2020 External Quality Review

SANDHILLS CENTER

Submitted: February 26, 2021

Prepared on behalf of the
North Carolina Department of
Health and Human Services,
North Carolina Medicaid

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EXECUTIVE SUMMARY

The *Balanced Budget Act of 1997* requires State Medicaid Agencies that contract with Prepaid Inpatient Health Plans (PIHPs) to evaluate their compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358 (42 CFR § 438.358)*. This review determines the level of performance demonstrated by Sandhills Center (Sandhills). This report contains a description of the process and the results of the 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 the PIHP complies with service delivery as mandated by their *NC Medicaid Contract*
- Provide feedback for potential areas of further improvement
- Verify the delivery and determine the quality of contracted health care services

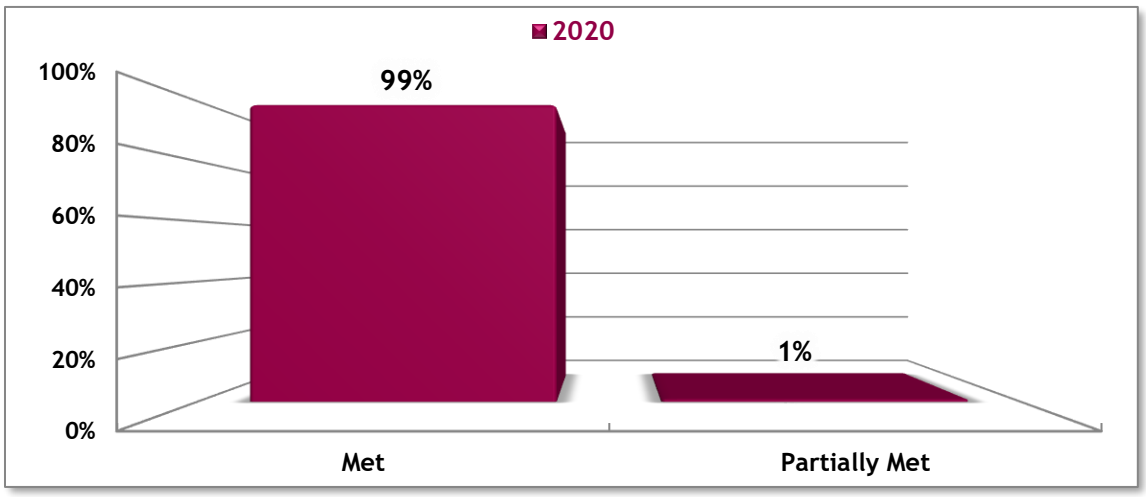
The process used for the EQR was based on the Centers for Medicare & Medicaid Services (CMS) protocols for EQR of Medicaid Managed Care Organizations (MCOs) and PIHPs. The review includes a Desk Review of documents, Onsite interviews, compliance review, validation of performance improvement projects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

Due to the COVID-19 pandemic, the 2020 EQR was delayed, and CCME implemented a focused review.

A. Overall Score

The 2020 Annual EQR reflects that Sandhills achieved a “Met” score for 99% of the standards reviewed. As Figure 1 indicates, 1% of the standards were scored as “Partially Met.” None of the 2020 EQR standards were scored as “Not Met.”

Figure 1: 2020 EQR Results



B. Overall Findings

The following provides a global or high-level summary of the status of the Recommendations and Corrective Action items from the 2019 EQR and the findings of the 2020 EQR. Specific Recommendations and Corrective Actions are detailed in each section of this report.

Information Systems Capabilities Assessment (ISCA)

In the 2019 EQR, Sandhills met 90% of the Administrative standards, which included the 2019 ISCA review, and received two Corrective Actions related to Sandhills' need to better capture and report ICD-10 Procedure and Diagnosis codes. Sandhills successfully implemented the 2019 Corrective Actions and met 100% of the ISCA standards in the 2020 EQR. Based on the findings in the 2020 EQR, it is recommended that Sandhills continue to work with providers and the State to increase the number of ICD-10 Procedure codes submitted into NCTracks.

Provider Services

In the 2019 EQR, there were two items requiring Corrective Action and three Recommendations in the Credentialing/Recredentialing section of Provider Services. Sandhills addressed all Corrective Action items and all Recommendations. Sandhills met 100% of the Credentialing/Recredentialing standards in this 2020 EQR. There are no Recommendations.

Quality Improvement

The Quality Improvement (QI) section included validation of Performance Measures and Performance Improvement Projects (PIPs). The Performance Measure Query was accurate for (b) Waiver measures. One (b) Waiver measure had a substantial rate decline from last year, and five measures had substantial rate increases. All (c) Waiver Performance Measures were above benchmark rates. The four validated PIPs all scored in the High Confidence range, although each PIP has Recommendations for improvement. That is an improvement over the

2019 EQR when three PIPs scored High Confidence and one PIP scored in the Confidence range. In this 2020 EQR, 100% of the Quality Improvement standards were met.

Utilization Management

In the 2019 EQR, Sandhills met 96% of Utilization Management (UM) standards and received two Corrective Actions and four Recommendations. The two Corrective Actions and two Recommendations were related to implementing monitoring plans for Intellectual/Developmental Disability (I/DD) and Transition to Community Live (TCLI) Care Coordination documentation by using data reports generated in the Quality Management Department. The remaining two Recommendations were related to updating the *Member Handbook* and a TCLI procedure. Sandhills addressed and implemented all 2019 Corrective Action items and Recommendations.

In the 2020 EQR, the UM section evaluated Care Coordination functions and documentation. Sandhills met 100% of the standards in this year's EQR, and received one Recommendation. CCME recommends Sandhills add details regarding Home and Community Based Services into I/DD Care Coordination policies and procedures.

Grievances and Appeals

In the 2019 EQR, Sandhills met 75% of the grievance and appeals standards and received 13 Corrective Actions and three Recommendations. These Corrective Actions and Recommendations primarily targeted compliance issues across Sandhills' policies and procedures, *Medicaid Provider Manual* and *Member Handbook*.

In the 2020 EQR, it was evident Sandhills corrected many of the appeal and grievance compliance issues noted in the 2019 EQR. Some required language regarding extended grievance resolution timeframes is still needed in Sandhills' *Member Handbook*, and appeals policies and procedures need additional detail regarding expedited appeals. The review of the grievance files showed the grievance resolution notifications did not always reflect all of the steps Sandhills took to resolve the grievance. Additionally, the review of the appeals files submitted showed staff were not starting the appeal resolution timeframe when an oral appeal was submitted by the enrollee. This practice is out of compliance with Sandhills' policies and procedures which state, "The timeframe for resolution starts when the first request is received, regardless of whether the request is received orally or in writing."

As a result, in this 2020 EQR, Sandhills met 90% of the appeals and grievance standards and received two Corrective Actions and five Recommendations.

Program Integrity

In the 2019 EQR, Sandhills met 97% of the Program Integrity (PI) standards. Two Corrective Actions were issued to address findings related to the PI file review, and Sandhills successfully addressed and implemented these Corrective Actions.

In the 2020 EQR, the Desk Review of Sandhills' PI files and documentation were assessed for compliance with federal and state regulations and Sandhills' contract with NC Medicaid. Sandhills met all of the PI standards in this year's EQR.

Encounter Data Validation

Based on the analysis of Sandhills' encounter data, it was concluded that the data submitted to NC Medicaid is complete and accurate. Minor issues were noted with both Institutional and Professional encounters due to Taxonomy codes and additional Diagnosis codes.

Sandhills has made progress in improving the accuracy of encounter data over the past couple of years and should continue to work on resolving issues related to Billing Taxonomy, Rendering Taxonomy, and additional Diagnosis codes. Denials due to Taxonomy codes remain the dominant cause of denial by a large margin. Sandhills should revisit the strategy it has put in place to address issues with invalid or missing Taxonomy codes and make necessary adjustments to further reduce Taxonomy code denials.

Diagnosis codes missing on Professional claims do not impact the ability to price the claims; however, this practice will impact NC Medicaid's ability to provide proper oversight and performance measure effectiveness. Sandhills should work with its providers to encourage complete and accurate reporting of additional Diagnosis codes.

METHODOLOGY

The process used for the 2020 EQR was based on the CMS protocols for EQR of MCOs and PIHPs. This review focused on the three federally mandated EQR activities: compliance determination, validation of Performance Measures, and validation of Performance Improvement Projects, as well as optional activity in the area of Encounter Data Validation, conducted by CCME's subcontractor, HMS. Additionally, as required by CCME's contract with NC Medicaid, an Information Systems Capabilities Assessment (ISCA) Audit and Medicaid program integrity (PI) review of the health plan was conducted by CCME's subcontractor, IPRO.

On November 2, 2020, CCME notified Sandhills that the annual EQR was being initiated (see *Attachment 1*). This notification included:

- Materials Requested for Desk Review
- Information Systems Capabilities Assessment (ISCA)
- Draft Onsite Agenda
- PIHP 2020 EQR Standards

Further, an invitation was extended to Sandhills 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 on November 22, 2020, and reviewed by CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. The Desk Review included a review of Credentialing, Grievance, Program Integrity, Care Coordination, and Appeal files.

The second segment of the EQR is typically a two-day Onsite review conducted at the PIHP's offices. However, due to COVID-19, this Onsite was conducted through a teleconference platform on January 28, 2021. This Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the Onsite visit, see *Attachment 2*. CCME's Onsite activities included:

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

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

FINDINGS

The findings of the EQR are summarized in the following pages of this report and are based on the regulations set forth in *42 CFR § 438* and the *NC Medicaid Contract* requirements between Sandhills and NC Medicaid. Strengths, Weaknesses, Corrective Action items, and Recommendations are identified, where applicable. Areas of review were identified as meeting a standard (Met), acceptable but needing improvement (Partially Met), failing a standard (Not Met), Not Applicable, or Not Evaluated, and are recorded on the Tabular Spreadsheet (*Attachment 4*).

A. Information Systems Capabilities Assessment (ISCA)

The review of Sandhills' system capabilities involved the use of the Information Systems Capabilities Assessment (ISCA) tool and review of supporting documentation such as Sandhills' Disaster Recovery Plan, claim audit reports, enrollment workflows, and Sandhills' Information Technology staffing patterns. This system analysis was completed as specified in the Centers for Medicaid and Medicare Services (CMS) protocol. During the Onsite, staff presented a member and claims systems review. Questions regarding the ISCA tool and follow-up on 2019 EQR findings were discussed with Sandhills staff.

In the 2019 EQR, Sandhills met 90% of the Administrative standards, which included the 2019 ISCA review, and received two Corrective Actions related to the need to better capture and report ICD-10 Procedure and Diagnosis codes. Sandhills successfully implemented the 2019 Corrective Actions and met 100% of the ISCA standards in the 2020 EQR.

Sandhills, like many other PIHPs in North Carolina, uses the AlphaMCS transactional, a hosted system environment produced by WellSky. The AlphaMCS system is used to process member enrollment and claims, submit encounters, and generate reports. WellSky modifies the user interface and conducts backend programming updates to the system.

The ISCA tool and supporting documentation for enrollment systems loading processes clearly define the process for enrollment data updates in the AlphaMCS enrollment system. During the ISCA Onsite, Sandhills provided a demonstration of the AlphaMCS enrollment system. The system maintains a member's enrollment history. The Global Eligibility File (GEF) file is imported daily into the AlphaMCS by WellSky. The daily eligibility file is compared to existing eligibility in the AlphaMCS. The member enrollment records are processed and compared against the existing enrollment information in the database.

During the Onsite, Sandhills stated that WellSky has a process in place to generate error reports and notify Sandhills when errors are encountered during the GEF load process. Sandhills confirmed that WellSky has not encountered any errors while uploading the daily and quarterly GEF files. During the Onsite, Sandhills stated they also load the GEF files to a local database that is used to compare the records with AlphaMCS. Sandhills confirmed they have encountered at most three record errors in the past year.

Enrollees are identified by unique system generated Patient IDs. During the process of loading the GEF file, recipients are matched by their Social Security number, name, and date of birth. New recipients are identified when there is no matching Social Security number, name, and date of birth existing in the member database. A unique patient ID is generated and assigned to new recipients.

Sandhills stores the Medicaid identification number received on the GEF. During the Onsite, Sandhills indicated that they rarely see members with multiple 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.

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. Sandhills has experienced a small decrease in year-end enrollment numbers over the past three years.

Table 1: Enrollment Counts

2017	2018	2019
194,894	188,683	184,964

On a monthly basis, Sandhills uses the 820 Capitation file to reconcile with their payments to identify missing payments and overpayments received. During the Onsite system demonstration, 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.

Sandhills' authorizations and claims are processed in the AlphaMCS system. 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. Demonstrations of Sandhills' Provider web claims entry portal and the AlphaMCS claims processing system were performed during the Onsite.

Sandhills receives claims from three sources, 837 electronic file, provider web portal, and paper claims. During the Onsite, Sandhills stated that they receive claims from out-of-state providers and Emergency Room (ER) claims on paper. Table 2 details the percent of claims with 2019 dates of service that were received via Electronic (HIPAA, Provider Web Portal) or Paper forms.

Table 2: Percent of Claims with 2019 Dates of Service

Source	HIPAA File	Paper	Provider Web Portal
Institutional	83%	>1%	17%
Professional	60%	>1%	40%

Sandhills processes claims within 18 days of receipt, and if approved, claims are paid within 30 days of receipt. If a required field is missing from a claim, the provider portal will not allow the claim to be submitted to Sandhills. If the claim is being submitted electronically via an electronic 837 file and one or more required fields are missing, the provider will receive a HIPAA 999 response file advising of the claim submission failure. Sandhills uses exception reports created from AlphaMCS to identify the missing information on the Institutional and Professional claims submitted electronically. Edits and checks that are in place for Institutional and Professional claims include, but are not limited to, 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 on a nightly basis. Data shows that 99.76% of Professional claims and 87.57% of Institutional claims are auto-adjudicated. On average, 99% of Professional claims and 98% of Institutional claims are paid within three months of the date of service.

Sandhills conducts audits of claims processed on a weekly and monthly basis. Sandhills staff conduct random audits of 3% of paid and 3% of denied claims processed for a week. Audits are conducted by a designated Claims Analyst 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 (QM) Department with assistance from Sandhills' Finance Department. Additional audits are conducted based on the observations of utilization management (UM) reviewers on a particular provider or service. A sample daily claims audit report and claims exception report was submitted for the Desk Review to show monitoring and oversight of claims processing in the AlphaMCS. During the Onsite, Sandhills indicated that the paid and denied claims with the five largest paid amounts are audited on a weekly basis. Sandhills also audits the claims examined by new-hire claims examiners to identify any specific training that is required.

On the AlphaMCS claim system, Sandhills captures as many as 25 ICD-10 Diagnosis codes via the provider web portal and as many as 29 ICD-10 Diagnosis codes for Institutional claims. For Professional claims, Sandhills has the ability to receive and store as many as 12 Diagnosis codes on both the provider web portal and HIPAA files. Sandhills captures ICD-10 Procedure codes and Diagnosis Related Groups (DRGs), if they are submitted on the claim. During the Onsite discussion, Sandhills stated that they are able to capture and submit Telehealth modifier codes during the ongoing COVID-19 pandemic.

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

Sandhills uses the AlphaMCS to generate reports with real time data. A local reporting database is also used to create reports. The enrollment, provider, claims, and authorization information that is captured in the AlphaMCS is available in the local reporting database. Sandhills maintains an internal database that is a copy of the AlphaMCS database and is refreshed on a daily basis using a backup copy of the database from WellSky. During the Onsite discussion, Sandhills stated that they also use raw GEF and global provider files to create reports. Sandhills uses a Pay and Deny application to reconcile the 820 capitation files, 834 enrollment files, and the Adam Holtzman paid and denied encounter data reports. Sandhills developed this application internally.

Full enrollment and claims history are maintained in the AlphaMCS system. During the Onsite discussion, Sandhills indicated that reporting database is backed up on a nightly basis, and Sandhills did not have any negative business impact due to the ongoing COVID-19 pandemic.

WellSky generates data extracts and reports for Sandhills within the AlphaMCS system. Sandhills also uses Microsoft SQL Server (MSSQL) and SQL Server Reporting Services (SSRS) to create reports internally from the reporting database. During the Onsite discussion, Sandhills stated that they create several ad hoc reports on a daily basis from their reporting database.

As of December 2019, Sandhills has addressed and implemented a Corrective Action from the 2019 EQR, meaning that Sandhills can now store and use the ICD-10 Procedure codes for reporting.

Internal claims reports were provided as supplemental documentation for the ISCA review. A sample claim exception report, the claims lag report, and the sample claims audit reports indicate Sandhills has oversight and monitoring of its claims processes.

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. Encounters that are approved by Sandhills are submitted to NCTracks. Sandhills has the ability to track claims from the adjudication process to their encounter submissions status. The 835 file from NCTracks is used to review denials. The extraction, submission, and reconciliation of encounter data are fully automated. During the Onsite discussion, Sandhills stated that they have developed a Pay and Deny application 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 2019. Table 3 provides a comparison of 2018 and 2019.

Table 3: Volume of 2018 and 2019 Submitted Encounter Data

2019	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	30,537	239	1,830	32,606
Professional	1,217,873	12,641	4,803	1,235,317
2018	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	32,547	154	147	32,848
Professional	1,137,210	25,220	6,216	1,168,646

Sandhills has a 99.5% acceptance rate for both Professional and Institutional encounters with dates of service in 2019. During the Onsite discussion, Sandhills stated that the slight increase in the number of denied Institutional encounters was due to duplicate encounter files being submitted to NCTracks. Sandhills is working on addressing this issue. Sandhills indicated that the three top denial reason codes were:

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

On average, Sandhills submits an encounter within five days of adjudication to NCTracks. It takes approximately 24 days to correct and resubmit an encounter to NCTracks. Sandhills uses a paid and denied report and the weekly 835 file to identify encounters that were denied.

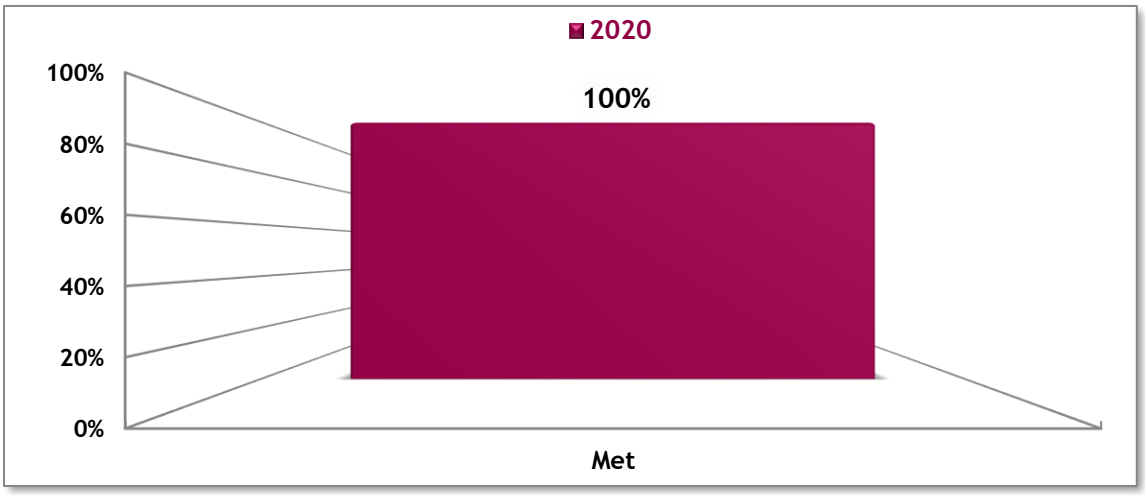
As stated in the ISCA, Sandhills has 176 Institutional and 4,084 Professional encounters still awaiting resubmission as of 11/01/2020. During the Onsite discussion, Sandhills stated that they have developed a Pay and Deny encounter reconciliation application that is based on the Adam Holtzman's paid and denied report. This application is used to identify the reason for rejection of the encounter and track the encounter through the different stages of resubmission. Sandhills exceeds NC Medicaid standards for encounter submissions and has less than a 0.5% denial rate of their encounter data submissions.

Sandhills reported on the number of ICD-10 Diagnosis codes submitted on Institutional and Professional encounters to NC Medicaid. For Institutional encounters, Sandhills is submitting as many as 29 ICD-10 Diagnosis codes and for Professional encounters, Sandhills is submitting

as many as 12 ICD-10 Diagnosis codes. Sandhills has addressed the Corrective Action from the 2019 EQR and is now able to submit all ICD-10 Diagnosis codes received on Institutional claims to NCTracks. During the Onsite, Sandhills inquired whether NCTracks has the ability to accept ICD-10 Procedure codes on Institutional encounters. NC Medicaid has confirmed that they have the ability to accept ICD-10 Procedure codes on Institutional encounters.

Figure 2 demonstrates that Sandhills met all of the standards in the 2020 ISCA EQR.

Figure 2: ISCA Findings



Strengths

- Sandhills can capture of as many as 29 Diagnosis codes on Institutional claims and 12 Diagnosis codes on Professional claims.
- Sandhills can capture and use the ICD-10 Procedure codes on Institutional claims for reporting.
- Sandhills can submit as many as 29 ICD-10 Diagnosis codes on Institutional encounters to NCTracks.
- Sandhills' current NCTracks encounter data acceptance rate is 99.5%. Sandhills has maintained their very high acceptance rate of encounter data submissions.

Weaknesses

- Sandhills does not have the ability to submit ICD-10 Procedure codes on encounter data extracts to NCTracks.

Recommendations

- Sandhills should continue to work with providers and the State to increase the number of ICD-10 Procedure codes submitted into NCTracks.

B. Provider Services

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

In Sandhills' 2019 EQR of Credentialing/Recredentialing, there were two items requiring Corrective Action and three items for which CCME issued a Recommendation. Sandhills addressed both of the Corrective Action items and all three Recommendations. Sandhills met 100% of the Credentialing/Recredentialing standards in the current EQR.

The Provider Credentialing Plan Procedure, N-CR 1a-19a, N-NM 3a, guides the credentialing and recredentialing processes. Policy and Procedure N-CR3, Credentialing Committee, defines the "Scope of Responsibilities & Duties" of the Sandhills Credentialing Committee. In the past, the Credentialing Subcommittee was a subgroup of the Clinical Advisory Committee. The Credentialing Committee is now a stand-alone committee. Dr. Anthony Carraway, a Board-Certified Psychiatrist and Sandhills' Chief Clinical Officer (CCO)/Medical Director, chairs the Committee. The Provider Credentialing Plan states, "The Chief Clinical Officer/Medical Director will designate a non-Sandhills Center physician committee member to chair the meeting in the event that the Chief Clinical Officer/Medical Director is unable to attend if voting is required."

The committee is currently composed of seven Sandhills staff members and six licensed, provider members. Sandhills staff members do not vote, except in the case of a tie vote, when the Sandhills CCO/Medical Director casts the deciding vote. A quorum is defined as "a majority of more than ½ of non-Sandhills Center staff voting members." The sample of Credentialing Committee meeting minutes reviewed for this EQR indicated a quorum was present.

Orientation materials, training opportunities and events, the *Medicaid/State Provider Manual*, and provider forms and documents are posted on Sandhills' website. New providers receive communications directing them to the materials. Sandhills offers an Annual Provider Orientation, which was provided electronically in 2020 due to COVID-19. The Annual Provider Orientation, which is posted on the website, included information from Quality Management, Finance, UM/Care Management, Customer Services, and Network Operations.

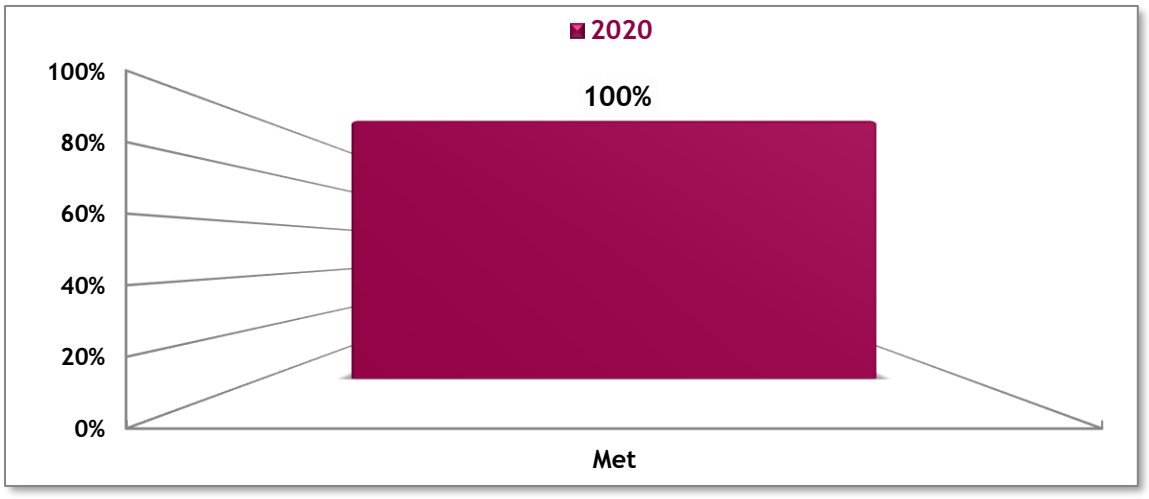
Under the COVID-19 flexibilities outlined in *NC Medicaid Contract Amendment # 9*, the annual *Network Adequacy and Accessibility Analysis* (Gaps Analysis) will be submitted "no later than ninety (90) calendar days after termination of the Amendment." At the last EQR, Sandhills reported they submitted Exception Requests to NC Medicaid in late June 2019 for Child and Adolescent Day Treatment, SA Comprehensive Outpatient Treatment Program, and Opioid

Treatment. As of the last Onsite review (August 28 and 29, 2019), NC Medicaid had not yet approved the Exception Requests for those services.

During the Onsite review for this EQR, Sandhills staff discussed actions taken to address the previously identified gaps, and reported the Opioid Treatment gap was closed. To address current gaps, Sandhills staff reported that there are several projects underway, including pilot projects for Partial Hospitalization, ambulatory detox, facility-based respite, and facility-based crisis services. As a result of an RFP for Level II and Level III providers, Sandhills awarded seven additional sites across five providers.

As Figure 3 indicates, 100% of the standards in the Provider Services review were scored as "Met".

Figure 3: Provider Services Findings



Strengths

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

C. Quality Improvement

The 2020 Quality Improvement (QI) EQR included Performance Measures and Performance Improvement Projects (PIPs) validation. CCME conducted a Desk Review of the submitted (b) and (c) Waiver Performance Measures and a review of each PIP's *Quality Improvement Description Form* for validation, using CMS standard validation protocols. An Onsite discussion occurred to clarify measurement rates for each of the measures and projects.

One Corrective Action was issued in the 2019 EQR related to one of Sandhills' PIPs. There was evidence Sandhills addressed this Corrective Action through the Corrective Action Plan process, however, the PIP was not validated in the 2020 EQR. In the 2019 EQR, four Recommendations were also given. Sandhills implemented these Recommendations, as well. In the 2020 EQR, there are no items requiring Corrective Action and five Recommendations regarding the PIPs.

The Performance Measure Query was accurate for (b) Waiver Measures and all measures were validated at 100% and "Fully Compliant." This was the same validation score earned in the 2019 EQR. There was a substantial decline from the last EQR in one measure, and five measures showed significant improvement over the past EQR. Those measures with improvement and decline were discussed during the Onsite interview. The five (c) Waiver Performance Measures were above benchmark rates and did not require further Onsite discussion. All measures were validated at 100% and "Fully Compliant" for this 2020 EQR.

The four validated PIPs all scored in the High Confidence range, although each PIP has Recommendations for improvement. These Recommendations are outlined in Table 20.

Performance Measure Validation

As part of the EQR, CCME conducted the independent validation of NC Medicaid-selected (b) and (c) Waiver performance measures. The selected measures are included in Table 4 and 5.

Table 4: (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 5: (c) Waiver Measures

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

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

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

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

(b) Waiver Measures Reported Results

The measures rates as reported by Sandhills are included in the tables that follow. The current rate in comparison to the rate at the previous EQR is presented in *Tables 6* through *15*.

There was a substantial increase of more than 21% for members receiving Outpatient Visits Within Seven Days in the category of Follow-up After Hospitalization for Mental Illness, Facility Based Crisis measure. There was a substantial decline of 13% for the 30-day Follow-up After Hospitalization for Mental Illness for PRTF measure. Follow-up After Hospitalization for Substance Abuse improved for 3-day, 7-day, and 30-day follow up by more than 30% in each category. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment for 18-20 year-olds improved by more than 14% when compared to the previous EQR.

Table 6: A.1. Readmission Rates for Mental Health

30-day Readmission Rates for Mental Health	2018	2019	Change
Inpatient (Community Hospital Only)	8.0%	8.4%	0.4%
Inpatient (State Hospital Only)	0.0%	0.0%	0.0%
Inpatient (Community and State Hospital Combined)	8.1%	8.4%	0.3%
Facility Based Crisis	7.7%	11.4%	3.7%
Psychiatric Residential Treatment Facility (PRTF)	11.2%	14.3%	3.1%
Combined (includes cross-overs between services)	9.3%	8.8%	-0.5%

Table 7: A.2. Readmission Rate for Substance Abuse

30-day Readmission Rates for Substance Abuse	2018	2019	Change
Inpatient (Community Hospital Only)	7.7%	4.7%	-3.0%
Inpatient (State Hospital Only)	0.0%	2.0%	2.0%
Inpatient (Community and State Hospital Combined)	8.0%	4.3%	-3.7%
Detox/Facility Based Crisis	2.4%	10.9%	8.5%
Combined (includes cross-overs between services)	7.8%	5.9%	-1.9%

Table 8: A.3. Follow-Up after Hospitalization for Mental Illness

Follow-up after Hospitalization for Mental Illness	2018	2019	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	40.7%	40.0%	-0.7%
Percent Received Outpatient Visit Within 30 Days	59.9%	58.2%	-1.7%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	60%	81.8%	**21.8%**
Percent Received Outpatient Visit Within 30 Days	80%	81.8%	1.8%
PRTF			
Percent Received Outpatient Visit Within 7 Days	22.4%	23.1%	0.7%
Percent Received Outpatient Visit Within 30 Days	59.2%	46.2%	**-13.0%**
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	40.2%	40.0%	-0.2%
Percent Received Outpatient Visit Within 30 Days	59.9%	58.2%	-1.7%

Table 9: A.4. Follow-Up After Hospitalization for Substance Abuse

Follow-up after Hospitalization for Substance Abuse	2018	2019	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	18.1%	21.3%	3.2%
Percent Received Outpatient Visit Within 30 Days	29.7%	34.1%	4.4%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	27.3%	58.6%	**31.3%**
Percent Received Outpatient Visit Within 7 Days	27.3%	69.0%	**41.7%**
Percent Received Outpatient Visit Within 30 Days	27.3%	69.0%	**41.7%**
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	18.5%	26.0%	7.5%
Percent Received Outpatient Visit Within 30 Days	29.6%	37.5%	7.9%

Table 10: B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2018	2019	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	44.0%	49.2%	5.2%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	40.9%	40.8%	-0.1%
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	39.4%	53.8%	14.4%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	29.8%	38.6%	8.8%
Ages 21–34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	53.7%	57.1%	3.4%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	44.0%	44.4%	0.4%
Ages 35–64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	52.5%	54.8%	2.3%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	43.7%	43.3%	-0.4%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	53.3%	60.0%	6.7%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	47.7%	48.3%	0.6%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	51.6%	55.3%	3.7%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	42.9%	43.4%	0.5%

Table 11: D.1. Mental Health Utilization-Inpatient Discharges and Average Length of Stay

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		2018	2019	Change	2018	2019	Change
3-12	Male	0.2	0.2	0.0	26.9	44.3	17.4
	Female	0.2	0.2	0.0	15.1	28.4	13.3
	Total	0.2	0.2	0.0	20.9	36.9	16
13-17	Male	0.9	1.0	0.1	33.5	49.5	16
	Female	1.8	2.0	0.2	24.5	23.1	-1.4
	Total	1.3	1.5	0.2	27.7	31.8	4.1
18-20	Male	1.3	1.3	0.0	10.7	7.9	-2.8
	Female	1.2	1.2	0.0	5.7	9.4	3.7
	Total	1.2	1.2	0.0	8.1	8.7	0.6
21-34	Male	4.3	3.5	-0.8	7.1	7.6	0.5
	Female	1.3	1.3	0.0	7.0	5.7	-1.3
	Total	1.9	1.8	-0.1	7.1	6.5	-0.6
35-64	Male	2.1	2.5	0.4	7.6	8.4	0.8
	Female	1.8	1.6	-0.2	7.6	7.5	-0.1
	Total	1.9	2.0	0.1	7.6	7.9	0.3
65+	Male	0.3	0.2	-0.1	18.5	21.9	3.4
	Female	0.2	0.2	0.0	12.7	16.2	3.5
	Total	0.3	0.2	-0.1	15.1	18.3	3.2
Unknown	Male	0.0	0.0	0.0	0.0	0.0	0.0
	Female	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0
Total	**Male**	1.0	**1.0**	**0.0**	**14.4**	**19.5**	**5.1**
	Female	1.0	**1.0**	**0.0**	**12.1**	**13.4**	**1.3**
	Total	1.0	**1.0**	**0.0**	**13.1**	**16.0**	**2.9**

Table 12: 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		
		2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
3-12	Male	11.23%	11.34%	0.11%	0.18%	0.03%	-0.15%	0.38%	0.23%	-0.15%	11.13%	11.30%	0.17%
	Female	8.19%	8.73%	0.54%	0.20%	0.03%	-0.17%	0.20%	0.11%	-0.09%	8.14%	8.71%	0.57%
	Total	9.76%	10.07%	0.31%	0.19%	0.03%	-0.16%	0.29%	0.17%	-0.12%	9.68%	10.05%	0.37%
13-17	Male	13.42%	14.15%	0.73%	0.91%	0.26%	-0.65%	0.65%	0.33%	-0.32%	13.19%	14.02%	0.83%
	Female	15.08%	16.10%	1.02%	1.63%	0.26%	-1.37%	0.29%	0.21%	-0.08%	14.79%	16.06%	1.27%
	Total	14.23%	15.12%	0.89%	1.27%	0.26%	-1.01%	0.47%	0.27%	-0.20%	13.98%	15.02%	1.04%
18-20	Male	8.73%	8.56%	-0.17%	1.11%	0.00%	-1.11%	0.02%	0.05%	0.03%	8.51%	8.55%	0.04%
	Female	10.98%	11.41%	0.43%	1.27%	0.07%	-1.20%	0.04%	0.03%	-0.01%	10.65%	11.39%	0.74%
	Total	9.91%	10.04%	0.13%	1.20%	0.04%	-1.16%	0.03%	0.04%	0.01%	9.63%	10.02%	0.39%
21-34	Male	24.48%	24.70%	0.22%	2.90%	0.00%	-2.90%	0.06%	0.00%	-0.06%	23.95%	24.70%	0.75%
	Female	18.33%	19.05%	0.72%	1.10%	0.03%	-1.07%	0.06%	0.03%	-0.03%	18.18%	19.05%	0.87%
	Total	19.67%	20.30%	0.63%	1.49%	0.02%	-1.47%	0.06%	0.02%	-0.04%	19.43%	20.30%	0.87%
35-64	Male	22.61%	22.00%	-0.61%	1.50%	0.02%	-1.48%	0.01%	0.01%	0.00%	22.41%	22.00%	-0.41%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	Female	23.82%	23.70%	-0.12%	1.45%	0.03%	-1.42%	0.03%	0.03%	0.00%	23.62%	23.70%	0.08%
	Total	23.37%	23.06%	-0.31%	1.47%	0.02%	-1.45%	0.02%	0.02%	0.00%	23.17%	23.06%	-0.11%
65+	Male	6.11%	5.30%	-0.81%	0.32%	0.00%	-0.32%	0.02%	0.00%	-0.02%	5.91%	5.30%	-0.61%
	Female	5.76%	5.48%	-0.28%	0.14%	0.00%	-0.14%	0.00%	0.00%	0.00%	5.73%	5.48%	-0.25%
	Total	5.87%	5.42%	-0.45%	0.20%	0.00%	-0.20%	0.01%	0.00%	-0.01%	5.79%	5.42%	-0.37%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**Male**	**13.75%**	**13.75%**	**0.00%**	**0.78%**	**0.07%**	**-0.71%**	**0.30%**	**0.17%**	**-0.13%**	**13.57%**	**13.70%**	**0.13%**
	Female	**14.02%**	**14.37%**	**0.35%**	**0.88%**	**0.06%**	**-0.82%**	**0.13%**	**0.08%**	**-0.05%**	**13.87%**	**14.36%**	**0.49%**
	Total	**13.90%**	**14.10%**	**0.20%**	**0.84%**	**0.06%**	**-0.78%**	**0.20%**	**0.12%**	**-0.08%**	**13.74%**	**14.07%**	**0.33%**

Table13: 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		
		2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
3-12	Male	0.02%	0.01%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.01%	-0.01%
	Female	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
	Total	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
13-17	Male	0.91%	0.89%	-0.02%	0.01%	0.02%	0.01%	0.23%	0.19%	-0.04%	0.76%	0.79%	0.03%
	Female	0.71%	0.78%	0.07%	0.04%	0.03%	-0.01%	0.28%	0.23%	-0.05%	0.54%	0.63%	0.09%
	Total	0.81%	0.84%	0.03%	0.02%	0.03%	0.01%	0.25%	0.21%	-0.04%	0.65%	0.71%	0.06%
18-20	Male	2.10%	2.02%	-0.08%	0.27%	0.05%	-0.22%	0.30%	0.26%	-0.04%	1.88%	1.96%	0.08%
	Female	2.16%	2.34%	0.18%	0.22%	0.01%	-0.21%	0.48%	0.43%	-0.05%	1.88%	2.20%	0.32%
	Total	2.13%	2.18%	0.05%	0.24%	0.03%	-0.21%	0.39%	0.35%	-0.04%	1.88%	2.08%	0.20%
21-34	Male	8.26%	8.24%	-0.02%	0.81%	0.21%	-0.60%	1.26%	1.19%	-0.07%	7.77%	7.95%	0.18%
	Female	7.28%	7.60%	0.32%	0.40%	0.14%	-0.26%	1.30%	1.27%	-0.03%	6.99%	7.40%	0.41%
	Total	7.50%	7.74%	0.24%	0.49%	0.16%	-0.33%	1.29%	1.25%	-0.04%	7.16%	7.52%	0.36%
35-64	Male	8.70%	8.80%	0.10%	0.85%	0.13%	-0.72%	1.36%	1.19%	-0.17%	7.96%	8.46%	0.50%
	Female	5.93%	6.51%	0.58%	0.40%	0.07%	-0.33%	1.02%	1.08%	0.06%	5.54%	6.31%	0.77%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	Total	6.96%	7.37%	0.41%	0.57%	0.09%	-0.48%	1.15%	1.12%	-0.03%	6.44%	7.11%	0.67%
65+	Male	1.79%	1.74%	-0.05%	0.12%	0.02%	-0.10%	0.45%	0.19%	-0.26%	1.52%	1.66%	0.14%
	Female	0.42%	0.51%	0.09%	0.00%	0.00%	0.00%	0.05%	0.07%	0.02%	0.40%	0.48%	0.08%
	Total	0.86%	0.92%	0.06%	0.04%	0.01%	-0.03%	0.18%	0.11%	-0.07%	0.76%	0.88%	0.12%
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	2.33%	2.32%	-0.01%	0.21%	0.04%	-0.17%	0.39%	0.33%	-0.06%	2.13%	2.22%	0.09%
	Female	2.75%	2.90%	0.15%	0.17%	0.04%	-0.13%	0.51%	0.50%	-0.01%	2.57%	2.79%	0.22%
	Total	2.57%	2.65%	0.08%	0.19%	0.04%	-0.15%	0.45%	0.42%	-0.03%	2.38%	2.54%	0.16%

Table 14: 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		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	3-12			13-17			18-20			21-34		
Anson	0.00%	0.00%	0.00%	1.94%	2.06%	0.12%	4.17%	3.05%	-1.12%	5.15%	5.16%	0.01%
Guilford	0.02%	0.03%	0.01%	0.95%	0.95%	0.00%	2.00%	2.28%	0.28%	4.95%	5.59%	0.64%
Harnett	0.03%	0.01%	-0.02%	0.50%	0.79%	0.29%	1.22%	1.24%	0.02%	3.37%	3.80%	0.43%
Hoke	0.00%	0.00%	0.00%	0.54%	0.78%	0.24%	1.77%	1.93%	0.16%	5.25%	3.18%	-2.07%
Lee	0.00%	0.02%	0.02%	0.61%	0.74%	0.13%	0.79%	1.20%	0.41%	5.58%	6.21%	0.63%
Montgomery	0.00%	0.04%	0.04%	1.08%	1.37%	0.29%	2.37%	2.58%	0.21%	8.46%	9.39%	0.93%
Moore	0.04%	0.02%	-0.02%	1.06%	0.90%	-0.16%	1.79%	1.67%	-0.12%	10.78%	11.34%	0.56%
Randolph	0.00%	0.03%	0.03%	0.79%	0.71%	-0.08%	1.89%	1.50%	-0.39%	6.85%	6.47%	-0.38%
Richmond	0.04%	0.02%	-0.02%	0.50%	1.32%	0.82%	2.58%	2.63%	0.05%	8.89%	9.70%	0.81%
	35-64			65+			Unknown			Total		
Anson	7.82%	7.52%	-0.30%	0.45%	1.75%	1.30%	0.00%	0.00%	0.00%	3.07%	3.07%	0.00%
Guilford	7.12%	7.98%	0.86%	1.40%	1.50%	0.10%	0.00%	0.00%	0.00%	2.38%	2.62%	0.24%
Harnett	3.80%	3.83%	0.03%	0.49%	0.42%	-0.07%	0.00%	0.00%	0.00%	1.40%	1.50%	0.10%
Hoke	7.54%	5.72%	-1.82%	1.15%	0.64%	-0.51%	0.00%	0.00%	0.00%	2.37%	1.79%	-0.58%

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		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	3-12			13-17			18-20			21-34		
Lee	5.58%	6.57%	0.99%	0.21%	0.21%	0.00%	0.00%	0.00%	0.00%	1.89%	2.20%	0.31%
Montgomery	9.52%	9.25%	-0.27%	1.09%	0.78%	-0.31%	0.00%	0.00%	0.00%	3.28%	3.43%	0.15%
Moore	7.65%	8.55%	0.90%	0.45%	0.58%	0.13%	0.00%	0.00%	0.00%	3.41%	3.61%	0.20%
Randolph	6.41%	6.14%	-0.27%	0.36%	0.36%	0.00%	0.00%	0.00%	0.00%	2.42%	2.27%	-0.15%
Richmond	7.21%	8.63%	1.42%	1.12%	1.77%	0.65%	0.00%	0.00%	0.00%	3.40%	3.94%	0.54%

Table 15: 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		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	3-12			13-17			18-20			21-34		
Anson	7.74%	6.76%	-0.98%	14.02%	13.18%	-0.84%	6.45%	7.17%	0.72%	13.35%	13.06%	-0.29%
Guilford	7.60%	7.94%	0.34%	13.62%	14.87%	1.25%	9.19%	9.53%	0.34%	12.71%	13.10%	0.39%
Harnett	8.42%	9.25%	0.83%	13.68%	14.63%	0.95%	10.14%	9.27%	-0.87%	10.95%	11.74%	0.79%
Hoke	8.58%	9.01%	0.43%	13.28%	13.28%	0.00%	7.33%	8.71%	1.38%	9.98%	11.55%	1.57%
Lee	8.20%	6.95%	-1.25%	12.69%	11.24%	-1.45%	8.27%	6.89%	-1.38%	11.67%	11.63%	-0.04%
Montgomery	7.22%	7.23%	0.01%	10.61%	13.32%	2.71%	7.11%	8.15%	1.04%	9.20%	12.27%	3.07%
Moore	8.27%	8.32%	0.05%	12.29%	14.57%	2.28%	9.03%	9.39%	0.36%	13.36%	14.51%	1.15%
Randolph	6.26%	7.14%	0.88%	12.55%	13.84%	1.29%	8.78%	8.53%	-0.25%	12.28%	11.28%	-1.00%
Richmond	11.73%	10.68%	-1.05%	15.70%	17.34%	1.64%	8.56%	9.30%	0.74%	12.76%	14.76%	2.00%
	35-64			65+			Unknown			Total		
Anson	19.32%	18.08%	-1.24%	8.43%	10.09%	1.66%	0.00%	0.00%	0.00%	11.89%	11.36%	-0.53%
Guilford	20.24%	19.78%	-0.46%	6.16%	5.24%	-0.92%	0.00%	0.00%	0.00%	11.50%	11.73%	0.23%
Harnett	16.22%	15.25%	-0.97%	6.14%	6.79%	0.65%	0.00%	0.00%	0.00%	10.96%	11.34%	0.38%
Hoke	15.85%	15.83%	-0.02%	4.60%	3.83%	-0.77%	0.00%	0.00%	0.00%	10.44%	10.92%	0.48%
Lee	16.33%	14.77%	-1.56%	4.11%	4.06%	-0.05%	0.00%	0.00%	0.00%	10.42%	9.37%	-1.05%
Montgomery	17.50%	17.66%	0.16%	5.76%	8.70%	2.94%	0.00%	0.00%	0.00%	9.64%	10.91%	1.27%
Moore	17.74%	19.77%	2.03%	5.11%	6.92%	1.81%	0.00%	0.00%	0.00%	11.21%	12.30%	1.09%
Randolph	18.38%	17.02%	-1.36%	7.25%	5.68%	-1.57%	0.00%	0.00%	0.00%	10.56%	10.54%	-0.02%
Richmond	17.55%	20.20%	2.65%	5.08%	5.73%	0.65%	0.00%	0.00%	0.00%	12.93%	13.81%	0.88%

(b) Waiver Validation Results

All measures received a validation score of 100% and were found "Fully Compliant." The stored procedures have been updated to address NC Medicaid's most recent changes to the measures. Table 16 contains validation scores for each of the 10 (b) Waiver Performance Measures.

Table 16: (b) Waiver Performance Measure Validation Scores

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

(c) Waiver Measures Reported Results

Five (c) Waiver measures were chosen for validation. The rates reported by Sandhills and the State benchmarks are displayed in Table 17: (c) Waiver Measures Reported Results 2019 - 2020.

Table 17: (c) Waiver Measures Reported Results 2019-2020

Performance Measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	1321/1321 = 100%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	1321/1321 = 100%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	83/94 = 88.3%	85%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	1280/1280 = 100%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	91/91 = 100%	85%

Note: Annual rates reported using SHC Innovations Waiver Reporting 11/1/2019 Excel file; Quarterly rates reported using SHC Innovations Waiver Reporting 8/1/2020 Excel file.

Documentation on data sources, data validation, source code, and calculated rate for the five measures was provided. Additionally, all rates met or exceeded the State Performance Benchmarks.

(c) Waiver Validation Results

All (c) Waiver Measures met the validation requirements and were Fully Compliant as shown in Table 18, (c) Waiver Performance Measure Validation Scores. The validation worksheets offer detailed information on validation and calculation steps for (c) Waiver measures.

Table 18: (c) Waiver Performance Measures Validation Scores

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

Performance Improvement Project (PIP) Validation

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

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

PIP Validation Results

Sandhills submitted seven projects for validation. Of those seven, four were validated. The validated PIPs included: Access to BH Assessment (non-clinical), TCLI Transition Days (non-clinical), Increase EBP for Medication Management (clinical), and Assure Consistent Connection to Community Services Following FBC Services (clinical). Table 19: PIP Summary of Validation Scores provides an overview of the previous year's validation scores with the current scores.

Table 19: PIP Summary of Validation Scores

Project Type	Project	2019 Validation Score	2020 Validation Score
Clinical	Increase EBP for Medication Management	Not Validated	79/80 = 98.8% High Confidence in Reported Results
	Assure Consistent Connection to Community Services Following FBC Services	Not Validated	79/80 = 98.8% High Confidence in Reported Results
Non-Clinical	Access to Routine BH Assessments	105/111 = 95% High Confidence in Reported Results	84/90 = 93.3% High Confidence in Reported Results
	TCLI Transition Days	79/85 = 93% High Confidence in Reported Results	72/74 = 97.3% High Confidence in Reported Results

All validated PIPs received a validation score withing the High Confidence range and met the validation requirements. Two PIPs validated for the 2020 EQR were also validated in the 2019 EQR. These two PIPs are Access to BH Assessment and TCLI Transition Days. In 2019, there were two Recommendations for each of these PIPs. Sandhills addressed and implemented both Recommendations.

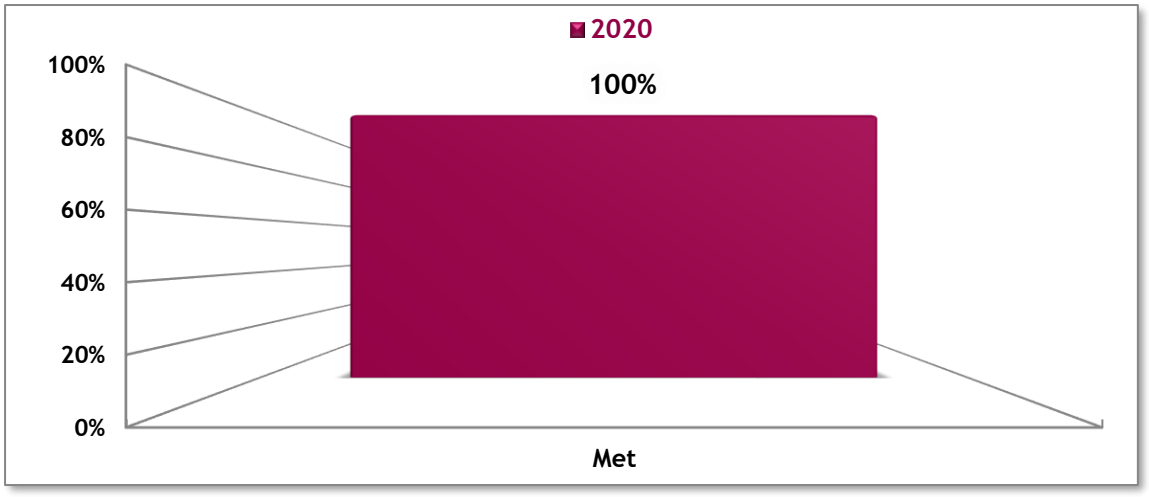
Recommendations for the Increase EBP for Medication Management, Assure Consistent Connection to Community Services Following FBC Services, Access to Routine BH Assessments, and TCLI Transition Days projects centered around statistical testing, the documentation of the data source, and quantitative improvement. These Recommendations are displayed in *Table 20: Performance Improvement Project Recommendations*.

Table 20: Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Increase EBP for Medication Management	Is there any statistical evidence that any observed performance improvement is true improvement?	Statistical testing was not conducted on rates.	Add a chi square or Fisher's exact test to compare rates and report the p-value in the results.
Assure Consistent Connection to Community Services Following FBC Services	Is there any statistical evidence that any observed performance improvement is true improvement?	Statistical testing was not conducted on rates.	Add a chi square or Fisher's exact test to compare rates and report the p-value in the results.
Access to Routine BH Assessments	Did the plan employ valid sampling techniques that protected against bias?	It is unclear how a Fisher's exact test is used to ensure a valid random sample, as it is a statistical test to compare independent proportions.	Omit the Fisher's exact test as a method for validating the sample. Consider using a random function in Excel as an alternative to generate random selection.
	Did the study design clearly specify the sources of data?	Data source is not clearly documented.	Add information in the Data Collection section on how the caller enters the data and the database system is used for data collection.
TCLI Transition Days	Was there any documented, quantitative improvement in processes or outcomes of care?	Number of days from issue to transition increased from 57 to 67 which is not improvement.	Continue interventions and determine if specific interventions are more beneficial as COVID 19 crisis continues that limit contact with consumers.

Details of the validation activities for the PMs and PIPs and specific outcomes related to each activity may be found in *Attachment 3, CCME EQR Validation Worksheets*. For this 2020 EQR, all standards in the Quality Improvement section received a "Met" score, as shown in Figure 4.

Figure 4: Quality Improvement Findings



Strengths

- PIPs were based on analysis of comprehensive aspects of enrollee needs and services, and rationale for each topic was documented.
- Performance Measure query was accurate for (b) Waiver measures.
- (c) Waiver measure rates were above State benchmark rates.

Weaknesses

- Statistical testing was not conducted on rates for the Increase EBP for Medication Management and the Assure Consistent Connection to Community Services Following FBC Services PIP.
- It is unclear how a Fisher's exact test was used to ensure a valid random sample, as it is a statistical test to compare independent proportions for the Access to Routine BH Assessments PIP.
- Data source is not clearly documented in the Access to Routine BH Assessments PIP.
- The TCLI Transition Days PIP did not show improvement as the number of days from issue to transition increased from 57 to 67.

Recommendations

- Add a chi square or Fisher's exact test to compare rates and report the p-value in the results for the PIPs.

- Omit the Fisher's exact test as a method for validating the sample and use a random function in Excel as an alternative to generate random selection for the Access to Routine BH Assessments PIP.
- Add information in the Data Collection section on how the caller enters the data and the database system used for data collection for the Access to Routine BH Assessments PIP.
- Continue interventions and determine if specific interventions are more beneficial as the COVID-19 crisis continues to limit contact with consumers for the TCLI Transition Days PIP.

D. Utilization Management

The External Quality Review (EQR) of Utilization Management (UM) included a review of the Care Coordination and Transition to Community Living Initiative (TCLI) programs. CCME reviewed relevant policies, procedures, Organizational Chart, and 11 files of enrollees participating in Mental Health/Substance Use Disorder (MH/SUD), Intellectual/Developmental Disability (I/DD), and TCLI Care Coordination.

In the 2019 EQR, Sandhills met 96% of UM standards. CCME issued two Corrective Actions and two Recommendations related to implementing a data-driven monitoring plan for IDD/MHSUD/TCLI documentation. The review found that 30% of I/DD progress notes and 17% of TCLI progress notes were submitted outside of the required timeframes stated in Sandhills' policies and procedures. Furthermore, it was discovered that Sandhills had data reports already in place that could be used during supervision and monitoring of Care Coordination activities. To address this, Sandhills created an enhanced monitoring process that incorporated data reports developed by the Quality Management Department that review progress notes submission times and other departmental benchmarks. The remaining two Recommendations were to update policies and procedures and the *Member Handbook*. Sandhills addressed these Recommendations.

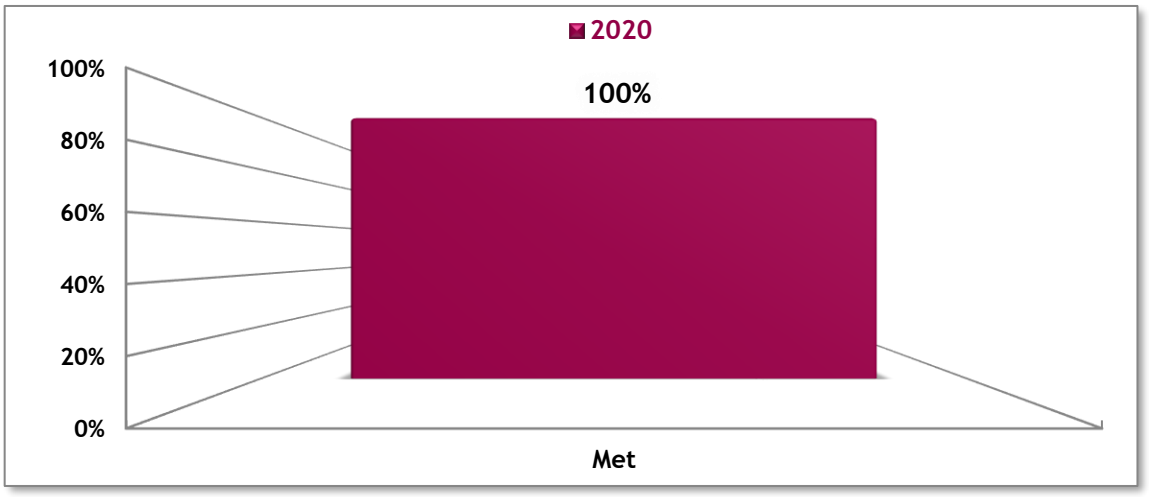
For this year's EQR, there were no Corrective Actions and one Recommendation. According to data reports, Sandhills has made significant improvement in the timeliness of Care Coordination progress notes. The October 2020 *Late Progress Note Report* showed that only .48% of I/DD and 1.67% of TCLI progress notes were submitted outside the required seven-day timeframes. Additionally, the review of I/DD and TCLI progress notes for this file review showed similar percentages of late progress notes.

The review of Sandhills' I/DD policies found a lack of information regarding Home and Community Based Services (HCBS). During the Onsite discussion, Sandhills stated that the information was included in the *I/DD Monitoring Plan*. However, a review of the *I/DD Monitoring Plan* found no information regarding HCBS or the use of the State required *Monitoring Checklist*. CCME recommends that Sandhills add an explanation of HCBS and the use of the State-required *Monitoring Checklist* to either a current procedure or a relevant manual or documents. The review of I/DD files found that most of the monthly face-to-face

monitoring occurred at Day Treatment facilities or within the community. While minimal monthly monitoring occurred in the residential setting, the monitoring of Innovations services still met *NC Clinical Coverage Policy 8P* guidance. The review of MHSUD/TCLI files found that policies and procedures were followed as formulated.

Figure 5 indicates that 100% of the Care Coordination standards were scored as "Met" in the 2020 EQR.

Figure 5: Utilization Management Findings



Strengths

- Sandhills showed significant improvement in Care Coordination progress notes and other documentation compared to the 2019 EQR.
- Sandhills has implemented a data-driven monitoring plan in IDD/MHSU/TCLI Care Coordination, utilizing several monitoring reports generated by the Quality Management Department.
- Sandhills executed quality care coordination activities during the COVID-19 pandemic.

Weaknesses

- Monitoring standards for HCBS are not referenced in a policy or procedure, and there is not a reference regarding the State-required *Monitoring Checklist*.

Recommendations

- Add an explanation of Home and Community Based Services (HCBS) and the use of the required *State Monitoring Checklist* to a procedure, relevant I/DD Care Coordination manual, or I/DD document.

E. Grievances and Appeals

The grievances and appeals EQR for Sandhills included a Desk Review of policies and procedures, 10 grievance and 10 appeal files, the grievances and Appeals Logs, the *Medicaid/State Provider Manual*, the *Member Handbook, the Utilization Management Plan,* and information about grievances and appeals available on the Sandhills website. A virtual Onsite discussion with staff occurred to further clarify Sandhills' documentation and grievance and appeal processes.

Sandhills met 75% of the grievances and appeals standards in the 2019 EQR. As a result, 13 Corrective Actions and nine Recommendations were issued to address concerns within Sandhills' policies and procedures, *Member Handbook*, *Medicaid/State Provider Manual*, Sandhills' website, and the grievance and appeal files reviewed.

In the 2020 EQR, Sandhills met 90% of the grievances and appeals standards, resulting in two Corrective Actions and five Recommendations.

Grievances

Procedure CORE 35a, Consumer Grievance Process-Medicaid, is the primary policy and procedure that documents the process by which Sandhills must resolve grievances. In the 2019 EQR, CCME provided six Recommendations primarily aimed at addressing inconsistent language within that policy and procedure. Inconsistencies were found in the use of two terms, "grievance" and "complaint," in the timeframe for acknowledging grievances, in the notifications related to extended grievances, and in the timeframe for maintaining grievance files. One Recommendation was also given to address the inconsistent use of "grievance" and "complaint" within the *Medicaid Provider Manual*.

The 2020 EQR noted that Sandhills revised Procedure CORE 35a, Consumer Grievance Process-Medicaid, to reflect the use of the single term "grievance." The *Member Handbook* also included the consistent use of the term "grievance." As of November 13, 2020, the *Medicaid State Provider Manual* includes a more consistent use of "grievance." However, different uses of the term "complaint" were still evident in two areas of the manual. During the Onsite, staff confirmed these two references to "complaint" were missing during the revision process.

Procedure CORE 35a, Consumer Grievance Process-Medicaid now consistently states the written acknowledgement of a grievance is sent "within 5 working days of the receipt of the grievance" in both the High and Low Risk sections of the procedure. This was a Recommendation from the 2019 EQR.

Procedure CORE 35a Consumer Grievance Process-Medicaid was also revised to include the notification requirements when Sandhills extends the grievance resolution timeframe. This

revision was also in response to a 2019 EQR Recommendations and is required by *42 CFR § 438.408*.

Sandhills revised Procedure CORE 35a Consumer Grievance Process-Medicaid to include that Grievance files "are maintained for 5 years", per *NC Medicaid Contract, Attachment M, B. Record Keeping and Reporting*. This revision was the result of a 2019 EQR Recommendation.

In the 2020 EQR, it was noted Sandhills' *Member Handbook* includes information about the right of an enrollee or their representative to request an extension to the grievance resolution timeframe. However, there is no information about the process followed when Sandhills extends the grievance resolution timeframe. CCME recommends Sandhills add this information to the handbook, including the notifications required by *42 CFR § 438.408 (c)(1)* and *(c)(2)*.

The review of the grievances files selected for this 2020 EQR showed the acknowledgment letters and grievance resolution notifications were sent within the timeframe required by Sandhills' policies and procedures and *NC Medicaid Contract*, *Attachment M, Section C*. There was also information within the grievances files showing when referrals of the grievances are made internally to other Sandhills' departments.

Information about the grievance resolution notifications was concise but did not always reflect the internal steps taken by Sandhills to resolve the grievance. For example, most letters only stated, "The review was able to substantiate the grievance at this time. Recommendations were given to the provider." Procedure CORE 35a Consumer Grievance Process-Medicaid requires these notifications to include "all actions taken to resolve the grievance." While is it understood some information cannot be disclosed to the grievant, CCME recommends Sandhills routinely review the grievance resolution notifications to identify opportunities to improve the content of these notifications.

Appeals

The 2019 EQR of appeals included 13 Corrective Actions and three Recommendations, most of which aimed to bring Sandhills' 18 appeals policies and procedures into compliance with the *NC Medicaid Contract* and federal requirements around Medicaid appeals. None of the 18 appeals policies and procedures provided consistently accurate information regarding appeals requirements. In the 2020 EQR, CCME observed that Sandhills addressed all of the 2019 EQR Corrective Actions and Recommendations.

In the 2019 EQR, CCME issued two Corrective Actions aimed at correcting misinformation in the *Medicaid Provider Manual* and *Member Handbook* about the procedure for filing an appeal. Through the Corrective Action Plan process, Sandhills revised these documents, and CCME approved the revisions in December 2019. In the 2020 EQR, it was evident that the *Member Handbook* was not finalized and published on Sandhills' website until September 2020 and the *Provider Operations Manual* was not finalized and published on Sandhills' website

until December 2020. As a result, misinformation, such as who can file an appeal, within the *Member Handbook* was publicly available for a year, and misinformation within the Medicaid Provider Manual was publicly available for two years. *NC Medicaid Contract, Section 7.11 Provider Manual* and *Section 6.9 Enrollee Written Materials* state, the "PIHP shall correct materials errors within a reasonable timeframe." CCME recommends Sandhills define and adhere to a "reasonable timeframe" for correcting errors identified in the *Member Handbook* and the *Provider Manual* and publishing them on the website. CCME also recommends that this timeframe be documented in an applicable procedure.

Another Corrective Action issued in the 2019 EQR focused on ensuring the appeals policies and procedures detailed all of the required notifications when Sandhills denies a request to expedite an appeal. Sandhills addressed this Corrective Action, but one requirement was overlooked. No language in any of Sandhills' policies and procedures outlines the requirement of Sandhills to notify enrollees of their right to file a grievance if Sandhills denies a request to expedite an appeal. This enrollee right is required by *42 CFR § 438.410 (c)(2)*.

For this year's appeals EQR, Sandhills submitted the Appeals Log that showed 37 Medicaid appeals were processed between October 2019 and September 2020. From that log, 10 appeals files were selected; six standard and four expedited appeals. Sandhills reported no first-level appeals were withdrawn, extended, or deemed invalid by Sandhills between October 2019 and September 2020. Prior to the Onsite, CCME confirmed with Sandhills that no appeals processed between October and December of 2020 were withdrawn, extended, or deemed invalid. Therefore, none of these types of appeals files were reviewed for Sandhills in the 2020 EQR.

The 2020 EQR found that eight of the 10 appeals files reviewed were acknowledged and resolved in a timely manner. In the two files that were out of compliance, the appeal was first initiated orally by the enrollee, but the appeal resolution timeframe did not start until the receipt of the subsequent written notice. This was evident by review of the Appeals Coordinator notes and Appeals Log. As a result, both appeals were out of compliance with the required notification timeframes. This practice was also evident in a third file, but this file showed the acknowledgement and appeal resolution notifications were issued within the required timeframes. Per Sandhills' appeals policies and procedures, "the timeframe for resolution starts when the first request is received, regardless of whether the request is received orally or in writing." This procedural language is congruent with *Attachment M* of the *NC Medicaid Contract, Section G(3)(a)*, and *42 CFR § 438.406(b)(3)*.

In addition to the appeal file findings, several documentation errors were noted within the Appeals Log, Appeal Coordinator notes, and the Expedited Appeal Checklist. Most often these were incorrect dates of oral and written appeal receipt, written acknowledgement notifications, or oral notifications from staff to appellants. For example, of the four appeals files where the appeal was initiated orally, only one was captured on the Appeals Log.

During the Onsite, staff described the current monitoring process and provided a template of an appeal audit tool (labeled *NCQA & URAC UM Denial File Audit Tool*). Staff explained appeal files are reviewed quarterly, but the Appeals Log is not routinely reviewed for completeness and accuracy. Review of the appeal audit tool provided by Sandhills during the Onsite showed the tool targeted only a few appeal elements required by *NC Medicaid Contract* and federal regulations. Specifically, there is no compliance review of the timeliness of written acknowledgement notifications, expedited appeals, and appeals submitted orally.

As the Appeals Log, Appeals Coordinator notes, and the Expedited Appeals Checklist are the sources of critical appeals data, Sandhills needs to enhance the monitoring process to include routine review of data and documentation within these documents for accuracy. This review should also include a compliance review to ensure all notifications, both written and oral, are provided within the required timeframes, especially those appeals initiated orally.

Figure 6, Grievances and Appeals Findings indicates Sandhills met 90% of the grievances and appeals standards in the 2020 EQR.

Figure 6: Grievances and Appeals Findings

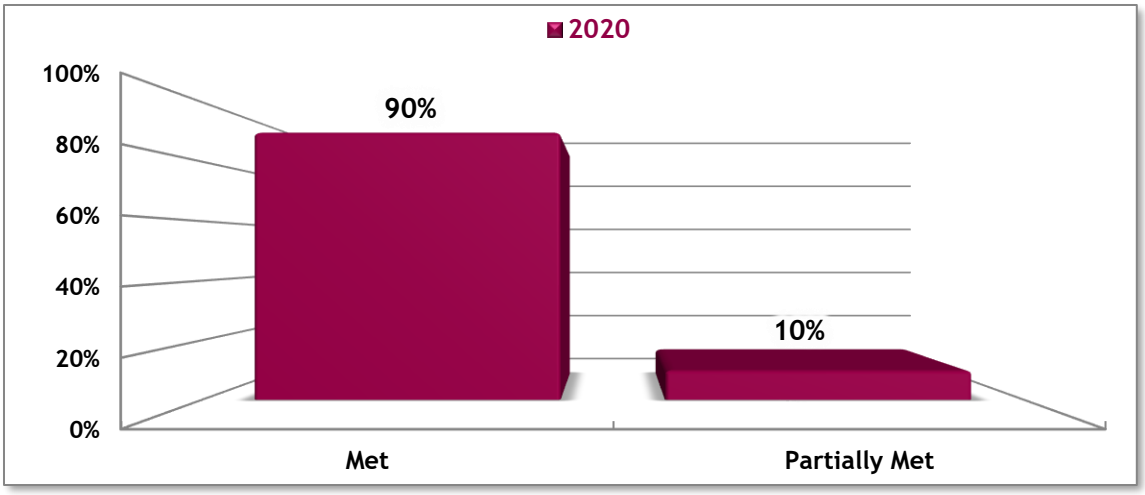


Table 21: Grievances and Appeals

Section	Standard	2020 Review
Appeals	A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	Partially Met
	The PIHP applies the appeal policies and procedures as formulated	Partially Met

Strengths

- Within the appeals files reviewed, staff detailed interactions with appellants, including efforts to obtain additional appeal information.
- Sandhills successfully implemented almost all of the Corrective Actions and *Recommendation*s from the 2019 EQR.

Weaknesses

- In the *Medicaid/State Provider Manual*, the term "Complaint" was used instead of "grievance" in the two instances. The term "grievance" needs to be used consistently throughout the manual to prevent confusion.
- The *Member Handbook* contains information about the enrollee's right to request an extension to the grievance resolution timeframe but does not include information about the process when Sandhills extends the grievance resolution timeframe.
- The grievance resolution notifications within the files reviewed restate the reason for the grievance but contain minimal to no information about the internal steps taken by Sandhills to resolve the grievance.
- Misinformation, such as who can file an appeal, within the *Member Handbook* was publicly available on Sandhills' website for a year, and misinformation within the *Provider Manual* was publicly available on Sandhills' website for two years.
- Sandhills' appeals policies and procedures do not include the requirement to notify enrollees of their rights to file grievances if Sandhills denies a request to expedite an appeal.
- In two of the 10 files reviewed in this year's EQR, it was noted the Appeals Coordinator did not consider the date and time of the oral appeal as the start of the appeals resolution timeframe.
- In the appeals file review, there were several documentation errors noted within the Appeals Log, Appeals Coordinator notes, and the Expedited Appeals Checklist.

Corrective Actions

- Revise Sandhills' policies and procedures to state the requirement that Sandhills notify the enrollee of his right to file a Grievance if Sandhills denied a request to expedite an appeal.
- Enhance the current appeal monitoring process to ensure compliance of appeals processes and notifications, especially those appeals initiated orally.

Recommendations

- Revise the *Medicaid/State Provider Manual* to consistently use the term "grievance."
- Add information to the *Member Handbook* regarding the process followed when Sandhills extends the grievance resolution timeframe. Include the notifications required by *42 CFR § 438.408 (c)(1) and (c)(2).*
- Routinely review the grievances resolution notifications to identify opportunities to provide more details regarding the internal steps Sandhills took to resolve the grievance.
- Define a "reasonable timeframe" for correcting errors identified in *Member Handbook* and *Medicaid/State Provider Manual* and publishing them on Sandhills' website. Add this timeframe to an applicable procedure.
- In the enhanced appeals monitoring process, include routine review of the Appeals Log to ensure data and documentation within the log are complete and accurate.

F. Program Integrity

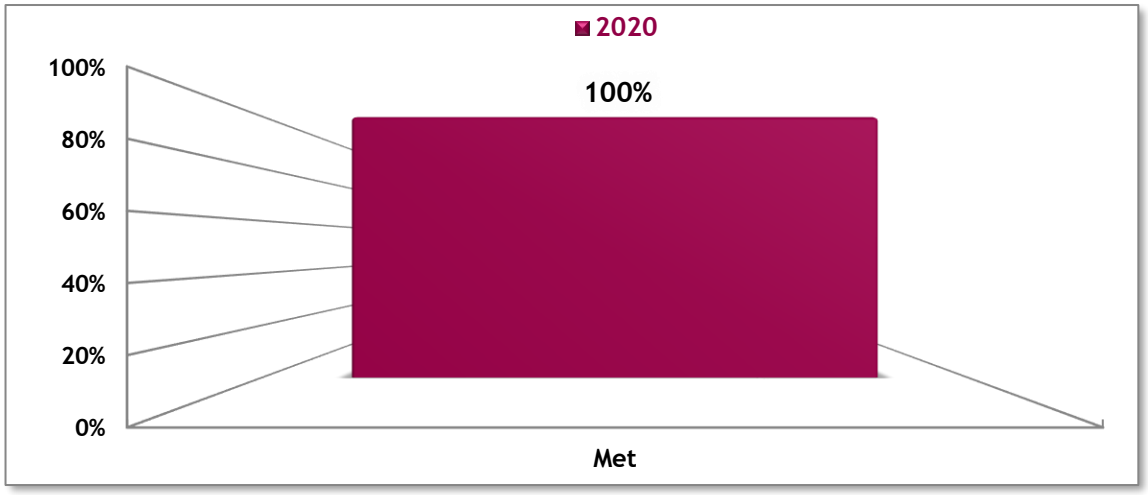
The Program Integrity (PI) EQR involves an assessment of Sandhills' compliance with federal and state regulations regarding PI functions. CCME conducted a Desk Review of Sandhills' documentation, including a review of Sandhills' policies, procedures, training materials, organizational charts, job descriptions, committee meeting minutes and reports, provider agreements, enrollment application, PI workflows, *Provider Operations Manual*, employee handbook, newsletters, conflict of interest forms, and the Compliance Plan. Onsite interviews were conducted to discuss the findings within the Desk Materials and PI files.

In the 2019 EQR, Sandhills met 97% of the PI standards. Two Corrective Actions were issued to address findings related to the 2019 PI file review. and both targeted the need for increased monitoring of the PI files to ensure all elements required by *NC Medicaid Contract, Section 14.2* were captured within the file documentation.

In the 2020 EQR, A sample of 15 PI files for the period from October 1, 2019 through September 30, 2020 were selected from those submitted by Sandhills. These files were thoroughly reviewed to ensure Sandhills investigates a credible allegation of fraud and provides NC Medicaid Program Integrity with the information required on a template approved by NC Medicaid. This review showed that all 15 files met the requirements and that Sandhills addressed the Corrective Actions issued in the 2019 EQR.

In the 2020 EQR, a Desk Review of Sandhills' documentation was also conducted to assess compliance with federal and state regulations and Sandhills' contract with NC Medicaid. Findings within the Desk Materials were discussed with the Compliance and Program Integrity personnel during the Onsite, and Sandhills' documentation was noted to be fully compliant.

Figure 7: Program Integrity Findings



Strengths

- Sandhills has a detailed Annual Compliance Plan that includes metrics on the prior year's activities as well as a plan for the upcoming year.
- During the Onsite, Sandhills provided a trend analysis that identifies the sources of PI referrals and case types.

G. Encounter Data Validation

The scope of the review, guided by the CMS Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid by Sandhills for the period of January 2019 through December 2019. 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' encounter data elements
- A review of NC Medicaid 's encounter data acceptance report

Results and Recommendations

Issue: Taxonomy code for Billing and Rendering providers

Taxonomy values were consistently populated; however, this is the most frequent denial reason among Sandhills' encounter submissions. This information is key for passing the front end edits put in place by the State and to effectively price the claim. NCTracks is expecting the correct combination of NPI, Taxonomy code, and Procedure code. The Taxonomy code did not always match up with the Taxonomy values enrolled in NCTracks for the Billing and/or Rendering Provider and the service that was provided. These errors result in denials by the NC Medicaid that must be corrected and resubmitted.

Resolution:

Continue to follow the process built by Sandhills and AlphaMCS. As time passes and providers are educated, the initial denials due to invalid Taxonomy codes should naturally go down. Sandhills realized such improvement in 2019. The total number of denials related to the Taxonomy code has dropped significantly. Even in terms of percentage share of all denials, denials related to Taxonomy code accounted for a smaller percentage. In 2017 and 2018, invalid taxonomies made up 70% and 48% of all denials, respectively. This figure was 28% for 2019 and clearly shows the progress Sandhills has made. However, Taxonomy code remains, by far, the most common denial reason, suggesting there is still room for improvement through continued provider education and by following the processes to ensure reconciliation of Taxonomy codes between the provider, Sandhills, and NCTracks.

Issue: Other Diagnosis

Other Diagnosis codes were often missing, especially on Professional claims. Principal and admitting diagnoses were populated consistently, and Sandhills has made notable progress in reporting additional Diagnosis codes. However, too many Professional claims are missing additional diagnosis.

Resolution:

Sandhills made significant progress in reporting additional Diagnosis codes, especially on Institutional claims. Some improvements were also seen in Professional claims. However, there are many providers who never report more than one Diagnosis code. To address this issue, it is recommended that Sandhills alert such providers to remind them to ensure that submitted claims are complete and accurate, including Diagnosis codes.

Conclusion

Based on the analysis of Sandhills' encounter data, we have concluded that the data submitted to NC Medicaid is complete and accurate. Minor issues were noted with both Institutional and Professional encounters due to Taxonomy codes and additional Diagnosis codes.

Sandhills has made great progress in improving the accuracy of encounter data over the past couple of years and should stay on course with resolving issues related to Billing Taxonomy, Rendering Taxonomy, and additional Diagnosis codes. Denials related to Taxonomy code are still the dominant cause of denial by a large margin. Sandhills should revisit the strategy it has put in place to address issues with invalid or missing Taxonomy codes, as well as a reconciliation process and make necessary adjustments to further reduce Taxonomy code denials noted previously.

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

November 2, 2020

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 2020 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 one-day, virtual Onsite that will address contractually required services.

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

The CMS EQR protocols can be found at:

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

Due to COVID-19 and the issuance of the contractual flexibilities issued by the State outlined in Contract Amendment #9, the 2020 EQR will be a focused review. The focus of this review will be on the Corrective Actions from the previous EQR and Sandhills Center functions that impact enrollee health and safety. Similarly, for the 2020 EQR, the two day Onsite previously performed at PIHP offices will conducted during a one day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **January 28, 2021**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

In preparation for the Desk Review, the items on the enclosed **Desk Materials List** are to be submitted electronically. **Please note that, to facilitate a timely review, there are three lists on the Desk Materials List (items 9, 10, and 19.a) that should be submitted by no later than November 6, 2020.** The remaining items are due by no later than **November 23, 2020**. Also, as indicated in item 20 of the Desk Materials List, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted with the other Desk Materials on **November 23, 2020**.

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

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

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 5

Cc: Theresa Clark, Sandhills Contract Manager
Tasha Griffin, NC Medicaid Contract Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager
Hope Newsome, NC Medicaid Quality Management Specialist

SANDHILLS

Focused External Quality Review 2020

MATERIALS REQUESTED FOR DESK REVIEW

****Please note that the lists requested in items 9, 10, and 19.a must be uploaded by no later than November 6, 2020. The remainder of items must be uploaded by no later than November 23, 2020.**

1. Copies of all current policies and procedures, as well as a complete index which includes policy and procedure name, number, and department owner. The date of the addition/review/revision should be identifiable on each policy/procedure. *(Please do not embed files within word documents.)*
2. Organizational Chart of all staff members including names of individuals in each position including their degrees, licensure, and any certifications required for their position. Include any current vacancies. In addition, please include any positions currently filled by outside consultants/vendors.
3. Description of major changes in operations such as expansions, new technology systems implemented, etc. Include any major changes to PIHP functions related to COVID-19.
4. A summary of the status of all Corrective Action items from the previous External Quality Review. Please include evidence of Corrective Action implementation.
5. List of providers credentialed/recredentialed in the last 12 months (October 2019 through September 2020). Include the date of approval of initial credentialing and the date of approval of recredentialing.
6. A description of the Quality Improvement, Utilization Management, and Care Coordination Programs. Include a Credentialing Program Description and/or Plan, if applicable.
7. Minutes of committee meetings for the following committees:
    a. Credentialing (for the three, most recent committee meetings)
    b. UM (for the three, most recent committee meetings)
    c. Any clinical committee meeting minutes showing discussion of Clinical Practice Guidelines impacted by COVID-19.
8. Membership lists and a committee matrix for all committees, including the professional specialty of any non-staff members. Please indicate which members are voting members. Include the required quorum for each committee.
9. By November 6, 2020, submit a copy of the complete Appeals Log for the months of October 2019 through September 2020. Please indicate on the log: the appeal type (standard, expedited, extended, withdrawn, or invalid), the service appealed, the date the appeal was received, and the date of appeal resolution.
10. By November 6, 2020, submit a copy of the complete grievances log for the months of October 2019 through September 2020. Please indicate on the log: the nature of the grievance, the date received, and the date of grievance resolution.

11. Copies of all appeal notification templates used for expedited, invalid, extended, and withdrawn appeals.
12. For appeals and grievances, please submit a description of your monitoring process that reviews compliance of oral and written notifications, completeness of documentation within the appeal and grievance records, accuracy of appeal and grievance logs, etc. Provide details regarding frequency of monitoring and any benchmarks, performance metrics, and reporting of monitoring outcomes.
13. Please submit a summary of new provider orientation processes and include a list of materials and training provided to new providers.
14. For MH/SU, I/DD, and TCLI Care Coordination, please submit a description of your monitoring plan that reviews compliance of Care Coordinator documentation. Include in the description the elements reviewed (timeliness of progress notes, timeliness of Innovations monitoring, timeliness of Quality of Life surveys, review of quality, completeness of discharge notes, accuracy of documentation, etc.). Provide details regarding frequency of monitoring, and any benchmarks, performance metrics, and reporting of monitoring outcomes.
15. For Care Coordination enrollees files, please provide:
    a. three MH/SU Care Coordination enrollee files (two active since 2018 and one recently discharged)
    b. three I/DD Care Coordination enrollee files (two active since 2018 and one recently discharged)
    c. four TCLI Care Coordination enrollee files (one active since 2018, one who received In-Reach, one who transitioned to the community and one recently discharged).

    NOTE: Care Coordination enrollee files should include all progress/contact notes, monitoring tools, Quality of Life surveys, and any notifications sent to or received from the enrollees.
16. Information regarding the following selected Performance Measures:

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

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

Required information includes the following for each measure:

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

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

c. Reporting frequency and format;

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

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

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

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

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

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

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

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

18. Provide copies of the following Credentialing/Recredentialing files:

a. Credentialing files for the five most recently credentialed practitioners/agency (as listed below)

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

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

A. Insurance:

1. Proof of all required insurance, or a signed and dated statement/waiver/attestation from the practitioner/agency indicating why specific insurance coverage is not required
2. For practitioners joining already-contracted agencies, include copies of the proof of insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.

B. Other:

1. 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).
2. Ownership disclosure information/form (For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file).

b. Recredentialing files for the five most recently recredentialed practitioners/agency (as listed below)

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

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

A. Insurance:

1. Proof of all required insurance, or a signed and dated statement/waiver/attestation from the practitioner/agency indicating why specific insurance coverage is not required.
2. For practitioners joining already-contracted agencies, include copies of the proof of insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.

B. Other:

1. 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).
2. 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).
3. Site visit/assessment reports if the provider has had a quality issue or a change of address.
4. Ownership disclosure information/form (For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file).

19. a. By November 6, 2020, submit a copy of the complete listing of Program Integrity case files active during October 2019 through September 2020. On this list, provide the following for each case file:
    i. Date case opened
    ii. Source of referral
    iii. Category of case (enrollee, provider, subcontractor)
    iv. Current status of the case (opened, closed)

    b. Program Integrity Plan and/or Compliance Plan.

    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.

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

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

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

    g. Provider Manual and Provider Application.

    h. Enrollee Handbook

    i. Subcontractor Agreement/Contract Template.

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

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

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

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

c. A copy of the IT Disaster Recovery Plan.

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

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

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

a. Include all adjudicated claims (paid and denied) from January 1, 2019 – December 31, 2019. 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, 2019 – December 31, 2019. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2020

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Please submit the item missing from credentialing/recredentialing files, for the provider identified on the separate list (titled "Sandhills Cred.Recred Supplemental Documentation list"), for information obtained during the credentialing/recredentialing process. Please upload into folder 18.

2. The IDD Late Note Entries Report for October 2020 into folder 14.

3. Most recent *Denial and Appeal Monitoring Activities* report. Please create a subfolder in folder 9 labelled "Pre Onsite materials" and place documentation there.

4. Most recent Appeals Data Charts (July 2020-December 2020, if available). Please add documentation into "Pre Onsite materials" subfolder in folder 9.

5. Any appeals deemed invalid or withdrawn in November 2020 or December 2020. If none were deemed invalid or withdrawn, please upload a statement to that effect. Please add documentation into "Pre Onsite materials" subfolder in folder 9.

C. Attachment 3: EQR Validation Worksheets

- Mental Health (b Waiver) Performance Measures Validation Worksheet
    - Readmission Rates for Mental Health
    - Readmission Rates for Substance Abuse
    - Follow-up after Hospitalization for Mental Illness
    - Follow-up after Hospitalization for Substance Abuse
    - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
    - Mental Health Utilization –Inpatient Discharge and Average Length of Stay
    - Mental Health Utilization
    - Identification of Alcohol and Other Drug Services
    - Substance Abuse Penetration Rate
    - Mental Health Penetration Rate

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

- Performance Improvement Project Validation Worksheet
    - Increase Evidenced Based Practice for Medication Management
    - Assure Consistent Connection to Community Services Following FBC Services
    - Access to Routine Behavioral Health Assessments
    - Transition to Community Living Initiative Transition Days

CCME EQR Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of Measure:	**Readmission Rates for Mental Health**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina DMA/DHB Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of Measure:	**Readmission Rates for Substance Abuse**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina DMA/DHB Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of Measure:	**Follow-up After Hospitalization for Mental Illness**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina DMA/DHB Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of Measure:	**Follow-up After Hospitalization for Substance Abuse**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina DMA/DHB Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of Measure:	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina DMA/DHB Technical Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA
SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using DMA template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of Measure:	**Mental Health Utilization- Inpatient Discharged and Average Length of Stay**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina DMA/DHB Technical Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA
SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using DMA template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of Measure:	**Mental Health Utilization**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina DMA/DHB Technical Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA
SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using DMA template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of Measure:	**Identification of Alcohol and Other Drug Services**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina DMA/DHB Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of Measure:	**Substance Abuse Penetration Rate**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina DMA/DHB Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of Measure:	**Mental Health Penetration Rate**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina DMA/DHB Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Performance Measure Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC
Reporting Year:	**2019**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	Proportion of beneficiaries reporting they have a choice between providers. IW D10
Reporting Year:	**2019**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	Percentage of level 2 and 3 incidents reported within required timeframes. IW G2
Reporting Year:	**2019**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	Percentage of beneficiaries who received appropriate medication. IW G5
Reporting Year:	**2019**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8
Reporting Year:	**2019**
Review Performed:	**2021**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Sandhills**
Name of PIP:	**INCREASE EBP FOR MEDICATION MANAGEMENT**
Reporting Year:	2019-2020
Review Performed:	01/2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data extracted in a systematic manner.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are reported.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Network monitoring staff enter and run report for rate.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	The report states that 2108 will be baseline year.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rate are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation until 3rd Qtr FY 19/20, and then temporary suspension of most regular monitoring activities occurred.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions including training for staff and standardization of the pool of reviewed charts and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate improved from 49% to 87%, which is above the benchmark rate.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to have face validity.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NOT MET**	Statistical testing was not conducted on rates. ***Recommendation: Add a chi square or Fisher's exact test to compare rates and report the p-value in the results.***
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Only two measurement periods.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Sandhills**
Name of PIP:	**ASSURE CONSISTENT CONNECTION TO COMMUNITY SERVICES FOLLOWING FACILITY BASES CRISIS SERVICES**
Reporting Year:	2019-2020
Review Performed:	01/2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data extracted in a systematic manner.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are reported.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed monthly and reported quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	UM staff run the data.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters and interpretation of rate and lowest rate for the measure.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate improved from 59% to 91%, which is above the benchmark rate of 70%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to have face validity.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NOT MET**	Statistical testing was not conducted on rates. ***Recommendation: Add a chi square or Fisher's exact test to compare rates and report the p-value in the results.***
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Only one measurement has been above the goal rate of 70% so unable to judge,

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Sandhills**
Name of PM:	**Access to Routine Behavioral Health Assessments**
Reporting Year:	**2019**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	Sample was sufficient.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**PARTIALLY MET**	It is unclear how a Fisher's exact test is used to ensure a valid random sample, as it is a statistical test to compare independent proportions. ***Recommendation: Omit the Fisher's exact test as a method for validating the sample and use a random function in Excel as an alternative to generate random selection.***
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	Sample was sufficient.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to processes of care, health status, and functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data are collected using mystery shopper survey methodology.
6.2 Did the study design clearly specify the sources of data? **(1)**	**NOT MET**	Data source is not clearly documented. ***Recommendation: Add information in the Data Collection section on how the caller enters the data and the database system used for data collection.***
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using a call script.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**NA**	Data collection instruments are not clearly documented; unable to judge.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed and reported quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Customer service coordinator collects data.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.

Component / Standard (Total Points)	Score	Comments
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters and interpretation of rate and lowest rate for the measure.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate most recently declined from 70% to 55%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement reported.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical testing was conducted on rates using Fisher's exact test.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**84**
Project Possible Score	**90**
Validation Findings	**93.3%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Sandhills**
Name of PIP:	**HOUSING SLOT TO TRANSITION DAYS- TCLI**
Reporting Year:	**2019-2020**
Review Performed:	**01/20/21**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed and reported quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	TCLI support specialist collects data.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly measures are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly number of days.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent number of days are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included number of days per quarter.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Number of days from issue to transition increased from 57 to 67 which is not improvement. ***Recommendation: Continue interventions and determine if specific interventions are more beneficial as the COVID-19 crisis continues to limit contact with consumers***.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Improvement not reported as number of days increased.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No statistical testing was conducted as the outcome is a single aggregate value, and not a rate.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**72**
Project Possible Score	**74**
Validation Findings	**97.3%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

D. Attachment 4: Tabular Spreadsheet

CCME PIHP Data Collection Tool

PIHP Name:	Sandhills
Collection Date:	2020

I. Information Systems Capabilities Assessment (ISCA)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A. Management Information Systems						
1. Enrollment Systems						
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Sandhills has standard processes in place for enrollment data updates. 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 every 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 patients' IDs are unique to members. Historical enrollment information is captured and maintained for all members.
1.2 The MCO is able to identify and review any errors identified during, or as a result, of the State enrollment file load process.	X					WellSky produces exception reports and notifies Sandhills if any errors are encountered during the GEF data load process. Sandhills confirmed that they have not encountered any errors. During the Onsite, Sandhills stated that they also upload the GEF file to a local database and use the database to compare the records to the AlphaMCS. Sandhills indicated that they have been encountered a maximum of three error records in the past year.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.	X					During the Onsite discussion, 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 MCO 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, 87.57% of Institutional and 99.76% of Professional claims are auto-adjudicated. Auto-adjudication is performed daily. Claims in excess of $5,000, Emergency Department claims, and Professional ED claims with a POS for emergency room are pended for manual review. Manual review of claims is performed on a daily basis.
2.2 The MCO has processes and procedures in place to monitor review and audit claims staff.	X					Sandhills has processes in place to monitor and audit claims staff. Sandhills audits a random sample of 3% of paid claims and 3% of denied claims processed in a one-week period on a weekly basis. Sandhills conducts weekly and monthly audits on claims processed. Paid and denied claims with the top 5 billed amounts and all paper claims are audited for accuracy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.3 The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	X					During the Onsite system demonstration of the AlphaMCS claims system, it was evident that ICD-10 Procedure codes, Revenue codes, and Diagnosis Related Groups (DRG) codes are captured in the AlphaMCS system. The Revenue codes and DRG are also included for encounter data submission reporting. As many as 25 ICD-10 Diagnosis codes are captured for Institutional claims received via the web portal, and as many as 29 Diagnosis codes can be captured on Institutional claims received electronically. For Professional encounters, as many as 12 ICD-10 Diagnosis codes are captured electronically and via the web portal.
2.4 The MCO's claim system screens store and track claim information and claim adjudication/payment information.	X					
3. Reporting						
3.1 The MCO'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. Sandhills stores and uses the ICD-10 Procedure codes for reporting. This improvement is related to a Corrective Action in the 2019 EQR. Historical data is stored in the AlphaMCS system from the inception of the LME/MCO.
3.2 The MCO 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 on a nightly basis. A disaster recovery policy and procedure were provided along with the ISCA tool.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Encounter Data Submission						
4.1 The MCO has the capabilities in place to submit the State required data elements to NC MEDICAID on the encounter data submission.	X					Sandhills submits all secondary Diagnosis codes for Professional encounters. Sandhills submits all secondary Diagnosis codes on Institutional encounters to NCTracks. This improvement is related to a Corrective Action in the 2019 EQR. ICD-10 Procedure codes are captured in the AlphaMCS system but are not included for encounter data submissions. During the Onsite, Sandhills inquired whether NCTracks has the ability to accept ICD-10 Procedure codes on encounter data extracts. NC Medicaid confirmed that they have the ability to accept ICD-10 Procedure codes on Institutional encounter data extracts. ***Recommendation: Continue to work with providers and the State to increase the number of ICD-10 Procedure codes submitted into NCTracks.***
4.2 The MCO has the capability to identify, reconcile and track the encounter data submitted to NC MEDICAID.	X					Sandhills has developed a Pay and Deny application 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 MCO has policies and procedures in place to reconcile and resubmit encounter data denied by NC MEDICAID.	X					Sandhills has clear processes in place to address denied encounter submissions. Encounter denial reports were provided and ISCA documentation shows flow charts and procedures for encounter data submissions to NC Medicaid.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.4 The MCO has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to NC MEDICAID	X					Sandhills' Claims and Information Technology (IT) Departments are responsible for working on the denied encounters and resubmitting them to NCTracks. The encounter data acceptance rate has been consistent with the 2019 EQR findings. Sandhills' staff was able to speak to encounter data submissions and reconciliation process.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II. A. Credentialing and Recredentialing						
1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					Procedure N-CR 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 to the Chief Clinical Officer (CCO)/Medical Director, who is responsible for oversight of clinical aspects of the Credentialing/ Recredentialing Program. The lists of CCO-approved "clean" applications are sent via email to Credentialing Committee members for review. The Credentialing Committee is chaired by the CCO/Medical Director. Per section N-CR 3a of the *Provider Credentialing Plan*,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						committee 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 Credentialing Committee Minutes indicate which members are "voting" members, which members are present, which member(s) made specific motions, and the outcome of votes cast. The meeting notes contain evidence of the committee discussion and decision-making. Sandhills delegates credentialing to UNC and Moses Cone hospital systems for their employees. The two hospital systems submit to Sandhills a monthly credentialing roster. The individual practitioners are entered as "delegates" in the Alpha system and are not available for direct referrals.
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Credentialing files reviewed for the EQR were organized and contained appropriate information. CCME identified the following issues in the file review:
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					Sandhills addressed the Corrective Action from the last EQR. Files reviewed for the current EQR contained proof of all required insurance coverage. For providers joining already-contracted agencies, files included copies of the agency insurance coverage and verification that the provider is covered under the agency insurance.
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.3 Valid DEA certificate; and/or CDS certificate	X					
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					At the last EQR, there was an issue regarding Primary Source Verification (PSV) of education for Physicians Assistants (PAs), since the NC Medical Board has verified that they do not conduct PSV of education. During the Onsite for this EQR, staff reported Sandhills has now subscribed to the AMA Physician Masterfile, which conducts PSV of education for physicians and PAs. If the PA is not enrolled in the AMA Physician Masterfile, Sandhills requires transcripts from the college/university for the highest degree obtained.
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					
3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					The credentialing/recredentialing files do not include a screenshot of the *State Excluded Provider List* (*SEL*), which, though not required, could serve as PSV. The Application Checklist in most files states "Spreadsheet Viewed" for the required query of the *State Excluded Provider List* (SEL), but no date is listed. During the Onsite discussion, the Sandhills staff confirmed that the date the *SEL* is viewed is recorded on the Sandhills Primary Source Verification spreadsheet.
3.1.10 Query for the System for Awards Management (SAM);	X					
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	X					
3.1.14 Names of hospitals at which the physician has admitting privileges, if any	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.15 Ownership Disclosure is addressed.	X					
3.1.16 Criminal background Check	X					For Licensed Independent Practitioners, background checks are conducted via the NC State Bureau of Investigation. During the Onsite discussion, Sandhills staff verified agencies conduct criminal background checks for owners, directors, officers, administrators, and staff. This practice was approved by NC Medicaid. Sandhills' agency contracts require the agency conduct the background checks. Agencies submit their background check policy with their Sandhills Agency Application. Sandhills conducts the PSVs outlined in the *NC Medicaid Contract*.
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files reviewed for the EQR were organized and contained appropriate information. CCME identified the following issues in the file review:
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					Sandhills addressed the Corrective Action from the last EQR. Files reviewed for the current EQR contained proof of all required insurance coverage. For providers joining already-contracted agencies, files included copies of the agency insurance coverage and verification that the provider is covered under the agency insurance.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
4.2.3 Valid DEA certificate; and/or CDS certificate	X					
4.2.4 Board certification if claimed by the applicant;	X					
4.2.5 Malpractice claims since the previous credentialing event;	X					
4.2.6 Practitioner attestation statement;	X					
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					
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					The credentialing/recredentialing files do not include a screenshot of the *State Excluded Provider List* (*SEL*), which, though not required, could serve as PSV. The Application Checklist in most files states "Spreadsheet Viewed" for the required query of the *State Excluded Provider List* (*SEL*), but no date is listed. During the Onsite discussion, the Sandhills staff confirmed that the date the *SEL* is viewed is recorded on the Sandhills Primary Source Verification spreadsheet.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.9 Requery of the SAM.	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (OIG LEIE);	X					
4.2.11 Requery of the Social Security Administration's Death Master File	X					
4.2.12 Requery of the NPPES;	X					
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					
4.2.14 Ownership Disclosure is addressed.	X					
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					The Credentialing Committee 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					Procedure N-PM4a, Provider Sanctions, includes possible sanctions, including termination, for compliance issues, fraud/waste/abuse, and quality of care concerns.
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					

III. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III. Quality Improvement						
III. A Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					Performance Measure query was accurate for (b) Waiver measures. One (b) Waiver measure had a substantial rate decline. Five (b) Waiver measures had rate increases. All (c) Waiver measures were above the State benchmark rates.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III. B Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					Sandhills submitted seven projects for validation. Of those seven, four were validated. The validated PIPs included: Access to BH Assessment (non-clinical), TCLI Transition Days (non-clinical), Increase EBP for Medication Management (clinical), and Assure Consistent Connection to Community Services Following FBC Services (clinical).
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					The four validated PIPs scored in the High Confidence range, although each PIP had errors and CCME provided recommendations for improvement. The errors and recommendations included: Statistical testing was not conducted on rates for the Increase EBP for Medication Management and the Assure Consistent Connection to Community Services Following FBC Services PIP. ***Recommendation: Add a chi square or Fisher's exact test to compare rates and report the p-value in the results.*** It is unclear how a Fisher's exact test is used to ensure a valid random sample, as it is a statistical test to compare independent proportions for the Access to Routine BH Assessments PIP. ***Recommendation: Omit the Fisher's exact test as a method for validating the sample and use a random function in Excel as an alternative to generate random selection.*** Data source is not clearly documented for the Access to Routine BH Assessments PIP. ***Recommendation: Add information in the Data Collection section on how the caller enters the data and the database system used for data collection.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The TCLI Transition Days PIP did not show improvement as the number of days from issue to transition increased from 57 to 67. ***Recommendations: Continue interventions and determine if specific interventions are more beneficial as the COVID-19 crisis continues to limit contact with consumers.***

IV. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. A Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					In the 2019 EQR, CCME recommended that Sandhills update the *Member Handbook* to describe the availability of and eligibility for MH/SA and I/DD Care Coordination services. This Recommendation was addressed.
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					Sandhills has Policy and Procedure, Clinical Triage Dispositions in place that denotes the provider's role when completing the face-to-face pretreatment assessment.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					Sandhills has Policy and Procedure, Health Education and Communication that outlines the process of assessing each enrollee's need at the first point of contact with Customer Services Representatives.
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					
2.5 Quality monitoring and continuous quality improvement;	X					Sandhills has Policy and Procedure, Internal Monitoring in place that discusses the Quality Management Department's role in ensuring continuous quality monitoring and improvement of care coordination activities. IDD/MHSU/TCLI has monitoring plans in place that are used to conduct individual Care Coordinator supervision. Individual monitoring is based on data derived from the Quality Management Department.
2.6 Determination of which Behavioral Health Services are medically necessary;	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					
2.10 Ensure privacy for each Enrollee is protected.	X					

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					Sandhills' Policy and Procedure, I/DD Care Coordination Monitoring of Plan Implementation, outlines the monitoring of Innovations services and the I/DD Care Coordinator's responsibilities per *NC Clinical Coverage Policy 8P* and *NC Medicaid Contract Section 7*. The policy and procedure lacked information regarding HCBS monitoring standards and the use of the State-required *Monitoring Checklist*. During the Onsite, Sandhills stated that requirements for HCBS monitoring standards were in the *I/DD Monitoring Plan*. However, a review of the plan found no information related to HCBS monitoring or the use of the State-required *Monitoring Checklist*. ***Recommendation: Add an explanation of Home and Community Based Services (HCBS) and the use of the required State Monitoring Checklist to a procedure, relevant I/DD Care Coordination manual, or I/DD document.***
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					A Corrective Action was issued during the 2019 EQR for Sandhills to use a data-driven approach to enhance the monitoring of the I/DD progress note submission timeframe. Additionally, Sandhills was issued a Recommendation to use available data to analyze and target I/DD documentation standards. Sandhills addressed the Corrective Action and Recommendation. The review of IDD/MHSUD files for this EQR showed significant improvement in submitting progress notes and other required documentation in a timely manner. The files showed that Sandhills Care Coordination policies and procedures are being followed.
IV. B Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					
2.1 Care Coordination activities occur, as required.	X					
2.2 Person Centered Plans are developed as required.	X					During the 2019 EQR, it was recommended that Sandhills either add to a current TCLI procedure, or create a new policy and procedure, to include the responsibilities of the TCLI program, (i.e., participation in treatment planning, documentation requirements for progress notes,) and supervision of TCLI staff. This Recommendation was addressed.
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					Sandhills has updated the *TCLI Internal Monitoring Results Calculator Report* to include a review of TCLI staff's efforts to explore member interest in Supported Employment. According to the quarterly report, the first quarter review showed that 45% of files included a discussion about Supported Employment. The second and third quarter showed a downward trend, which corresponds with the COVID-19 Pandemic.
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					
2.5 QOL Surveys are administered timely.	X					The review of TCLI files found all Quality of Life (QOL) surveys were present and completed in a timely manner.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 information on the TCLI initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					
6. A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	X					During the 2019 EQR, a Corrective Action was issued to enhance the current monitoring process using a data-driven approach to bring the TCLI progress notes into compliance with the required timeframe for submission. Additionally, Sandhills was issued a Recommendation to use available data to analyze and target TCLI documentation standards. Sandhills addressed the Corrective Action and Recommendation. The review of this year's TCLI files showed significant improvement in the timely submission of TCLI documentation and progress notes. Furthermore, the review showed that Sandhills' policies and procedures are being followed.

V. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					In the 2020 EQR, it was noted that Sandhills revised Procedure CORE 35a Consumer Grievance Process-Medicaid to reflect the use of the single term "grievances". The *Member Handbook* also included the consistent use of the term "grievance." The Medicaid State Provider Manual effective November 13,2020 includes a more consistent use of "grievance." However, the term "complaint" was still evident in two areas of the manual. ***Recommendation: Revise the Medicaid/State Provider Manual to consistently use the term "grievance."***
1.1 Definition of a grievance and who may file a grievance;	X					
1.2 The procedure for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					Procedure CORE 35a Consumer Grievance Process-Medicaid now consistently states the written acknowledgement of a grievance is sent "within 5 working days of the receipt of the grievance" in both the High and Low Risk sections of the procedure. This was a Recommendation from the 2019 EQR. Procedure CORE 35a Consumer Grievance Process-Medicaid was also revised to include the notification requirements when Sandhills extends the grievance resolution timeframe. This revision was also in response to a 2019 EQR Recommendations and is required by *42 CFR § 438.408*. Sandhills' *Member Handbook* includes information about the right of an enrollee or their representative to request an extension to the grievance resolution timeframe. However, there is no information

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						about the process followed when Sandhills extends the grievance resolution timeframe. CCME recommends Sandhills add this information to the handbook, including the notifications required by *42 CFR § 438.408 (c)(1) and (c)(2)*. ***Recommendations: Add information to the Member Handbook regarding the process followed when Sandhills extends the grievance resolution timeframe. Include the notifications required by 42 CFR § 438.408 (c)(1) and (c)(2).***
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					Procedure CORE 35a Consumer Grievance Process-Medicaid notes the Chief Clinical Officer/Medical Director's role in the grievance resolution process and documentation of this consultation was present within the grievance files.
1.5 Maintenance of a grievance log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Procedure CORE 35a Consumer Grievance Process-Medicaid was revised by Sandhills to include that grievance files "are maintained for 5 years", per *NC Medicaid Contract*, *Attachment M, B. Record Keeping and Reporting*. This revision was the result of a 2019 EQR Recommendation.
2. The PIHP applies the grievance policy and procedure as formulated.	X					The review of the grievances files selected for this 2020 EQR showed the acknowledgment letters and grievance resolution notifications were sent within the timeframes required by Sandhills' policies and procedures and *NC Medicaid Contract, Attachment M, Section C*. There was also information within the grievances files showing when referrals of the grievance are made internally to other Sandhills' departments. Information about the grievance resolution notifications did not always reflect the internal steps taken by Sandhills to resolve the grievance. For example, most letters only stated, "The review was able to substantiate the grievance at this time. Recommendations were given to the provider." Procedure CORE 35a Consumer

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Grievance Process-Medicaid requires these notifications to include "all actions taken to resolve the grievance." ***Recommendation: Routinely review the grievance resolution notifications to identify opportunities to provide more details regarding the internal steps Sandhills took to resolve the grievance.***
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					In the 2019 EQR, a Recommendation was provided to maximize the use of the data to include more in-depth analysis such as analyzing trends, monitoring provider performance, and identifying quality improvement opportunities. During the Onsite discussion, Sandhills stated they are utilizing data and developing a Quality Review process for grievances.
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					
V. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 The definitions an appeal and who may file an appeal;	X					In the 2019 EQR, CCME issued two Corrective Actions aimed at correcting misinformation in the *Medicaid Provider Manual* and *Member Handbook* about the procedure for filing an appeal. Through the Corrective Action Plan process, Sandhills revised these documents and CCME approved the revisions in December 2019. In the 2020 EQR, it was evident that the *Member Handbook* was not finalized and published on Sandhills' website until September 2020 and the *Medicaid/State Provider Manual* was not finalized and published on Sandhills' website until December 2020. As a result, misinformation, such as who can file an appeal, within the *Member Handbook* was publicly available for a year, and misinformation within the *Medicaid Provider Manual* was publicly available for two years. *NC Medicaid Contract, Section 7.11 Provider Manual* and *Section 6.9 Enrollee Written Materials* both state, the "PIHP shall correct materials errors within a reasonable timeframe." ***Recommendation: Define a "reasonable timeframe" for correcting errors identified in Member Handbook and Provider Manual and publishing them on Sandhills' website. Add this timeframe to an applicable procedure.***
1.2 The procedure for filing an appeal;	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;		X				One Corrective Action issued in the 2019 EQR focused on ensuring the appeals policies and procedures detailed all of the required notifications when Sandhills denies a request to expedite an appeal. Sandhills addressed this Corrective Action. However, there is no language in any of the Sandhills' policies and procedures that outlines the requirement of Sandhills to notify enrollees of their rights to file grievances if Sandhills denies a request to expedite an appeal. This notification to the enrollee of their grievance right is required by *NC Medicaid Contract, Attachment M, Section A.d.2.ii and 42 CFR § 438.410 (c)(2).* ***Corrective Action: Revise Sandhills' policies and procedures to state the requirement that Sandhills notify the enrollee of his or her right to file a grievance if Sandhills denied a request to expedite an appeal.***
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP applies the appeal policies and procedures as formulated.		X				The 2020 EQR appeal file review found that eight of the 10 files reviewed were acknowledged and resolved in a timely manner. In the two files that were out of compliance, the appeal was first initiated orally by the enrollee, but the appeal resolution timeframe did not start until the receipt of the subsequent written notice. This was evident by review of the Appeals Coordinator notes and Appeals Log. As a result, both appeals were out of compliance with the required notification timeframes. This practice was also evident in a third file, but this file showed the acknowledgement and appeal resolution notifications were issued within the required timeframes. Per Sandhills' appeals policies and procedures, "the timeframe for resolution starts when the first request is received, regardless of whether the request is received orally or in writing." This procedural language is congruent with *Attachment M* of the NC *Medicaid Contract, Section G(3)(a)*, and *42 CFR § 438.406(b)(3)*. During the Onsite, staff described the current monitoring process and provided a template of an appeal audit tool (labeled NCQA & URAC UM Denial File Audit Tool). Staff explained appeal files are reviewed quarterly, but the Appeals Log is not routinely reviewed for completeness and accuracy. Review of the appeal audit tool provided by Sandhills during the Onsite showed the tool targeted only a few appeals elements required by *NC Medicaid Contract* and federal regulations. Specifically, there is no compliance review of the timeliness of written acknowledgement notifications, expedited appeals, appeals submitted orally, etc. ***Corrective Action: Enhance the current appeals monitoring process to ensure compliance of appeal processes and notifications, especially those appeals initiated orally.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					In addition to the appeals file findings, several documentation errors were noted within the Appeals Log, Appeals Coordinator notes, and the Expedited Appeals Checklist. Most often these were incorrect dates of oral and written appeal receipt, written acknowledgement notifications, and oral notifications from staff to appellants. For example, of the four appeals files where the appeal was initiated orally, only one was captured on the Appeals Log. As the Appeals Log, Appeals Coordinator notes, and the Expedited Appeals Checklist are the sources of critical appeals data, Sandhills needs to enhance their current monitoring process to include routine review of data and documentation within these files for accuracy. This review should also include a compliance review to ensure all notifications (written and oral) are provided within the required timeframes, especially those appeals initiated orally. ***Recommendation: In the enhanced appeals monitoring process, include routine review of the Appeals Log to ensure data and documentation within the log are complete and accurate.***
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					

VI. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI A. General Requirements						
1. PIHP shall be familiar and comply with *Section 1902 (a)(68)* of the *Social Security Act*, *42 CFR § 438.455* and *1000* through *1008*, as applicable, including proper payments to providers and methods for detection of fraud and abuse.	X					
2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents', and subcontractors,' compliance with the requirements of this *Section 14* of the *NC Medicaid Contract*.	X					
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					Sandhills' Provider Agreement details Program Integrity requirements.
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					Sandhills' Policy and Procedure, Investigative Process, provides a workflow detailing the process by which Sandhills investigates grievances related to fraud, waste and abuse.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with *42 CFR § 438.608* that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the *NC Medicaid Contract* Administrator on an annual basis.	X					
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of *42 CFR § 438.608* and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under *NC Medicaid Contract* in accordance with *42 CFR § 438.608(a)(1)(iv).*	X					

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					
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					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
and procedures and the False Claims Act as identified in *Section 1902(a)(66)* of the *Social Security Act;*						
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing, and development of corrective action initiatives;	X					
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					
8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including NC Medicaid or MFCU/MID, and including supplying all data in a uniform format provided by NC Medicaid and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by the Division as provided in *NC Medicaid Contract Section 13.2-Monetary Penalties.*	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9. In accordance with *42 CFR § 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) for each overpayment that is not specified in an Attachment Y Report within the applicable month. In addition, PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse.	X					
10.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure. This process shall include procedures for logging the complaint, determining if the complaint is valid, assigning the complaint, investigating, appeal, recoupment, and closure. The detailed workflow needs to differentiate the steps taken for fraud versus abuse; PIHP shall establish and implement policies for treatment of recoveries of all overpayments from PIHP to Providers and contracted agencies, specifically including retention policies for treatment of recoveries of overpayments due to fraud, waste, or abuse. The retention policies shall include processes, timeframes, and required documentation for payment of recoveries of overpayments to the State in situations where PIHP is not permitted to retain some or all of the recoveries of overpayments. This provision shall not apply to any	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
10.4 Process for tracking overpayments and collections based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on Attachment Y – Audits/Self-Audits/investigations.	X					
10.5 Process for handling self-audits and challenge audits.	X					
10.6 Process for using data mining to determine leads.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.7 Process for informing PIHP employees, subcontractors, and providers regarding the *False Claims Act.*	X					
10.8 If PIHP makes or receives annual payments of at least $5,000,000, PIHP shall establish and maintain written policies for all employees, contractors, or agents that detail information about the *False Claims Act* and other federal and state laws as described in the *Social Security Act 1902(a)(66)*, including information about rights of employees to be protected as whistleblowers.	X					
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid-standardized elements or a NC Medicaid-approved template;	X					
10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
information in a readily available database or other search mechanism.						
11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.	X					
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					The PI files review in the 2020 EQR showed Sandhills initiated investigations within the required timeframes.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13. In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						The EQR of the Sandhills PI files showed all required information was available with the files reviewed.
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					
13.2 Source/origin of complaint;	X					
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					
13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated; and dates of suspected intentional misconduct;	X					
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.6 All communications between PIHP and the Provider concerning the conduct at issue, when available.	X					
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					
13.8 Total Sample Amount of Funds Investigated per Service Type	X					
14. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;	X					
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and	X					
14.7 The legal and administrative status of the case.	X					
14.8 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					
14.9 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					
14.10 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					
14.11 Information on Biller/Owner;	X					
14.12 Additional Provider Locations that are related to the allegations;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.13 Legal and Administrative Status of Case.	X					
15. PIHP and NC Medicaid shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of State and Federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.	X					
16. PIHP shall use the NC Medicaid Fraud and Abuse Management System (FAMS) or a NC Medicaid approved alternative data mining technology solution to detect and prevent fraud, waste, and abuse in managed care.	X					
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					

18. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month or the next business day if the 10th day is a non-business day (i.e., weekend or State or PIHP holiday). In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to NC Medicaid Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59 p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to NC Medicaid Program Integrity all Network Provider contract terminations 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.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI 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 evidence of fraud by the Provider; or Legal proceedings related to the Provider's alleged fraud are completed						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
and the Provider is cleared of any wrongdoing.						
1.1 In the circumstances described in *Section 14.3 (c)* above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.	X					
2. Upon receipt of a payment suspension notice from NC Medicaid Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of NC Medicaid Program Integrity's suspension and lasting until PIHP is notified by NC Medicaid Program Integrity in writing that the suspension has been lifted.	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid Program Integrity due to allegations of suspected fraud without prior written approval from NC Medicaid Program Integrity or the MFCU/MID. If PIHP takes administrative action, including issuing a Notice of Overpayment based on such fraud that precedes the submission date of a Division referral, the State will adjust the PIHP capitated payment in the amount of the original overpayment identified or One Thousand Dollars ($1,000) per case, whichever amount is greater.	X					

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

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

E. Attachment 5: Encounter Data Validation Report

Sandhills

Encounter Data Validation Report

performed on behalf of

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

February 10, 2020

Prepared By:

hms

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

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Background

Health Management Systems (HMS) 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. DHHS may use encounter data for purposes including, but not limited to, setting PIHP capitation rates, measuring the quality of services managed by PIHPs, assuring compliance with State and federal regulations, and for oversight and audit functions."

In order to use 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 the review, guided by the CMS Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid by Sandhills for the period of January 2019 through December 2019. 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 to confirm receipt and any compliance errors. The behavioral health encounter claims are then validated by applying a list of edits provided by the State (See Appendix 1) and adjudicated accordingly by Medicaid Management Information System (MMIS). Using 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 2019, Sandhills submitted 1,101,897 unique encounters to the State. Similar to the prior year, less than 1% of all 2019 encounters submitted have not been corrected and accepted by NC Medicaid. However, Institutional claims saw a large increase in denial rate, up from 0.45% to 5.61%.

2019	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
Institutional	32,606	30,537	239	1,830	5.61%
Professional	1,235,317	1,217,873	12,641	4,803	0.39%
Total	1,267,923	1,248,410	12,880	6,633	0.52%

A review of NC Medicaid 's acceptance report showed that most of the Institutional denials occurred in May 2019. Many of these denials were not resubmitted and accepted by NC Medicaid in 2019. Despite this fact, the overall denial rate in 2019 still decreased slightly compared to 2018.

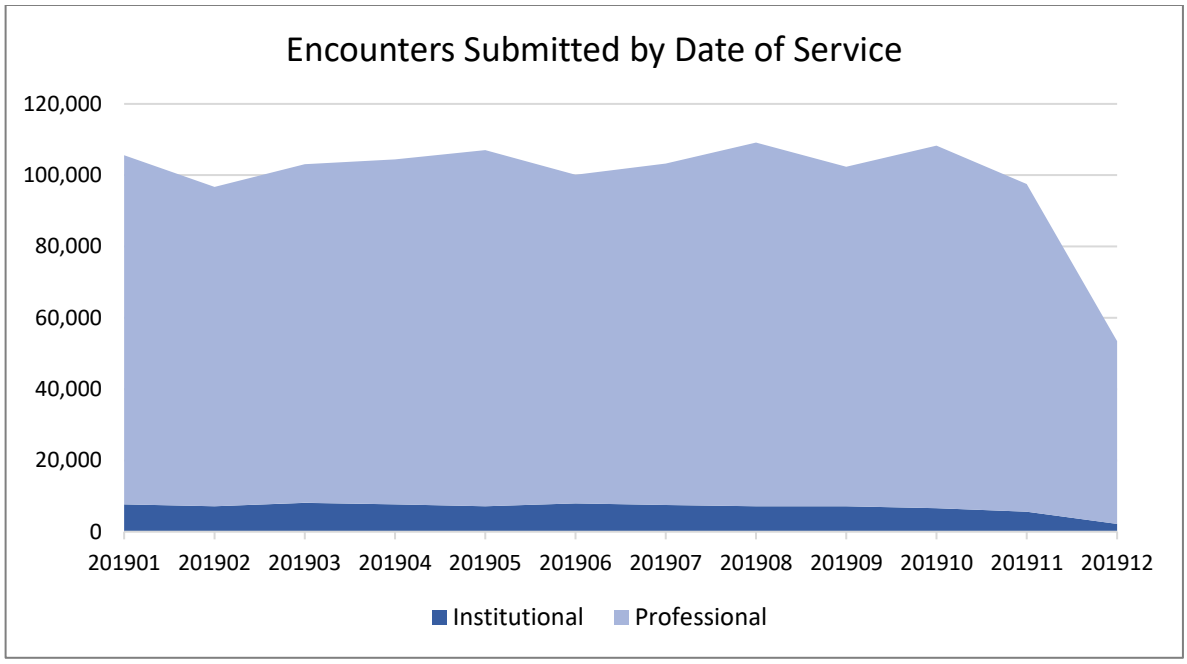
Overall, 28% of all denials were related to Taxonomy codes. Combined with an overall reduction in number of denials and decreasing share of Taxonomy code related denials, Sandhills continues to do a good job of reconciling and mitigating denials. Sandhills' strategy for correcting encounter denials includes the following steps:

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

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

Analysis of Encounters

The analysis of encounter data evaluated whether Sandhills submitted complete, accurate, and valid data to NC Medicaid for all claims paid between January 1, 2019 and December 31, 2019. Sandhills worked with their EDI vendor to convert each 837I and 837P file submitted to NC Medicaid during the requested audit period to an excel spreadsheet and sent to HMS via SFTP. This included 1,160,495 Professional claim line items and 91,633 Institutional claim line items. These figures include line level detail as well as voids and resubmissions for previously denied claims, including denials prior to 2019. Therefore, these numbers do not match the metrics reported in Sandhills' ISCA response.



In order to evaluate the data, HMS ingested and combined all batch encounter files, and loaded them to a consolidated database. After data onboarding was completed, HMS applied proprietary, internally designed data analysis tools to review each data element, focusing on the data elements defined as required. These tools evaluate the presence of data in each field within a record as well as whether the value for the field is within accepted standards. Results of these checks were compared with general expectations for each data field and to the CMS standards adopted for encounter data. The following table depicts the specific data expectations and validity criteria applied. Professional and Institutional files included older dates of service that were resubmitted to NC Medicaid during 2019.

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

Data Element	*Expectation*	*Validity Criteria*
Recipient ID	Should be valid ID as found in the State's eligibility file. Can use State's ID unless State also accepts Social Security Number.	100% valid
Recipient Name	Should be captured in such a way that makes separating pieces of name easy. Expect data to be present and of good quality	85% present. Lengths should vary, but there should be at least some last names of >8 digits and some first names of < 8 digits, validating that fields have not been truncated. Also, a high percentage of names should have at least a middle initial.

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

Data Element	*Expectation*	*Validity Criteria*
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 (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

Data Quality Standards for Evaluation of Submitted Encounter Data Fields Adapted and Revised from CMS Encounter Validation Protocol		
Data Element	***Expectation***	***Validity Criteria***
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 following table outlines the key fields that were reviewed to determine if information was present, whether the information was the correct type and size, and whether or not the data populated was valid. Although the complete data set was reviewed and all data values validated, the fields identified in the following tables 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	1,252,577	100.00%	1,252,577	100.00%	1,252,577	100.00%	1,252,577	100.00%
Recipient Name	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%
Recipient Date of Birth	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%
MCO/PIHP ID	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%
Provider ID	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%
Attending/Rendering Provider ID	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%
Provider Location	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%
Place of Service	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%
Specialty Code / Taxonomy – Billing	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%
Specialty Code / Taxonomy - Rendering / Attending	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%
Principal Diagnosis	1,252,576	100.00%	1,252,576	100.00%	1,252,576	100.00%	1,252,576	100.00%
Other Diagnosis	255,076	20.36%	255,076	20.36%	255,076	20.36%	255,076	20.36%
Dates of Service	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%
Unit of Service (Quantity)	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%	1,252,583	100.00%
Procedure Code	1,195,096	95.41%	1,195,096	95.41%	1,195,096	95.41%	1,195,096	95.41%
Procedure Code Modifier	390,325	31.16%	390,325	31.16%	390,325	31.16%	390,325	31.16%
Patient Discharge Status Code Inpatient	92,125	100.00%	92,125	100.00%	92,125	100.00%	92,125	100.00%
Revenue Code	92,125	100.00%	92,125	100.00%	92,125	100.00%	92,125	100.00%

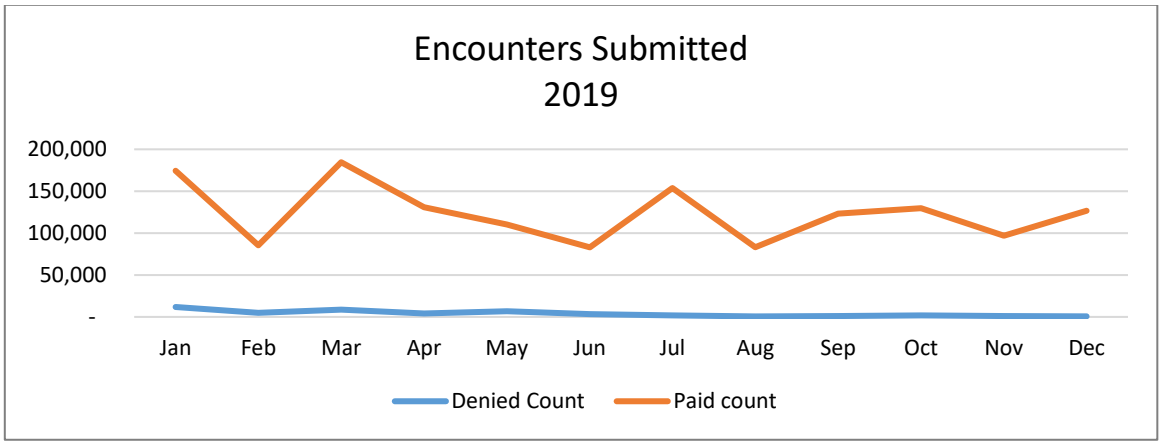
There were very few inconsistencies in the data other than the denial issues highlighted in Sandhills' ISCA response and NC Medicaid 's encounter acceptance report. Institutional claims contained complete and valid data in 17 of the 18 key fields (94%) with noted issues to Procedure codes. Some Institutional claims were missing Procedure codes on the line level detail where the Revenue code is not enough to identify the service that was provided. For example, when laboratory Revenue codes are used CPT/HCPCS should be present to clarify which lab procedure was performed.

Overall, there has been a great deal of improvement in the accuracy of Institutional encounter data elements over the past couple of years. In particular, Taxonomy codes and Diagnosis code related denials have dropped significantly, and those that are denied are being reconciled following the process that Sandhills and AlphaMCS have put in place to resolve.

Professional encounter claims submitted contained complete and valid data in 14 of the 15 key Professional fields (93%). The primary issue was the infrequent reporting of Other Diagnosis on Professional services. The principal Diagnosis code was populated 100% of the time; however, there is some inconsistency in additional Diagnosis codes being present. Specifically, some providers never reported additional Diagnosis codes.

Encounter Acceptance Report

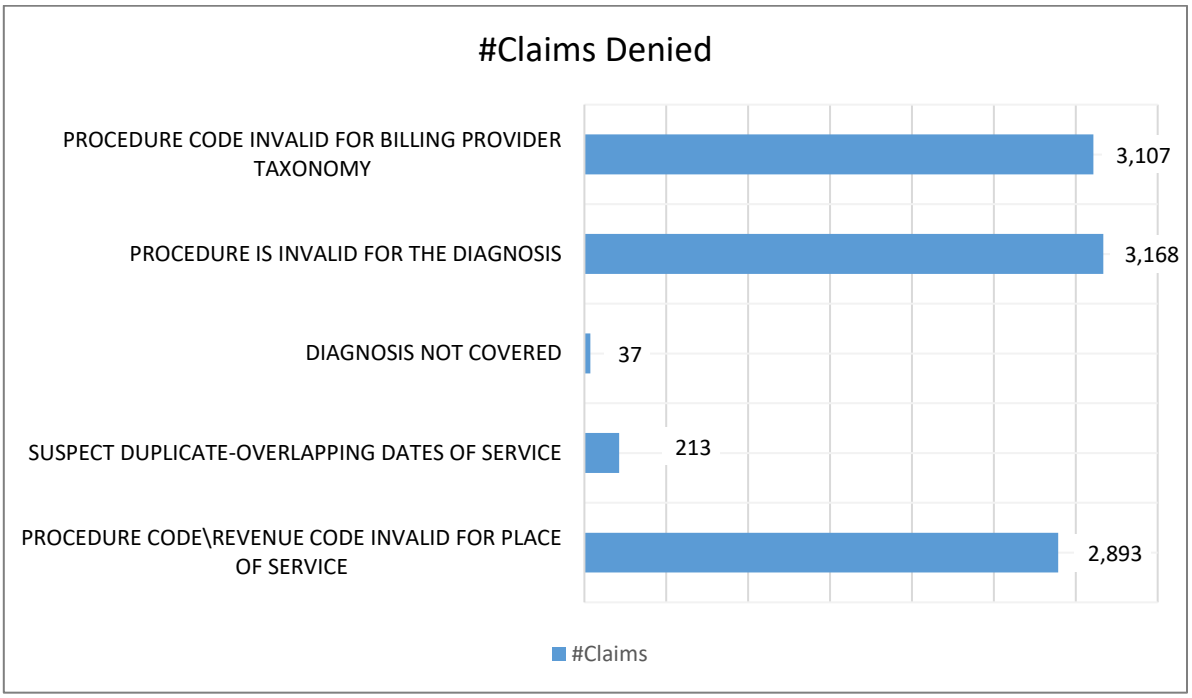
In addition to evaluating the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write which made it difficult to tie back to the ISCA response and converted encounter files since only the Date of Service for each is available. During the 2019 weekly check write schedule, Sandhills submitted a total of 1,101,897 encounters to NC Medicaid. On average, 3% of all encounters submitted were denied, with the vast majority of the denials occurring in the first half of 2019.

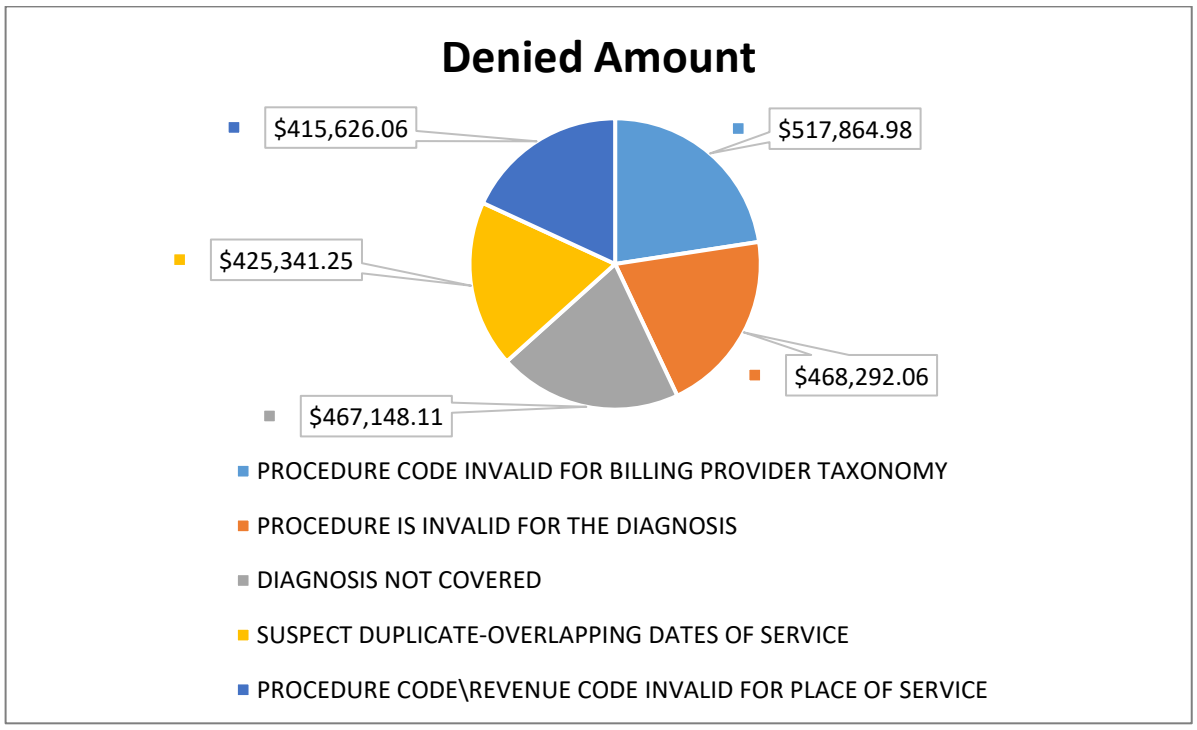


Evaluation of the top denials for Sandhills' encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis above. The top denials also align with the same denial reasons for the 2018 dates of services reviewed in last year's report. Encounters were denied primarily for:

- Procedure code invalid for billing provider Taxonomy
- Procedure is invalid for the diagnosis
- Diagnosis not covered
- Suspect duplicate-overlapping dates of services
- Procedure code/Revenue code invalid for Place of Service

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





Results and Recommendations

Issue: Taxonomy code for Billing and Rendering providers

Taxonomy values were consistently populated; however, this is the most frequent denial reason among Sandhills' encounter submissions. This information is key for passing the front end edits put in place by the State and to effectively price the claim. NCTracks is expecting the correct combination of NPI, Taxonomy code, and Procedure code. The Taxonomy code did not always match up with the Taxonomy values enrolled in NCTracks for the Billing and/or Rendering Provider and the service that was provided. These errors result in denials by the NC Medicaid that must be corrected and resubmitted.

Resolution:

Continue to follow the process built by Sandhills and AlphaMCS. As time passes and providers are educated, the initial denials due to invalid Taxonomy codes should naturally go down. Sandhills realized such improvement in 2019. The total number of denials related to the Taxonomy code has dropped significantly. Even in terms of percentage share of all denials, denials related to Taxonomy code accounted for a smaller percentage. In 2017 and 2018, invalid taxonomies made up 70% and 48% of all denials, respectively. This figure was 28% for 2019 and clearly shows the progress Sandhills has made. However, Taxonomy code remains, by far, the most common denial reason, suggesting there is still room for improvement through continued provider education and by following the processes to ensure reconciliation of Taxonomy codes between the provider, Sandhills, and NCTracks.

Issue: Other Diagnosis

Other Diagnosis codes were often missing, especially on Professional claims. Principal and admitting diagnoses were populated consistently, and Sandhills has made notable progress in reporting additional Diagnosis codes. However, too many Professional claims are missing additional diagnosis.

Resolution:

Sandhills made significant progress in reporting additional Diagnosis codes, especially on Institutional claims. Some improvements were also seen in Professional claims. However, there are many providers who never report more than one Diagnosis code. To address this issue, it is recommended that Sandhills alert such providers to remind them to ensure that submitted claims are complete and accurate, including Diagnosis codes.

Conclusion

Based on the analysis of Sandhills' encounter data, we have concluded that the data submitted to NC Medicaid is complete and accurate. Minor issues were noted with both Institutional and Professional encounters due to Taxonomy codes and additional Diagnosis codes.

Sandhills has made great progress in improving the accuracy of encounter data over the past couple of years and should stay on course with resolving issues related to Billing Taxonomy, Rendering Taxonomy, and additional Diagnosis codes. Denials related to Taxonomy code are still the dominant

cause of denial by a large margin. Sandhills should revisit the strategy it has put in place to address issues with invalid or missing Taxonomy codes, as well as a reconciliation process and make necessary adjustments to further reduce Taxonomy code denials noted previously.

The issue with missing Diagnosis codes on Professional claims does not impact the ability to price the claims; however, it will have an impact to NC Medicaid's ability to provide proper oversight and measure effectiveness. Sandhills should work with its providers to encourage complete and accurate reporting of additional Diagnosis codes.

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