerator adhered to all numerator specifications.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**SANDHILLS CENTER**
Name of PM:	**IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	08/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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**	Complete documentation for calculations was in place.

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**	Data sources used to calculate denominator values are complete.
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 the performance measure denominator adhered to all 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**	Data sources used to calculate the numerator are complete.
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 the performance measure numerator adhered to all numerator specifications.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**SANDHILLS CENTER**
Name of PM:	**SUBSTANCE ABUSE PENETRATION RATE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	08/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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**	Complete documentation for calculations was in place.

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**	Data sources used to calculate denominator values are complete.
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 the performance measure denominator adhered to all 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**	Data sources used to calculate the numerator are complete.
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 the performance measure numerator adhered to all numerator specifications.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**SANDHILLS CENTER**
Name of PM:	**MENTAL HEALTH PENETRATION RATE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	08/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Specifications Guide

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**	Complete documentation for calculations was in place.

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**	Data sources used to calculate denominator values are complete.
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 the performance measure denominator adhered to all 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**	Data sources used to calculate the numerator are complete.
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 the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

PIHP Name	**SANDHILLS CENTER**
Name of PM	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals.
Reporting Year	2017-2018
Review Performed	08/19

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N6. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N7. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate is in SHC_C Waiver Excel file
R4. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**SANDHILLS CENTER**
Name of PM	Proportion of Individual Support Plans that address identified health and safety risk factors
Reporting Year	2017-2018
Review Performed	08/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**SANDHILLS CENTER**
Name of PM	Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need.
Reporting Year	2017-2018
Review Performed	08/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**SANDHILLS CENTER**
Name of PM	Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available
Reporting Year	2017-2018
Review Performed	08/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**SANDHILLS CENTER**
Name of PM	Proportion of beneficiaries reporting they have a choice between providers
Reporting Year	2017-2018
Review Performed	08/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**SANDHILLS CENTER**
Name of PM	Percentage of level 2 and 3 incidents reported within required timeframes
Reporting Year	2017-2018
Review Performed	08/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**SANDHILLS CENTER**
Name of PM	Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.
Reporting Year	2017-2018
Review Performed	08/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**SANDHILLS CENTER**
Name of PM	Percentage of medication errors resulting in medical treatment
Reporting Year	2017-2018
Review Performed	08/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**SANDHILLS CENTER**
Name of PM	Percentage of beneficiaries who received appropriate medication
Reporting Year	2017-2018
Review Performed	08/19

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
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REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate is in SHC_C Waiver Excel file
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**SANDHILLS CENTER**
Name of PM	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required
Reporting Year	2017-2018
Review Performed	08/19

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

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

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

VALIDATION SUMMARY

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

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

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

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

AVERAGE VALIDATION PERCENTAGE & AUDIT DESIGNATION
100% FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

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

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and computed as a percentage.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	The rate dropped in the most recent remeasurement to below 15% goal.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses were conducted quarterly.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results and findings are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Analysis identified initial and repeat measurements.

Component / Standard (Total Points)	Score	Comments
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Conclusions and recommendations based on findings were included in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	The rate was steady for a few quarters, and finally decreased substantially in the last quarter's measurement.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement appears to be result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not calculated as sampling is not being utilized.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	90
Project Possible Score	90
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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 CENTER**
Name of PIP:	**SHAPING THE NETWORK - NON-CLINICAL**
Reporting Year:	2018
Review Performed:	2019

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Network Management observed a trend which showed a growing increase in the number of Medicaid providers who never provided services in the SHC Network.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	Sandhills addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Not Met**	Research question is stated on page 2 but does not include a goal number or statement about types of interventions. **Corrective Action: Reformulate study question to include the goal number and types of interventions that will be implemented to shape the network and decrease inactive providers.**
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is defined in measurable goal section.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of	**Met**	Measures are related to processes of care.

Component / Standard (Total Points)	Score	Comments
care with strong associations with improved outcomes? **(1)**		
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified (paid claims and provider data from SHC MC system)
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel involved in study are listed on page 2 in data collection section.

Component / Standard (Total Points)	Score	Comments
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions have been initiated based on results and issues with database.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses were conducted quarterly.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results and findings are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Analysis identified initial and repeat measurements.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Conclusions and recommendations based on findings were included in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	The rate has achieved goal of 57 or less in the last 4 quarters.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement appears to be a result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses were not required.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge; sustainability will be met if 3 consecutive quarterly rates are above goal.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	80
Project Possible Score	90
Validation Findings	89%

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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 CENTER**
Name of PIP:	**ACCESS TO ROUTINE BEHAVIORAL HEALTH ASSESSMENTS IN A TIMELY AND APPROPRIATE MANNER- NON-CLINICAL**
Reporting Year:	2018
Review Performed:	2019

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	60% of providers did not meet access standard for routine appointments.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	Sandhills addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is stated on page 2 in "Focus of Project" section.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is defined in measurable goal section.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.

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

Component / Standard (Total Points)	Score	Comments
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Analysis identified initial and repeat measurements.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Conclusions and recommendations based on findings were included in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	The rate has been above goal of 60% for the last two quarters (3rd and 4th Quarter FY 18-19).
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement appears to be a result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Not Met**	Statistical analyses were not conducted. **Corrective Action: Because sampling is utilized, a statistical test (z test or Fisher's exact) should be conducted and reported.**
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge; sustainability will be met if 3 consecutive quarterly rates are above goal.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	105
Project Possible Score	111
Validation Findings	95%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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 CENTER**
Name of PIP:	**TCLI- TRANSITION DAYS NON-CLINCAL**
Reporting Year:	2017
Review Performed:	2018

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

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

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

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

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

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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

CCME PIHP Data Collection Tool

PIHP Name:	Sandhills
Collection Date:	2019

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A. General Approach to Policies and Procedures						
1. The PIHP has in place policies and procedures that impact the quality of care provided to Enrollees, both directly and indirectly.	X					It was recommended by CCME in the previous year's EQR that Sandhills streamline their policy and procedure set, as many of the policies and procedures overlap and/or contradict one another. It is also evident that a large number of policies and procedures are no longer relevant to Sandhills' functions. Sandhills did not follow this Recommendation and, instead, added another 4 policies and 3 procedures to their set in the past year. Per staff, approximately 25 policies and procedures have been retired in the past 3 years, yet Sandhills has added almost double that number of policies and procedures during that same timeframe. Sandhills' only procedure governing the management of policies and procedures, *Policy and Procedure Core 3, Policy and Procedure Maintenance, Review and Approval*, does not describe a policy and procedure termination or retirement process. ***Recommendation: Develop an interdepartmental, vigorous and active process for retiring Sandhills' policies and procedures that are no longer relevant to Sandhills' functions. Describe in detail this process for retiring policies and procedures in Policy and Procedure Core 3, Policy and Procedure Maintenance Review Approval.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. B. Organizational Chart / Staffing						
1. The PIHP's resources are sufficient to ensure that all health care products and services required by the State of North Carolina are provided to enrollees. At a minimum, this includes designated staff performing in the following roles:						Sandhills Organizational Chart and Onsite discussion demonstrated all departments are adequately staffed to perform essential PIHP functions.
1.1 A full time administrator of day-to-day business activities;	X					Victoria Whitt continues in her role as Sandhills' Chief Executive Officer.
1.2 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities.	X					Dr. Anthony Carraway serves as Chief Clinical Officer/Medical Director (CCO). In the past year, Dr. Carraway's job description was updated to more accurately reflect his current duties and oversight. This was a recommendation in the previous year's EQR as some NC Medicaid contractual obligations of the Medical Director were not present in his job description. Dr. Kenneth Marks continues in his role as a part-time Associate Medical Director (AMD) and his availability to Sandhills has increased since the retirement of the previous AMD. During the Onsite, his responsibilities were described and these functions aligned with the written description of his "responsibilities and duties". He is only denoted on the Organizational Chart as reporting to Dr. Carraway despite departmental responsibilities such as, TCLI support and involvement in quality of care and UM functions. ***Recommendation: Denote on the Organizational Chart Dr. Marks' routine departmental involvement to better show this medical support of Sandhills' functions.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Operational relationships of PIHP staff are clearly delineated.	X					The Organization Chart demonstrates departmental staffing, lines of authority, and staff reporting structures.
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all PIHP staff positions, including those that are required by NC Medicaid.	X					Sandhills' staff meet required educational, licensure and training requirements outlined in the *NC Medicaid Contract, Section 6.7.6* per the information provided in job descriptions and confirmed during Onsite interviews.
I. C. Confidentiality						
1. The PIHP formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Sandhills has in excess of 40 confidentiality policies and procedures that sufficiently address state and federal regulations regarding health and information privacy requirements.
2. The PIHP provides HIPAA/confidentiality training to new employees and existing staff.	X					*Policy and Procedure Core 27, Staff Training Program* explains that new staff are trained in confidentiality specific to their new position within the first 2 days of employment. Additional training to new staff is provided during the new employee orientation that is completed within the new staff's first month of employment.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I D. Management Information Systems						
1. Enrollment Systems						
1.1 The PIHP capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Sandhills has standard processes in place for enrollment data updates. WellSky uploads the daily and quarterly GEF files to the AlphaMCS enrollment system. Sandhills uses the monthly 820 capitation file to reconcile the payment received each month to the GEF to determine if any payments were missing or if overpayments were received. Demographic data is captured in the AlphaMCS system and patient IDs are unique to members. Historical enrollment information is captured and maintained for all members.
1.2 The PIHP is able to identify and review any errors identified during, or as a result, of the State enrollment file load process.	X					WellSky produces exception reports and notifies Sandhills if any errors are encountered during the GEF data load process. During the Onsite, Sandhills indicated that no errors have been encountered to date.
1.3 The PIHP's enrollment system member screens store and track enrollment and demographic information.	X					During the Onsite, Sandhills demonstrated the AlphaMCS enrollment screens and their capability to store the demographic information. All historical data for members is stored and merged under one member ID.
2. Claims System						
2.1 The PIHP processes provider claims in an accurate and timely fashion.	X					The majority of claims received are electronic or through the provider web portal. Very few claims are received via paper. Approximately, 87.15% of Institutional and 99.76% of Professional claims are auto-adjudicated. Auto-adjudication is performed daily.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Claims in excess of $5,000, emergency department (ED) claims, and Professional ED claims with a point of service for emergency room are pended for manual review. Manual review of claims are performed daily.
2.2 The PIHP has processes and procedures in place to monitor, review and audit claims staff.	X					Sandhills has processes in place to monitor and audit claims staff. Sandhills audits a random sample of 3% of all claims processed in a one week period weekly. Sandhills conducts weekly and monthly audits on claims processed. Paid and denied claims with the top 5 billed amounts and paper claims are audited for accuracy.
2.3 The PIHP has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 diagnosis codes received on an 837 Institutional and 837 Professional file. The PIHP has the capability of receiving and storing ICD-10 procedure codes on an 837 Institutional file.	X					Onsite review of the AlphaMCS claims system shows compliance with this listed element. ICD-10 Procedure codes, revenue codes and Diagnosis-related group (DRG) codes are captured in the AlphaMCS system. The revenue codes and DRG are also included for encounter data submission reporting. Up to 25 diagnosis codes are captured for Institutional claims received via the web portal and up to 29 diagnosis codes can be captured on Institutional claims received electronically. For Professional encounters, up to 12 diagnosis codes are captured electronically and via the web portal. Capture of additional diagnosis codes on Institutional encounters satisfies the requirement of the prior audit's *Corrective Action Plan*.
2.4 The PIHP's claim system screens store and track claim information and claim adjudication/payment information.	X					Onsite review of the claim system screens identified the capture of adjudication/payment information for the claims.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Reporting						
3.1 The PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.		X				Sandhills captures all required diagnosis codes and is capable of capturing additional Procedure, DRG and revenue codes that are submitted on the claims. Currently, Sandhills does not store and use the ICD-10 Procedure codes for reporting. During the Onsite, Sandhills indicated that they are working with WellSky to store and use the ICD-10 Procedure codes for reporting. Historical data is stored in the AlphaMCS system from the inception of Sandhills. ***Corrective Action: Update Sandhills' system and reporting database to be able to store and report on the ICD-10 Procedure codes.***
3.2 The PIHP has processes in place to back up the enrollment and claims data repositories.	X					Sandhills has processes in place that backup the enrollment and claims data in the AlphaMCS system nightly. A disaster recovery policy and procedure was provided along with the *ISCA tool*.
4. Encounter Data Submission						
4.1 The PIHP has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.		X				Sandhills captures all required secondary diagnosis codes for Professional encounters, and has partially addressed last year's Corrective Action item. Sandhills should update their encounter data submission process to submit all ICD-10 secondary diagnosis codes captured in the AlphaMCS from an Institutional claim to be submitted to NCTracks. 25 ICD-10-CM diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837I and the maximum number that is captured by NCTracks.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Sandhills indicated that they are working with WellSky to update their submission process to submit all diagnosis codes. ICD-10 Procedure codes are captured in the AlphaMCS system but are not included for encounter data submissions. During the Onsite, Sandhills indicated that they are working with WellSky to update their system to start submitting the ICD-10 Procedure codes. Sandhills includes Procedure codes for certain lab, drug or radiology services on encounter data submissions. ***Corrective Action: Update Sandhills' encounter data submission process to be able to submit all ICD-10 diagnosis codes present on an 837I.*** ***Update Sandhills' encounter data submission process to be able to submit ICD-10 Procedure codes present on an 837I.***
4.2 The PIHP has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					Sandhills has created an encounter reconciliation database that uses 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.
4.3 PIHP 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.
4.4 The PIHP has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to NC Medicaid.	X					Communications are established between IT and Claims Departments to address NCTracks encounter denials. The encounter data process has improved significantly over the years, and staff is able to speak to encounter data submissions and reconciliation process. Staff is well informed and is dedicated to improving encounter data submissions and reducing the number of denials.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II. A. Credentialing and Recredentialing						
1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					Several policies and procedures address the credentialing and recredentialing processes. *Procedure N-CR 1a-19a, N-NM 3a* is identified as the *Provider Credentialing Plan.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	X					*Section N-CR3, Credentialing Committee*, of the *Provider Credentialing Plan* defines "clean" and "unclean" applications. Approval of "clean" credentialing and recredentialing applications is delegated by the Clinical Advisory Committee (CAC) to the Chief Clinical Officer (CCO), who is responsible for oversight of clinical aspects of the Credentialing/Re-credentialing Program. The lists of CCO-approved "clean" applications are sent via email to CAC members for review. The Credentialing Subcommittee (CS) of the CAC is chaired by the CCO/Medical Director. Per section N-CR 3a of the *Provider Credentialing Plan*, CS meetings are "typically held monthly by conference call or via email", and "votes may be submitted by email…by those subcommittee members who are present at the meeting." Sandhills staff are nonvoting members of the committee, with the exception that the CCO votes in the event of a tied vote. The CS Committee Meeting Notes indicate which members are "voting" members, which members are present, which member(s) made specific motions, and which members cast votes at specific meetings. The meeting notes contain evidence of the CS discussion and decision-making. *NC Medicaid Contract, Attachment B, Section 7.7.3,* allows PIHPs to accept credentialing conducted by hospitals for their providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Sandhills has delegated credentialing to the UNC Hospital System and to Cone Health. *Policy N-CR17, Credentialing Delegation,* confirms Sandhills "retains authority to make the final credentialing determination regarding any provider."
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					*Procedure NCR 1a-19a, NM 3a Provider Cred Plan*, states, "Licensed Practitioners who do not employ any staff shall not be required to obtain Worker's Compensation or Employer's Liability insurance." The procedure also states, "CONTRACTOR with three (3) or more employees shall secure Worker's Compensation and Occupational Disease Insurance" and "Employer's Liability Insurance". The procedure does not address how Sandhills will verify whether practitioners have three or more employees. Credentialing files are well-organized and contain appropriate information. Issues identified with some files are detailed in the standards that follow. ***Recommendation: Revise Procedure NCR 1a-19a, NM 3a Provider Cred Plan, and any other documents that include the credentialing process, to address how Sandhills will verify whether practitioners have three or more employees (and, therefore, need to provide proof of Worker's Compensation or Employer's Liability insurance (WC/EL) insurance). See NC Medicaid Contract, Attachment B, Section 7.7.***
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;		X				Five of 6 initial credentialing Licensed Independent Practitioner (LIP) files had no evidence of WC/EL insurance or a statement confirming why it was not needed. This was also an issue at the last EQR. At that Onsite review, Sandhills personnel indicated they had

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						developed a new form for practitioners to complete, to address auto insurance and WC/EL insurance. The form required practitioners to indicate whether they transport enrollees (so would need to provide proof of auto liability insurance) and whether they have 3 or more employees (so would need WC/EL insurance). Files submitted for the current EQR did not have that form. ***Corrective Action: Verify credentialing files contain proof of all required insurance coverage (or the relevant statement from the provider about why it is not required). For providers joining already-contracted agencies, include (in the files uploaded for Desk Review) copies of the insurance coverage for the agency, and verification the provider is covered under the plans. See NC Medicaid Contract, Attachment B, Section 7.7.***
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					Professional education is Primary Source Verified (PSV) by most licensing boards. *NC Medicaid Contract, Attachment O* states the "PIHP may rely on the relevant licensure board's PSV of education status of License Practitioner applicants." The NC Medical Board licenses physicians and Physician Assistants. As noted at the last EQR, the NC Medical Board has indicated they do not conduct PSV of education or certification. If a physician is board certified, the PSV of board certification serves as PSV for education, as the board conducts PSV of education. If the physician graduated from an international medical school, the PSV of the Educational Commission for Foreign Medical Graduates (ECFMG)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						certification serves as PSV for education, as ECFMG conducts PSV of education. If a Physician Assistant is certified by the National Commission on Certification of Physician Assistants (NCCPA), the PSV of certification serves as PSV of education, as the NCCPA conducts PSV of education. Initial credentialing files were submitted for 3 physicians, and 1 initial credentialing file was submitted for a Physician Assistant. Two of the physicians are board certified. The other physician is not board certified. The file for that physician contained PSV of his education. The review of the one initial credentialing file submitted for a Physician Assistant shows that he is not certified by the NCCPA, so PSV of his education is needed, but did not occur. ***Recommendation: If the Physician Assistant is not certified by the NCCPA, ensure PSV of education is in the credentialing file. Revise the Provider Credentialing Plan Procedure, N-CR 1a-19a, N-NM 3a, Credentialing Checklists, and any other documents containing the list of required materials, to indicate Sandhills will conduct PSV of education of physicians and Physicians Assistants. See NC Medicaid Contract, Attachment O.***
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					
3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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;						
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					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.14 Names of hospitals at which the physician has admitting privileges, if any	X					
3.1.15 Ownership Disclosure is addressed.	X					
3.1.16 Criminal background Check	X					
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					*Procedure NCR 1a-19a, NM 3a Provider Cred Plan*, states, "Licensed Practitioners who do not employ any staff shall not be required to obtain Worker's Compensation or Employer's Liability insurance." The procedure also states, "CONTRACTOR with three (3) or more employees hall secure Worker's Compensation and Occupational Disease Insurance" and "Employer's Liability Insurance". The procedure does not address how Sandhills will verify whether practitioners have 3 or more employees. Recredentialing files are well-organized and contain appropriate information. Issues identified with some files are detailed in the standards that follow. ***Recommendation: Revise Procedure NCR 1a-19a, NM 3a Provider Cred Plan, and any other documents that include the recredentialing process, to address how Sandhills will verify whether practitioners and have 3 or more employees (and, therefore, need to provide proof of WC/EL insurance). See NC Medicaid Contract, Attachment B, Section 7.7.***
4.1 Recredentialing every three years;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements		X				Four of 5 recredentialing LIP files and 4 of the 6 recredentialing files of Licensed Practitioners (LPs-joining contracted practices) had no evidence of WC/EL insurance or a statement confirming why it was not needed. Following Onsite discussion, Sandhills submitted notes from 3 agencies stating that the practitioner is covered under their insurance, but evidence of WC/EL insurance was not submitted. This was also an issue at the last EQR. At that Onsite review, Sandhills personnel indicated they had developed a new form for practitioners to complete, to address auto insurance and WC/EL insurance. The form required practitioners to indicate whether they transport enrollees (so would need to provide proof of auto liability insurance) and whether they have 3 or more employees (so would need WC/EL insurance). Files submitted for the current EQR did not have that form. ***Corrective Action: Verify recredentialing files contain proof of all required insurance coverage (or the relevant statement from the provider about why it is not required). For providers joining already-contracted agencies, include (in the files uploaded for Desk Review) copies of the insurance coverage for the agency, and verification the provider is covered under the plans. See NC Medicaid Contract, Attachment B, Section 7.7.***
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (OIG LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File	X					
4.2.12 Query of the NPPES;	X					
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					
4.2.14 Ownership Disclosure is addressed.	X					
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					The Credentialing Subcommittee Meeting Notes reflect consideration of quality of care concerns and other items for recredentialing candidates.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					See *Procedure NPM 4, 4a Provider Sanctions*.
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					
II B. Adequacy of the Provider Network						
1. The PIHP maintains a network of providers that is sufficient to meet the health care needs of enrollees and is consistent with contract requirements.	X					*Procedure N-NM1a, Scope of Services (Medicaid)* states, "Sandhills Center has both a formal annual assessment process and an ongoing process to ensure network sufficiency." Procedure *N-NM 23, Out-of-Network Client Specific Agreements/Contracts*, directs the process for obtaining medically necessary services when an in-network provider is not available. "If it seems to be a good fit", Sandhills asks existing providers to add sites or services, and uses RFPs to recruit providers as needed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 Enrollees have a Provider location within a 30 – mile distance of 30 minutes' drive time of their residence. Rural areas are 45 miles and 45 minutes. Longer distances as approved by NC Medicaid are allowed for facility based or specialty providers.	X					*Core 34a, Access to Services*, includes 30 minutes/30 miles, 45 minutes/45 miles access standards. The *Sandhills 2019 Community Mental Health Substance Use and Developmental Disabilities Services Network Adequacy and Accessibility Report* identified three services for which Sandhills did not meet access and choice standards. In late June 2019, Sandhills submitted *Exception Requests* for Child and Adolescent Day Treatment, SA Comprehensive Outpatient Treatment Program, and Opioid Treatment. NC Medicaid has not yet approved *the Exception Requests* for those services. A Recommendation at the last EQR was "*Analyze reports to determine gaps; develop strategies to address identified gaps"*. Quarterly *Managed Care Accessibility Analysis* reports, also referred to as "*Geo Maps*," are referenced in Health Network Committee. meeting minutes, with some discussion. The Quarterly *Managed Care Accessibility Analysis* reports from the July/August/September 2018 report through the April/May/June 2019 report list MST at between 55.2% and 57.4%. A gap in MST was also identified at the last EQR, though the *2019 Network Adequacy and Accessibility Report* lists MST at 100%. Minutes lack evidence of detailed analysis of reports or an action plan to address identified gaps. For example, the *01/08/19 NCM Committee Meeting Minutes* state "MST is at 56%". The minutes go on to state, "Karen stated she does not have very many providers requesting to join the network for MST". There is no evidence of discussion or of developing a strategy to address the gap. When a gap in choice/access for a service is identified, it is inadequate to just post a report and state "not very many providers requesting to join the network for MST". ***Recommendation: Analyze reports to determine gaps; develop strategies to address identified gaps.***

1.2 Enrollees have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the enrollee may utilize an out-of-network specialist with no benefit penalty.	X					Page 5 of *Procedure N-CR1a-19a, N-NM 3a, Provider Credentialing Plan*, confirms Sandhills will pay for medically necessary services to be delivered with an in-network provider if available, or with an out-of-network provider if no in-network provider is available. The *NM 23, 23a Out-of-Network Client Specific Agreements/ Provider Payment Agreements (Medicaid)* procedure addresses provision of medically necessary services when an in-network provider is not available. The "Can I Receive Services from Non-Network Providers" section on page 12 of the *Member Handbook* states, "You may receive services from a non-network provider if: • You cannot be safely or appropriately transferred to a network facility or program • You require care, but the right care is not available in a network program or facility. • You have an emergency and cannot get to a provider in the Sandhills Center Network. If you receive unauthorized services from a provider not in the Sandhills Center Network you may be responsible for the cost (except in an emergency). Call the call center if you have questions about a provider outside the Sandhills Center network or about specialty care that is not covered under the Sandhills Center Health Plan – 1-800-256-2452." The "Are Services From All Providers Covered" on page 7 of the *Member Handbook* states, "Services from providers not in the Sandhills Center Network are not covered unless it is an emergency. Some services may not be provided at the same time as others. For questions about services, call 1-800-256-2452." ***Recommendation: Revise the Member Handbook to clearly indicate that, if a network specialist is not available, the member may use an out-of-network specialist with no benefit penalty. See 42 CFR § 438.206 and NC Medicaid Contract, Attachment B, Section 6.4.5.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 The sufficiency of the provider network in meeting enrollee demand is formally assessed at least annually.	X					Sandhills conducts the annual community needs and gaps analysis as required by DHHS and uses the information for its *Network Development Plan*.
1.4 Providers are available who can serve enrollees with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Client-specific contracts are employed, if needed. Page 48 of the *Medicaid Provider Manual* states, "Provider must deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds." The *Sandhills Cultural Competency Plan* was approved by the Network Leadership Council in September 2018. It is included in the *Medicaid Provider Manual*, and page 75 includes a link to the plan on the Sandhills website.
1.5 The PIHP demonstrates significant efforts to increase the provider network when it is identified as not meeting enrollee demand.	X					Page 5 of Sandhills' *Network Development Plan for 2019* lists types of providers (such as 1 new SACOT provider; 1 new Child and Adolescent Day Treatment provider, and addition of Day Treatment Services at another provider) added since the last *Gaps Analysis Report*. The Sandhills website indicates the provider network is closed for new providers or additional services, other than the specific listed services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Provider Accessibility						
2.1 The PIHP formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Page 82 of the *Medicaid Provider Manual* addresses Availability, including Appointments and Office Wait Time. *Procedure CORE 34a, Access to Services*, lists the standards for access to services. *Procedure N-NM 2a, Provider Network Access and Availability (Medicaid)*, addresses Access and Availability Standards for appointments and office wait times. *Attachment S* of the *NC Medicaid Contract*, "Availability" section includes, "the Provider must provide face-to-face emergency care immediately for life threatening emergencies". The "Availability" section on page 4 of *Procedure N-NM 2a, Provider Network Access and Availability (Medicaid)*, includes this requirement.
II C. Provider Education						
1. The PIHP formulates and acts within policies and procedures related to initial education of providers.	X					*Procedure N-NM 6a, Participating Provider Relations Program (Medicaid),* addresses New Provider Orientation and Annual Orientation. The *Cover Email for Executed Contracts* includes a link to Orientation Materials.
2. Initial provider education includes:						Relevant information was located in the *Medicaid Provider Manual*, *the Member Handbook*, or on Sandhills' website, unless otherwise indicated.
2.1 PIHP purpose and mission;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.2 Clinical Practice Standards;	X					A link to the Clinical Practice Guidelines is on the "For Providers" section of the Sandhills website. The *Medicaid Provider Manual* references the Clinical Practice Guidelines and indicates the provider is responsible to "maintain services at an optimal level to meet member needs by providing services in accordance with Sandhills Center Practice Guidelines". The link on page 18 of the *Medicaid Provider Manual* to the Clinical Practice Guidelines on the Sandhills website did not work. This was also an issue at the last EQR, resulting in a Recommendation at that time. During the Onsite Review, Sandhills staff indicated they are able to access the Clinical Practice Guidelines via the link in the *Medicaid Provider Manual*. Before the Exit Conference of the Onsite Review, the link in the *Medicaid Provider Manual* posted on the Sandhills website was fixed. ***Recommendation: Sandhills indicated during the Onsite Review of the current EQR that they had corrected the link in the Medicaid Provider Manual to the Clinical Practice Guidelines. As recommended at previous EQRs, Sandhills should have a staff member periodically check links to ensure they work.***
2.3 Provider responsibilities;	X					Provider responsibilities are addressed throughout the *Medicaid Provider Manual*.
2.4 PIHP closed network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
requirements, and required availability.						
2.5 Access standards related to both appointments and wait times;	X					The *Medicaid Provider Manual* provides the correct access standards for both appointments and wait times.
2.6 Authorization, utilization review, and care management requirements;	X					
2.7 Care Coordination and discharge planning requirements;	X					
2.8 PIHP dispute resolution process;	X					Information is included in the *Medicaid Provider Manual*. A *Medicaid Provider Dispute Resolution Flow Chart* is posted on the Sandhills website.
2.9 Complaint investigation and resolution procedures;	X					
2.10 Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements;	X					
2.11 Enrollee rights and responsibilities	X					Enrollee rights are listed beginning on page 93 of the *Medicaid Provider Manual*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.12 Provider program integrity requirements that include how to report suspected fraud, waste and abuse, training requirements as outlined in the False Claims Act, and other State and Federal requirements.	X					The Home page of the Sandhills website has a link to the Program Integrity (PI) section of the website. The PI section of the Sandhills website, and page 169 of *the Medicaid Provider Manual*, have instructions for reporting fraud, waste and abuse. The PI section of the website has links to the Office of the Inspector General's Compliance Resource portal and the Centers for Medicare and Medicaid Services (CMS) Fraud, Waste and Abuse Toolkit.
3. The PIHP provides ongoing education to providers regarding changes and/or additions to its programs, practices, enrollee benefits, standards, policies and procedures.	X					A Training Calendar on the Sandhills website includes training opportunities, workshops and other available events for Sandhills' providers.
II D. Clinical Practice Guidelines for Behavioral Health Management						
1. The PIHP develops Clinical Practice Guidelines for behavioral health management of its enrollees that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					*Procedure ADM 2a, Best Practices*, addresses Clinical Practice Guidelines.
2. The PIHP communicates the Clinical Practice Guidelines for behavioral health management and the expectation that they will be followed for PIHP enrollees to providers.	X					The *Medicaid Provider Manual* lists the "Sandhills Center Contracted Provider Responsibilities," including "Review Sandhills Center website for updates on a regular basis. Sandhills Center Clinical Practice Guidelines can be found in the Provider Service section." Page 18 of the *Medicaid Provider Manual* includes a link to the relevant page on the website, but the link goes to "Page not found". During the Onsite Review, Sandhills staff indicated they are able to access the Clinical Practice Guidelines via the link in the *Medicaid*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Provider Manual. Before the Exit Conference of the Onsite Review, the link in the *Medicaid Provider Manual* posted on the Sandhills website was fixed. Page 27 of the *Medicaid Provider Manual* indicates it is a provider responsibility to "Maintain services at an optimal level to meet member needs by providing services in accordance with Sandhills Center Practice Guidelines." ***Recommendation: Sandhills indicated during the Onsite Review of the current EQR that they had corrected the link in the Medicaid Provider Manual to the Clinical Practice Guidelines. As recommended at previous EQRs, Sandhills should have a staff member periodically check links to ensure they work.***
II E. Continuity of Care						
1. The PIHP monitors continuity and coordination of care between providers.	X					*Procedure QM2a, Monitoring Continuity of Care*, addresses ensuring continuity of care between providers.
II F. Practitioner Medical Records						
1. The PIHP formulates policies and procedures outlining standards for acceptable documentation in the Enrollee medical records maintained by providers.	X					*Procedure HIM 4a, Clinical and Business Records*, and the *Medicaid Provider Manual* address standards for acceptable documentation in the enrollee medical records. Page 16 of the *Medicaid Provider Manual* informs providers of their responsibility to "maintain clinical records that meet the requirements of the NC DMH/DD/SAS records Management and Documentation Manual for providers (APSM 45-2)." There are several other references to *APSM 45-2*, including a link to the NC DHHS webpage with access to the *APSM 45-2* manual.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The Provider section of the Sandhills website includes a link to the *Records Management and Documentation Manual* page on the DHHS website.
2. The PIHP monitors compliance with medical record documentation standards through formal periodic medical record audit and addresses any deficiencies with the providers.	X					
3. The PIHP has a process for handling abandoned records, as required by the contract.	X					*Procedure HIM 5a, Request for Provider Records*, addresses the process for handling abandoned records.

III. ENROLLEE SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III A. Enrollee Rights and Responsibilities						
1. The PIHP formulates policies outlining enrollee rights and procedures for informing enrollees of these rights.	X					*Policy and Procedure Core 37, Consumer Rights and Responsibilities* contain all enrollee rights and the procedure for informing enrollee of these rights.
2. Enrollee rights include, but are not limited to, the right:	X					Page 16-17 of the *Member Handbook* contains all the rights listed in this subsection.
2.1 To be treated with respect and due consideration of dignity and privacy;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;						
2.3 To participate in decisions regarding health care;						
2.4 To refuse treatment;						
2.5 To be free from any form of restraint of seclusion used as a means of coercion, discipline, convenience or retaliation;						
2.6 To request and receive a copy of his or her medical record, except as set forth in 45 C.F.R. §164.524 and in N.C.G.S. § 122C-53(d), and to request that the medical record be amended or corrected in accordance with *45 CFR § 164.*						
2.7 Of enrollees who live in Adult Care Homes to report any suspected violation of their enrollee rights, to the appropriate regulatory authority as outlined in *NCGS § 131-D21*.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III B. Enrollee PIHP Program Education						
1. Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid waiver managed care program which they are contractually entitled, including:	X					*Procedure CS 15a, Providing Medicaid Enrollees Access to Information*, states, "Sandhills Center is required to mail an enrollee education letter to an enrolled member within 14 days of the initial request for service." All of the sub standards are contained in enrollee written materials unless described in the comment section for that substandard.
1.1 A description of the benefits and services provided by the PIHP and of any limitations or exclusions applicable to covered services. These descriptions must have sufficient detail to ensure the Enrollees understand the benefits to which they are entitled and may include a web link to the PIHP Benefit Plan. This includes a descriptions of all Innovations Waiver services and supports;						
1.2 Benefits include access to a 2nd opinion from a qualified health care professional within the network, or arranges for the enrollees to obtain one outside the network, at no cost to the enrollee;						This information is included on page 16 of the *Member Handbook*.
1.3 Updates regarding program changes;						This information is included on page 9 of the *Member Handbook*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.4 A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;						Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) information is on pages 10-11 of the *Member Handbook*. Other member benefits are explained also.
1.5 An explanation of the Enrollee's responsibilities and rights and protection as set forth in *42 CFR § 438.100;*						
1.6 An explanation of the Enrollee's rights to select and change Network Providers						This information is included on pages 16-17 of the *Member Handbook*.
1.7 The restrictions, if any, on the enrollee's right to select and change Network Providers						This information is included on page 12 of the *Member Handbook*.
1.8 The procedure for selecting and changing Network Providers						This information is included on page 12 of the *Member Handbook*.
1.9 Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request);						This information is included on page 12 of the *Member Handbook*. The online *Medicaid Provider Directory* has all required fields.
1.10 The non-English languages, if any, spoken by each Network Provider;						There is a field for "Languages" in the *Medicaid Provider Directory* search. The Onsite discussion revealed, information is entered into the AlphaMCS system from the initial credentialing form filled out by the provider. It is updated if the provider submits a "change of information" form to Sandhills. The AlphaMCS system refreshes the online *Medicaid Provider Directory* every morning.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.11 The extent to which, and how, after-hours and emergency coverage are provided, including:						
1.11.1 What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services in accordance with *42 CFR § 438.114* and EMTALA;						Page 7-8, and 13 of the *Member Handbook* has information for members about Emergency Behavioral Health services, Emergency services, and Post Stabilization services. Page 8 of the *Member Handbook* defines emergency as: "A life threatening emergency is when you believe you need care right away so that you or another person does not get hurt." Post stabilization is explained on page 13 of the *Member Handbook* as: "After a crisis or hospitalization, you need services to help you remain stable and well."
1.11.2 The fact that prior authorization is not required for emergency services;						Page 12 of the *Member Handbook* states: "You have an emergency and cannot get to a provider in the Sandhills Center Network. If you receive unauthorized services from a provider not in the Sandhills Center Network, you may be responsible for the cost (except in an emergency)."
1.11.3 The process and procedures for obtaining Emergency Services, the use of 911 telephone services or the equivalent;						On page 8 of the *Member Handbook*, in the section "When you call for Help", it states, "An experienced staff will help you decide if you are in need of behavioral health services. In an emergency, the Call Center may send a crisis team or contact 911 to help you. Call Center staff can make an appointment with a provider near you. Your call is private and confidential." "In an emergency, or any life threatening situation, you should call 911 or go to the nearest hospital Emergency Department. You do not have to call Sandhills Center first."
1.11.4 The locations at which Providers and hospitals						Locations of Post Stabilization Services are documented on page 13 of the *Member Handbook*, in section "Services Following a Crisis or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
furnish the Emergency Services and Post Stabilization services covered under the contract;						Hospitalization". That section states, "After a crisis or hospitalization, you need services to help you remain stable and well. The following locations provide follow-up services:" Daymark Recovery: Anson: 704-694-6588 Harnett: 910-893-5727 Hoke: 910-875-8156 Lee: 919-774-6521 Montgomery: 910-572-3681 Moore: 910-295-6853 Randolph: 336-633-7000 Richmond: 910-895-2462 Monarch Behavioral Health: Guilford –Greensboro: 336-676-6840 RHA: Guilford- High Point: 336-899-1505 Page 8 of the *Member Handbook* states, "In an emergency, or any life-threatening situation, you should call 911 or go to the nearest hospital Emergency Department. You do not have to call Sandhills Center first." Specific locations where Emergency services are offered are not mentioned in the *Member Handbook* or searchable within the *Medicaid Provider Directory*. The locations where Post Stabilization services are offered are listed in the *Member Handbook*. ***Recommendation: In the Member Handbook, Medicaid Provider Directory, or both places, add locations where Emergency services are provided, in addition to Post Stabilization services. Sandhills may choose to add this in the Medicaid Provider Directory as a search criterion, in a new Service Category for Emergency and Post-Stabilization services.***
1.11.5 A statement that, subject to the provisions of the NC Medicaid contract, the Enrollee has a right to use any hospital or other setting for Emergency care;						On page 8 of the *Member Handbook* it states, "In an emergency, or any life threatening situation, you should call 911 or go to the nearest hospital Emergency Department. You do not have to call Sandhills Center first."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.12 The PIHP's policy on referrals for Specialty Care to include cost sharing, if any, and how to access Medicaid benefits that are not covered under the NC Medicaid contract;						Page 12 of the *Member Handbook* has a section called "Can I receive services from non-network providers." In that section, members are to "call the *Call Center* if they have questions about a provider outside the Sandhills Center network or about specialty care that is not covered under the Sandhills Center Health Plan."
1.13 Any limitations that may apply to services obtained from Out-of Network Providers, including disclosures of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of Network Providers, and the procedures for obtaining authorization for such services.						Information about Out-of-Network providers are located on pages 12-13 of the *Member Handbook*.
1.14 How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost-sharing;						This is located on page 11 of the *Member Handbook* in the section "Am I Eligible for State-Funded Services."
1.15 Procedures for obtaining out-of-area or out-of-state coverage of services, if special procedures exist;						Page 13 of the *Member Handbook* states, "If you are out of the Sandhills area and need services, have the provider contact our Network Department at 1-855-777-4652." There is no documentation of the procedures for obtaining out-of-state coverage. Add the process to obtain out-of-state coverage to the *Member Handbook*. ***Recommendation: In the Member Handbook, add member procedures for obtaining out-of-state coverage of services.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.16 Information about medically necessary transportation services by the department of Social Services in each country;						Page 13 of the *Member Handbook* states, "The Department of Social Services has a free ride service you may use. The service is to help you get to the doctor or other medical appointments."
1.17 Identification and explanation of State laws and rules Policies regarding the treatment of minors;						This information concerning minors is found on Page 18 of the *Member Handbook*.
1.18 The enrollee's right to recommend changes in the PIHP's policies and services						Page 18 of the *Member Handbook* contains this enrollee right.
1.19 The procedure for recommending changes in the PIHP's policies and services;						Page 18 of the *Member Handbook* contains this procedure for enrollees. "You have the right to recommend changes to LME-MCO Policy and Procedures. To recommend changes, contact the LME/MCO: 1) By phone: 1-800-256-2452 2) By writing: Sandhills Center P.O. Box 9 West End, NC 27376 3) In person:185 Grant St, West End NC 27376."
1.20 The Enrollee's right to formulate Advance Directives;						Page 18 of the *Member Handbook* has information on this enrollee right.
1.21 The Enrollee's right to file a grievance concerning non-actions, and the Enrollee's right to file an appeal if PIHP takes an action against an Enrollee;						Page 22 of the *Member Handbook* has information on how to file a grievance.
1.22 The accommodations made for non-English speakers, as specified in *42 CFR § 438.10(c)(5);*						This is covered on page 7 of the *Member Handbook*, in the section "Assistance In Other Languages". That section states, "Call Center staff will connect you to a translator, if needed. This service is free. Please call 1-800-256-2452 if you have questions."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.23 Written information shall be made available in the non-English languages prevalent in the PIHP's services area.						Written enrollee information is available is Spanish, the prevalent non-English language at Sandhills, as stated on page 2 of the *Member Handbook*. Onsite discussion revealed that Sandhills can request written materials in any language from their translation service. The turn-around time is 1-2 days for that translation service.
1.24 The availability of oral interpretation service for non-English languages and how to access the service;						
1.25 The availability of interpretation of written information in prevalent languages and how to access those services						
1.26 Information on how to report fraud and abuse; and						Page 22 of the *Member Handbook* has information on how to report fraud and abuse.
1.27 Upon an Enrollee's request, the PIHP shall provide information on the structure and operation of the agency and any physician incentive plans.						Sandhills has an organizational brochure that can be shared.
1.28 Information on grievance, appeal and fair hearing procedures and information specified in *42 CFR § 438.10 (g).*						Page 16 of the *Member Handbook* states, "The right to a State Fair Hearing about any action taken by Sandhills Center, including a service denial."
2. Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.	X					*Policy and Procedure CS 15, Providing Medicaid Enrollees with Access to Information* states, "All enrolled members receive notification annually of their right to request information on services, member rights, appeals, and a copy of the *Sandhills Center Member Handbook*."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified *in 42 CFR § 438.10 (f) (61)* and *438.10 (g)* at least 30 days before calendar days before the intended effective date of the change; and (2) . termination of their provider within fifteen (15) calendar days after PIHP receives notice that NC Medicaid or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.	X					5 terminated provider files were reviewed. In one case, the enrollees seeing the terminating provider were notified of the termination 6 days outside the 15 calendar day goal. This meets the contract requirement of Section 6.10. Sandhills made a "good faith effort" to give notice within 15 calendar days. This was a Corrective Action in the previous EQR.
4. Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation of prevalent non-English languages as required by the contract.	X					Page 2 of the *Member Handbook* states, "To get a large print copy of this Handbook, call 1-800-256-2452. It is also on our website at www.sandhillscenter.org. If you need a handbook in Spanish, one is on our website, or call our toll free number 1-800-256-2452." "If you have questions, call Sandhills Center at 1-800-256-2452. For hearing impaired, use the TTY service at 1-866-518-6778 to speak to someone who will help you." Page 7 of the *Member Handbook*, "Call Center staff will connect you to a translator, if needed. This service is free. Please call 1-800-256-2452 if you have questions." As a result of a Recommendation last EQR, Procedure *CS 11a Education and Training for Enrollees* was updated to include, "All written material will be written in minimally 12-point font. All large print documents will be written in minimally 18-point font."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. The PIHP maintains and informs Enrollees of how to access a toll-free vehicle for 24-hours Enrollee access to coverage information from the PIHP, including the availability of free oral translation services for all languages and care management services such as crisis interventions.	X					The following information is on page 4 of the *Member Handbook*, "Sandhills Center 24 Hour Toll-Free Access and Information Line: 1-800-256-2452."
III C. Behavioral Health and Chronic Disease Management Education						
1. The PIHP enables each enrollee to choose a Provider upon enrollment and provides assistance as needed.	X					This information is documented on page 12 of the *Member Handbook* under the section, "Choosing a Provider".
2. The PIHP informs enrollees about the behavioral health education services that are available to them and encourages them to utilize these benefits.	X					On the Sandhills website, there is a calendar of educational events color coded by provider and community. Sandhills contracts with NC Families United to deliver the educational training to enrollees, families, and the community.
3. The PIHP tracks the participation of enrollees in the behavioral health education services.	X					Data on enrollee participation is prepared monthly by NC Families United and kept with the Care Coordination team.
III D. Call Center						
1. The PIHP provides customer services that are responsible to the needs of the Enrollees and their families. Services include:	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 Respond appropriately to inquiries by enrollees and their family members (including those with limited English proficiency);	X					All calls are answered by a Customer Service Representative and handled by Protocol.
1.2 Connect enrollees, family members and stakeholders to crisis services when clinically appropriate;	X					For all suspected crisis calls, Customer Service Representatives complete a warm transfer to a clinician. The caller is triaged for the appropriate crisis service.
1.3 Provide information to enrollees and their family members on where and how to access behavioral health services;	X					
1.4 Train its staff to recognize third-party insurance issues, recipient appeals, and grievances and to route these issues to the appropriate individual;	X					
1.5 Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;	X					Sandhills continues to work with Cardinal on rollover call metrics to meet all Call Center metric standards. This was a Recommendation from the last EQR.
1.6 Process referrals twenty-four (24) hours per day, seven (7) days per week; 365 days per year; and	X					
1.7 Process Call Center linkage and referral requests for services twenty-four (24) hours per day, seven (7) days per week, 365 days per year.	X					The soft-phone system has made Call Center functions easier for staff. They can access it through the computer and carry their identifying information with them to any computer. This will enable Call Center staff to work remotely in the event of an emergency or weather event.

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV A. The Quality Improvement (QI) Program						
1. The PIHP formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to enrollees.	X					*The Quality Management Program/Plan FY 2018-2019* documents the formal Quality Improvement (QI) Program plan, goals and objectives, and other details.
2. The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.	X					Page 133 of the *Medicaid Provider Manual* states, "A routine utilization review will be inclusive of, but not limited to evaluations of services across the delivery spectrum; evaluations of members by diagnostic category or complexity level; evaluations of providers by capacity, service delivery, and best-practice guidelines and evaluations of utilization trends." Procedure NPM-7a, Monitoring the Provision of Evidence-Based Best Practice Services describes the process for monitoring provider compliance with EBP guidelines. Onsite interview reveals this procedure is followed and Sandhills is offering a biannual *Training for Excellence in Clinical Practice*. This training is an 18-hour, in-person, experiential training provided over 3 days to promote best clinical practices in outpatient settings.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					There is no specific policy or procedure in place for detecting the over and underutilization of services. However, page 5 of the *UM Program Description 2019-2020* states that the "CM/UM program will monitor/track report data on a quarterly basis for evidence of over and/or underutilization of services as well as inappropriate utilization of restrictive levels of care for corrective action."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.	X					The *ECHO Survey Tracking.xlsx* document tracks results that score lower than the state average on *the Child and Adult ECHO Survey* for years 2016, 2017, and 2018. Each low scoring item has an Action/Comment section which documents notes and interventions for each item. The scores are compared from year to year. Of the 39 items tracked over 3 years, only 1 item scored lower the following year when comparisons were completed.
5. The PIHP reports the results of the enrollee satisfaction survey to providers.	X					At the July 12, 2018 GQIC meeting, *2017 ECHO and 2017 Provider Satisfaction Survey* results copies were presented to review. There was a Power Point summary of both survey results uploaded for this meeting. There was no mention of a summary of the results being talked about at the meeting. Onsite discussion revealed that the Power Point presentation of the survey results was presented to the committee. Survey results and this presentation of the results is posted on the Sandhills website and presented at Provider Forum.
6. The PIHP reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					The 2018 *ECHO Survey* and 2018 *Provider Satisfaction Survey* results were presented at the February 26, 2019 QMC meeting. Members also reviewed the *ECHO Survey Tracking.xlsx* document before the April 23, 2019 QMC meeting. QMC discussed interventions and outcomes for the *ECHO Survey* results.
7. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, time frame for implementation and completion, and the person(s) responsible for the project(s).	X					The *QM Work Plan FY 2018-2019* includes 7 identified tasks. Tasks from the *QM Work Plan FY 2017-2018* that were on-going did not carry over. Each Task has documentation for Responsible Staff, Start Date, Due Date, Percent Completed, Updated Date, and Actions Taken/ Comments. ***Recommendation: Update the QM Work Plan FY 2018-2019 to track all QM activities including tasks that carry over from FY 2017-2018.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV B. Quality Improvement Committee						
1. The PIHP has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Management Committee (QMC) is the committee that oversees the Quality Management Program at Sandhills. Global Continuous Quality Improvement Committee (GCQI) is the provider representation subcommittee for QMC. The role of the GCQI committee is defined in the *Quality Management Program/Plan FY 2018-2019* as "…a committee to provide feedback to the QMC regarding QIPs, quality of care concerns, and results of monitoring activities as they relate to QOC issues." However, there was no feedback or discussion from committee members in these areas documented on the GCQI committee minutes. The GCQI minutes need to document this discussion. ***Recommendation: Facilitate GCQI meetings so that feedback is captured in meeting minutes for: QIPs, quality of care concerns, and results of monitoring activities as they relate to quality of care (QOC) issues.*** There was no report documented in QMC minutes pertaining to updates from the GCQI. There are Sandhills staff that attend both GCQI and QMC. Those staff members should report back to QMC on the updates from GCQI. ***Recommendation: Begin reporting the GCQI meeting summary at QMC meetings and documenting the update in the QMC meeting minutes.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The composition of the QI Committee reflects the membership required by the contract.	X					QMC Membership is comprised of 20 staff members of Sandhills, representing all areas of the organization. In addition, one Consumer & Family Advisory Council (CFAC) member is on the QMC. The CCO and the Quality Management Director co-chair the committee. There are 23 provider members of the Global Quality Improvement Committee (GQIC) and 13 members is a quorum. In an effort to have a quorum at more meetings, GQIC has been restructured, and new members recruited. Meetings are held quarterly instead of bi-monthly. Members are asked to attend all meetings, but required to attend 2 of the 4 meetings annually. Attendance significantly increased for the February and May 2019 meetings. February attendance was 20/23 and May was 16/23. This was a Corrective Action item last EQR and improvement was maintained.
3. The QI Committee meets at regular intervals.	X					In the past year, the QMC met every month except December.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Detailed minutes are documented at each QMC meeting.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					B waiver measures: The overall validation score was in the fully compliant range, with an average validation score of 100% across the ten measures. C waiver measures: The overall validation score was in the fully compliant range, with an average validation score of 100% across the ten measures. Documentation included the data collection methodology, data validation, and data sources, as well as the latest reported rates.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".		X				Three PIPs received a score of "High Confidence" in reported results. The PIP "Shaping the Network to improve provider choice and ensure members access to quality services" received a score of "Confidence" in reported results. A total of 3 PIPs have Recommendations/ Corrective Actions. ***Corrective Action: Make corrections to the "Shaping the Network to improve provider choice and ensure members access to quality services" PIP as outlined in Table 22.*** ***Recommendation: 2 PIPs have Recommendations outlined in Table 23.*** Additionally, The EBP Specialty PIP was discussed during the Onsite. This PIP was not validated for 2019 due to a change in PIP status. The initial EBP Specialty PIP focused on Bipolar and PTSD diagnoses. In January 2019, the PIP patient population changed to include all EBP Specialty diagnoses. After discussion Onsite, Sandhills will initiate a new PIP that will include all EBP Specialty diagnoses that will be retroactive beginning January 2019, which was when NC Medicaid approved this change. ***Recommendation: Close the current EBP Specialty PIP and initiate a new EBP Specialty PIP that includes all EBP Specialty diagnoses.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV E. Provider Participation in Quality Improvement Activities						
1. The PIHP requires its providers to actively participate in QI activities.	X					The Integrated Care project is a good example of providers who participate in a quality initiative from Sandhills.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Providers receive valuable outcomes-based QI feedback from the Integrated Care project. This initiative started as a pilot program in 2016 and now has 11 providers participating.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					*The Quality Management Program/Plan FY 2018-2019* explains the process of the *Quality Management Program Evaluation* including what is evaluated and how the evaluation is documented. *The Quality Management Program Evaluation* reviews the QM Program including the program goals with rating, outcome, barriers, and recommendations for each goal. Overviews of the enrollee and provider survey results are included in the program evaluation.
2. The annual report of the QI program is submitted to the QI Committee and to the PIHP Board of Directors.	X					The *Quality Management Program Evaluation 2018-2019* will be presented to the Board of Directors in the August 2019 meeting. QMC voted to approve the *Quality Management Program Evaluation* 2018-2019.

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. The Utilization Management (UM) Program						
1. The PIHP formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					
1.1 structure of the program;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 consideration of new technology;	X					Information about consideration for new technology was added to the *Medicaid Provider Manual*. This was a 2018 EQR *Corrective Action Plan* item.
1.6 the appeal process, including a mechanism for expedited appeal;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.7 the absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					
1.8 mechanisms to detect underutilization and overutilization of services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The policies and procedures include the Chief Clinical Officer's oversight of (UM) activities including, the Inter-rater Reliability Process and active participation in the UM Committee.
3. The UM program design is reevaluated annually, including Provider input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
4. Utilization management standards/criteria are consistently applied to all enrollees across all reviewers.	X					
5. Emergency and post stabilization care is provided in a manner consistent with contract and federal regulations.	X					
6. Utilization management standards/criteria are available for Providers.	X					
7. Utilization management decisions are made by appropriately trained reviewers	X					
8. Initial utilization decisions are made promptly after all necessary information is received	X					Review of the sample of UM files showed that all decisions were completed and notification to enrollees provided within the required timeframes.
9. Denials						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.1 A reasonable effort that is not burdensome on the enrollee or the provider is made to obtain all pertinent information prior to making the decisions to deny services	X					
9.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
9.3 Denial decisions are promptly communicated to the provider and enrollee and include the basis for the denials of service and the procedure for appeal	X					
V C. Care Coordination						
1. The PIHP utilizes care coordination techniques to ensure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					The *Member Handbook* lacks information about the availability of and eligibility for Care Coordination services. ***Recommendation: Describe the availability of and eligibility for MH/SA and I/DD Care Coordination services in the Member Handbook.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					The 2018 EQR included the recommendation to provide additional information in a policy and procedure about MH/SA Care Coordination oversight in the development of the member's Person Centered Plan. This information was added *to Procedure CC 22a, MH/SA Care Coordination: Levels of Care Coordination*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.5 Quality monitoring and continuous quality improvement;	X					
2.6 Determination of which Behavioral Health Services are medically necessary;	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					The 2018 EQR included a recommendation to define a progress note structure for MH/SA Care Coordinators. Sandhills now uses a PIE (Purpose, Intervention and Effectiveness) note structure and this information was added to *Policy and Procedure CC-8, MH/SA Care Coordination Documentation Requirements*.
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					
3. The PIHP applies the Care Coordination policies and procedures as formulated.		X				In the files submitted for this year's EQR, 30% of the I/DD Care Coordination progress notes were out of compliance with the submission timeframes required by Sandhills' policies and procedures. This issue was identified in the last year's EQR. ***Corrective Action: Enhance the current monitoring process using a data driven approach to bring the I/DD progress notes into compliance with the required timeframe for submission. This enhanced monitoring process should be outlined in the I/DD Care Coordination policies and procedures.*** Sandhills has data and reports that are used in individual care coordinator's supervision, but does not use this data to identify and address quality issues within the Care Coordination Department as a whole. ***Recommendation: Use available data to analyze and target issues with progress note timeliness, or any other issues within the I/DD Care Coordination Unit. This data could be used to measure individual care coordinator adherence, develop a departmental dashboard, drive a quality improvement project, or quantify employee performance.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. D Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.						
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					
2.1 Care Coordination activities occur as required.	X					
2.2 Person Centered Plans are developed as required.	X					TCLI policies and procedures do not capture overarching responsibilities of the TCLI program such as, participation in treatment planning, documentation requirements for progress notes, and supervision of TCLI staff. ***Recommendation: Either add to TCLI policies and procedures the overarching responsibilities of the TCLI program such as, participation in treatment planning, documentation requirements for progress notes, and supervision of TCLI staff, or reference existing Care Coordination policies and procedures that already outline these responsibilities.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 present, when appropriate, in the files reviewed. The *Transition to Community Living (TCLI) Program Improvement Project (PIP), Increase Timely Completion and Submission of the Quality of Life Surveys* has been closed as a result of maintaining a 98-100% completion rate QOL surveys for the past 5 quarters.
3. Transition, diversion and discharge processes are in place for TCLI members as outlined in the DOJ Settlement and DHHS Contract.	X					
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.	X					
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing	X					As a result of an EQR Recommendation last year, Sandhills added information about the availability of TCLI services to the *Member*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						*Handbook*. During the Onsite interview Sandhills provided information about and uploaded a TCLI brochure.
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				In the files submitted for this year's EQR, 17% of the TCLI Care Coordination progress notes were out of compliance with the submission timeframes required by Sandhills' policies and procedures. This issue was identified in the last year's EQR. ***Corrective Action: Enhance the current monitoring process using a data driven approach to bring the TCLI progress notes into compliance with the required timeframe for submission. This enhanced monitoring process should be outlined in the TCLI Care Coordination policies and procedures.*** Sandhills has data and reports that are used in individual care coordinator's supervision, but does not use this data to identify and address quality issues within the Care Coordination Department as a whole. ***Recommendation: Use available data to analyze and target issues with progress note timeliness, or any other issues within the TCLI Care Coordination Unit. This data could be used to measure individual care coordinator adherence, develop a departmental dashboard, drive a quality improvement project, or quantify employee performance.***

VII. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					Sandhills has adopted the use of the term "grievance" and has edited *Policy and Procedure CORE 35, Consumer Grievance Process-Medicaid*, to reflect the use of the single term "grievances" but three references to the term "complaint" still remain in this procedure. The term "complaint" is also used interchangeably with grievance in the *Medicaid Provider Manual*. ***Recommendations: Ensure edits within Procedure CORE 35a, Consumer Grievance Process-Medicaid consistently reflects the use by Sandhills of the term "grievance".*** ***Recommendation: Ensure the use of the term "grievance" is consistent across all print materials, including Medicaid Provider Manual.***
1.1 Definition of a grievance and who may file a grievance;	X					
1.2 The procedure for filing and handling a grievance;	X					The 2018 EQR Recommendation regarding adding information about the web-based grievance intake form were included within *Procedure CORE 35a, Consumer Grievance Process-Medicaid.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					In *Procedure CORE 35a, Consumer Grievance Process-Medicaid* an acknowledgement of a grievance is sent "within 5 working days of the receipt of the grievance" in the "Low Risk Grievances" section. However, this timeframe is not included in the "High Risk Grievance" section. ***Recommendations: Add to Procedure Core 35a that and acknowledgement of a grievance is sent "within 5 working days of the receipt of the grievance" to the "High Risk Grievances" section.*** *Procedure CORE 35a Consumer Grievance Process-Medicaid* is missing 2 details in the notification requirements, "Time Extension for all grievances", section when Sandhills extends a grievance resolution timeframe. The missing details *includes* a "prompt" phone call and written notification "within 2 calendar days". ***Recommendation: Add the details for the extension timeframe to Procedure CORE 35a Consumer Grievance Process-Medicaid. Edit the last sentence in the "Time Extension for all grievances" section to read, "The member will be notified with a prompt phone call and the member will notified in writing within 2 calendar days, that Sandhills will make reasonable efforts to give the enrollee "prompt oral notice" of the delay and "within 2 calendars give the enrollee written notice of the reason to extend the timeframe, per 42 CFR § 438.408."***
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,* includes the Chief Medical Officer/Medical Director within the procedure.

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					The timeframe to maintain grievance records in not included within *Procedure, CORE 35a, Consumer Grievance Process-Medicaid.* Include within the procedure the maintenance of grievance records, per *NC Medicaid Contract, Attachment M, Section* B. Record Keeping and Reporting. ***Recommendation: Include within Procedure, CORE 35a, Consumer Grievance Process- Medicaid, that grievance records 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					
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The review of the *Grievances Log* verified that data is available and used however, the use of the data for analysis, and trending was not present. The Onsite interview clarified that the data is used for basic analysis that includes type, frequency and by provider. Increase the use of the data to include in depth analysis such as; trend analysis of grievances and changes within a timeframe, frequency by member, service and provider, overall analytics by provide, variances over a timeframe etc. ***Recommendation: Maximize the use of the data to include more in-depth analysis such as trend analysis, monitoring provider performance and identifying quality improvement opportunities.***
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					None of the 9 policies and 9 procedures provide concurrent information regarding contractual requirements. During the 2018 EQR, recommendations were given and corrections required in an effort to bring all policies and procedures into consistent compliance. In addition, it was recommended in the 2018 EQR Administrative section that Sandhills "streamline" their policy and procedure set to simplify the policy and procedure revision process and prevent incorrect and conflicting information within policies and procedures. Sandhills did revise one policy and one procedure in the past year, but this left the remaining eight policies and eight procedures with incorrect and/or contradicting information. For example, the description of who can file an appeal varies across all nine policies and nine procedures. ***Recommendation: Develop an interdepartmental, comprehensive plan to bring Sandhills' appeals policies and procedures into compliance with Attachment M of the NC Medicaid Contract and in 42 CFR § 438 Subpart F. Ensure this plan includes review and revision of any other documentation addressing appeals (such as the UM/CM Plan, Sandhills' website, appeals brochure, etc.) Retire unnecessary appeal policies and procedures.***
1.1 The definitions an appeal and who may file an appeal;		X				*Policy and Procedure HUM 33, Non-Certification Appeal Process* correctly states the requirement of signed consent by the enrollee or legal guardian when anyone other than the enrollee or legal guardian files an appeal. However, this procedure (*Procedure HUM 33a, Non-Certification Appeals Process*) goes on to contradict this definition when explaining who can file an expedited appeal. There is no explanation that signed consent from the enrollee is still required for expedited appeals when anyone other than the enrollee

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						or legal guardian files an appeal. This was a Corrective Action from last year that was not implemented. Sandhills' website and *Member Handbook* also do not provide clear information regarding who can file an appeal. **T**his also was a Corrective Action from last year's EQR. Only two of Sandhills' 18 policies and procedures correctly defines an appeal. *Policy and Procedure HUM 33, Non-Certification Appeals Process* accurately states an appeal is a "request for review of an adverse benefit determination". *Policy and Procedure HUM 38, Expedited Appeals Process Timeframe* also includes this definition but then goes on to contradict the definition by defining an appeal as an "administrative review". All other policies and procedures contain this incorrect definition. Correcting this definition in all appeal policies and procedures was a recommendation from last year's EQR. ***Corrective Actions: Add to all of Sandhills' policies and procedures the requirement of signed consent by the enrollee or legal guardian when anyone other than the enrollee or legal guardian files an appeal. See NC Medicaid Contract, Attachment M, G.1.*** ***Correct the Sandhills' website and Member Handbook to reflect that signed consent by the enrollee, when anyone other than the enrollee or legal guardian files an appeal, is required.*** ***Correct the definition of an appeal in to remove the word "administrative" from the definition. See NC Medicaid Contract, Attachment M, Section G.1.***
1.2 The procedure for filing an appeal;		X				Only one of Sandhills' policies or procedures indicate that the first level appeal process must be exhausted prior to an appellant requesting a second level appeal at the Office of Administrative

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Hearings. The *Member Handbook* also does not clarify this for members. This was a Recommendation from last year's EQR. One of Sandhills' procedures accurately defines the allowable timeframe for an appeal to be submitted. All other policies and procedures either do not define the allowable timeframe for filing an appeal or incorrectly define it. This was a Corrective Action from last year's EQR. Within the *Medicaid Provider Manual*, the language is unclear regarding appeal information. There are two sections; an "Appeals" section on page 102 of the manual and a "Reconsiderations/Appeals" section which is on page 129 of the manual. Information in these two sections differs. For example, information regarding who can file an appeal and the timeframe for filing an appeal is contradictory. ***Corrective Actions: Add information to all of Sandhills' policies and procedures and the Member Handbook to indicate that the first level appeal process with Sandhills must be exhausted prior to an appellant requesting a second level appeal at the Office of Administrative Hearings. See NC Medicaid Contract, Attachment M, Section I.1..*** ***Add to all of Sandhills' policies or procedures that the timeframe for filing an appeal is within 60 days of the mailing date of the UM denial notification. See NC Medicaid Contract, Attachment M, Sections G.2 and E.5.*** ***Within the Medicaid Provider Manual, combine the two sections addressing "Appeals" and "Reconsiderations/Appeals" into one section that accurately explains Sandhills' Medicaid appeal process.***

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					When additional information was submitted by appellants for appeal consideration, staff labelled this as simply "additional documentation" or "reconsideration documentation" and did not specify what was received or reviewed by the appeal reviewers. This was a Recommendation from last year. While documents are now specified in the Peer Reviewers' reports, documents listed on the appeal resolution notice remain ambiguous and do not assure the enrollee that all submitted information was reviewed. ***Recommendation: Ensure staff specify the documents submitted for the appeal review and include the names of the documents in the appeal resolution notification.***
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;		X				Only one of Sandhills' policies and procedures contain the correct criteria by which expedited appeals should be reviewed. All other policies and procedures, including the policy and procedure dedicated to expedited appeals, have either no criteria or incorrect criteria. This was a Corrective Action from last year's EQR. Sandhills' appeal policies and procedures do not provide clear information regarding the process Sandhills follows when deciding whether to accept a request to expedite an appeal. *Procedure HUM 33a, Non-Certification Appeals Process* first states Sandhills "will honor any request for an expedited appeals", but then goes on to use words like "when able" and "unless there are extenuating circumstances". Sandhills is required to only deny those requests to expedite appeals when the criteria for an expedited appeal, as outlined in federal regulations and *NC Medicaid Contract*, is not "Met." This was a Corrective Action from last year's EQR. None of Sandhills' policies and procedures contain the requirement that Sandhills provide "prompt" oral notification when a request to expedite an appeal is denied by Sandhills.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Corrective Actions: Add the correct criteria for expedited appeals to Sandhills' policies and procedures. Specifically, "that taking the time for a standard resolution could seriously jeopardize an Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function." See NC Medicaid Contract, Attachment M, Section H.1. ***Clarify in all of Sandhills' policies and procedures how requests for expedited appeals are processed. Include detail regarding how the decision to deny a request to expedite an appeal is made, by whom, and where consideration of expedited criteria is documented.*** ***Also ensure appeal policies and procedures consistently state that Sandhills will provide "prompt" oral notice if Sandhills denies a request to expedite an appeal. See NC Medicaid Contract, Attachment M, Section H.9.b .***
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				Sandhills added information about extending appeal timeframes to some of their policies and procedures but omitted the requirement that, when Sandhills extends the appeal timeframe, the extension has to be "to the satisfaction" of NC Medicaid. This information is missing from all but one of Sandhills' policies and procedures. Also, Sandhills is required to provide "prompt oral" notification to an enrollee when Sandhills extends the appeal resolution timeframe. This information is either missing or incorrect in all but one procedure. In last year's EQR, it was recommended that Sandhills add information to their *Medicaid Provider Manual* regarding the appeal resolution notification enrollees receive and the timeframe by which that notification is issued. Information about expedited appeals was added to the *Medicaid Provider Manual*, however, no information is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						available in the manual that explains to providers when standard appeal resolution notifications are sent. ***Corrective Actions: Add to all of Sandhills' appeal policies and procedures that Sandhills extends appeal resolution timeframes "to the satisfaction" of NC Medicaid. Ensure staff document in the appeal record the reason the decision is in the best interest of the enrollee when Sandhills extends an appeal resolution timeframe. See NC Medicaid Contract, Attachment M, Section G.5 (ii).*** ***Add to all of Sandhills' appeal policies and procedures that Sandhills provides "prompt oral" notification to enrollees when Sandhills extends the appeal resolution timeframe. Ensure this is also explained in any policy or procedure that describes extensions of expedited appeals. See NC Medicaid Contract, Attachment M, Section G.6.*** ***Recommendation: Clarify in the Medicaid Provider Manual the timeframe by which an enrollee and/or provider can expect a resolution notification from Sandhills when processing a standard appeal.***
1.6 Written notice of the appeal resolution as required by the contract;	X					The process of providing notices of appeal resolution are adequately and accurately explained in all appeal policies and procedures.
1.7 Other requirements as specified in the contract.	X					
2. The PIHP applies the appeal policies and procedures as formulated.	X					The appeal file review showed Sandhills' staff processed the appeals correctly and within the required timeframes. Within the appeal record, staff are now detailing interactions with appellants including efforts to obtain additional appeal information and oral notifications

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						related to expedited appeals. As a result, each reviewed file clearly demonstrated the steps taken by staff in processing appeals.
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.		X				Analysis of appeals data is required of Sandhills by *NC Medicaid Contract, Section 7.5.2.* to identify quality assurance and /or program integrity opportunities. Sandhills reports appeal data to the Quality Management Committee monthly and to the Utilization Management (UM) Committee quarterly. Appeal data are reported by type (disability, service type, age group, appeal level, appeal outcome, etc.) and across time, but there is no evidence of committee analysis of the data, discussion, or identification of any improvement opportunities. Additionally, The *UM/CM Plan* states appeals are analyzed "by provider" and reported to UM and Quality Management Committees. The appeals policies and procedures (*HUM 33 and HUM 40*) state the timeliness of appeals will be reviewed by committee. However, there is no evidence in UM and QM committees that either of these data elements were gathered, analyzed, or reviewed in committee. ***Corrective Action: Analyze appeals data to identify potential quality improvement or program integrity activities. Analysis would be evident in committee minutes. See NC Medicaid Contract, Section 7.5.2.*** ***Revise the UM/CM Plan and appeals policies and procedures to accurately and consistently describe this new appeals analysis process and the data elements that will be gathered, analyzed and discussed in committee.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					The appeal file review showed Sandhills' staff processed the appeals correctly and within the required timeframes. Within the appeal record, staff are now detailing interactions with appellants including efforts to obtain additional appeal information and oral notifications related to expedited appeals. As a result, each reviewed file clearly demonstrated the steps taken by staff in processing appeals.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. Delegation						
1. The PIHP has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					
2. The PIHP conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the PIHP if the PIHP were directly performing the delegated functions.		X				*Procedure CORE 9a, Delegation Oversight and Delegation Contracts,* outlines the criteria and processes used for monitoring delegates, including verifying "the contractor's compliance with contractual requirements no less than annually." The *Cardinal Innovations Annual Monitoring Review* summary was essentially a narrative of what Cardinal does. The summary read like a Pre-Delegation Assessment, was neither dated nor signed, and did not indicate the timeframe covered by the summary. Though Sandhills added the *State Exclusion List* query to the *Annual Delegation Assessment Tool* for the Credentialing Delegates (UNC and Moses Cone), neither delegate conducted the required query of the *State Exclusion List*. ***Corrective Action: Monitor the Credentialing Delegates to ensure they are conducting the required queries of the State Exclusion List. See NC Medicaid Contract, Section 1.14.4, Section 7.6.4, and Section 11.1.3.*** ***Recommendation: Ensure the Annual Monitoring Summary reports include the timeframe covered by the report, comply with Procedure CORE 9a, Delegation Oversight and Delegation Contracts, including information about any Corrective Actions, and are signed and dated.***

VIII. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII A. General Requirements						
1. PIHP shall be familiar and comply with Section 1902(a)(68) of the Social Security Act, *42 CFR § 438.455* and 1000 through 1008, as applicable, including proper payments to Providers and methods for detection of fraud and abuse.	X					This requirement is addressed in *Policy and Procedure ADM 11, Fraud, Waste and Abuse Monitoring* and in the *Corporate Compliance and Internal Audit Plan FY 2018-2019*.
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					This requirement is addressed in the *Corporate Compliance and Internal Audit Plan FY 2018-2019*.
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					This requirement is addressed in the *Medicaid Provider Manual* and in the *Procurement Contract* for provision of services template.
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					This requirement is addressed in *Policy and Procedure PI-1, Investigative Process* and the *PI Workflow*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII 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					This requirement is addressed in *Corporate Compliance and Internal Audit Plan FY 2018-2019*.
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					This requirement is addressed in *Corporate Compliance and Internal Audit Plan FY 2018-2019*. This requirement is also addressed in the training materials for providers and employees provided by the PIHP that pertain to program integrity, corporate compliance and fraud, waste, and abuse.

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					This requirement is addressed in the *Corporate Compliance and Internal Audit Plan FY 2018-2019*, *Policy and Procedure PI 1, Investigative Process*, and *Policy and Procedure ADM 11, Fraud, Waste and Abuse Monitoring* as it relates to identification, detection, and prevention of fraud, waste and abuse and establishing a primary point of contact.
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 N.C. Department of Justice ("MFCU/ MID').	X					This requirement is addressed in the *Corporate Compliance and Internal Audit Plan FY 2018-2019* and the quarterly meeting agendas and sign-in sheets submitted for 09/2018, 12/2018, 03/2019, and 06/2019.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. PIHP shall send staff to participate in monthly meetings with Division Program Integrity staff, either telephonically or in person at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.						
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. The Division recognizes that the scope of the PIHP's Regulatory Compliance Committee includes issues beyond those related to Program Integrity. 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					This requirement is addressed in the *Corporate Compliance and Internal Audit Plan FY 2018-2019* and in the PI training materials for providers and employees.
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing and development of corrective action initiatives;	X					This requirement is addressed in the *Corporate Compliance and Internal Audit Plan FY 2018-2019*.
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					This requirement is addressed in the *Corporate Compliance and Internal Audit Plan FY 2018-2019*.
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 promptly supplying all data in a uniform format provided by NC Medicaid and information requested for their respective	X					This requirement is partially addressed in the *Corporate Compliance and Internal Audit Plan FY 2018-2019*. The notification and timeliness requirement is address in the *PI Workflow*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
investigations within seven (7) business days or within an extended timeframe determined by Division as provided in Section 13.2 – Monetary Penalties.						
9. In accordance with *42 CFR § 436.606(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)	X					This requirement is addressed in the *Corporate Compliance and Internal Audit Plan FY 2018-2019*, which contains the PIHP's self-audits and investigations related to compliance issues.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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						
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					This requirement is addressed in *Policy and Procedure ADM 11, Fraud, Waste and Abuse Monitoring*.
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse;	X					This requirement is addressed in *Policy and Procedure ADM 11, Fraud, Waste and Abuse Monitoring, Policy and Procedure PI 6, Fraud Detection Software Systems*, and in the *PI Workflow*.
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	X					This requirement is addressed in multiple Sandhills PI policies and procedures. Discrepancies in the quality of documentation between PI files were identified during case file review and discussed during Onsite interviews. Although Sandhills has a detailed PI Workflow, it was discussed that this workflow may need to be reviewed with the PI team. Additionally, the PI Director discussed how he is assigning and tracking each PI case, since no specific method is used for prioritizing investigations. ***Recommendation: Retrain PI staff on the procedures of the PI Workflow for investigating allegations of Fraud, Waste, and Abuse to address discrepancies in the quality of documentation between PI files.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						
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					This requirement is addressed in the *Attachment Y* spreadsheet, *Policy and Procedure PI 7*, *Provider Self-Audit*, and the *Tentative Notice of Overpayment (TNO)* letter template.
10.4 Process for tracking overpayments and collections, based on fraud or abuse,	X					This requirement is addressed in the *Attachment Y* spreadsheet, containing cases being investigated for overpayment and collection.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on Attachment Y – Audits/Self-Audits/Investigations;						
10.5 Process for handling self-audits and challenge audits;	X					This requirement is addressed in *Policy and Procedure PI 1, Investigating Process and Policy and Procedure PI 7, Provider Self-Audit*.
10.6 Process for using data mining to determine leads;	X					This requirement is addressed in *Policy and Procedure PI 6, Fraud Detection Software System* and in the *Medicaid Provider Manual*.
10.7 Process for informing PIHP employees, subcontractors and providers regarding the False Claims Act;	X					This requirement is addressed in the training materials for employees provided by the PIHP that pertain to PI, corporate compliance and fraud, waste, and abuse. This training covers information regarding the *False Claims Act*. This requirement is also addressed in *Policy and Procedure ADM 11, Fraud, Waste and Abuse Monitoring*.
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					This requirement is addressed in the *Corporate Compliance & Internal Audit Plan FY 2018-2019*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					This requirement is addressed in *Policy and Procedure PI 2, Verification of Services Billed by Network Providers.*
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					This requirement is addressed in the *Provider Credentialing Plan Procedure*.
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					This requirement is addressed in the *Tentative Notice of Overpayment (TNO)* letter template provided by the PIHP.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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				Seven of the fourteen PI files "Met" the 10 business day requirement for initiation. Four files reviewed did not meet this requirement: #142, #166, #202, and #225. This requirement was unable to be determined in three files because either the date of referral or the date of initiation was not documented in the file: #149, #189, and #227. ***Corrective Action: Increase the monitoring of PI files to ensure all required elements are captured within the file documentation.*** ***Recommendation: Develop a standardized coversheet for each PI file to help monitor PI files and ensure key elements of the investigation (e.g., timeline of actions taken, subject, provider name, Medicaid provider ID, address, provider type, source/origin of complaint, date reported to PIHP, date PIHP initiated the investigation, contact information for PIHP staff persons, an estimated or actual dollar value of funds exposed, etc.) are captured within each file.***
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:						This requirement is addressed in the *Fraud, Waste and Abuse Monitoring Procedure*. This requirement is also addressed in the *Attachment Y* PI tracking document.
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					Fifteen of fifteen case files reviewed met this requirement.
13.2 Source/origin of complaint;	X					Fifteen of fifteen case files reviewed met this requirement.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					Fifteen of fifteen case files reviewed met this requirement.
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					Fifteen of fifteen case files reviewed met this requirement.
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					This requirement was not applicable for two case files reviewed. Thirteen of thirteen applicable case files reviewed met this requirement.
13.6 All communications between PIHP and the Provider concerning the conduct at issues, when available.	X					Fifteen of fifteen case files reviewed met this requirement.
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					Fifteen of fifteen case files reviewed met this requirement.
13.8 Total Sample Amount of Funds Investigated per Service Type.		X				One of 14 applicable case files reviewed did not meet this requirement: #233. ***Corrective Action: Increase the monitoring of PI files to ensure all required elements are captured within the file documentation.*** ***Recommendation: Develop a standardized coversheet for each PI file to help monitor PI files and ensure key elements of the***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						investigation (e.g., timeline of actions taken, subject, provider name, Medicaid provider ID, address, provider type, source/origin of complaint, date reported to PIHP, date PIHP initiated the investigation, contact information for PIHP staff persons, an estimated or actual dollar value of funds exposed, etc.) are captured within each file.
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:						No cases of enrollee fraud were provided for the review period.
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		

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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		
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; 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					This requirement is addressed in *Policy and Procedure ADM 11, Fraud, Waste and Abuse Monitoring*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					This requirement is addressed in *Policy and Procedure ADM 11, Fraud, Waste and Abuse Monitoring* and in *Policy and Procedure PI 6, Fraud Detection Software Systems*.
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					This requirement is addressed in *Policy and Procedure ADM 11, Fraud, Waste and Abuse Monitoring* and in *Policy and Procedure PI 6, Fraud Detection Software Systems*.
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	X					This requirement is addressed in the NCID-FAMS users monthly reports dated July 2018 through June 2019 and in *Attachment Y*. This requirement is also addressed in *Policy and Procedure PI 9, Program Integrity Reporting* and *Policy* and *Procedure ADM 11, Fraud, Waste and Abuse Monitoring Procedures*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
next business day if the 10th day is a non-business day (i.e. weekend or State or PIHP holiday). Section 9.8 Fraud and Abuse Reports. 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 11:59p.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 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.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII C. Provider Payment Suspensions and Overpayments						
1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, NC Medicaid Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If NC Medicaid determines that a full investigation is warranted, NC Medicaid shall make a referral within five (5) business days of such determination to the MFCU/ MID and will suspend payments in accordance with *42 CFR § 455.23*. At least monthly, NC Medicaid shall provide written notification to PIHP of the status of each such referral. If MFCU/ MID indicates that suspension will not impact their investigation, NC Medicaid may send a payment suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates 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						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					This requirement is addressed in *Policy and Procedure ADM 11, Fraud, Waste and Abuse Monitoring Procedure*.
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					This requirement is addressed in *Policy and Procedure ADM 11, Fraud, Waste and Abuse Monitoring Procedure*.

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					This requirement is addressed in *Policy and Procedure ADM 11, Fraud, Waste and Abuse Monitoring Procedure*.
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					This requirement is addressed in *Policy and Procedure ADM 11, Fraud, Waste and Abuse Monitoring Procedure*.
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,	X					This requirement is addressed in *Policy and Procedure ADM 11, Fraud, Waste and Abuse Monitoring Procedure*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						
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 N.C.G.S. 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	X					This requirement is addressed in the *Tentative Notice of Overpayment (TNO)* template.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
the Department to PIHP mandating such recovery.						
7. Recovery Audit Contactors (RACs) for the Medicaid program may audit Providers in the PIHP Network and may work collaboratively with PIHP on identification of overpayments. NC Medicaid shall require RACs to give PIHP prior written notice of such audits and the results of any audits as permitted by law.						
8. The MFCU/MID reserves the right to prosecute or seek civil damages regardless of payments made by the Provider to PIHP. The Parties shall work collaboratively to develop a plan for the disbursement of the share of monies that are recovered and returned to the state by the MFCU/MID for fraudulent claims paid by PIHP. NC Medicaid will examine options to refund returned funds to PIHP and/or to appropriately account for these recoveries in the rate setting process.						

IX. FINANCIAL SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IX. Financial						
1. The PIHP has policies and systems in-place for submitting and reporting financial data.	X					Sandhills has *Procedure FIN 32b, Financial Reports Certification,* which establishes guidelines for certifying their monthly financial reports to State Medicaid. They also have *Procedure 14b, Financial Reports to the DHB*, which outlines the names of the reports and the due dates. All finance policies and procedures CCME reviewed reflect an annual review date of February 2019. ***Recommendation: Enhance policies and procedures by adding details about who is responsible for duties and citing contract requirements.*** ***Add to Procedures 14b, Financial Reports to the DHB and 32b, Financial Reports Certification, the due dates of monthly reports to NC Medicaid (i.e., the 20th of each month).***
2. The PIHP has and adheres to a cost allocation plan that meets the requirements of *42 CFR § 433.34*.	X					The administrative cost allocation plan is documented in Sandhills' 58, *Administrative Cost Allocation*. The FY 2018-2019 Plan was provided as part of Sandhills' Desk Materials. NC Medicaid funds absorb 87.5% of the administrative costs (prior fiscal year was 85%).
3. PIHP maintains detailed records of the administrative costs and expenses incurred as required by the *NC Medicaid Contract*.	X					Sandhills provided a copy of their chart of accounts, which has a segment for Administrative charges codes and services charge codes. Sandhills has *Procedure 32a Maintenance of Financial Records,* which cites maintaining detailed records of the administrative costs pursuant to the *NC Medicaid Contract*.
4. Maintains an accounting system in accordance with *42 CFR § 433.32 (a).*	X					Sandhills uses Great Plains Accounting System version 2018, and claims are processed using AlphaMCS.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. The PIHP follows a record retention policy of retaining records for ten years. (*NC Medicaid Contract, Section 8.3.2* and *Amendment 4, Section 31).*	X					Sandhills' *Procedure FIN 32a, Maintenance of Financial Records,* addresses compliance with NC Medicaid requirements for record retention for all financial records, and this policy was updated to reflect the ten-year retention required by *NC Medicaid Contract, Section 8.3.2.*
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution in accordance with *NC Medicaid Contract*.	X					Sandhills maintains their Medicaid restricted risk reserve accounts with First Bank and provided bank statements in their Desk Materials for May and June 2019. The balance at 6/30/19 was $35,510,378. Sandhills has *Procedure FIN 31b, Restricted Risk Reserve,* which states that Sandhills maintains their restricted risk reserve with a federally guaranteed financial institution.
7. The required minimum balance of the Risk Reserve Account meets the requirements of the *NC Medicaid Contract*.	X					Sandhills has met the required minimum balance by depositing 2% of their monthly capitation payments into the Risk Reserve Account. They are required to contribute 2% of each monthly payment, until they reach 15% of their payments. They are presently at 13.2%.
8. All funds received by PIHP are accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as required by the *NC Medicaid Contract*.	X					Funds are segregated by funding source. The chart of accounts was provided in the Desk Materials. All reports and systems separate Medicaid funds.
9. The Medical Loss Ratio (MLR) meets the requirements of *42 CFR § 438.8* and the *NC Medicaid Contract*.	X					Sandhills' Medical Loss Ratio is required to be 85%, and they reported 91.6% before HCQI and 97.7% after HCQI costs for May 2019, and 91.6% before HCQI activities, 97.8% after for June 2019.

E. Attachment 5: Encounter Data Validation Report

Sandhills

Encounter Data Validation Report

performed on behalf of

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

September 18, 2019

Prepared By:

hms

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

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Background

Health Management Systems (HMS) has completed a review of the encounter data submitted by 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 PIHPs, assuring compliance with State and federal regulations, and for oversight and audit functions."

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

Overview

The scope of our review, guided by the Centers for Medicaid and Medicare Services (CMS) Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid and submitted to NC Medicaid by Sandhills for the period of January 2018 through December 2018. All claims paid by Sandhills should be submitted and accepted as a valid encounter to NC Medicaid. Our approach to the review included:

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

Review of Sandhills' ISCA response

The review of Sandhills' ISCA response was focused on section V. Encounter Data Submission.

NC Medicaid requires each PIHP to submit their encounter data for all paid claims on a weekly basis via 837 Institutional and Professional transactions. The companion guides follow the standard ASC X12 transaction set with a few modifications to some segments. For example, the PIHP must submit their provider number and paid amount to NC Medicaid in the Contract Information CN104 and CN102 segment of Claim Information Loop 2300.

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

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

Looking at claims with dates of service in 2017, Sandhills submitted 1,199,324 unique encounters to the State. To date, less than 1% of all 2018 encounters submitted have not been corrected and accepted by NC Medicaid.

2018	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
Institutional	30,734	29,855	743	136	0.4%
Professional	1,168,590	1,140,606	22,648	5,336	0.5%
Total	1,199,324	1,170,461	23,391	5,472	0.5%

Each year Sandhills has made significant improvements to their encounter submission process, increasing their acceptance rate and quality of encounter data year over year. The table below reflects the increase in acceptance rate from 88% to over 99%, well above NC Medicaid's expectations.

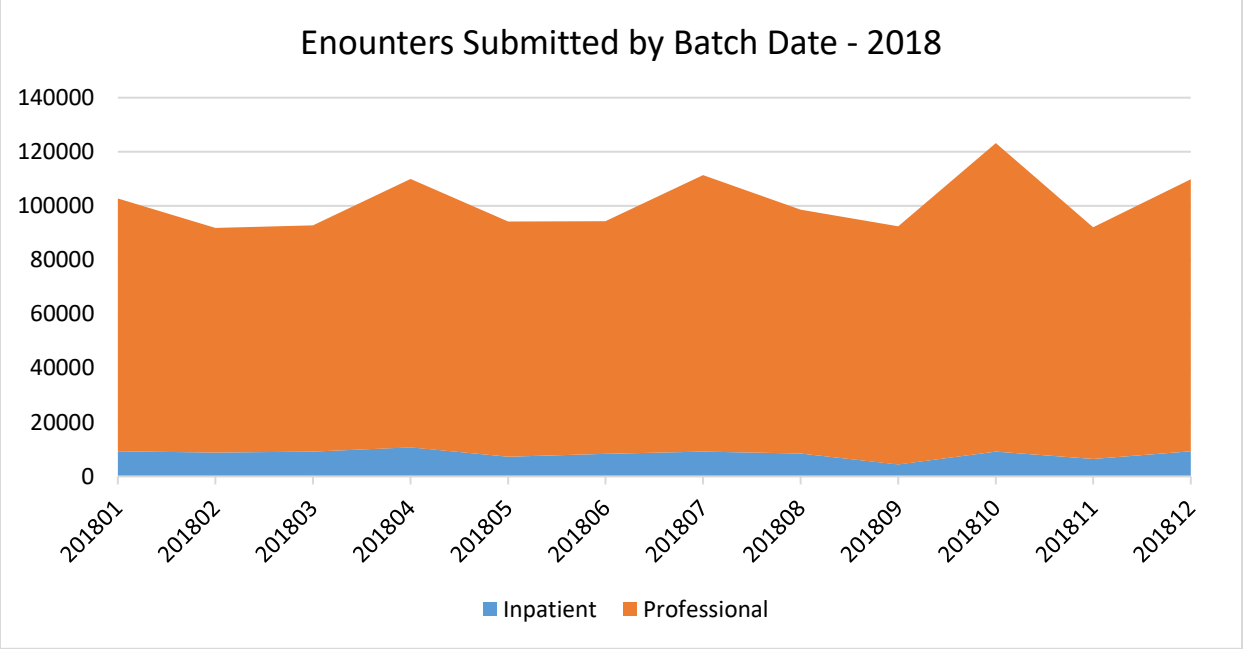
Year of Service	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
2016	1,150,666	923,609	92,786	134,271	12%
2017	1,169,756	1,031,325	97,737	40,694	3%
2018	1,199,324	1,170,461	23,391	5,472	0.5%

According to Sandhills' response and review of NC Medicaid's acceptance report, 35% of all ongoing denials are related to invalid Taxonomy Codes for the Billing and Rendering Provider. The PIHP has a detailed reconciliation and correction process in place to ensure that all denials are reviewed, corrected and resubmitted to NC Medicaid. Sandhills' strategy for correcting encounter denials includes the following steps:

- Running weekly queries to ensure all claims have been sent as an encounter
- Reconciling claim error reports with dedicated claim encounter staff
- Reconciling provider taxonomy and address information using Provider upload files (PUFs)
- Updating and maintaining provider education guidelines
- Rebilling corrected encounter denials

Analysis of Encounters

The analysis of encounter data evaluated whether Sandhills submitted complete, accurate, and valid data to NC Medicaid for all claims paid between January 1, 2018 and December 31, 2018. Sandhills converted each 837I and 837P file submitted to NC Medicaid during the requested audit period to an excel spreadsheet and sent to HMS via SFTP. This included more than one million Professional claims and just over one hundred thousand Institutional claims. Some may have been resubmissions for denials or adjustments, however, there was not an easy way to identify a subsequent adjustment looking at the data elements provided.



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

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

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
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
MCO/PIHP ID	Critical Data Element	100% valid
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	95% valid
Attending Provider ID	Should be an enrolled provider listed in the provider enrollment file (will accept the MD license number if it is listed in the provider enrollment file).	> 85% match with provider file using either provider ID or MD license number
Provider Location	Minimal requirement is county code, but zip code is strongly advised.	> 95% with valid county code > 95% with valid zip code (if available)
Place of Service	Should be routinely coded, especially for physicians.	> 95% valid for physicians > 80% valid across all providers
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% nonmissing and valid on physician or other applicable provider type claims (e.g., other practitioners)
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

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

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

Table: Evaluation of Key Fields

Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%
Recipient Name	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%
Recipient Date of Birth	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%
MCO/PIHP ID	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%
Provider ID	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%
Attending/ Rendering Provider ID	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%
Provider Location	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%
Place of Service	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%
Specialty Code / Taxonomy - Billing	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%
Specialty Code / Taxonomy - Rendering / Attending	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%
Principal Diagnosis	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%
Other Diagnosis	51,574	4.25%	51,574	4.25%	51,574	4.25%	51,574	4.25%
Dates of Service	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%

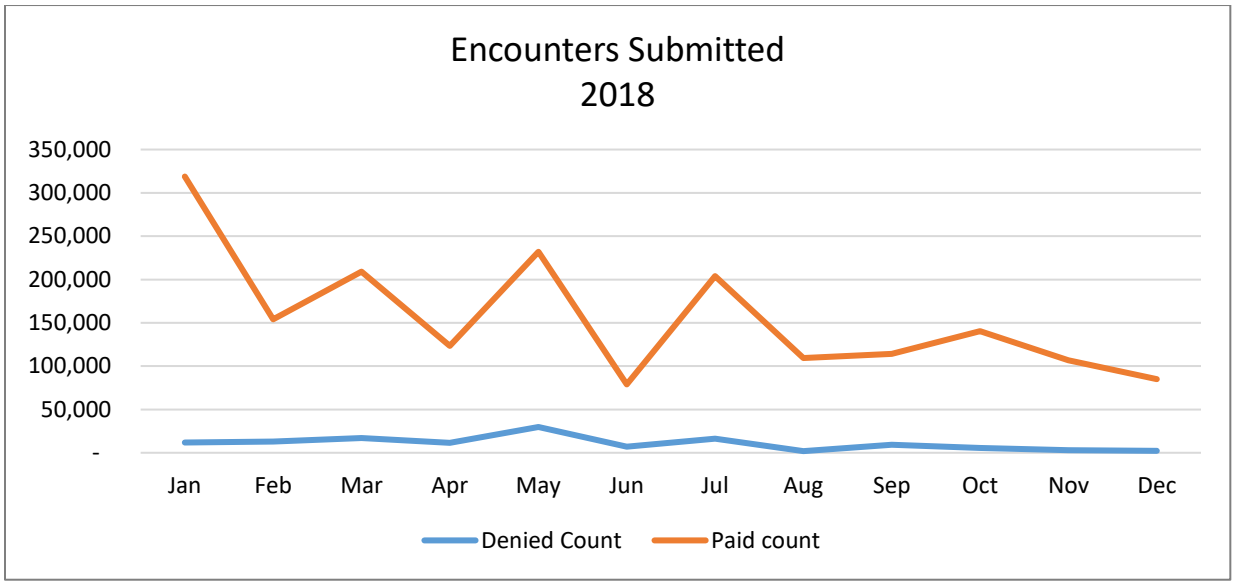
Unit of Service (Quantity)	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%	1,213,590	100.00%
Procedure Code	1,185,122	97.65%	1,185,122	97.65%	1,185,122	97.65%	1,185,122	97.65%
Procedure Code Modifier	386,900	31.88%	386,900	31.88%	386,900	31.88%	386,900	31.88%
Patient Discharge Status Code Inpatient	100,476	100.00%	100,476	100.00%	100,476	100.00%	99,472	99.00%
Revenue Code	100,476	100.00%	100,476	100.00%	100,476	100.00%	100,476	100.00%

Overall, 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. Only Admitting and Principal Diagnosis codes were populated for Institutional claims. The same issue was present in our 2017 claims review. A minor issue was noted with the Patient Discharge Status Code. Sandhills is allowing and reporting a discharge status of '00' which is not a valid value. The issue does not exceed the error threshold, so it is not reported as an error in the summary below.

Professional encounter claims submitted contained complete and valid data in 14 of the 15 key Professional fields (93%). The primary issue is the same as Institutional -- missing Other Diagnosis. The principal diagnosis code was populated 100% of the time, however, there was very little consistency in additional diagnosis codes being present. Other Diagnosis codes should be populated more than 4% of the time. Sandhills should also be capturing and submitting more than the primary and secondary diagnosis codes.

Encounter Acceptance Report

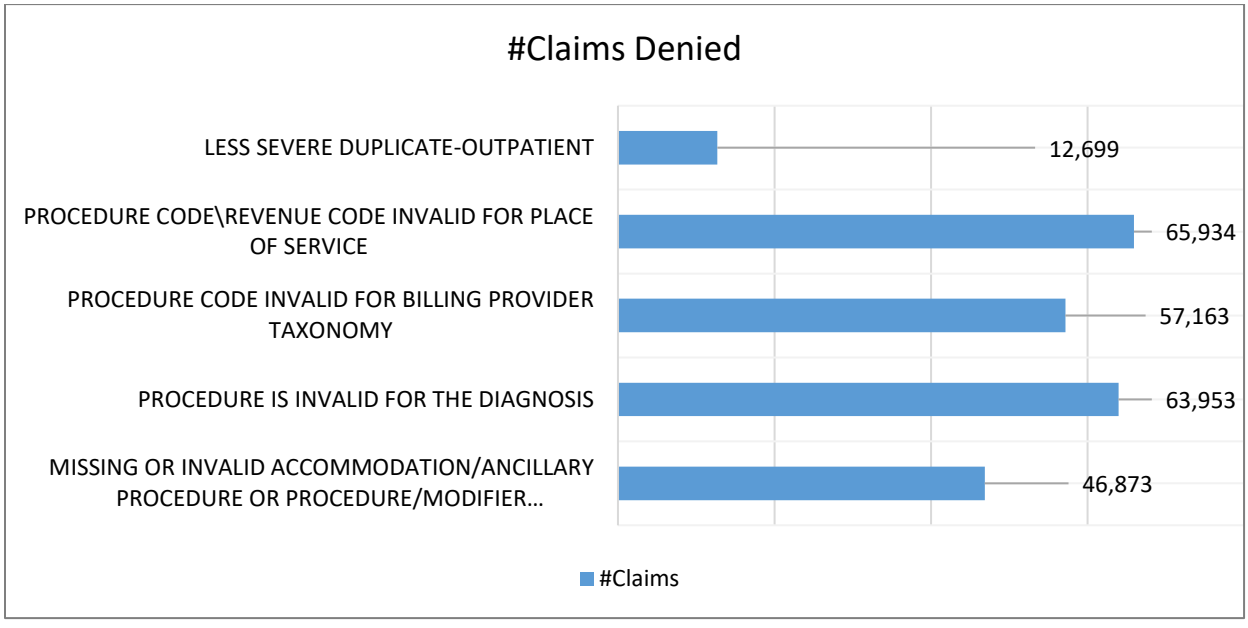
In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write and excludes duplicates or resubmission which made it difficult to tie back to the ISCA response and converted encounter files. Data provided by PIHP's reports for our review includes all submission and resubmissions during 2018 which may include older dates of service. During the 2018 weekly check write schedule, Sandhills submitted a total of 1,876,248 encounters to NC Medicaid. On average, 7% of all encounters submitted were initially denied.

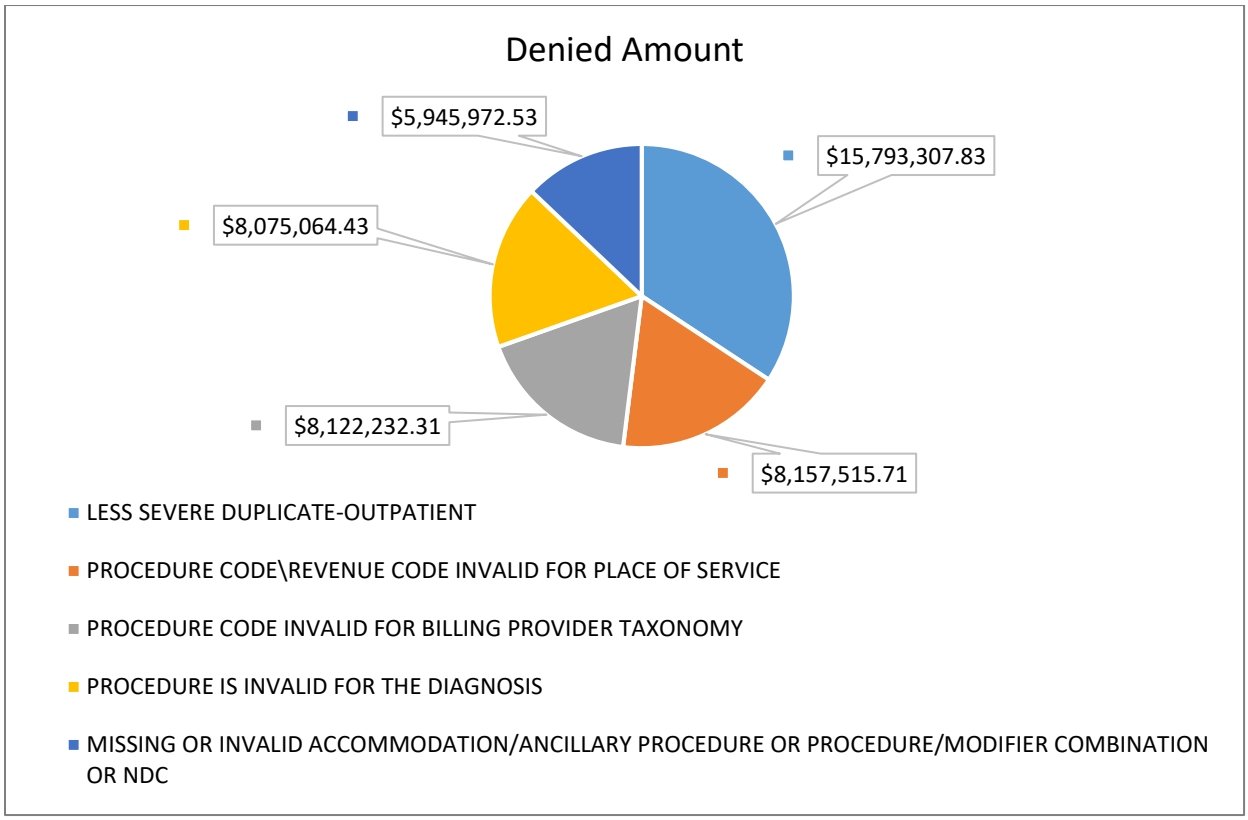


Evaluation of the top denials for Sandhills encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis above. Encounters were denied primarily for:

- Less severe duplicate – outpatient
- Procedure Code/Revenue Code invalid for Place of Service
- Procedure code invalid for billing provider taxonomy
- Procedure is invalid for the diagnosis
- Missing or invalid accommodation/ancillary procedure or procedure/modifier combination

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





Results and Recommendations

Issue: Other Diagnosis

Other Diagnosis was only populated 6% of the time for Institutional and Professional claims. Principal and admitting diagnosis was populated consistently where appropriate, however, no more than one additional diagnosis was received for any claim. This issue was present in the 2017 review. Sandhills should be capturing up to the maximum allowed

Resolution:

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

Conclusion

Based on the analysis of Sandhills' encounter data, we have concluded that the data submitted to NC Medicaid is complete and accurate as defined by NC Medicaid standards.

Their biggest issue was noted with the number of diagnosis codes being reported to NC Medicaid for both Professional and Institutional claims. Although the additional diagnosis codes do not impact adjudication, the codes are key for reporting, evaluating member health, and factors that will be used in a value based payment model. Sandhills should review and revise their 837 mapping immediately.

For the next review period, HMS is recommending that the encounter data from NCTracks be reviewed to look at encounters that pass front end edits and are adjudicated to either a paid or denied status. It is

difficult to reconcile the various tracking reports with the data submitted by the PIHP. Reviewing an extract from NCTracks would provide insight into how the State's MMIS is handling the encounter claims and could be reconciled back to reports requested from Sandhills. The goal is to ensure that Sandhills is reporting all paid claims as encounters to NC Medicaid. We also recommend that medical records be requested from providers to ensure the PIHP is receiving and capturing the correct information.

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 DHB REQ FOR FIN REV	IGNORE
00334	ENCOUNTER TAXON M/I	PAY AND REPORT
00335	ENCOUNTER PROV NUM MISSING	DENY
00337	ENC PROC CODE NOT ON FILE	PAY AND REPORT
00339	PRCNG REC NOT FND FOR ENC CLM	PAY AND REPORT
00349	SERV DENIED FOR BEHAV HLTH LM	IGNORE
00353	NO FEE ON FILE	PAY AND REPORT
00355	MANUAL PRICING REQUIRED	PAY AND REPORT
00358	FACTOR CD IND PROC NON-CVRD	PAY AND REPORT
00359	PROV CHRGS ON PER DIEM	PAY AND REPORT
00361	NO CHARGES BILLED	DENY
00365	DRG - DIAG CANT BE PRIN DIAG	DENY
00366	DRG - DOES NOT MEET MCE CRIT.	PAY AND REPORT
00370	DRG - ILLOGICAL PRIN DIAG	PAY AND REPORT
00371	DRG - INVLD ICD-9-CM PRIN DIAG	DENY
00374	DRG PAY ON FIRST ACCOM LINE	DENY
00375	DRG CODE NOT ON PRICING FILE	PAY AND REPORT
00378	DRG RCC CODE NOT ON FILE DOS	PAY AND REPORT
00439	PROC\REV CD INVLD FOR AGE	IGNORE
00441	PROC INVLD FOR DIAG	IGNORE
00442	PROC INVLD FOR DIAG	IGNORE
00613	PRIM DIAG MISSING	DENY

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

02105	POST-OP DATES M/I WITH MOD 55	IGNORE
02106	LN W/ MOD 55 MST BE SAME DOS	IGNORE
02107	XOVER CLAIM FOR CAP PROVIDER	IGNORE
02111	MODIFIER CC INTERNAL USE ONLY	IGNORE
02143	CIRCUMCISION REQ MED RECS	IGNORE
03001	REV/HCPCS CD M/I COMBO	IGNORE
03010	M/I MOD FOR PROF XOVER	IGNORE
03012	HOME HLTH RECIP NOT ELG MCARE	IGNORE
03100	CARDIO CODE REQ LC LD LM RC RI	IGNORE
03101	MODIFIER Q7, Q8 OR Q9 REQ	IGNORE
03200	MCE - INVALID ICD-9 CM PROC	DENY
03201	MCE INVLD FOR SEX PRIN PROC	PAY AND REPORT
03224	MCE-PROC INCONSISTENT WITH LOS	PAY AND REPORT
03405	HIST CLM CANNOT BE ADJ/VOIDED	DENY
03406	HIST REC NOT FND FOR ADJ/VOID	DENY
03407	ADJ/VOID - PRV NOT ON HIST REC	DENY
04200	MCE - ADMITTING DIAG MISSING	DENY
04201	MCE - PRIN DIAG CODE MISSING	DENY
04202	MCE DIAG CD - ADMIT DIAG	DENY
04203	MCE DIAG CODE INVLD RECIP SEX	PAY AND REPORT
04206	MCE MANIFEST CODE AS PRIN DIAG	DENY
04207	MCE E-CODE AS PRIN DIAG	DENY
04208	MCE - UNACCEPTABLE PRIN DIAG	DENY
04209	MCE - PRIN DIAG REQ SEC DIAG	PAY AND REPORT
04210	MCE - DUPE OF PRIN DIAG	DENY
04506	PROC INVLD FOR DIAG	IGNORE
04507	PROC INVLD FOR DIAG	IGNORE

04508	PROC INVLD FOR DIAG	IGNORE
04509	PROC INVLD FOR DIAG	IGNORE
04510	PROC INVLD FOR DIAG	IGNORE
04511	PROC INVLD FOR DIAG	IGNORE
07001	TAXON FOR ATTND/REND PROV M/I	DENY
07011	INVLD BILLING PROV TAXON CODE	DENY
07012	INVLD REND PROV TAXONOMY CODE	DENY
07013	INVLD ATTEND PROV TAXON CODE	PAY AND REPORT
07100	ANESTH MUST BILL BY APPR PROV	IGNORE
07101	ASC MODIFIER REQUIREMENTS	IGNORE
13320	DUP-SAME PROV/AMT/DOS/PX	DENY
13420	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
13460	POSSIBLE DUP-SAME PROV/PX/DOS	PAY AND REPORT
13470	LESS SEV DUPLICATE OUTPATIENT	PAY AND REPORT
13480	POSSIBLE DUP SAME PROV/OVRLAP	PAY AND REPORT
13490	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13500	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13510	POSSIBLE DUP/SME PRV/OVRLP DOS	PAY AND REPORT
13580	DUPLICATE SAME PROV/AMT/DOS	PAY AND REPORT
13590	DUPLICATE-SAME PROV/AMT/DOS	PAY AND REPORT
25980	EXACT DUPE. SAME DOS/ADMT/NDC	PAY AND REPORT
34420	EXACT DUP SAME DOS/PX/MOD/AMT	PAY AND REPORT
34460	SEV DUP-SAME PX/PRV/IM/DOS/MOD	DENY
34490	DUP-PX/IM/DOS/MOD/$$/PRV/TCN	PAY AND REPORT
34550	SEV DUP-SAME PX/IM/MOD/DOS/TCN	PAY AND REPORT
39360	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
39380	EXACT/LESS SEVERE DUPLICATE	PAY AND REPORT

49450	PROCDURE CODE UNIT LIMIT	PAY AND REPORT
53800	Dupe service or procedure	PAY AND REPORT
53810	Dupe service or procedure	PAY AND REPORT
53820	Dupe service or procedure	PAY AND REPORT
53830	Dupe service or procedure	PAY AND REPORT
53840	Limit of one unit per day	PAY AND REPORT
53850	Limit of one unit per day	PAY AND REPORT
53860	Limit of one unit per month	PAY AND REPORT
53870	Limit of one unit per day	PAY AND REPORT
53880	Limit of 24 units per day	DENY
53890	Limit of 96 units per day	DENY
53900	Limit of 96 units per day	DENY