CCME

2018 External Quality Review

VAYA HEALTH

Submitted: November 23, 2018

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

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EXECUTIVE SUMMARY

This report contains a description of the process and the results of the 2018 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the North Carolina Department of Health and Human Services' (NC DHHS) and NC Medicaid, formerly Division of Medical Assistance (DMA). The Balanced Budget Act of 1997 requires State Medicaid Agencies that contract with Prepaid Inpatient Health Plans (PIHPs) and/or Medicaid Managed Care Organizations (MCOs) to evaluate compliance with the state and federal regulations in *42 Code of Federal Regulations (CFR) 438.358* (*42 CFR § 438.358*). This report reflects CCME findings for Vaya Health (Vaya).

Goals of the review are to:

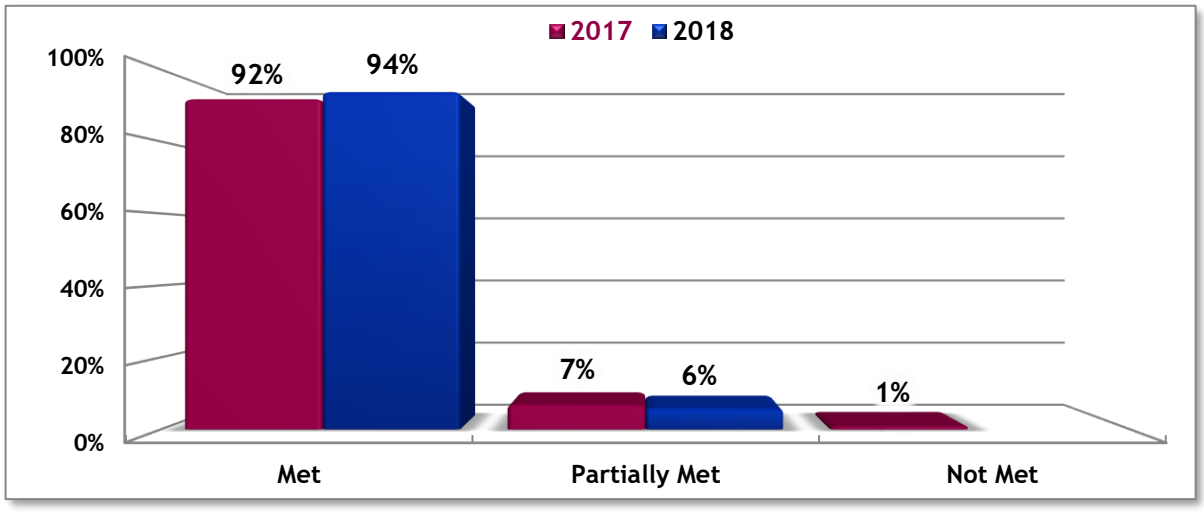
- Determine if Vaya complies with service delivery as mandated by its NC Medicaid contract
- Provide feedback for potential areas of further improvement
- Verify the delivery and quality of contracted health care services

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

A. Overall Findings

The 2018 Annual EQR reflects Vaya has a "Met" score for 94% of the standards reviewed. As Figure 1 indicates, 6% of the standards score as "Partially Met." It should be noted that the overall percentage of standards "Not Met" is .39% and so is not captured within the overall scores. Figure 1 also provides a comparison of Vaya's 2017 review results to 2018 results.

Figure 1: Annual EQR Comparative Results



B. Overall Recommendations

Recommendations that address each of the review findings are addressed in detail under each respectively labeled section of this report. CCME recommends implementing the following improvements in conjunction with the recommendations in each respective report section.

Administration

The 2018 Vaya EQR reflects the PIHP met 100% of the Administrative standards. Vaya made considerable effort to bring its policies and procedures into compliance with their policy requirements. The documentation submitted for this year's EQR shows all policies and procedures are accounted for and submitted in final, approved format. Vaya presented evidence of annual review and policy information within PolicyTech, Vaya's policy platform, that is congruent with individual policies and procedures.

CCME's review of Vaya's current organizational staffing shows that none of the current vacancies are affecting Vaya's core functions. CCME recommends again this year that Vaya ensure its *Organizational Chart* accurately reflects the oversight and job duties of the Medical Director and Assistant Medical Director.

The EQR of Vaya's confidentiality policies and practices shows that Vaya continues to maintain a complete set of policies and procedures that fully address both state and federal requirements for preserving enrollee confidentiality and protecting health information. Vaya's *Privacy Policy (2599)* does not specify a timeframe for training new employees on confidentiality, although this timeframe was defined by Vaya staff

members during the Onsite visit as "within 30 days." CCME recommends for the second time in as many EQRs that Vaya define this timeframe within the *Privacy Policy*.

Vaya has a comprehensive enrollment and claims processing system. Staff members are able to speak to their processes and provided a demonstration of the enrollment and claims data captured in the AlphaMCS. Vaya has worked with its providers to address encounter submission denials attributed to provider taxonomy and procedure code discrepancies. Vaya's encounter data acceptance rate is 95-97%.

Vaya's claims processing system is capable of capturing up to 22 ICD-10 diagnosis codes for institutional claims and up to 12 ICD-10 diagnosis codes for professional claims. The provider web portal captures up to 12 ICD-10 diagnosis codes for both institutional and professional claims. Vaya submits up to three diagnosis codes in the institutional encounter data submissions and up to two diagnosis codes in the professional encounter data submissions. Twenty-five ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837I and the maximum number captured by NCTracks. Twelve ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837P and the maximum number captured by NCTracks.

Provider Services

The Provider Services review includes Network Adequacy and Credentialing and Recredentialing. The "Partially Met" items for this review are due to the lack of query/re-query of the *State Exclusion List*, as required by *DMA Contract Attachment B, Section 1.14.4* and *7.6.4* and Vaya *Policy 2891, Credentialing Program*.

Several files do not contain Primary Source Verifications (PSVs), or other items needed for the EQR, or the PSVs are outdated. In response to CCME's request, Vaya provided additional documents. CCME recommends verifying credentialing and recredentialing files contain all required items obtained within required timeframes as outlined in the "Recommendations" section of this report.

Enrollee Services

Enrollee Services include enrollee rights and responsibilities, enrollee program education, behavioral health and chronic disease management education, and the Customer Service Center. One Vaya standard receives a score of "Partially Met." That standard involves providing enrollees with written information about the Medicaid waiver managed care program. CCME recommends specific corrective actions and recommendations for the *Provider Directory* and providing enrollees examples of the locations where providers and hospitals furnish post stabilization services under the contract.

Quality Improvement

Quality Improvement (QI) includes the QI program, QI Committee, Performance Measures, Performance Improvement Projects (PIPs), provider participation in QI activities, and an annual evaluation of the QI program. Vaya implemented all corrective actions and recommendations from the 2017 EQR. The only "Partially Met" item for this review is validation of the PIPs. Two of the four PIPS validated are not in the "High Confidence" validation range. CCME recommends three PIP corrections, including Inpatient Rapid Readmission, Integrated Care for Innovations Waiver Participants, and Transitions to Community Living Initiative-Increasing Housing. Corrective actions for the specific PIP errors are detailed by project in the Quality section of this report. CCME also identifies two additional recommendations for improvement.

Utilization Management

Utilization Management (UM) review includes review of the UM Department, Care Coordination, and Transitions to Community Living (TCLI) programs. Vaya meets 93% of the UM standards this year.

CCME requires three corrective actions and provides three recommendations. Corrective actions focus on monitoring care coordinator documentation to ensure they are compliant with Vaya policies and DMA Contract requirements. Detail needs to be added to Vaya policy regarding the required implementation of an *In-Reach/TCLI Transition Tool*. This is also requiring corrective action. Recommendations include ways to improve the Inter-Rater Reliability (IRR) process; monitoring care coordination follow up with members that are difficult to reach; and ways to enhance *Policy 2504* around the required person centered planning activities required by the TCLI program.

Grievances and Appeals

Vaya's EQR of grievances and appeals resulted in 80% of the standards being met. Those standards not met were primarily related to missing or incorrect information within Vaya's appeals policies and appeals practices more restrictive than the *DMA Contract* and federal regulations governing appeals.

The grievance program is a function of Vaya's Customer Services Department. Vaya meets all standards, and CCME provides four recommendations for improvement. While *Policy 2607* contains most elements of the grievance process, CCME recommends clarifying how to file an extension to a request. The policy indicates that "a written notice will be mailed to the consumer explaining the reason for the delay." CCME identified that a written notice must be mailed to consumer within two (2) days Per *42 CFR 438.402*.

CCME also recommends clarifying the membership of the "Grievance Team" to ensure inclusion of the Chief Medical Officer. Lastly, CCME recommends a monitoring process to

validate that the *Grievance Worksheet* is complete and included in the file as a part of the grievance record.

Five items identified by CCME in the appeal process need corrective action, and CCME identified another five recommendations for improvement. Two corrective action items are focused on processes implemented by Vaya that are more restrictive than is allowed in federal statutes and the *DMA Contract*. Vaya also has missing or incorrect elements in the appeal policy, the *Provider Operations Manual*, and *Member and Caregiver Handbook*; these elements address appeal extensions and expedited appeals. Lastly, CCME found that Vaya's definition of an appeal within Vaya's policy needs correction.

CCME's review of appeal files reveal some inconsistencies in notifications to appellants; therefore, CCME recommends that Vaya enhance its current appeal monitoring process to review all notifications, oral and written, and their respective timelines.

Delegation

Vaya reported two delegated entities. The submitted delegate files include contracts with Business Associate Agreements (BAA) for both delegates, as they have access to Protected Health Information (PHI). Vaya submitted evidence of annual monitoring of both delegates. There are no delegated entity items that require corrective action. For Delegation Assessments, CCME recommends that Vaya include the timeframe covered by the assessment, the date the assessment is completed, and the date it is signed by the Vaya staff member.

Vaya *Policy 2303, Delegation and Subcontracting*, includes a reference to "a mechanism for reporting delegation oversight no less than annually to the Quality Improvement Committee (QIC)." The QIC meeting minutes do not include reporting of delegation oversight of Vaya's two delegates, Prest and Associates and Partners Behavioral Health. CCME recommends that Vaya report delegation oversight in a QIC meeting annually, as referenced in Vaya policy *2303*, or revise the policy to eliminate the reference to annual reporting.

Program Integrity

Vaya demonstrates a strong Program Integrity (PI) function. Policies and procedures are organized, and case files are predominantly compliant. Vaya is implementing some key best practices. The PIHP has a well-integrated PI function employing touch points with compliance, credentialing, and independence to operate. Vaya uses data mining, specifically Financial Asset Management Systems (FAMS), and availing itself to additional collaboration with IBM in developing PIHP specific reporting.

Two recommendations from the prior year review, both related to policy language, and are met in the current review period. In addition, NC Medicaid informs us that the prior absence of meeting minutes was corrected, and Vaya is now submitting the written minutes of PI meetings as required.

Vaya has an opportunity to improve the area of updating policies and procedures to reflect complete contract language, particularly in the areas of PI file documentation and Payments/Suspensions. Vaya policies and procedures are sometimes limited to a high-level overview of the contractual requirements and therefore do not go into the depth necessary to assure all employees using these documents know the exact contract language. Vaya PI activities are subsumed with the broader customer service/complaint and grievance workflow. Vaya does not have sufficient detailed procedural documentation surrounding the investigation and documentation of fraud, waste, and abuse.

Financial Services

Vaya demonstrates ongoing financial stability. CCME's EQR financial Onsite review of Vaya financial services identifies two policy enhancements. CCME recommends Vaya add the five-business day requirement for Risk Reserve payments to *Policy 2748*. Also, Vaya should add Medicaid contract requirements and federal regulations to policies.

Encounter Data Validation

Based on the analysis of Vaya's encounter data, we have concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues were noted with both institutional and professional encounters. Vaya should take corrective action to resolve the issues identified with procedure code and diagnosis codes.

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

METHODOLOGY

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

On May 23, 2018, CCME sent notification to Vaya that the annual EQR was being initiated (see *Attachment 1*). This notification included:

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

Further, an invitation was extended to the health plan to participate in a pre-Onsite conference call with CCME and NC Medicaid providing Vaya an opportunity to seek clarification on the review process and ask questions regarding any of the desk materials requested by CCME.

The review consists of two segments. The first is a Desk Review of materials and documents received from Vaya on June 13, 2018 and reviewed in the offices of CCME (see *Attachment 1*). These items focus on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. Also included in the Desk Review is a review of credentialing, grievance, utilization, care coordination, case management, and appeal files.

The second segment is a two-day, Onsite visit conducted on October 23, 2018, and October 24, 2018, at Vaya's corporate office in Asheville, North Carolina. The Onsite visit was initially scheduled for July of 2018 but was requested to be rescheduled by the PIHP. NC Medicaid granted the rescheduled date, and new Onsite visit dates of September 19, 2018 and September 200, 2018. A hurricane then further delayed these dates, and October 23, 2018, and October 24, 2018, were established as the final Onsite visit dates. The Onsite occurred on these dates.

CCME's Onsite visit focuses 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 Vaya Administration and Staff

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

FINDINGS

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

A. Administration

CCME conducted an Administration function review focusing on Vaya's policies, procedures, staffing, compliance and confidentiality, information system, encounter data capture, and reporting.

Policies & Procedures

Administrative review of Vaya's policies and procedures includes review of the individual policies and procedures, the *Master Policy & Procedure List*, the policies and procedures that govern policy management, and PolicyTech, Vaya's policy management software platform.

The issues identified in the 2017 Vaya EQR include lack of annual policy review by Vaya and incongruent information (e.g., date of last review, date of last revision, next review date, etc.) documented within policies and procedures, the *Master Policy & Procedure List*, and PolicyTech. Additionally, in 2017 a large portion of the policies and procedures were either missing from the submitted Desk Materials or submitted in draft format.

The 2018 EQR of Vaya policies and procedures showed considerable effort was made to bring Vaya's policies and procedures into compliance with procedural requirements. The documentation submitted for the 2018 EQR demonstrates all policies and procedures are accounted for and submitted in final, approved format. Additionally, Vaya archived or terminated 72 policies and procedures, and created five new policies and procedures.

The policies and procedures and the accompanying *Master Policy & Procedure List for EQR 2018* reflect annual review occurred between January 2018 through June 2018, which brings the policy set into compliance with Vaya's policy requirements.

A live demonstration of PolicyTech included a review of a sample of policies and procedures within PolicyTech. The demonstration showed that, within this sample, information in PolicyTech is congruent with the individual policies and procedures and that Vaya is maximizing the policy management features PolicyTech offers.

Organizational Staffing/ Management

Brian Ingraham, Chief Executive Officer (CEO), provides leadership and day-to-day oversight of business activities for Vaya. A six-member Executive Administration team supports the CEO and is comprised of Chief Operations Officer, Chief Population Health Officer, Chief Information Officer, Chief Medical Officer, General Counselor/Chief Compliance Officer, and Chief Financial Officer. At the time Vaya uploaded its organizational chart, 14 full and part time positions were vacant in a variety of departments. This includes four vacancies within the Transitions to Community Living Initiative program. Staff members reported during the Onsite discussion that at least two of these positions are being filled. CCME did not find any evidence that these vacancies, or any of the other vacancies, are adversely affecting Vaya core functions.

Current clinical and medical oversight is led by Vaya's Chief Medical Officer (CMO) Dr. Craig Martin. CCME's review of Dr. Martin's job description shows that he is active in the activities required by his job description and *DMA Contract*. This involvement was corroborated by Dr. Martin and departmental staff during the Onsite interviews; however, the organizational chart provided does not accurately reflect the clinical oversight described in his job description or by staff. Specifically, there is no oversight of the Customer Service and Care Coordination staff by Dr. Martin indicated in the organizational chart. This was a recommendation in the 2017 EQR and will again be recommended this year.

The duties of the Assistant Medical Director (AMD), Dr. William Lopez, are unclear in the documentation CCME reviewed prior to the Onsite. CCME's review of the AMD job description reflects this position's primary involvement is with the Utilization Management Department, and this involvement is reflected in the organizational chart; however, the job description also states the AMD provides consultation to the Access Unit, Care Coordination, Community Collaboration, and Provider Network. This involvement is not noted on the organizational chart. Additionally, per the AMD job description, a small portion of this position's time is also designated for committee participation; however, Vaya committee minutes and the Vaya committee charter do not reflect AMD participation on a Vaya committee.

Staff reported during the Onsite discussion the organizational chart was recently revised and the lines of departmental oversight by Dr. Martin within the chart have been corrected. Staff members also report the organizational chart will be reviewed monthly to ensure it remains up to date. CCME recommends that Vaya, as a part of this review and revision process, verify the CMO and AMD job descriptions, oversight designations on the organizational chart, and the *DMA Contract* requirements (*Sections 6.7.6 and 7.1.3),* are accurately aligned.

The Organizational Chart includes credentials of each staff member including licensure, educational level, and certification status. This information shows that staff members are adequately credentialed for assigned job functions.

Confidentiality

Vaya is a Covered Entity under the Health Insurance Portability and Accountability Act (HIPAA). CCME reviewed Vaya procedures regarding the management and protection of consumer confidentiality. Vaya has a complete set of policies and procedures that fully address both state and federal requirements for preserving enrollee confidentiality and protecting health information. The review found Vaya demonstrates adequate compliance with:

- Access to Individually Identifiable Health Information
- HIPAA
- Authorization for Use and Disclosure
- Accounting of Disclosures
- Business Associates
- De-Identification of Protected Health Information (PHI)
- HIPAA Workforce
- Minimum Necessary Disclosures
- Personal Representatives
- Request for Privacy Protection of PHI
- Retention of Member Records
- Revoking Authorizations
- Use and Disclosure of PHI
- Privacy Complaints
- Notice of Privacy Practices

- Subpoena for Records
- Training of Board members

During the Onsite discussion, Vaya staff members described the onboarding process of new employees. New employee orientation occurs the first Tuesday of every month and includes training on confidentiality. Vaya's *Privacy Policy 2599* does not specify a timeframe for training new employees on confidentiality. This policy states new employees are trained "within a reasonable period of time." CCME recommended defining this "reasonable period of time" in the last two EQRs. CCME recommends again that Vaya clarify the timeframe. This change is particularly needed as staff members describe a consistent practice of Vaya providing confidentiality training to new employees within 30 days.

Information Systems Capabilities Assessment (ISCA)

IPRO, in contract with CCME and as recommended by the CMS Encounter Data Validation protocol, conducted the yearly review of Vaya's Information Systems Capabilities Assessment (ISCA).

Vaya, like many other behavioral health managed care organizations in North Carolina, uses the AlphaMCS transactional system, a hosted system environment produced by Mediware. Mediware modifies the user interface and conducts backend programming updates to the system. During the Onsite visit, Vaya stated that Mediware was recently rebranded as Wellsky; however, this report retains references to Mediware.

Prior to the Onsite visit, Vaya completed the 2018 ISCA tool and submitted supporting documentation, workflow, and procedures. IPRO reviewed the responses and followed up on areas requiring clarification via interviews and a system demonstration at the Vaya office located in Asheville, North Carolina on October 24, 2018. This review is part of the annual compliance audit conducted by CCME on October 23rd and 24th, 2018.

Enrollment Systems

Vaya experienced a small decrease in enrollment over the past three years; the year-end enrollment statistics for 2015 to 2017 are 171,329 in 2015, 170,064 in 2016, and 164,463 in 2017.

The ISCA tool and supporting documentation for enrollment systems loading processes clearly defines the process for enrollment data updates in the AlphaMCS enrollment system. During the ISCA onsite review, Vaya provided a demonstration of the AlphaMCS enrollment system. The system maintains a member's enrollment history. Global Eligibility File (GEF) files are imported daily into a SQL database. The member enrollment

records are split into separate records per month of eligibility. The daily eligibility file is compared to existing eligibility in the AlphaMCS. New recipients are added to the AlphaMCS with their accompanying eligibility information. For existing recipients, base information is updated with the data received in the GEF file. Enrollment records for a recipient in the AlphaMCS are merged if they contain contiguous or overlapping records for the same type of eligibility.

Vaya stores the Medicaid identification number received on the GEF. The Vaya eligibility system is able to merge multiple member records and link patient historical claims. Vaya providers have the capability to confirm member eligibility in the AlphaMCS Provider Portal. The AlphaMCS system is also able to capture demographic data like race, ethnicity, and language.

Monthly, Vaya uses the 820 Capitation file to reconcile with its per member/per month (PM/PM) payment to determine the categories of aid paid.

Claims Systems

Vaya claims are processed in the AlphaMCS system. IPRO conducted a review of Vaya processes for collecting, adjudicating and reporting claims by reviewing Vaya's ISCA response and supporting documentation. Vaya conducted a demonstration of the AlphaMCS provider web portal and claims processing system during the Onsite review.

Table 1: Percent of Claims with 2017 dates of service received via electronic (HIPAA, provider web portal) or paper forms.

Source	HIPAA File	Paper	Provider Web Portal
Institutional	64.52%	.08%	35.4%
Professional	88%	.02%	11.98%

Note: Paper claims are received for out-of-state services.

If a required field is missing from the claim, the Vaya provider web portal does not allow claim submission. If the claim is being submitted electronically via an electronic 837 file and one or more required fields are missing, the provider receives a 999 response file notifying the provider of the claim failure. Vaya claim processors do not change any information on the claims.

Vaya adjudicates claims nightly. Vaya auto-adjudicates 87.85% of institutional claims and 99.20% of professional claims.

Vaya processes claims within 18 days of receipt of a clean claim. If a claim is approved, payment is made within 30 calendar days of receipt. As stated in the ISCA, 90% of Vaya's clean claims for covered services are paid within 30 calendar days of the date of approval.

ICD-10 procedure codes and Diagnostic Related Groupings (DRGs) are not accepted by Vaya if the values are included by the provider on an 837I. Vaya's provider web portal does not have the capability to receive the ICD-10 procedure codes and DRGs. Vaya does not use DRGs for payment.

The Vaya AlphaMCS system can capture up to 12 ICD-10 diagnosis codes for professional claims and up to 22 ICD-10 diagnosis codes for institutional claims. The Vaya provider web portal can capture up to 12 diagnosis codes for both professional and institutional claims. Twenty-five ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837I, and 12 ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837P. Vaya does not have the capability to store all possible diagnosis codes submitted on an 837I file.

Vaya staff members audit at least 3% of all claims daily. Vaya staff members also audit high-dollar claims over $5,000 and paper claims regularly. Vaya Special Investigations Unit conducts investigations into claims suspected of fraud, waste, and abuse. During the Onsite visit, Vaya mentioned that 100% of all claims processed by new hires in the Finance Department are audited during the first 3-4 months, and random audits are conducted up to 9 months after the date of hire.

Reporting

Vaya's database and data warehouse captures all the enrollment and claims information within in the AlphaMCS. The database is refreshed with data from the AlphaMCS daily through a backup copy of the managed care database from Mediware. Data are extracted from the data warehouse to create reports and data extracts. Vaya uses reconciliation scripts to compare the data in the warehouse to the data in the source database. As stated in the ISCA, up to five years of claims data are available in the on-line AlphaMCS system. Historical data are available offline in the legacy MIS CMHC system.

For report development, Vaya uses Microsoft Transact SQL (T-SQL) programming language run on SQL Server Management Studio and SQL Server Integration Services (SSIS). Vaya has nine developers using Microsoft Transact SQL (T-SQL) to produce reports.

Encounter Data Submissions

Vaya has a defined process in place for encounter data submission, with 837 files submitted to NC Medicaid, and 835 files received from NC Medicaid through the NCTracks system. Vaya uses the 835 file from NCTracks to review denials. Vaya has the ability to track claims from the adjudication process to encounter submission status. The extraction, submission, and reconciliation of encounter data are fully automated.

Mediware updates and maintains details on encounters that are extracted for encounter data submission on 837 files and the response 835 files. Vaya receives a copy of the 835 and 837 files from Mediware and loads them into databases to identify and resolve encounter data denials. Vaya uses paid and denied reports to research and verify payment of denied encounters after rebilling. Vaya also uses an encounter denial detail report that indicates the header and line edit codes to identify denied encounters for a specific procedure code or provider. Denied encounters are reviewed manually and resubmitted weekly.

Vaya provided the breakdown of encounter data acceptance/denial rates for the 2017 year, with a 2016 year comparison. This is demonstrated in Table 2.

Table 2: Volume of 2016 and 2017 Submitted Encounter Data

2017	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	42,121	154	2,375	44,650
Professional	1,598,936	79,276	92,375	1,770,587
2016	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	40,703	114	1,614	42,431
Professional	1,632,066	219,657	0	1,851,723

Since December 2017, Vaya has a 95% encounter acceptance rate. The 2017 audit findings indicate that Vaya encounter data acceptance rate was approximately 90% and a large percentage of denials are related to incorrect taxonomy codes. Vaya has significantly improved encounter acceptance rates to meet the NC Medicaid standard. During the Onsite visit, Vaya advised that it has further improved the encounter denial rate to approximately 3%. The reduction in encounter denial rates is attributed to efforts in educating providers on billing practices and address taxonomy code issues. During the Onsite visit Vaya indicated that the three top denial reason codes are:

1. Provider Taxonomy denials
2. Provider licensure issues
3. Invalid procedure codes

On average, it takes Vaya 70.3 days to correct and resubmit an encounter to NCTracks. When a claim denial is returned to Vaya from NCTracks via the incoming 835 file, the Vaya Encounters Team coordinates with other departments and the billing provider to correct and resubmit the encounters depending on the denial reason code.

For institutional encounters, Vaya submits the principle, admitting, and one secondary diagnosis code on the 837I. For professional encounters, Vaya submits the principle and one secondary diagnosis codes on the 837P. 25 ICD-10 diagnosis codes for institutional encounters and 12 ICD-10 diagnosis codes for professional encounters are the maximum number of diagnosis codes that may be submitted on an 837I and 837P, respectively, and the maximum number captured by NCTracks. Vaya does not have the capability to submit all the possible 837I and 837P diagnosis codes to NCTracks. Vaya indicated that Mediware is in the process of testing additional secondary diagnosis codes, including physical health diagnosis codes on encounter data extracts to NC Medicaid. After successfully testing the encounter data extracts, Vaya will apply the change to submit all secondary diagnosis codes.

The following chart shows that 90% of the standards were scored as "Met" and 10% as "Partially Met." Figure 2 provides a comparison of the 2017 scores versus the 2018 scores.

Figure 2: Administration Comparative Findings

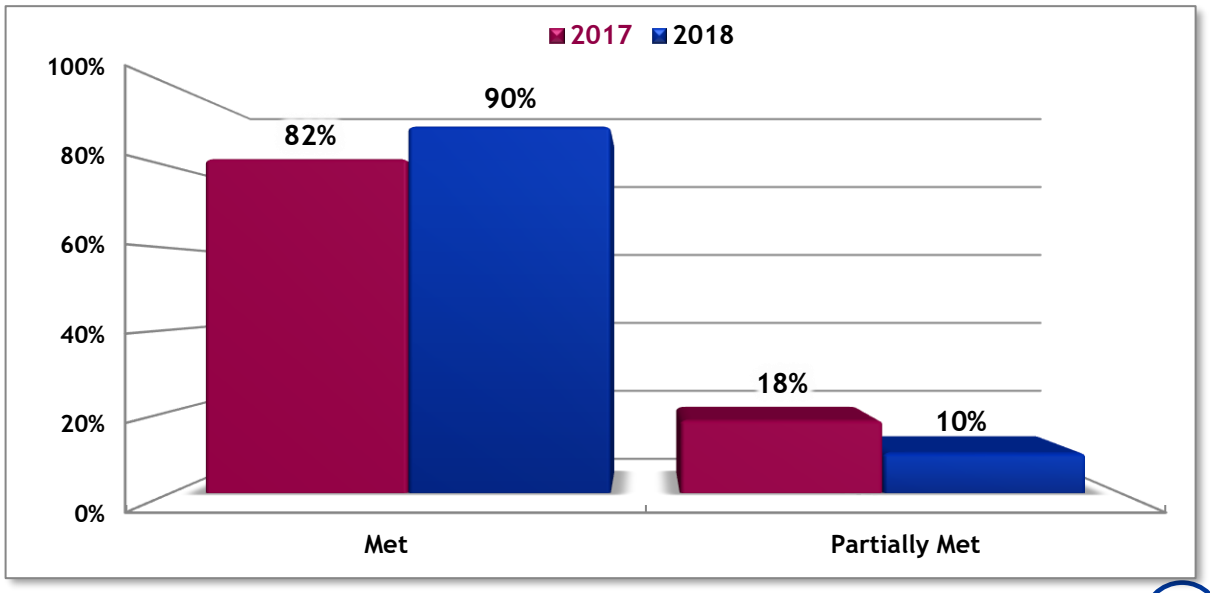


Table 3: Administration

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

Strengths

- Policies and procedures reflect considerable effort made by Vaya to bring policies and procedures into compliance with contractual requirements.
- Vaya is maximizing the policy management features PolicyTech offers.
- Substantial oversight by Vaya's CMO was evident during the Onsite discussion.
- Vaya has a comprehensive enrollment, claim processing, and reporting system.
- Vaya has the capability to merge multiple member records and is able to link member historical claims data to the merged member record.
- Vaya reconciles the monthly PM/PM payment with the 820 Capitation file, which provides Vaya with category of aid level reconciliation each month.
- Vaya auto-adjudicates clean claims; 87.85% of institutional claims and 99.20% of professional claims were auto-adjudicated during the reporting period.
- Vaya NCTracks encounter acceptance rate is approximately 95% - 97%. The PIHP made significant improvements in the acceptance rate of encounter data submissions.
- Enrollment, claims, and IT staff members are knowledgeable about processes and are dedicated to improving encounter data submissions while reducing the number of denials.

Weaknesses

- The 2018 Organizational chart provided does not accurately reflect the clinical oversight by the CMO and AMD, as described within the respective job descriptions.
- Vaya's *Privacy Policy (2599)* does not specify a timeframe for training new employees on confidentiality, but the timeframe was defined by staff members during the Onsite as consistently occurring within 30 days of a new employee hire date.

- Vaya does not have the ability to receive, store, and report all ICD-10 diagnosis codes for institutional claims. Vaya has the ability to store up to 22 ICD-10 diagnosis codes for institutional claims received electronically and up to 12 ICD-10 diagnosis codes for institutional claims received through the provider web portal.
- Vaya does not have the ability to receive, store, and report ICD-10 procedure codes and DRG codes.
- Vaya submits only up to three diagnosis codes on institutional encounter data extracts and up to two diagnosis codes on professional encounter data extracts.
- Vaya does not have the ability to submit ICD-10 procedure codes and DRG codes on encounter data extracts to NCTracks.

Corrective Action

- Update Vaya's system to accept up to 25 ICD-10 diagnosis codes for an 837I.Vaya captures only up to 22 ICD-10 diagnosis codes for institutional claims received electronically.
- Update the provider web portal to mirror UB04 claim form for institutional claims and capture up to 18 ICD-10 diagnosis codes. Vaya captures only up to 12 ICD-10 diagnosis codes for both institutional and professional claims through the provider web portal.
- Update Vaya's system and provider web portal to capture the ICD-10 procedure codes and DRGs. Vaya does not capture, store, or report ICD-10 procedure codes or DRG codes.
- Update Vaya's encounter data submission process to allow all ICD-10 diagnosis codes submitted on an institutional and professional 837 HIPAA file and provider web portal to be submitted to NCTracks. Twenty-five ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837I and the maximum number captured by NCTracks. NCTracks is capable of capturing up to 12 diagnosis codes for professional claims.
- Update Vaya's encounter data submission process to allow ICD-10 procedure codes and DRG codes to be submitted on encounter data extracts.

Recommendations

- Verify the CMO and AMD job descriptions, oversight designations on the organizational chart, and *DMA Contract* requirements of the PIHP Medical Director are accurately aligned as a part of an improved process to review and update Vaya's organizational chart.

- Add to the *Privacy Policy (2599)* that new staff members receive training on confidentiality during the new employee orientation, which occurs within 30 days of a new employee's hire date.

B. Provider Services

Vaya's Provider Services External Quality Review (EQR) is comprised of Credentialing and Recredentialing and Network Adequacy (including Provider Accessibility, Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, and Practitioner Medical Records). CCME reviewed relevant policies and procedures, the *Provider Operations Manual*, provider network information, credentialing/recredentialing files, the *Credentialing Committee Charter*, Credentialing Committee meeting minutes, the *2017 Community Behavioral Health Service Needs, Providers and Gaps Analysis* ("*Gaps Analysis*"), and the Vaya website.

Policies and procedures, including *2909, Credentialing Committee Policy* and *2891, Credentialing Program*, and the *Credentialing Committee Charter* guide the credentialing and recredentialing processes. Dr. Craig Martin, Chief Medical Officer (CMO) and a board-certified psychiatrist, chairs the Credentialing Committee. Dr. Will Lopez, the Assistant Medical Director (AMD) and a board-certified psychiatrist, is the Vice Chairperson of the committee. The *Credentialing Committee Charter* lists by name four Vaya staff members and four Provider Representative Members as Voting Members of the committee. Two additional Vaya staff members are listed as Non-Voting Members of the committee. Due to turn-over in Vaya staff, a total of nine different Vaya employees served as voting members, including Dr. Martin and former AMD Dr. John Nicholls, over the course of the 12 committee meetings and one electronic vote. The committee had five different Provider Representatives, due to one Provider Representative resigning from employment. Because the *Credentialing Committee Charter* lists committee members by name (rather than Vaya staff position title, for example), the charter must be revised whenever a staff member or a Provider Representative leaves the committee.

The *Credentialing Committee Charter* indicates the committee "shall meet as often as is necessary to ensure prompt response to credentialing request and to efficiently manage other Committee responsibilities, but no less than quarterly." The committee met at least monthly from June 2017 through May 2018. An electronic vote was conducted in February 2018. A quorum was present at each meeting. Provider Representative member meeting attendance ranged from 42% to 78%. Attendance by voting members of the Vaya staff ranged from 73% to 92%. Two Vaya staff members who were listed as members at only one meeting each are not included in these totals. Dr. Martin was not present at the June 22, 2017 meeting, and the meeting was chaired by Dr. John Nicholls, the former AMD.

The *Credentialing Committee Charter* defines a quorum as "A majority of voting members present," and states, "Members may assign (orally or in writing) a proxy to another member in advance of any meeting. Proxies so assigned shall be documented in the minutes at the outset of any meeting." The Credentialing Committee meeting minutes indicate which members are voting members of the committee. *Policy 2909, Credentialing Committee Policy*, notes, "Committee decisions require a majority vote. The Chair/SCSP can vote to break a tied vote." During Onsite discussion, staff indicated no history of a tied vote, but that Dr. Martin, CMO, would break the tie.

The credentialing and recredentialing file review shows the files are organized and contain appropriate information, with a few exceptions, as outlined in the following "Weaknesses" section and in the Tabular Spreadsheet.

In accordance with *DMA Contract Attachment B, Section 6.4*, Vaya conducts an annual gap and needs analysis. The Vaya *2017 Community Behavioral Health Service Needs, Providers and Gaps Analysis* ("*Gaps Analysis*") annual report includes a summary of "Progress and Achievements toward" the issues identified in the 2016 report. Vaya experienced an improvement from 95.24% to 99.67% in the "Access to Outpatient Services" category. There was also an increase in the number of respondents to the *Community Needs Assessment Survey* for the *2017 Gaps Analysis* as compared to the *2016 Gaps Analysis*.

The *2017 Gaps Analysis* lists thirteen Medicaid-funded services for which Vaya did not meet choice/access standards. Exception Requests were submitted to and approved by NC Medicaid for those services. During Onsite discussion, staff reported that the data gathered for the *2018 Gaps Analysis* showed "pretty much the same thing" as the *2017 Gaps Analysis*. Vaya described barriers to meeting the standards that require two providers within 30 minutes/30 miles, especially the rural location and low population of many of the counties in the catchment area. Vaya staff reported they can obtain providers for some of the services, but there is "not enough Medicaid mass to sustain the service."

The *Network Development Plan (NDP)* addresses service needs identified through several different mechanisms, including the *Annual Gaps Analysis*, the *Annual Community Needs Assessment*, reports from external stakeholders, and an internal *Service Gap Referral Form* process.

Newly-contracted providers receive a letter that provides orientation information, including a link to the Vaya website, with the statement "the *Provider Operations Manual* can be downloaded from our website." During the Desk Review, and from at least

June 19, 2018 through July 27, 2018, there was no current, approved, final *Provider Operations Manual* available on the website. The draft manual posted on the website was from June 2017, and some icons on the website linked to an old *2015 Smoky Mountain Center Provider Manual*. At the time of the Onsite visit, the current *Provider Operations Manual* and several previous *Provider Operations M*anuals are posted on the website.

Policy 2427, Development of Clinical Guidelines, states the guidelines are "selected, adopted, developed, reviewed, and updated through the Clinical Practices Committee, Clinical Advisory Committee and with the involvement of practicing clinicians." The *Provider Operations Manual* provides a link to the Clinical Practice Guidelines; however, at the time of the Desk Review, the link directed the user to "Coverage Information" in the "Utilization Management" section of the Provider tab on the Vaya website; there was nothing named "Clinical Practice Guidelines" posted on the website. The document that included Clinical Practice Guidelines was named *Vaya Approved Best Practice Guidelines*. At the time of the Onsite visit, the *Vaya Approved Best Practice Guidelines* was replaced with Clinical Practice Guidelines, though the links to several of the guidelines are broken.

During the Onsite visit, Vaya staff highlighted several initiatives. Donald Reuss, MA, Senior Director-Provider Network Operations, reported that data showed that most children admitted to inpatient care were discharged to a Psychiatric Residential Treatment Facility (PRTF) for four to six months. The children were discharged from the PRTF to Residential Treatment Level 3 for another four to six months, and then went to therapeutic foster care for an undetermined amount of time. This resulted in children being out of their homes for around a year or more. Vaya contracted with a provider to add an assessment center for children, to give hospitals an option for a step down from hospital care. The child is typically at the assessment center for 30 days. Community providers and agencies, including the Department of Social Services and the school, are involved while the child is evaluated. A home assessment is conducted, and wrap-around services for the child and family are developed. Sixty-five to seventy-five percent of those children returned home, and none of the children who returned home have returned to a higher level of care.

Vaya staff reported they have also been doing a lot of work with law enforcement, with special emphasis on efforts to divert those with behavioral health issues from the legal system and jail. Vaya provided numerous Crisis Intervention Team (CIT) trainings and worked with law enforcement on Sequential Intercept Mapping, including training of four Vaya staff members. County funds in some rural counties are being invested in drug courts, and a judge who covers Yancy and Madison counties is preparing to start a drug court.

Figure 3, Provider Services Findings shows 100% of the standards in the Provider Services section are scored as "Met." Scores of "Partially Met" are due to the lack of a current

Provider Operations Manual on the Vaya website during the review period, and due to Vaya's failure to query/requery *The North Carolina Medicaid Provider Termination and Exclusion list* (known as the *State Exclusion List*) as required by *DMA Contract Attachment B, Section 1.14.4* and *7.6.4* and Vaya *Policy 2891, Credentialing Program.*

Figure 3: Provider Services Findings

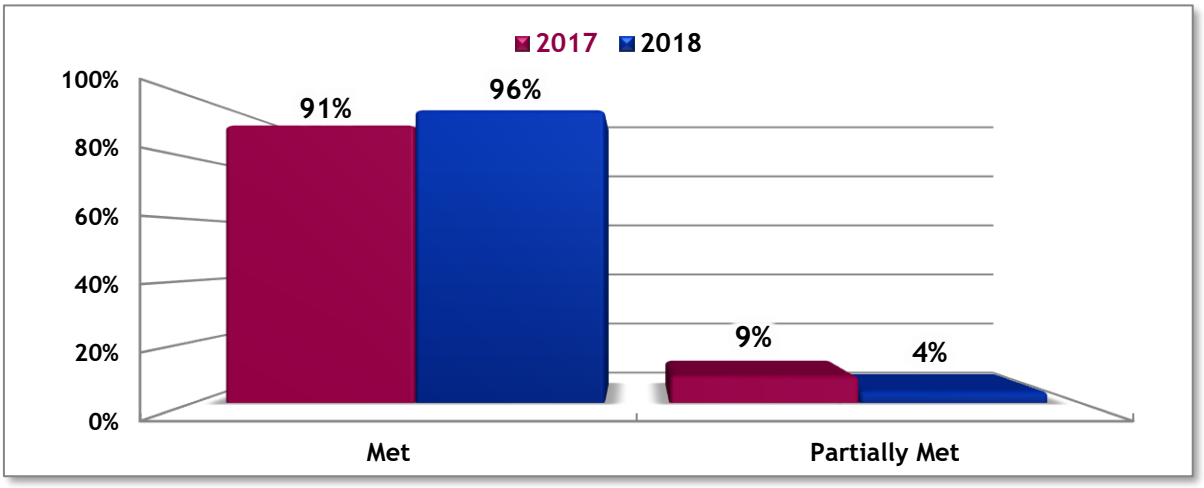


Table 4: Provider Services

Section	Standard	2017 Review
Credentialing and Recredentialing	Credentialing: Verification of information on the applicant, including: Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	**Partially Met**
	Recredentialing: Verification of information on the applicant, including: Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	**Partially Met**
Provider Education	The PIHP formulates and acts within policies and procedures related to initial education of providers	**Partially Met**

Strengths

- The *Provider Operations Manual* has a chart titled "Important Contacts" with contact information for Vaya departments or teams.
- Vaya provides a toll-free Provider Help Line and a separate toll-free line for business calls.
- The Vaya website includes a chart with instructions and links to the correct forms for people requesting network enrollment.
- Vaya contracts with a provider for a child assessment center, resulting in decreased lengths of placement outside the home for children along with development of wraparound services for children and their families.
- Vaya provided numerous Crisis Intervention Team (CIT) trainings and works with law enforcement in a Sequential Intercept Mapping project, including training four Vaya staff members.

Weaknesses

- Credentialing and recredentialing files uploaded for Desk Review were missing items, including proof of all of the required types of insurance or an explanation of why it would not be required; Ownership Disclosure; Primary Source Verification (PSV) of some clinical licensure; PSV of Division of Health Service Regulation (DHSR) licensure; and site visit reports. In response to the *Onsite Request List*, Vaya provided additional information from agency files. Other documents were provided during the Onsite visit.
- Some of the PSVs submitted for Desk Review were older than 180 days from the time of the credentialing decision. Vaya provided updated PSVs during the Onsite visit.
- No supervision contract was found in the file of one provider with LCAS-A and one provider with LMFT-A, and Vaya did not provide the supervision contracts in response to the *Onsite Request List*. Vaya subsequently obtained the supervision contracts and provided them during the Onsite visit.
- No evidence of a query of the *State Exclusion List* was found in the submitted credentialing or recredentialing files and Vaya submitted no evidence in response to *Onsite Request List*. During the Onsite visit, Vaya staff reported this item was overlooked and they were not doing the query; Vaya staff started completing the query after receiving the *Onsite Request List* from CCME.
- During the Desk Review, and from at least 06/19/18 through 07/27/18, there was no current, approved, final *Provider Operations Manual* available on the website. The draft manual that was posted on the website was from June 2017, and some icons on the website linked to an old *2015 Smoky Mountain Center Provider Manual*.

- The "Emergent" section of the Access to Care Timeframes on page 47 of *the Provider Operations Manual* does not include the requirement that the "Provider must provide face-to-face emergency care immediately for life threatening emergencies."
- Page 62 of the *Provider Operations Manual* provides information about Clinical Practice Guidelines and includes a link to "*Coverage Information*" on the "*Utilization Management*" section of the website. During the Desk Review, the linked webpage did not include "Clinical Practice Guidelines." What was posted was labeled "Vaya Approved Best Practice Guidelines." At the time of the Onsite visit, the posted guidelines were updated/replaced and named "Clinical Practice Guidelines."
- The *Provider Operations Manual* submitted for Desk Review does not include the "right of enrollees who live in Adult Care Homes to report any suspected violation of an Enrollee right to the appropriate regulatory authority as outlined in *NCGS §131D-21*." See *DMA Contract Attachment B, Section 6.13.2*.

Corrective Actions

- Verify all credentialing and recredentialing files include evidence of the query of the State Exclusion List, as required by *DMA Contract Attachment B, Section 7.6.4* and by *Policy 2891, Credentialing Program, Section XI, Credentialing Verification Process.*
- Ensure a current *Provider Operations Manual* is always available to providers. See *DMA Contract Attachment B, Section 7.11.*

Recommendations

- Verify credentialing and recredentialing files contain all required information and PSVs. Specific recommendations are included in the Tabular Spreadsheet that follows.

  Note: If Vaya does not keep a copy of the relevant information in the individual credentialing or recredentialing files, retrieve or print copies from the relevant files or from Cactus (software program) and upload as part of the credentialing/ recredentialing files for the EQR desk review. See *DMA Contract Attachment B, Section 7.7, DMA Contract Attachment O,* and *DMA Contract Attachment B, Section 7.9.*
- Contact licensure boards to confirm if a practitioner with "associate" licensure (LCAS-A, LCSW-A, LMFT-A, etc.) listed on the licensure board website is confirmation of a current supervision contract. Verify credentialing files include supervision contracts for practitioners for whom they are required (Licensed Psychological Associates and practitioners with an "Associate" licensure designation), based on responses from licensure boards. See *DMA Contract, Attachment O.*
- Revise the "Access to Care Timeframes" in the *Provider Operations Manual* to include the requirement for providers to "provide face-to-face emergency care immediately for life-threatening emergencies." See *DMA Contract, Attachment S.*

- Revise the *Provider Operations Manual* to include the "right of enrollees who live in Adult Care Homes to report any suspected violation of an Enrollee right to the appropriate regulatory authority as outlined in NCGS §131D-21." See *DMA Contract Attachment B, Section 6.13.2*.

C. Enrollee Services

CCME conducted a review of Enrollee Services, including policies and procedures, the *Member and Caregiver Handbook*, the submitted enrollee educational materials, the Customer Service Center training materials, and a variety of items on the Vaya website.

Karla Mensah is the Senior Director of Customer Services and oversees the Customer Services Manager, Christin Elliott and the Customer Service Clinician Director, Jana Aitken. All Customer Service Representatives are Qualified Professionals and all Customer Service Clinicians are Licensed Professionals. Marketing and communications materials for members and their families are created and maintained by the Marketing and Communications Department led by Tracy Hayes, General Counsel and Chief Compliance Officer. The Materials Review Workgroup reviews formal marketing materials annually and recommends updates or changes. The enrollee education offerings are managed within the Community Relations Department under the leadership of Stacey Sorrells, Consumer Relations Director.

Within 14 days of enrollment, Vaya sends a new member packet that includes a welcome letter describing the Medicaid managed care program, *Notice of Privacy Practice* including member rights, and a Customer Services pocket card that includes the phone numbers to Vaya services. The welcome letter includes directions to download the *Member and Caregiver Handbook* from the Vaya website as well as a statement that the handbook can be mailed to members upon request.

The Access to Services toll-free phone number is provided in the letter, which informs enrollees that a Vaya team member will answer and connect them to services needed. The Network Provider Directory is searchable on the Vaya website under the Member and Caregivers section, Provider Search. The uploaded *Provider Directory* in the desk materials is missing fields for "accepting new patients" and "non-English language spoken by the provider." The printable *Provider Directory* generated online has a field for "Languages" and is not clear if this means languages spoken by the providers or languages that can be interpreted at the provider practice. Written materials provided to enrollees are missing examples of the locations where providers and hospitals furnish post stabilization services covered under the contract. Vaya has several large print member materials, and has notices of the availability of large print copies in its *Member and Caregiver Handbook*.

Vaya offers several enrollee education options managed within the Community Relations Department. The Community Education 2018 Flyer notes many initiatives available to enrollees. On the website under the Community – Training & Outreach heading, Vaya lists crisis intervention and suicide prevention trainings. Crisis intervention training targets law enforcement and first responders. Suicide prevention training is a 2-hour free class open to the public that prepares participants to question, persuade, and refer those struggling with thoughts of suicide to life-saving help. The online Events and Training Calendar offers additional training for members and caregivers.

Vaya maintains a toll-free 24/7 Access to Care Line that can be used for any need or question from a member or caregiver. The Vaya Customer Services Representatives and Clinicians follow the Customer Services policies and procedures including *Policy 2422, Customer Services Clinical Decision Making and Triage*. This policy ensures the enrollee is directed to correct level of care. The organization chart lists no vacancies within the Customer Service Department. Call metrics remain adequate with average speed of answer and average abandoned call rates meeting Vaya's goals in *Policy 2411, Customer Services Telephone Performance Standard and Monitoring*. *Policy 2411* includes attaining an average blocked call rate of 5% or less each month, but this statistic is not included in the Call Performance Statistics submitted for Desk Review. Per Onsite interview, the blocked call rate is 0%.

A contract with Partners Behavioral Health remains in place for roll-over calls. The process in place to monitor those calls meets all standards. Vaya also has a Customer Service email address. Administrative support monitors the email box during the day and one to two people are assigned to monitor it at night and on weekends. The support email is used mostly for incoming faxes. If a clinical matter is emailed, it is routed to clinical staff in the Customer Service. Vaya indicated this does not happen often and that staff members return calls within one hour, which is consistent with the *DMA Contract requirement*.

In the following chart, 94% of the standards received a "Met" score and 6% received a "Partially Met" score. No standard was scored "Not Met."

Figure 4 compares 2017 EQR scores to 2018 EQR scores.

Figure 4: Enrollee Services Findings

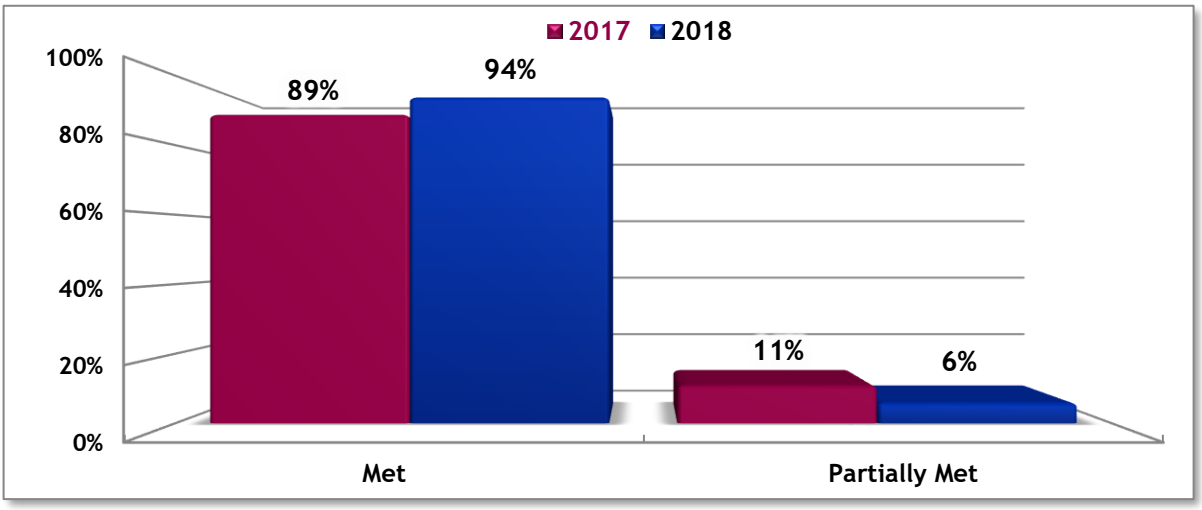


Table 5: Enrollee Services

Section	Standard	2018 Review
Enrollee PIHP Program Education	Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid waiver managed care program which they are contractually entitled, including: • Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request • The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract	**Partially Met**

Strengths

- The Community Relations Department has a process for creating and maintaining all enrollee written materials in a font of 12 point or larger and all large print material in 18 point or larger, per federal regulation.
- Educational opportunities are presented on the Vaya website on the Events and Training Calendar. Information about registering and marketing flyers is included for the event or training as appropriate.

- Vaya has a reciprocal contract with Partners Behavioral Health for overflow calls and describes this process as transparent to callers.

Weaknesses

- The *Provider Directory* uploaded as part of the desk materials is missing fields for "accepting new patients" and "provider spoken language." During the Onsite visit, Vaya discovered a more current copy on the website that can be generated and printed. This version has fields for "accepting new patients" and "Languages" which are not on the *Provider Directory* uploaded in the EQR Desk Materials.
- The printable *Provider Directory* generated online has a field for "Languages" and is not clear if this means languages spoken by the providers or languages that can be interpreted at the provider practice. The online Provider Search has a field for Spoken Languages that is clearer.
- Within enrollee written materials, there are no examples of the locations where providers and hospitals furnish post stabilization services covered under the contract.

Corrective Actions

- Verify all forms of the *Provider Directory* are updated. Coordinate Desk Material uploads so that the most recent documentation is uploaded.
- Within enrollee written materials, include examples of the locations where providers and hospitals furnish post stabilization services covered under the contract within enrollee written materials.

Recommendation

- In every format of the *Provider Directory*, clarify the field for "Provider Spoken Languages" spoken by each network provider.

D. Quality Improvement

Quality Improvement (QI) includes the QI program, QI Committee, Performance Measures (PMs), Performance Improvement Projects (PIPs), provider participation in QI activities, and an annual evaluation of the QI program.

The Senior Director of Performance & Quality Improvement, Patty Wilson, has the authority and responsibility for the overall operation of the QM Program. Craig Martin, MD, serves as the Chief Medical Officer (CMO) and provides support for the QM Department. Dr. Martin chairs the Quality Improvement Committee (QIC) and Ms. Wilson is the Vice Chairperson of the QIC. The department recently reorganized, but after the EQR period.

The *Quality Management Program Description 2017* describes a complete and formal QI/ Quality Assurance (QA) program. The *Quality Management Program Description*, on page 7, lists the QA activity of "Provider compliance with clinical practice guidelines: Rate of compliance with guidelines for selected services." Vaya monitors the Clinical Practice Guideline for "Best Practice Treatment of Opioid Dependence as promulgated by the National Institute of Drug Abuse (NIDA) – Opioid." The *Quality Improvement Program Evaluation 2017-18* reports the monitoring of this Clinical Practice Guideline from July 2017 – June 2018. Data for six criteria are assessed for adherence to the Clinical Practice Guidelines. Six of the seven clinics reviewed meet all the criteria. One clinic meets 50% of the criteria and successfully completed a corrective action plan.

The Quality Improvement Advisory Team (QIAT) carries out critical QM functions under the direction of the QM Director, Steven Kozicki. The QIAT functions as liaisons with other Vaya departments to assist in identifying and addressing needs/opportunities for improvement through the application of QM techniques. The QIAT also manages system-wide satisfaction surveys. During the Onsite interview, Vaya confirmed it follows this practice and no measures are identified by the QIAT for improvement from the 2017 enrollee surveys. However, there was no evidence of discussion of lower scoring measures in a formal committee, like the QIC. CCME recommends bringing lower scoring enrollee survey items to QIC for discussion and decisions about the need for quality improvement. Enrollee Survey analysis from QIAT is presented in Provider Council, QIC, Executive Leadership Team (ELT), and to the Board of Directors (BOD) meetings.

Vaya shortened the format of the *2018 QM Annual Workplan*, as recommended in the last EQR. QIC committee membership consists of Vaya staff, CFAC members, and providers. Vaya conducted monthly meetings, except for the months of June and December, and minutes are complete for all meetings. A quorum was attained at each meeting and members attended regularly.

During the Onsite interview, Vaya described including providers in the Integrated Care QIP and Emergency Department Value-Based Payments projects. Other measures are discussed during Provider Council Meetings, but no specific examples of providers receiving interpretation of their QI performance data and feedback regarding QI activities is provided. CCME recommends providing more feedback for provider's individual QI activities. Examples include: Select B and C Waiver measures for individual providers and involve QI/QA staff in the process for Individual QIPs so providers can receive feedback on their QIPs as they work toward desired outcomes.

The *Quality Improvement Program Evaluation 2017-2018* contains comprehensive information about all QA and QI activities. It details a summary of the QI program and

major accomplishments during the year. For QI and QA activities the evaluation gives the activity, lead staff, goals, project dates, progress notes, recommendations, and when the activity was last updated, including staff who updated it. The document ends addressing adequacy of resources, training, scope, and content specific to Vaya. This is a comprehensive program evaluation that gives any reader insight into the Vaya QM program. The Program Evaluation was reviewed by the QIC, the BOD, and the Marketing Department.

Performance Measure Validation

As part of the EQR for Vaya, CCME conducted the independent validation of NC Medicaid selected B and C waiver PMs. The measures selected for validation are listed in the tables that follow.

Table 6: B Waiver Measures

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

Table 7: C Waiver Measures

C WAIVER MEASURES	
Number and percentage of new waiver enrollees who have a LOC prior to receipt of services	Proportion of PCPs that are completed in accordance with DMA requirements
Proportion of providers that meet licensure, certification, and/or other standards prior to their furnishing waiver services	Proportion of records that contain a signed Freedom of Choice Statement
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Proportion of participants reporting their Care Coordinator helps them understand which waiver services are available to them

C WAIVER MEASURES	
Proportion of providers reviewed according to PIHP monitoring schedule to determine continuing compliance with licensing, certification, and contract and waiver standards	Proportion of participants reporting they have a choice between providers
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	Proportion of claims paid by the PIHP for Innovations waiver services that have been authorized in the service plan

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

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

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

B Waiver Measures

B Waiver measures are included in Tables 8 through 17 for the 2016 and 2017 period that was reviewed. The inpatient readmission rate for substance abuse improved substantially, as did the follow-up after hospitalization for substance abuse. The follow-up after hospitalization for mental illness in the PRTF population shows a substantial decline in rate, and a need to consider how to improve the rate for that population.

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

30-day Readmission Rates for Mental Health	2016	2017	Change
Inpatient (Community Hospital Only)	9.0%	10.6%	1.60%
Inpatient (State Hospital Only)	4.5%	0.0%	-4.50%
Inpatient (Community and State Hospital Combined)	9.1%	10.8%	1.70%
Facility Based Crisis	3.6%	7.5%	3.90%
Psychiatric Residential Treatment Facility (PRTF)	7.7%	13.1%	5.40%
Combined (includes cross-overs between services)	10.7%	12.2%	1.50%

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

30-day Readmission Rates for Substance Abuse	2016	2017	Change
Inpatient (Community Hospital Only)	9.1%	10.1%	1.00%
Inpatient (State Hospital Only)	11.1%	0.0%	-11.10%
Inpatient (Community and State Hospital Combined)	9.4%	9.7%	0.30%
Detox/Facility Based Crisis	6.9%	5.5%	-1.40%
Combined (includes cross-overs between services)	10.8%	11.1%	0.30%

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

Follow-up after Hospitalization for Mental Illness	2016	2017	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	43.3%	48.4%	5.10%
Percent Received Outpatient Visit Within 30 Days	63.3%	66.3%	3.00%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	78.7%	59.5%	-19.20%
Percent Received Outpatient Visit Within 30 Days	84.6%	73.8%	-10.80%
PRTF			
Percent Received Outpatient Visit Within 7 Days	30.4%	25.0%	-5.40%
Percent Received Outpatient Visit Within 30 Days	56.9%	56.3%	-0.60%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	8.3%	48.4%	40.10%
Percent Received Outpatient Visit Within 30 Days	24.1%	66.2%	42.10%

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

Follow-up after Hospitalization for Substance Abuse	2016	2017	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	20.2%	32.2%	12.00%
Percent Received Outpatient Visit Within 30 Days	34.6%	43.6%	9.00%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	41.9%	46.9%	5.00%
Percent Received Outpatient Visit Within 7 Days	45.2%	53.1%	7.90%
Percent Received Outpatient Visit Within 30 Days	54.8%	66.7%	11.90%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	9.8%	37.3%	27.50%
Percent Received Outpatient Visit Within 30 Days	21.6%	49.2%	27.60%

**NR = Denominator is equal to zero.*

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2016	2017	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	19.4%	46.7%	27.30%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	31.1%	27.2%	-3.90%
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	15.7%	42.7%	27.00%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	28.1%	26.1%	-2.00%
Ages 21–34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	19.5%	58.4%	38.90%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	46.4%	47.8%	1.40%
Ages 35–64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	24.0%	49.4%	25.40%

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2016	2017	Change
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	31.5%	34.3%	2.80%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	20.5%	43.2%	22.70%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	19.2%	21.1%	1.90%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	21.4%	51.8%	30.40%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	36.4%	37.8%	1.40%

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

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		2016	2017	Change	2016	2017	Change
3–12	Male	0.5	0.4	-0.1	47.4	44.4	-3.0
	Female	0.3	0.3	0	40.7	34.3	-6.4
	Total	0.4	0.3	-0.1	44.9	40.7	-4.2
13–17	Male	1.5	1.4	-0.1	52.5	37.8	-14.7
	Female	2.6	2.5	-0.1	29.5	24.2	-5.3
	Total	2.0	1.9	-0.1	38.1	29.2	-8.9
18–20	Male	1.5	1.7	0.2	25.5	14.9	-10.6
	Female	1.5	1.7	0.2	8.3	5.9	-2.4
	Total	1.5	1.7	0.2	16.3	10.1	-6.2
21–34	Male	4.6	5.3	0.7	8.4	9.3	0.9
	Female	1.6	2.1	0.5	6.5	8.0	1.5
	Total	2.4	2.9	0.5	7.4	8.6	1.2
35–64	Male	3.6	4.0	0.4	8.9	9.6	0.7
	Female	3.0	3.0	0	7.6	8.8	1.2
	Total	3.2	3.4	0.2	8.2	9.2	1
65+	Male	0.7	0.5	-0.2	9.4	10.1	0.7
	Female	0.6	0.4	-0.2	11.8	11.7	-0.1
	Total	0.6	0.5	-0.1	11.0	11.1	0.1
Unknown	Male	0.0	0.0	0	0.0	0.0	0
	Female	0.0	0.0	0	0.0	0.0	0
	Total	0.0	0.0	0	0.0	0.0	0
TOTAL	**Male**	**1.7**	**1.8**	**0.1**	**21.4**	**17.1**	**-4.3**
	Female	**1.5**	**1.6**	**0.1**	**14.5**	**12.8**	**-1.7**
	Total	**1.6**	**1.7**	**0.1**	**17.6**	**14.8**	**-2.8**

Table 14: D.2. Mental Health Utilization -% of Members that Received at Least 1 Mental Health Service in the Category Indicated during the Measurement Period

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
3-12	Male	16.12%	16.62%	0.50%	0.42%	0.38%	-0.04%	1.14%	1.22%	0.08%	15.92%	16.54%	0.62%
	Female	12.44%	12.71%	0.27%	0.29%	0.25%	-0.04%	0.35%	0.45%	0.10%	12.37%	12.67%	0.30%
	Total	14.33%	14.72%	0.39%	0.36%	0.32%	-0.04%	0.76%	0.84%	0.08%	14.20%	14.66%	0.46%
13-17	Male	19.14%	18.42%	-0.72%	1.45%	1.29%	-0.16%	1.45%	1.51%	0.06%	18.84%	18.13%	-0.71%
	Female	22.29%	22.53%	0.24%	2.18%	2.34%	0.16%	0.90%	0.94%	0.04%	22.02%	22.20%	0.18%
	Total	20.67%	20.42%	-0.25%	1.81%	1.80%	-0.01%	1.19%	1.24%	0.05%	20.39%	20.11%	-0.28%
18-20	Male	11.78%	10.92%	-0.86%	1.31%	1.56%	0.25%	0.06%	0.10%	0.04%	11.47%	10.67%	-0.80%
	Female	14.51%	14.28%	-0.23%	1.23%	1.58%	0.35%	0.05%	0.03%	-0.02%	15.34%	13.95%	-1.39%
	Total	13.25%	12.69%	-0.56%	1.27%	1.57%	0.30%	0.06%	0.06%	0.00%	13.55%	12.40%	-1.15%
21-34	Male	30.00%	29.93%	-0.07%	3.99%	4.01%	0.02%	0.02%	0.06%	0.04%	29.67%	29.63%	-0.04%
	Female	25.30%	23.50%	-1.80%	1.43%	1.74%	0.31%	0.02%	0.04%	0.02%	25.19%	23.33%	-1.86%
	Total	26.49%	25.12%	-1.37%	2.08%	2.31%	0.23%	0.02%	0.05%	0.03%	26.32%	24.91%	-1.41%
35-64	Male	23.36%	23.82%	0.46%	2.82%	2.94%	0.12%	0.00%	0.01%	0.01%	23.14%	23.48%	0.34%
	Female	28.03%	27.57%	-0.46%	2.66%	2.50%	-0.16%	0.02%	0.01%	-0.01%	27.73%	27.31%	-0.42%
	Total	26.16%	26.07%	-0.09%	2.72%	2.67%	-0.05%	0.01%	0.01%	0.00%	25.90%	25.78%	-0.12%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
65+	Male	6.44%	7.65%	1.21%	0.75%	0.51%	-0.24%	0.00%	0.00%	0.00%	6.13%	7.40%	1.27%
	Female	6.64%	7.98%	1.34%	0.51%	0.44%	-0.07%	0.00%	0.00%	0.00%	6.46%	7.82%	1.36%
	Total	6.58%	7.88%	1.30%	0.58%	0.47%	-0.11%	0.00%	0.00%	0.00%	6.36%	7.69%	1.33%
Unknown	Male	80.00%	0.00%	-80.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	80.00%	0.00%	-80.00%
	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	33.33%	0.00%	-33.3%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	33.33%	0.00%	-33.33%
TOTAL	Male	18.10%	18.26%	0.16%	1.43%	1.41%	-0.02%	0.73%	0.77%	0.04%	17.86%	18.05%	0.19%
	Female	18.70%	18.61%	-0.09%	1.34%	1.38%	0.04%	0.23%	0.26%	0.03%	18.59%	18.43%	-0.16%
	Total	18.44%	18.46%	0.02%	1.38%	1.39%	0.01%	0.44%	0.48%	0.04%	18.27%	18.27%	0.00%

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

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
3–12	Male	0.02%	0.01%	-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%	0.01%	0.01%	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	1.35%	1.23%	-0.12%	0.06%	0.09%	0.03%	0.15%	0.12%	-0.03%	1.26%	1.13%	-0.13%
	Female	0.94%	0.99%	0.05%	0.10%	0.10%	0.00%	0.07%	0.06%	-0.01%	0.85%	0.91%	0.06%
	Total	1.15%	1.11%	-0.04%	0.08%	0.09%	0.01%	0.11%	0.09%	-0.02%	1.06%	1.02%	-0.04%
18–20	Male	3.03%	2.95%	-0.08%	0.45%	0.37%	-0.08%	0.29%	0.33%	0.04%	2.87%	2.83%	-0.04%
	Female	2.73%	2.78%	0.05%	0.46%	0.43%	-0.03%	0.30%	0.19%	-0.11%	2.56%	2.64%	0.08%
	Total	2.87%	2.86%	-0.01%	0.45%	0.40%	-0.05%	0.29%	0.26%	-0.03%	2.70%	2.73%	0.03%
21–34	Male	12.17%	12.03%	-0.14%	1.20%	1.44%	0.24%	0.54%	0.58%	0.04%	11.85%	11.67%	-0.18%
	Female	10.36%	10.36%	0.00%	0.85%	0.87%	0.02%	0.87%	0.86%	-0.01%	10.06%	10.11%	0.05%
	Total	10.82%	10.78%	-0.04%	0.94%	1.01%	0.07%	0.79%	0.79%	0.00%	10.51%	10.50%	-0.01%
35–64	Male	8.66%	9.04%	0.38%	1.33%	1.44%	0.11%	0.60%	0.59%	-0.01%	8.20%	8.62%	0.42%
	Female	6.53%	6.87%	0.34%	0.72%	0.70%	-0.02%	0.45%	0.52%	0.07%	6.29%	6.56%	0.27%
	Total	7.38%	7.74%	0.36%	0.96%	1.00%	0.04%	0.51%	0.55%	0.04%	7.05%	7.38%	0.33%
65+	Male	1.06%	1.07%	0.01%	0.15%	0.11%	-0.04%	0.05%	0.09%	0.04%	1.00%	0.98%	-0.02%
	Female	0.28%	0.28%	0.00%	0.04%	0.02%	-0.02%	0.01%	0.00%	-0.01%	0.25%	0.25%	0.00%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	Total	0.52%	0.52%	0.00%	0.07%	0.05%	-0.02%	0.02%	0.03%	0.01%	0.48%	0.48%	0.00%
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	3.16%	3.21%	0.05%	0.41%	0.44%	0.03%	0.21%	0.21%	0.00%	3.01%	3.07%	0.06%
	Female	3.52%	3.62%	0.10%	0.35%	0.35%	0.00%	0.28%	0.28%	0.00%	3.38%	3.49%	0.11%
	Total	3.36%	3.44%	0.08%	0.37%	0.39%	0.02%	0.25%	0.25%	0.00%	3.22%	3.30%	0.08%

Table 16: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Alexander	0.00%	0.00%	0.00%	0.85%	0.29%	-0.56%	0.94%	0.80%	-0.14%	8.95%	10.41%	1.46%
Alleghany	0.00%	0.00%	0.00%	1.32%	1.40%	0.08%	0.57%	2.26%	1.69%	6.09%	7.77%	1.68%
Ashe	0.00%	0.00%	0.00%	0.97%	0.56%	-0.41%	2.00%	1.48%	-0.52%	6.96%	6.62%	-0.34%
Avery	0.00%	0.00%	0.00%	0.88%	1.95%	1.07%	1.82%	0.00%	-1.82%	5.91%	5.77%	-0.14%

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County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Buncombe	0.00%	0.01%	0.01%	1.30%	1.04%	-0.26%	3.05%	3.01%	-0.04%	7.90%	9.21%	1.31%
Caldwell	0.03%	0.00%	-0.03%	0.67%	0.90%	0.23%	1.71%	1.75%	0.04%	8.56%	9.03%	0.47%
Cherokee	0.00%	0.00%	0.00%	1.14%	1.37%	0.23%	1.72%	2.94%	1.22%	6.60%	8.07%	1.47%
Clay	0.00%	0.00%	0.00%	1.42%	0.65%	-0.77%	2.90%	1.50%	-1.40%	9.18%	9.82%	0.64%
Graham	0.00%	0.00%	0.00%	1.12%	0.84%	-0.28%	1.83%	3.01%	1.18%	4.78%	7.19%	2.41%
Haywood	0.00%	0.00%	0.00%	1.67%	2.32%	0.65%	4.03%	3.44%	-0.59%	12.69%	11.36%	-1.33%
Henderson	0.00%	0.01%	0.01%	0.84%	0.69%	-0.15%	1.73%	2.01%	0.28%	5.69%	5.57%	-0.12%
Jackson	0.00%	0.08%	0.08%	1.61%	1.57%	-0.04%	2.65%	3.01%	0.36%	8.62%	8.68%	0.06%
Macon	0.00%	0.04%	0.04%	1.27%	1.49%	0.22%	1.80%	2.60%	0.80%	8.80%	8.21%	-0.59%
Madison	0.00%	0.00%	0.00%	0.92%	0.63%	-0.29%	2.80%	1.58%	-1.22%	7.53%	8.03%	0.50%
McDowell	0.00%	0.00%	0.00%	1.21%	0.74%	-0.47%	3.37%	2.58%	-0.79%	12.04%	9.90%	-2.14%
Mitchell	0.00%	0.00%	0.00%	0.24%	0.51%	0.27%	1.32%	1.46%	0.14%	10.58%	9.25%	-1.33%
Polk	0.00%	0.00%	0.00%	0.38%	0.81%	0.43%	0.48%	0.44%	-0.04%	5.79%	5.04%	-0.75%
Rutherford	0.02%	0.00%	-0.02%	0.99%	0.41%	-0.58%	2.11%	1.26%	-0.85%	6.24%	6.57%	0.33%
Swain	0.00%	0.00%	0.00%	3.63%	2.48%	-1.15%	3.25%	4.07%	0.82%	7.56%	6.34%	-1.22%
Transylvania	0.00%	0.00%	0.00%	0.95%	1.81%	0.86%	2.69%	3.23%	0.54%	7.15%	7.69%	0.54%
Watauga	0.00%	0.00%	0.00%	1.30%	1.42%	0.12%	3.82%	3.48%	-0.34%	6.63%	5.08%	-1.55%
Wilkes	0.04%	0.02%	-0.02%	0.47%	0.63%	0.16%	1.58%	1.51%	-0.07%	8.06%	10.08%	2.02%

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County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Yancey	0.08%	0.00%	-0.08%	0.70%	0.18%	-0.52%	1.69%	1.20%	-0.49%	6.76%	5.75%	-1.01%
TOTAL	**0.01%**	**0.01%**	**0.00%**	**1.09%**	**1.01%**	**-0.08%**	**2.35%**	**2.27%**	**-0.08%**	**8.13%**	**8.44%**	**0.31%**
	35-64			65+			Unknown			Total		
Alexander	5.57%	5.76%	0.19%	0.00%	0.33%	0.33%	0.00%	0.00%	0.00%	2.54%	2.80%	0.26%
Alleghany	5.01%	5.53%	0.52%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.08%	2.55%	0.47%
Ashe	4.10%	5.75%	1.65%	0.13%	0.41%	0.28%	0.00%	0.00%	0.00%	2.13%	2.40%	0.27%
Avery	7.59%	6.56%	-1.03%	0.93%	0.24%	-0.69%	0.00%	0.00%	0.00%	2.68%	2.37%	-0.31%
Buncombe	8.30%	8.74%	0.44%	0.94%	1.10%	0.16%	0.00%	0.00%	0.00%	3.50%	3.75%	0.25%
Caldwell	5.10%	5.16%	0.06%	0.40%	0.71%	0.31%	0.00%	0.00%	0.00%	2.68%	2.81%	0.13%
Cherokee	7.39%	7.32%	-0.07%	0.14%	0.42%	0.28%	0.00%	0.00%	0.00%	2.96%	3.23%	0.27%
Clay	7.37%	7.59%	0.22%	0.34%	0.34%	0.00%	0.00%	0.00%	0.00%	3.43%	3.23%	-0.20%
Graham	4.44%	5.60%	1.16%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.81%	2.43%	0.62%
Haywood	12.60%	12.91%	0.31%	0.92%	1.13%	0.21%	0.00%	0.00%	0.00%	5.52%	5.41%	-0.11%
Henderson	5.71%	6.04%	0.33%	0.42%	0.74%	0.32%	0.00%	0.00%	0.00%	2.05%	2.10%	0.05%
Jackson	9.43%	9.79%	0.36%	0.60%	0.77%	0.17%	0.00%	0.00%	0.00%	3.69%	3.83%	0.14%
Macon	9.15%	8.34%	-0.81%	0.57%	0.88%	0.31%	0.00%	0.00%	0.00%	3.51%	3.30%	-0.21%
Madison	5.69%	5.89%	0.20%	0.57%	0.89%	0.32%	0.00%	0.00%	0.00%	2.80%	2.85%	0.05%
McDowell	7.58%	8.78%	1.20%	0.64%	0.71%	0.07%	0.00%	0.00%	0.00%	4.02%	3.76%	-0.26%

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County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	35-64			65+			Unknown			Total		
Mitchell	5.53%	5.01%	-0.52%	0.92%	0.24%	-0.68%	0.00%	0.00%	0.00%	2.98%	2.62%	-0.36%
Polk	4.60%	3.45%	-1.15%	0.56%	0.54%	-0.02%	0.00%	0.00%	0.00%	1.89%	1.61%	-0.28%
Rutherford	4.48%	5.27%	0.79%	0.42%	0.42%	0.00%	0.00%	0.00%	0.00%	2.33%	2.42%	0.09%
Swain	4.70%	4.68%	-0.02%	0.47%	0.98%	0.51%	0.00%	0.00%	0.00%	2.78%	2.57%	-0.21%
Transylvania	7.69%	9.52%	1.83%	1.64%	2.04%	0.40%	0.00%	0.00%	0.00%	3.24%	3.91%	0.67%
Watauga	8.37%	8.42%	0.05%	0.63%	1.00%	0.37%	0.00%	0.00%	0.00%	3.05%	2.84%	-0.21%
Wilkes	5.33%	8.40%	3.07%	0.45%	0.33%	-0.12%	0.00%	0.00%	0.00%	2.47%	3.39%	0.92%
Yancey	7.10%	6.83%	-0.27%	0.39%	0.82%	0.43%	0.00%	0.00%	0.00%	2.68%	2.44%	-0.24%
TOTAL	**7.03%**	**7.58%**	**0.55%**	**0.59%**	**0.75%**	**0.16%**	**0.00%**	**0.00%**	**0.00%**	**3.07%**	**3.22%**	**0.15%**

Table 17: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Alexander	11.60%	10.96%	-0.64%	17.17%	15.98%	-1.19%	7.17%	9.56%	2.39%	10.70%	9.35%	-1.35%
Alleghany	8.86%	11.27%	2.41%	12.89%	15.92%	3.03%	8.05%	3.95%	-4.10%	16.35%	16.18%	-0.17%
Ashe	11.58%	10.72%	-0.86%	18.06%	17.21%	-0.85%	9.14%	9.47%	0.33%	12.55%	11.37%	-1.18%
Avery	9.07%	7.91%	-1.16%	18.02%	18.83%	0.81%	12.27%	10.95%	-1.32%	11.05%	13.12%	2.07%
Buncombe	13.64%	14.00%	0.36%	21.81%	22.00%	0.19%	14.22%	15.34%	1.12%	20.37%	19.44%	-0.93%
Caldwell	9.09%	9.14%	0.05%	15.16%	15.85%	0.69%	8.90%	9.87%	0.97%	9.37%	10.59%	1.22%
Cherokee	12.94%	12.34%	-0.60%	19.11%	20.41%	1.30%	10.59%	9.80%	-0.79%	16.61%	15.44%	-1.17%
Clay	13.43%	12.27%	-1.16%	17.44%	16.23%	-1.21%	14.49%	8.27%	-6.22%	17.05%	15.79%	-1.26%
Graham	9.99%	7.59%	-2.40%	15.13%	12.61%	-2.52%	7.32%	10.24%	2.92%	12.63%	14.04%	1.41%
Haywood	16.16%	15.35%	-0.81%	20.38%	20.39%	0.01%	13.59%	14.32%	0.73%	18.69%	18.14%	-0.55%
Henderson	9.33%	9.94%	0.61%	14.71%	13.91%	-0.80%	10.04%	10.66%	0.62%	13.66%	14.56%	0.90%
Jackson	10.45%	12.01%	1.56%	18.01%	19.96%	1.95%	12.31%	13.23%	0.92%	13.61%	14.25%	0.64%
Macon	13.48%	12.98%	-0.50%	21.76%	21.22%	-0.54%	13.63%	13.20%	-0.43%	15.63%	14.69%	-0.94%
Madison	11.90%	10.55%	-1.35%	20.21%	18.94%	-1.27%	15.84%	12.66%	-3.18%	18.28%	16.50%	-1.78%
McDowell	11.61%	12.65%	1.04%	17.99%	19.42%	1.43%	11.36%	13.02%	1.66%	14.34%	14.24%	-0.10%
Mitchell	11.53%	11.02%	-0.51%	16.71%	14.76%	-1.95%	11.84%	11.65%	-0.19%	12.03%	13.00%	0.97%
Polk	19.93%	19.08%	-0.85%	24.05%	28.51%	4.46%	14.76%	11.40%	-3.36%	12.50%	11.51%	-0.99%
Rutherford	8.64%	9.48%	0.84%	17.23%	17.50%	0.27%	10.28%	10.98%	0.70%	15.87%	14.22%	-1.65%

2018 External Quality Review

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		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
Swain	8.11%	8.41%	0.30%	15.03%	16.98%	1.95%	9.09%	10.17%	1.08%	11.09%	9.27%	-1.82%
Transylvania	12.41%	14.82%	2.41%	18.55%	21.86%	3.31%	10.56%	11.21%	0.65%	15.37%	16.76%	1.39%
Watauga	9.41%	11.40%	1.99%	19.77%	20.96%	1.19%	12.98%	11.85%	-1.13%	14.02%	11.64%	-2.38%
Wilkes	10.34%	12.00%	1.66%	15.57%	15.56%	-0.01%	8.29%	8.40%	0.11%	11.78%	11.47%	-0.31%
Yancey	9.01%	10.59%	1.58%	15.65%	11.58%	-4.07%	12.29%	9.56%	-2.73%	11.33%	9.58%	-1.75%
Total	11.60%	11.91%	0.31%	17.17%	18.49%	1.32%	7.17%	11.79%	4.62%	10.70%	14.79%	4.09%
	35-64			65+			Unknown			Total		
Alexander	15.59%	16.67%	1.08%	5.62%	9.83%	4.21%	0.00%	0.00%	0.00%	12.20%	12.34%	0.14%
Alleghany	21.44%	24.18%	2.74%	2.69%	13.57%	10.88%	0.00%	0.00%	0.00%	12.35%	15.00%	2.65%
Ashe	17.97%	19.52%	1.55%	5.31%	10.61%	5.30%	0.00%	0.00%	0.00%	12.97%	13.57%	0.60%
Avery	16.35%	15.94%	-0.41%	6.71%	8.03%	1.32%	0.00%	0.00%	0.00%	12.00%	12.03%	0.03%
Buncombe	24.78%	24.92%	0.14%	12.50%	16.03%	3.53%	0.00%	0.00%	0.00%	18.19%	18.59%	0.40%
Caldwell	15.28%	16.51%	1.23%	8.26%	12.00%	3.74%	0.00%	0.00%	0.00%	11.20%	12.16%	0.96%
Cherokee	21.12%	20.27%	-0.85%	5.28%	5.19%	-0.09%	0.00%	0.00%	0.00%	15.21%	14.74%	-0.47%
Clay	19.15%	17.32%	-1.83%	5.76%	7.07%	1.31%	0.00%	0.00%	0.00%	14.86%	13.50%	-1.36%
Graham	17.98%	18.05%	0.07%	4.79%	5.63%	0.84%	0.00%	0.00%	0.00%	11.92%	11.32%	-0.60%
Haywood	25.47%	25.72%	0.25%	9.46%	16.05%	6.59%	0.00%	0.00%	0.00%	18.36%	18.79%	0.43%
Henderson	21.55%	21.47%	-0.08%	17.21%	20.12%	2.91%	0.00%	0.00%	0.00%	13.65%	14.18%	0.53%
Jackson	17.49%	19.93%	2.44%	6.10%	9.82%	3.72%	0.00%	0.00%	0.00%	13.12%	14.89%	1.77%
Macon	20.86%	21.87%	1.01%	4.26%	7.52%	3.26%	0.00%	0.00%	0.00%	15.62%	15.71%	0.09%
Madison	19.02%	18.77%	-0.25%	8.01%	10.22%	2.21%	0.00%	0.00%	0.00%	15.28%	14.53%	-0.75%

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		
	2016	2017	Change	2016	2017	Change	2016	2017	Change	2016	2017	Change
	3-12			13-17			18-20			21-34		
McDowell	18.16%	18.80%	0.64%	6.50%	12.73%	6.23%	0.00%	0.00%	0.00%	13.88%	15.19%	1.31%
Mitchell	17.95%	17.52%	-0.43%	6.68%	6.44%	-0.24%	0.00%	0.00%	0.00%	13.05%	12.66%	-0.39%
Polk	19.57%	16.40%	-3.17%	10.58%	17.52%	6.94%	0.00%	0.00%	0.00%	18.18%	18.24%	0.06%
Rutherford	24.17%	23.91%	-0.26%	10.42%	12.46%	2.04%	0.00%	0.00%	0.00%	14.72%	14.95%	0.23%
Swain	13.13%	13.10%	-0.03%	2.79%	3.43%	0.64%	0.00%	0.00%	0.00%	10.02%	10.20%	0.18%
Transylvania	22.09%	20.66%	-1.43%	14.55%	14.11%	-0.44%	0.00%	0.00%	0.00%	15.80%	17.04%	1.24%
Watauga	23.26%	23.51%	0.25%	8.56%	10.98%	2.42%	0.00%	0.00%	0.00%	14.32%	14.96%	0.64%
Wilkes	17.68%	20.19%	2.51%	5.29%	10.94%	5.65%	0.00%	0.00%	0.00%	12.21%	13.81%	1.60%
Yancey	18.17%	17.39%	-0.78%	4.90%	8.23%	3.33%	0.00%	0.00%	0.00%	11.92%	11.66%	-0.26%
TOTAL	**20.83%**	**21.21%**	**0.38%**	**9.00%**	**12.59%**	**3.59%**	**0.00%**	**0.00%**	**0.00%**	**14.73%**	**15.28%**	**0.55%**

B Waiver Validation

The overall validation score is in the Fully Compliant range, with an average validation score of 100% across the ten measures. The data collection and validation methodologies, sources, and rates were submitted and documentation is organized. The final validation for the ten measures is combined to present an overall validation score (see Performance Measure Validation Worksheets for details). Table 18 contains validation scores for each of the ten B Waiver Performance Measures.

Table 18: B Waiver Performance Measure Validation Scores 2017

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

C Waiver Measures

For reviews of 2016-2017 C Waiver measures, Vaya made changes to the measures validated. Vaya chose eight new measures, and retained two previously-validated measures. Documentation is included for all ten C waiver measures. The rates reported by Vaya are displayed in the Table 19.

Table 19: C Waiver Measures Validation Results

Performance measure	Data Collection	July 1, 2016-June 30, 2017*
Proportion of Level of Care evaluations completed at least annually for enrolled participants	Semi Annually	602/602=100%
Proportion of Level of Care evaluations completed using approved processes and instrument	Semi Annually	624/624=100%
Proportion of New Level of Care evaluations completed using approved processes and instrument	Semi Annually	17/17=100%
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Annually	0/0= NA
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	Annually	362/378=95.77%
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	Annually	2349/2349=100%
Proportion of Individual Support Plans that address identified health and safety risk factors	Semi Annually	1101/1101=100%
Percentage of participants reporting that their Individual Support Plan has the services that they need	Annually	2349/2349=100%
Proportion of individuals for whom an annual ISP and/or needed updates took place	Annually	2349/2128= 100%
Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval	Quarterly	16/16= 100%

*NA= Denominator is equal to zero.

C Waiver Validation

The overall validation score is in the fully compliant range, with an average validation score of 100% across the ten measures. Table 20 display the validation scores for each of the ten measures. Vaya provided documentation of data sources, data validation, source code, and calculated rate for the ten C waiver measures. For the "proportion of individuals for whom an annual ISP and/or needed updates took place" measure, the numerator is larger than the denominator in the Excel file and Vaya clarified during the Onsite visit that this is due to multiple beneficiaries having multiple updates, thus more updates than beneficiaries are calculated.

Table 20: C Waiver Performance Measure Validation Scores 2016-2017

Performance Measure	Validation Score
Proportion of Level of Care evaluations completed at least annually for enrolled participants	100%
Proportion of Level of Care evaluations completed using approved processes and instruments	100%
Proportion of New Level of Care evaluations completed using approved processes and instruments	100%
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	100%
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	100%
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	100%
Proportion of Individual Support Plans that address identified health and safety risk factors	100%
Percentage of participants reporting that their Individual Support Plan has the services that they need	100%
Proportion of individuals for whom an annual ISP and/or needed updates took place	100%
Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval	100%
Average Validation Score & Audit Designation	**100% FULLY COMPLIANT**

Performance Improvement Project (PIP) Validation

Validation of the PIPs was conducted in accordance with the protocol developed by CMS titled, *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology. The components assessed are:

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

Table 21 provides a summary of the validation scores for each 2017 Project:

Table 21: Performance Improvement Project Validation Scores

Project Type	Project	2017 Validation Score	2018 Validation Score
Clinical	Follow-up after discharge from inpatient substance abuse disorder treatment	Not Validated	62/62=100% High Confidence in Reported Results
	Inpatient Rapid Readmission	Not Validated	74/85=87% Confidence in Reported Results
Non-Clinical	Integrated Care for Innovations Waiver Participants	Not Validated	56/78=72% Confidence in Reported Results
	TCLI- Increasing Housing	Not Validated	57/62=92% High Confidence in Reported Results

Tables 22, 23, and 24 display each PIP, the section of the standard not met or partially met, the reason for the not met or partially met score, and an associated recommendation.

Table 22: Inpatient Rapid Readmission

Section	Reasoning	Recommendation
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results and findings are presented using a line chart with percentages. The numerator and denominator for those percentages are not reported. The benchmark comparison rate is not represented in the results, which allows for comparison across timepoints with benchmark.	Report the numerator and denominator in a table for each measurement period. Include the benchmark rate in the table for comparative purposes.
Was there any documented, quantitative improvement in processes or outcomes of care?	Rate increased, which is not improvement.	Initiate new interventions to address increase in readmission rates.

Table 23: Integrated Care for Innovations Waiver Participants

Section	Reasoning	Recommendation
Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	The graph is labeled 2017 although the narrative says 2016.	Revise the report so that the trend graph data labels are consistent with the narrative.
Did the study use objective, clearly defined, measurable indicators?	Measure is defined, although it is difficult to determine if there are two separate rates that are reported or one rate.	If two separate rates are reported based on age group, then define two indicators using the numerator and denominator in the report.
Was an analysis of the findings performed according to the data analysis plan?	Analyses are stated as occurring weekly, whereas the plan states analyses are conducted monthly.	Include data analysis plan as weekly and monthly if data are being reviewed at both timepoints.
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results are presented based on a weekly review, but the dates of these reviews are not documented, nor are the numerator, denominator, and rate for the project results summary.	Include the monthly and/or weekly numerator/denominator and rate for the indicator(s) in the results. A table is the best way to present data, along with the benchmark for comparative purposes.

Table 24: TCLI- Increasing Housing

Section	Reasoning	Recommendation
Did the study use objective, clearly defined, measurable indicators?	Measure is defined as including a numerator and denominator, although it is not a percentage. It is a numeric value for each month.	Revise the report so the definition of the indicator is not a percentage but a numeric value.

This year Vaya scored a "Met" on 94% of the standards, a "Partially Met" on 6% of the standards, and no standards received a "Not Met". Figure 5 shows the 2017 and 2018 Quality standards scoring.

Figure 5: Quality Improvement Findings

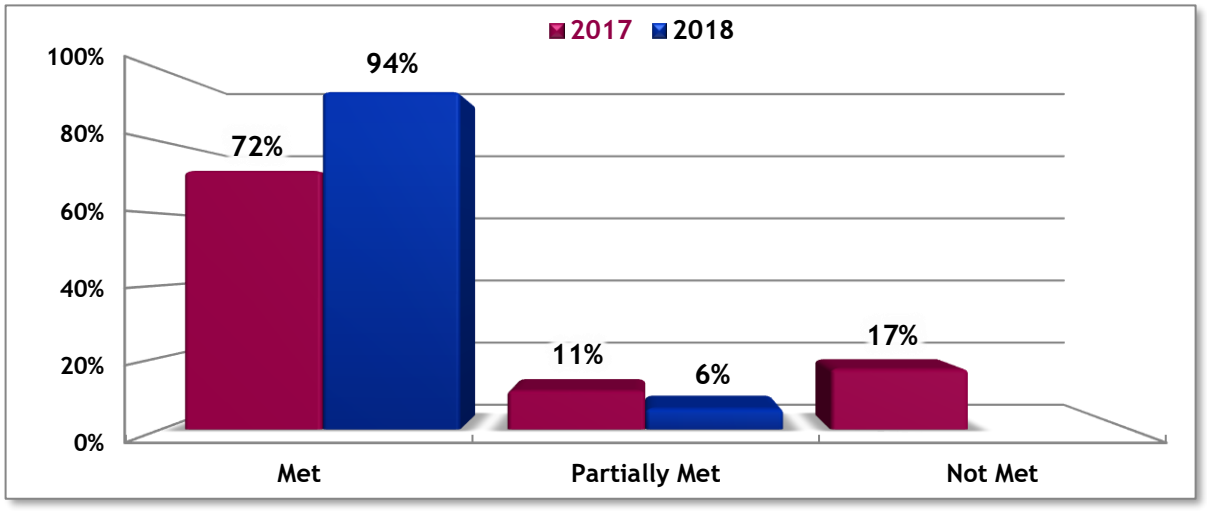


Table 25: Quality Improvement

Section	Standard	2018 Review
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	**Partially Met**

Strengths

- Vaya developed a process to monitor Provider Clinical Practice Guidelines concentrating on "Best Practice Treatment of Opioid Dependence as promulgated by the National Institute of Drug Abuse (NIDA) – Opioid."

- Vaya changed the format of the *2018 QM Annual Workplan* to shorten it and have it fit on a few pages as recommended during the prior year's EQR.
- The *Quality Improvement Program Evaluation 2017-2018* contains information about all QA and QI activities.

Weaknesses

- The QIAT analyzes the enrollee survey data and prepares a summary of the survey results presented to the Vaya BOD, the CFAC, and QIC, as well as internally throughout Vaya." The Onsite interview confirmed Vaya follows this practice and no measures are identified by the QIAT for improvement from the 2017 enrollee surveys. Vaya provided no evidence of discussion about lower scoring survey items in a formal committee like the QIC to allow QIC members to weigh in and vote for or against improvement on low scoring measures.
- Two of the four PIPS validated are not in the "High Confidence" validation. PIPs that have specific items for correction include:
  - Inpatient Rapid Readmission
  - Integrated Care for Innovations Waiver Participants
  - TCLI- Increasing Housing
- During the Onsite interview Vaya described including providers in several PDSA cycles for the Integrated Care QIP and Emergency Department Value-Based Payments project. Other measures are discussed at Provider Council Meetings, but Vaya provides no specific examples of providers receiving interpretation of their QI performance data and feedback regarding QI activities.

Corrective Action

- Correct specific PIP errors by project. See Tables 22, 23, and 24 for corrections.

Recommendations

- Bring lower scoring enrollee survey items to QIC for discussion and decisions on the need for quality improvement actions on those lower scoring items.
- Provide more feedback for provider's individual QI activities. Examples include:
  - Select B and C Waiver measures for individual providers.
  - Involve QI/QA staff in the process for Individual QIPs so providers can receive feedback on QIPs as they work toward desired outcomes.

E. Utilization Management

CCME conducted an External Quality Review (EQR) of Vaya Utilization Management (UM) functions which includes the *Utilization Management Plan* and *Program Description*, Complex Care Coordination Outcomes, *Member and Caregiver Handbook*, *Provider Operations Manual*, and all UM Care Coordination and Transitions to Community Living (TCLI) procedures. In addition, CCME reviewed UM approval and adverse benefit determination, Care Coordination, and TCLI files. CCME also conducted an Onsite interview and discussion that further clarified staff and departmental processes.

The Vaya UM Department is overseen by Dr. Craig Martin, Chief Medical Officer (CMO), and Maggie Farrington, MA, is the UM Director. Vaya has Utilization Managers; Ingrid Bolick, MA, LMFT, oversees Mental Health/Substance Use (MH/SU) members, and Rachel Smith, MS, LPC, oversees the Intellectual and Developmental Disability (I/DD) members in the UM Department.

UM Policy, 3004, Detecting Over and Under-Utilization of MH/SU/I/DD Services provides procedures regarding mechanisms for monitoring overutilization and outliers of service. CCME focused its review of data and reports used for Overutilization and Under Utilization management, including "High Cost/ High Risk Individuals." During the Onsite interview, CCME and Vaya discussed the data analysis process used to identify over utilizers and underutilization. Vaya conducts this monitoring process regularly to prevent over utilization and to identify members who might not be receiving needed services.

Policy 3004, Vaya's *Utilization Management Program Description* describes the structure of the UM program, standards, and staffing. The plan is reviewed and updated at least annually by the CMO, the UM Director and Director of Member Appeals with input from the Executive Leadership Team. The annual appraisal assesses Vaya adherence to the clinical plan and identifies any changes needed.

Vaya has UM standards and guidelines available for providers; this documentation is posted on the Vaya website and available in print. The *Provider Operations Manual* has a link to the Clinical Practice Guidelines. The assessment tool used for young children is the Children's Assessment of Needs and Strengths (CANS) and the practice guidelines for children include the use of Applied Behavioral Analysis (ABA) and Autism Disorder Syndrome Guidelines. Vaya UM decisions are made by appropriate clinicians, and Vaya includes qualification requirements in policy along with a brief description of each role and associated responsibilities.

Policy 2377, UM Department Training, Staffing, Monitoring and Supervision also provides information about the inter-rater reliability (IRR) procedure. Vaya uses an 80% benchmark/concordance rate for UM staff and completes the IRR process quarterly.

CCME's Onsite discussion of Vaya's IRR process revealed that the MH/SU and I/DD UM Care Managers consistently average a concordance rate of 90-100%.

During the Onsite interview, Vaya clarified the Peer Reviewer IRR process. The peer reviewer IRR process measures the rate of agreement between UM adverse benefit determinations and their appeal outcomes. This measure, as was reported during the Onsite discussion, has proven to not measure concordance. Per staff report, disagreement in clinical decisions is primarily due to the presence of new information. The use of vignette-based IRR process for all peer reviewers would improve the validity and reliability of the IRR process for peer reviewers and create consistency with UM IRR processes.

Review of UM decisions showed both approval and denial decisions were based on medical necessity and decided by an appropriately licensed peer reviewer. One of the twenty-five approval decision was completed on the 14th day, and the letter was and sent on the 18th day. This resulted in a late decision. In addition, Vaya has an expedited request that was decided in 72 hours; however, the PIHP did not provide notification within 72 hours, as is required by DMA Contract, Section 7.4.14. This lack of timely notification in two of the fifty UM files reviewed reflected noncompliance with Vaya policy in less than 1% of the files and so does not warrant a recommendation or corrective action.

Rhonda Cox MA, HSP-PA, the Chief Population Health Officer, oversees the Care Coordination Program. Sara Wilson, MSW, LCSW, is the Senior Director of the Care Coordination Program and three regional Care Coordinators also support the program. *Policy 2335, Care Coordination Populations, Processes, Roles and Responsibilities* provides information about care coordination and the role of care coordination with members who have complex healthcare needs. Vaya has implemented the Incedo platform and care coordination leadership is learning the system and its capabilities that support the Care Coordination Program.

Policy 2324, Development and Implementation and Monitoring of an Individual Service Plan (ISP) defines the role of the I/DD Care Coordinator in the development of the ISP and steps associated with the process. *Policy 2347 Person Centered Plan Development for Members Assigned to Care Coordination* provides the procedure and steps that MH/SU Care Coordinators take to participate in the development of a Person Centered. Both policies clear guidance to care coordinators in supporting the treatment planning process.

CCME's review of the Care Coordination file review includes eight member files with co-occurring and or substance misuse issues. Of these files, five members did not follow-up with care coordinators. The care coordination notes showed that in three of these files, care coordinators attempted two phone calls and sent a letter. This action is not consistent with *Policy 2335, Care Coordination Populations, Processes, Roles*. CCME's

Onsite discussion found that statistics reflecting Vaya's inability to reach members are high, and that Care Coordinators spend 30-40% of their time "chasing" members. This led to the formulation of the Unable to Reach section in *Policy 2335*, that requires three phone contacts prior to sending an Unable to Reach notification.

TCLI activities are guided by one overarching policy (*Policy 2405, Transitions to Community Living*). There is no discussion in this policy of person centered planning, as is described in *DMA Contract, Section 15.3*. This policy does reference a mechanism for Transition Year Funds; however, CCME found no documentation within the files reviewed discussing access to these funds.

CCME's review of the TCLI files also found that the *In-Reach/TCLI Transition Tool* was not included in the files when In-Reach was initiated, and, during the Onsite review, CCME found staff were not familiar with the form. In eight files where members receive In-Reach, the *In-Reach/ TCLI Transition Tool* is not present. This tool is not referenced within the TCLI policy. CCME recommends Vaya add details to *Policy 2405* for completing the transition tool and ensuring appropriate person centered planning for TCLI members. CCME also recommends that TCLI files are monitored to ensure discussions with TCLI members regarding Transition Year funds are occurring and that transition tools, when appropriate, are completed and within the files.

QOL surveys are present in three files, and one of the files contains an 11-month survey. During the Onsite interview, Vaya indicated that since September 2017, transition care coordinators complete, monitor, and ensure that *QOL* surveys are captured in the TCLI member files.

Figure 6: Utilization Management Findings provides a comparison of the 2017 and 2018 UM EQR scores.

Figure 6: Utilization Management Findings

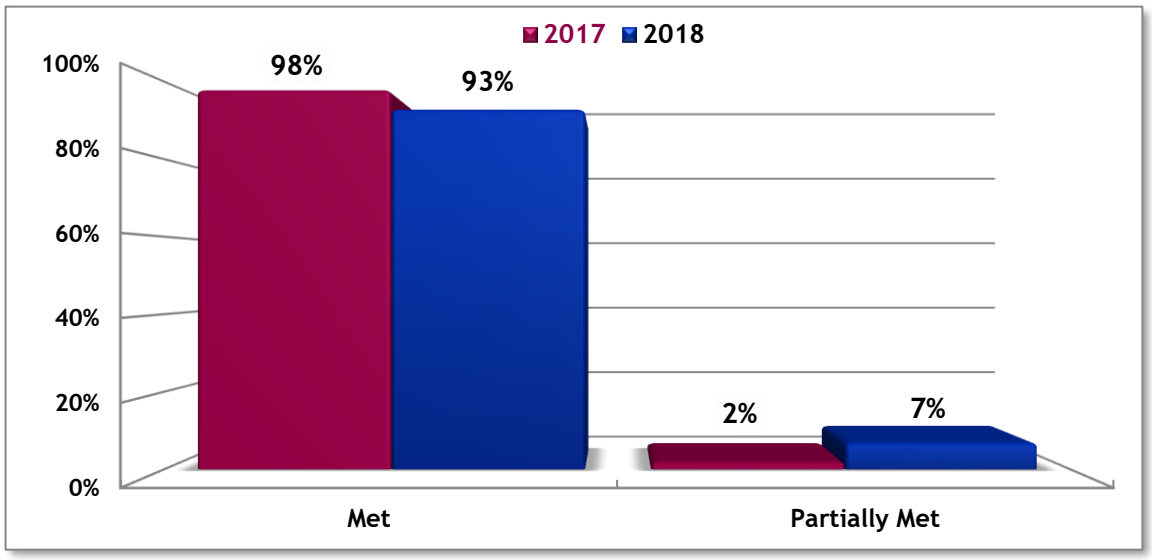


Table 26: Utilization Management

Section	Standard	2018 Review
Care Coordination	The PIHP applies the Care Coordination policies and procedures as formulated	Partially Met
	Care Coordination activities occur as required	Partially Met
Transition to Community Living Initiative	A review of files demonstrates the PIHP is following appropriate TCL policies, procedures and processes, as required by NC DMA, and developed by the PIHP	Partially Met

Strengths

- Vaya's *Utilization Management Plan and Program Description* define the UM's program purpose, scope, structure components, and staff qualifications.
- Vaya has an *Approved Guidelines List* available for providers. It is posted on the Vaya website and is available in print.
- Overutilization and underutilization are monitored closely.
- Care Coordination includes monitoring coordination, linking services, and discharges of the I/DD and MH/SU populations. This includes providing follow-up activities for enrollees.

- Care coordination staff members are co-located with external stakeholders in community settings.
- The TCLI Program exceeds the number of members expected to be served during the time under review.

Weaknesses

- The peer reviewer IRR process measures the rate of agreement between UM adverse benefit determinations and their appeal outcomes. This measure, as was reported during the Onsite discussion, has proven to not measure concordance. Per staff report, disagreement in clinical decisions is primarily due to the presence of new information.
- The care coordination notes showed that, in three of five files where care coordination members were not following up with care coordination, care coordinators attempted two phone calls and sent a letter. This action is not consistent with *Policy 2335, Care Coordination Populations, Processes, Roles*.
- *Policy 2405, Transitions to Community Living* does reference a mechanism for Transition Year Funds; however, CCME found no documentation within the TCLI files reviewed showing discussions with TCLI members regarding the purpose and access to these funds.
- The *In-Reach/TCLI Transition Tool* is not included in eight of the files reviewed where this tool would be required.
- There is no reference to the required *In-Reach/TCLI Transition tool* in *Policy 2405, Transitions to Community Living*.
- There is no reference in *Policy 2405, Transitions to Community Living* to person centered planning activities, as is described in *DMA Contract, Section 15.3*.

Corrective Actions

- Monitor contacts by Care Coordinators with members that are not following up with care coordination. Ensure in this monitoring that contact attempts are consistent with *Policy 2335, Care Coordination Populations, Processes, Roles and Responsibilities*.
- Enhance Vaya's current TCLI monitoring processes to ensure TCLI care coordinators complete an *In-Reach/TCLI Transition Tool*, when appropriate, and that discussions with TCLI member regarding the purpose and access of Transition Year Funds are occurring. for all members and discussions with TCLI members regarding access to Transition Year funds are occurring.
- Add details to *Policy 2405, Transitions to Community Living* regarding the requirements around the completion of *In-Reach/TCLI Transition Tool*.

Recommendations

- The use of vignette-based IRR process for all peer reviewers would improve the validity and reliability of the IRR process for peer reviewers and create consistency with UM IRR processes.
- Add details to *Policy 2405, Transitions to Community Living*, regarding required person centered planning activities by the TCLI program, per *DMA Contract, 15.3 Person Centered Planning*.

F. Grievances and Appeals

Grievances

The Grievances section of the External Quality Review (EQR) includes a thorough review Vaya's grievance and complaint policies and procedures, Grievance Logs, 25 grievance files, and information presented during the Onsite interview.

Vaya grievance functions are located in the Customer Services Department. Christina Dupuch, MSW, Chief Operating Officer, Ms. Karla Mensah, MBA, Senior Director Customer Services, and Stephanie Hopfinger, BS, Grievance Lead, oversee the department. All staff are trained on the identification, documentation, and process for handling and routing grievances during New Employee Orientation.

Vaya states in *Policy 2607* that it has 90 days to resolve a grievance, and that the PIHP strives to resolve grievances within 30 days. The policy is unambiguous and contains most required elements. The process to extend a grievance time frame is stated on page 5, item 17. The steps are clear; however, Vaya needs to add a timeframe element for clarification and accuracy. "If Vaya determines to or a grievant request to extend the timeframe for resolution, the Grievance Team will notify the grievant in writing." Per *42 CFR 438.402,* the notification letter is required to be mailed within two days from the decision by Vaya to extend the grievance resolution timeframe.

Vaya defines procedural steps of filing and handling a grievance in policy. Vaya also has an internal process that includes the use of a *Grievance Worksheet*. The *Grievance Worksheet* includes the procedural steps for handling a grievance and supports the procedural steps in *Policy 2607*. Including the use of the *Grievance Worksheet* in *Policy 2607* ensures that all procedural steps for handling a grievance are followed consistently.

During the Onsite discussion, Vaya provided information about the Chief Medical Officer (CMO) involvement with grievances and the "Grievance Team" membership. Members of the Grievance Team are not defined in the policy and the CMO's role in the resolution process is not clear. Adding the definition of the Grievance Team and its membership roster provides clarification about the members involved in the procedures.

CCME's review of the grievance files indicates that the grievance policies and procedures are followed. Vaya has an internal process that includes the documentation of procedural steps in the *Grievance Worksheet*. A *Grievance Worksheet* is used to follow the procedures, but Vaya has several files missing the *Grievance Worksheet* and several files with an incomplete *Grievance Worksheet*. CCME recommends a monitoring process to validate that the *Grievance Worksheet* is complete and, in the file, supporting procedures in *Policy 2607*.

The Vaya *Grievance Log* includes both grievances and complaints. During the Onsite interview, Vaya stated it separates the complaint from the grievance data and submits only "grievances" to the state in the *Grievance Log*. Vaya monitors *Grievance Log* data monthly for potential patterns and opportunities for improvement.

Appeals

The EQR of Vaya's appeal process includes reviewing governing policies and procedures, the *Member and Caregiver Handbook, The Provider Operations Manual,* the *Denial and Appeal Log*, Vaya's website, and 25 appeal files.

Vaya's *Denial and Appeal Log* shows it processed 186 first level appeals and 37 second level appeals between July 2017 and June 2018. Vaya's appeal process is guided by the *Policy 2384*, Member Appeals of Adverse Decisions. While this policy is thorough and written well, Vaya has a few appeal requirements that are missing or incorrect.

Per *Policy 2384*, appellants are required to submit Vaya's *Reconsideration Request Form*. This policy states, "To request a Local Reconsideration, the member/ LRP must complete and return the *Reconsideration Request Form* included with the *Notice of ABD*." Similarly, the *Member and Caregiver Handbook* states, "To request a reconsideration of a Medicaid adverse benefit determination, you must complete and return the Vaya reconsideration request form." Neither the *DMA Contract* nor the federal regulations governing appeals require a specific form. Appeal rights exist regardless of whether Vaya's form is submitted and individuals should be able to file appeals in any format so long as they are providing sufficient information to Vaya to consider the appeal.

Per *Policy 2384*, "If a signed and completed *Reconsideration Request Form* is received more than 20 days after the oral request, the date of receipt of the written request is considered to be the Reconsideration Request date for the purpose of issuing the Notice of Resolution." This practice allows Vaya to extend the appeal resolution timeframe up to 50 days. *42 CFR 438.406(b)(3)* states PIHPs must "Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal)." Further, *42 CFR 438.408(b)(2)* and the *DMA Contract, Attachment G.4* require standard appeals to be resolved and notification

provided within 30 days. The only exception to this timeframe is if a written request is never received or an extension to the appeal resolution timeframe is issued.

Vaya's appeals *Policy 2384*, the *Provider Operations Manual*, and *Member and Caregiver Handbook* do not clarify that if Vaya extends an appeal resolution timeframe the will make reasonable efforts to give the enrollee prompt oral notice of the delay. Also, the enrollee must be notified in writing of the extension within two calendar days and informed of the right to file a grievance if they disagree with the extension. This notification requirement is in *DMA contract, Attachment M, G.6 i* and *ii*.

There is also missing or incorrect information in Vaya's appeal policy, *Member and Caregiver Handbook*, and *Provider Operations Manual* regarding the required notification process when an expedited appeal is requested and denied. NC Medicaid requires the PIHP to "give the Enrollee prompt oral notice for the denial (make reasonable efforts) and a written notice within two (2) calendar days." This requirement is in *DMA Contract, Attachment M 9.b.*

The 2017 EQR recommended that Vaya add the process implemented for denying a request for expedited appeal to policy. During the Onsite discussion, staff described the process for review and denial of a request for expedited appeal, including review by the CMO. CCME recommends that Vaya document this process in policy and note that the CMO is involved.

Vaya's appeals policy guides staff through the required steps for notifying appellants of an appeal decision. Within this process description, steps 13 and 14 use the terms "partially overturned" and "partially upheld" but, the policy only indicates additional appeal rights are offered via a decision notice when an appeal is "partially upheld." During the Onsite discussion, staff agreed these terms are synonymous and both of these appeal outcomes, given the decision is not wholly in favor of the appellant, require notification to appellants per policy as described under "partially overturned."

Policy 2384 defines an appeal as "Medicaid Appeal means a request for a new consideration of an authorization request that resulted in an ABD." (ABD is an abbreviation of Adverse Benefit Determination). The definition of an appeal within the *DMA Contract Section, Attachment M, G(1)* and *42 CFR § 438.400(b)* defines an appeal as "the request for review of an adverse benefit determination." As this definition is a federal requirement, CCME requires a corrective action to address the definition in policy.

Errors within the *Provider Operations Manual* and the *Member and Caregiver Handbook* are also noted. The *Provider Operation Manual* states, "we always send an acknowledgement letter when we receive a reconsideration request." Not only does the manual not say when an acknowledgment letter is sent, per Vaya policy, "Requests for

Expedited Appeal that are accepted do not require written acknowledgement." CCME recommends amending the *Provider Operations Manual* to reflect when acknowledgment letters are sent and under what appeal circumstances. The *Member and Caregiver Handbook* erroneously say that appellants can request an extension to the "60-day timeframe." CCME recommends revising this language to state the "30-day timeframe" can be extended by an appellant.

Review of the 25 appeal files submitted for this EQR reflect all decisions are processed and notifications mailed within the timeframes required by *DMA Contract*; however, five appeal files show notifications by appeal staff are inconsistent with contractual or Vaya procedural requirements:

- One of the appeal files shows an acknowledgment letter was mailed outside of the "one (1) business day" required by Vaya policy. This acknowledgement letter was sent four days after receiving the written appeal request.
- One standard appeal file has no evidence of a written acknowledgement letter. This was later determined to be an invalid appeal, but Vaya did not submit an invalid notification for this EQR.
- One file has inconsistencies regarding processing an expedited appeal. An oral request for an expedited appeal was submitted on March 2, 2018, but resolution notifications did not occur until seven days later. It is unclear within the narrative of the appeal file what occurred within those seven days, but within the file, there is an absence of any acknowledgement and potential late oral and written notifications to the appellant.
- Another file has no evidence of an oral or written expedited appeal resolution.
- One appeal reflects it was resolved and notification provided 31 days after receiving the appeal.

CCME and Vaya discussed these inconsistencies during the Onsite interview. Vaya staff explained that each appeal is reviewed for compliance, but as 25% of the files showed inconsistencies, bolstering Vaya's monitoring of appeals notifications will ensure better compliance with contractual, regulatory, and procedural requirements. CCME recommends increasing and improving monitoring to include review of all written and oral notifications, including invalid notifications, acknowledgements, and resolution notifications. CCME also recommends monitoring reviews for timeliness of all notifications.

Vaya presented evidence in the Quality Improvement Committee (QIC) minutes that the PIHP analyzes appeal trends by number, type, percentage of adverse benefit determinations that are appealed, funding source, outcome, and appeal level. The QIC discusses the appeal data quarterly, with one exception during the second quarter of the 2018 calendar year.

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

Figure 7: Grievances and Appeals Comparative Findings

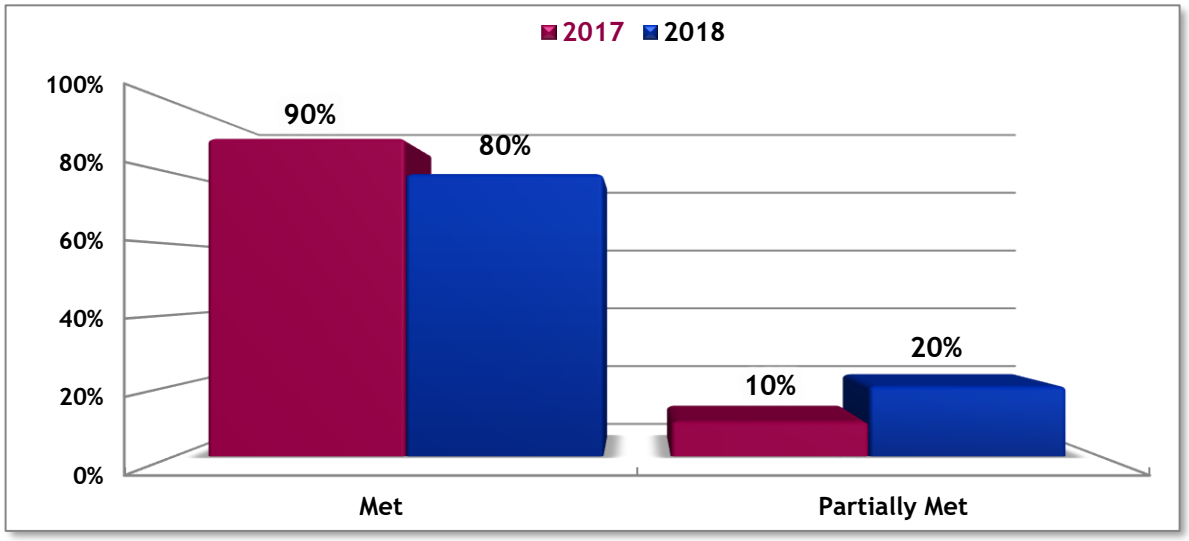


Table 27: Grievances and Appeals

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

Strengths

- Vaya's *Grievance Log* contains data for grievances and complaints. Vaya can separate the complaint data from the grievance data. Vaya only submits grievance data to the state in the *Grievance Log*.
- *Policy 2384*, Member Appeals of Adverse Decisions is clear and thorough.
- All of the appeals files CCME reviewed show decisions are rendered within the required timeframes and by appropriate appeal peer reviewers.

- Vaya staff members understand most of the appeal requirements.
- Vaya presents evidence in the Quality Improvement Committee minutes that the PIHP analyzes appeal trends by number, type, percentage of UM denial decisions that are appealed, funding source, outcome, and appeal level.

Weaknesses

- The *Grievance Worksheet* includes the procedural steps for handling a grievance but is not referenced in *Policy 2607*.
- The members of the Grievance Team are not defined in *Policy 2607*. During the Onsite interview, Vaya clarified that the Grievance Team membership includes the CMO. Updating the policy will ensure that the CMO is involved in the grievance resolution process.
- In *Policy 2607*, the correct process to extend a grievance is stated on page 5, item 17, "If Vaya determines to or a grievant request to extend the timeframe for resolution, the Grievance Team will notify the grievant in writing." Per *42 CFR 438.402*, the notification letter is mailed within two days from the decision.
- Per *Policy 2384* appellants are required to submit Vaya's *Reconsideration Request Form*. Similarly, the *Member and Caregiver Handbook* states, "To request a reconsideration of a Medicaid adverse benefit determination, you must complete and return the Vaya reconsideration request form." Neither the *DMA Contract* nor the federal regulations governing appeals require a specific form. Appeal rights exist regardless of whether Vaya's form is submitted, and individuals should be able to file appeals in any format so long as they provide sufficient information for Vaya to consider the appeal.
- *Policy 2384* allows Vaya to extend the appeal resolution timeframe "If a signed and completed *Reconsideration Request Form* is received more than 20 days after the oral request." *DMA Contract* and federal regulations do not allow PIHPs to extend appeal timeframes.
- Vaya's appeals *Policy 2384*, the *Provider Operations Manual*, and *Member and Caregiver Handbook* do not clarify that if Vaya extends an appeal resolution timeframe, the PIHP will make reasonable efforts to give the enrollee prompt oral notice of the delay. Also, the enrollee must be notified in writing of the extension within two calendar days and informed of the right to file a grievance if disagreeing with the extension.
- Vaya has missing or incorrect information in its appeal policy, *Member and Caregiver Handbook*, and *Provider Operations Manual* regarding the required notification process when an expedited appeal is requested and denied.

- Vaya's appeal policy does not contain any information regarding the process that is implemented when Vaya decides to accept or deny a request for an expedited appeal. Involvement by the CMO is also not described in this policy but was described by staff during the Onsite discussion.
- Vaya's appeals policy guides staff through the required steps in notifying appellants of an appeal decision. Within this process description, steps 13 and 14 use the terms "partially overturned" and "partially upheld;" the policy only indicates additional appeal rights are offered via a decision notice when an appeal is "partially overturned."
- The definition of an appeal is incorrect in *Policy 2384*.
- *The Provider Operations Manual* and the *Member and Caregiver Handbook* state an acknowledgement letter is mailed when a *Reconsideration Request* is received, but this contradicts Vaya's appeals policy which states a written acknowledgement is not required when filing an expedited appeal.
- *The Member and Caregiver Handbook* erroneously states that appellants can request an extension to the "60-day timeframe."
- Five of the 20 first level appeal files show notifications by appeal staff are not in compliance with *DMA Contract* and Vaya procedural requirements.

Corrective Actions

- Revise the language within *Policy 2384* and the *Member and Caregiver Handbook* to clarify that any written request, should the request provide sufficient information for Vaya to consider the appeal, can initiate the first level appeal process.
- Revise *Policy 2384* to reflect that all oral requests are treated as appeals and begin the 30 day timeframe for Vaya to resolve the appeal. The only exception is when, following an oral appeal request, a written request is not submitted within the 60 days of the mailing date of the *Notice of Adverse Benefit Determination*.
- Revise *Policy 2384* to state that if Vaya extends an appeal resolution timeframe, the PIHP will make reasonable efforts to give the enrollee prompt oral notice of the delay. Also, include that the enrollee must be notified in writing of the extension within two calendar days and informed of the right to file a grievance if disagreeing with the extension.
- Revise *Policy 2384*, the *Provider Operations Manual*, and the *Member and Caregiver Handbook* to include information that enrollees are given prompt oral notice and a written notice within two calendar days when Vaya denies a request for an expedited appeal.
- Change the definition of an appeal within *Policy 2384* to "the request for review of an adverse benefit determination."

Recommendations

- Include the use and steps of the *Grievance Worksheet* in *Policy 2607, Complaints and Grievances*, to ensure procedures for handling grievances are followed and completed consistently.
- In the Definitions section of *Policy 2607, Complaints and Grievances*, include the definition of the Grievance Team and its membership, including CMO involvement in the grievance resolution process.
- Include in *Policy 2607* that when Vaya extends the grievance process, the *Notice of Extension Letter* is sent within two days per *42 CFR § 438.402*.
- Add detail to *Policy 2384* that describes the process Vaya uses when reviewing and denying a request for an expedited appeal, including CMO involvement.
- Correct the language in *Policy 2384* to clarify that any appeal decision not wholly in favor of the appellant requires notification of appeal rights.
- Clarify in the *Provider Operations Manual* and *Member and Caregiver Handbook* that Vaya is not required to send a written acknowledgement when an expedited appeal is filed.
- Correct the typographic error on pg. 61 of the *Member and Caregiver Handbook* to say appellants can request an extension to the "30-day timeframe."
- Increase and improve the monitoring process of all written and oral notifications, including invalid notifications, acknowledgements, and resolution notifications. Ensure monitoring includes a review of all notifications for timeliness.

G. Delegation

CCME's EQR of Delegation functions includes a review of the relevant policy (*2303, Delegation and Subcontracting*), the submitted *Delegate List*, Delegation Contracts/Letters of Agreement, and Delegation Monitoring Tools. CCME also conducted an Onsite interview with relevant staff.

Vaya has two delegated entities, as evidenced in Table 28. During the 2017 EQR, Vaya had a contract with Cardinal Innovations for call roll-over coverage during specified times. The contract with Cardinal Innovations ended July 1, 2017. Vaya also delegated credentialing to seven hospitals in 2017. Those delegation agreements ended July 1, 2017, as a delegation agreement with hospitals for credentialing of hospital personnel is no longer required (*DMA Contract Attachment B, Section 7.7.3*).

Table 28: Delegated Entities

Delegated Entities	Service
Prest and Associates	Peer Review/ UM
Partners Behavioral Health	Call roll over

Vaya's *Policy 2303, Delegation and Subcontracting*, outlines the process for delegating administrative functions to another entity, and includes the requirements for ongoing oversight. The policy is consistent with the provisions of *42 CFR § 438.230* and *DMA Contract Attachment B, Section11, Subcontracts*. Both delegates correct issues as they arise and pursue corrective actions as needed.

The referenced policy states that the "Vaya department with primary responsibility for the delegated function(s) shall provide ongoing oversight of the delegation agreement and the delegated entity's performance of those functions. This oversight shall include development and implementation of an oversight delegation plan approved by the Regulatory Compliance Manager or designee that includes the following elements," including "E. A mechanism for reporting delegation oversight no less than annually to the Quality Improvement Committee (QIC)." The QIC meeting minutes do not include reporting of delegation oversight of Prest and Associates or of Partners.

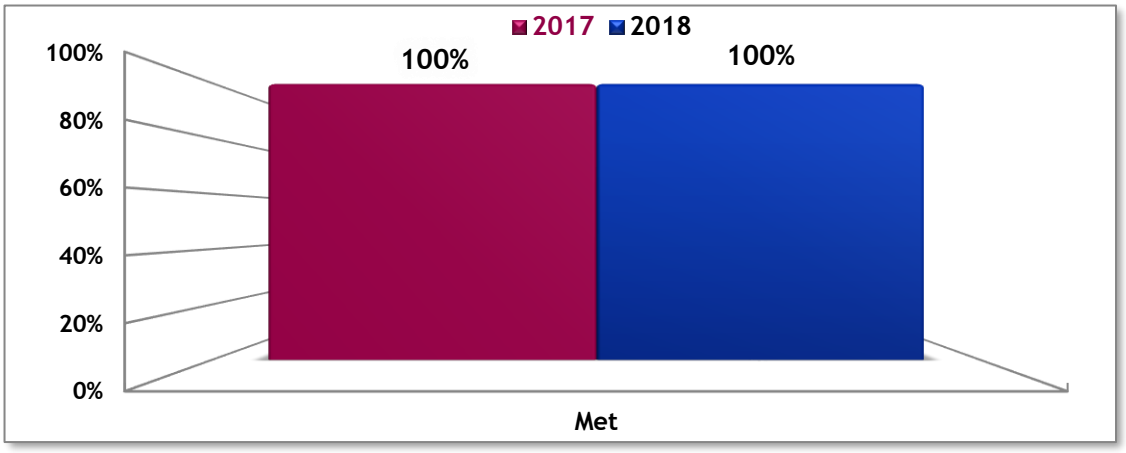
Vaya reported peer reviews conducted by Prest and Associates are "reviewed for completeness, adherence to Vaya guidelines and quality along with all internal peer reviews." The process includes a review by a Vaya Clinical Support Team clinician using a standard review template. Concordance reports are created for the reviews. Individual reviewers at Prest are not listed or monitored separately.

Karla Mensah, MBA, Vaya's Senior Director of Customer Services, meets monthly with the relevant staff member from Partners to monitor calls and complete the *Call Monitoring Checklist*. Vaya reported Partners met call metrics for the calls answered by Partners.

Vaya had no Corrective Actions from the 2017 EQR. The only *Recommendation* from the previous EQR is no longer relevant, since Vaya no longer delegates any credentialing.

As noted in Figure 8, 100% of the standards in the 2018 Delegation review received a "Met" score. Figure 8 also provides a comparison of the 2017 scores versus the 2018 scores.

Figure 8: Delegation Comparative Findings



Strengths

- Vaya has an executed contract, including a Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement, with each delegate.
- Vaya conducted the required annual monitoring for each delegate.
- Monthly meetings are held with Partners staff to monitor calls. Vaya Clinical Support Team clinicians conduct quarterly monitoring of Prest Peer Reviews.

Weaknesses

- Vaya *Policy 2303, Delegation and Subcontracting*, includes a reference to "a mechanism for reporting delegation oversight no less than annually to the Quality Improvement Committee (QIC)." The supplied QIC meeting minutes do not include reporting of delegation oversight of Prest and Associates or of Partners.
- Vaya staff completed a *Delegation Assessment* form for Partners Behavioral Health, but it does not include the timeframe covered by the assessment, the date the assessment was completed, or the date it was signed by the Vaya staff member.

Recommendations

- Report delegation oversight in a QIC meeting annually, as referenced in Vaya *Policy 2303*, or revise the policy to eliminate the reference to annual reporting by the QIC.
- For *Delegation Assessments*, include the timeframe covered by the assessment, the date the assessment was completed, and the date signed by the Vaya staff member.

H. Program Integrity

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

IPRO's review of Vaya began in June 2018, with an offsite review of Vaya program integrity (PI) files and documentation. IPRO analyzed the files and documentation and conducted Onsite interviews October 24, 2018, with the Chief Compliance Officer (CCO) and PI staff. The period of review is June 1, 2017 through May 31, 2018.

File Review

IPRO requested the universe of PI files from Vaya for the June 1, 2017 through May 31, 2018 review period and selected a random sample of 15 files with a two file oversample, resulting in a total of 17 reviewed files.

Contract Requirement: In each case where the PIHP investigates a credible allegation of fraud, the PIHP shall provide NC Medicaid Program Integrity with the following information on a DMA approved template:

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

Findings

Fifteen of 15 files contain the following requirements:

- Source/origin of complaint
- Date reported to the PIHP or, if developed by the PIHP, the date the PIHP initiated the investigation

- Description of the suspected intentional misconduct, with specific details including: the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations, or policies violated, and dates of conduct
- Amount paid to the provider for the last three years (amount by year) or during the period of the alleged misconduct, whichever is greater. (12 files contain the required documentation with three (3) non applicable; this element is fully compliant.)
- Contact information for PIHP staff persons with practical knowledge of the workings of the relevant programs
- Sample or exposed dollar amount, when available. (Thirteen (13) files contain the required documentation with two non applicable; this element is fully compliant.)

All communications between the PIHP and the provider concerning the conduct at issue, when available. Fourteen (14) of fifteen (15) files contain the required documentation. In one case the reviewer found no evidence of communication between the PIHP and the provider. During the Onsite interview, IPRO ascertained that this one file was mistakenly identified by the PIHP as a closed file during the PI files sample request. In contrast, the file is open and in the early stages of investigation. Vaya stated during the Onsite interview that as of October 9, 2018, (after the review period) communication with the provider was initiated. IPRO determined that the requirement is not applicable for this one file; this requirement is met.

The following requirements are not met fully:

- Subject (name, Medicaid provider ID, address, provider type)
- Thirteen of 15 files contain all required documentation.
- Two of 15 files do not contain the Medicaid Provider ID; the files do contain an internal provider reference number.
- Medicaid Provider IDs are not on the *Investigation Referral Form*. The reviewer was able to find the Provider ID only as a part of the output from the Vaya claims system that accompanies 13 of the case files.

Contract Requirement: In each case of suspected enrollee fraud, the PIHP shall provide NC Medicaid program integrity with:

- The enrollee's name, birth date, and Medicaid number
- The source of the allegation
- The nature of the allegation
- Copies of all communications between the PIHP and the provider concerning the conduct at issue

- Contact information for PIHP staff persons with practical knowledge of the allegation
- The date reported to the State
- The legal and administrative status of the case.

Findings

No cases under review involve suspected enrollee fraud.

Documentation

IPRO conducted a Desk Review of Vaya's documentation to assess compliance with federal and state regulations and contract with NC Medicaid. The documentation review includes Vaya policies, procedures, training materials, organizational charts, job descriptions, committee meeting minutes and reports, provider agreements, enrollment application, workflow, provider manual, employee handbook, newsletters, conflict of interest forms, and *Compliance Plan*. This information reviewed falls under three topic areas: General Requirements, Fraud and Abuse, and Provider Payment Suspensions. IPRO conducted Onsite interviews September 20, 2018, with the Chief Compliance Officer (CCO) and PI staff to review the offsite documentation and file review findings.

General Requirements

Findings

All documentation required under Section VIII A. General Requirements is addressed in Vaya documentation.

Fraud and Abuse

Findings

All documentation required under Section VIII B. Fraud and Abuse is addressed.

Provider Payment Suspensions

Findings

Missing from the documentation is explicit language pertaining to the following areas:

- Lifting of payment suspensions within three days of notification from NC Medicaid.
- Providing access to NC Medicaid for information and personnel needed to defend investigations referred by the PIHP.
- Recouping overpayments or other funds due to the PI Department if instructed by the PI Department.

As noted in Figure 9, 93% of the PI standards received a "Met" score in 2017 and 2018.

Figure 9: Program Integrity Findings

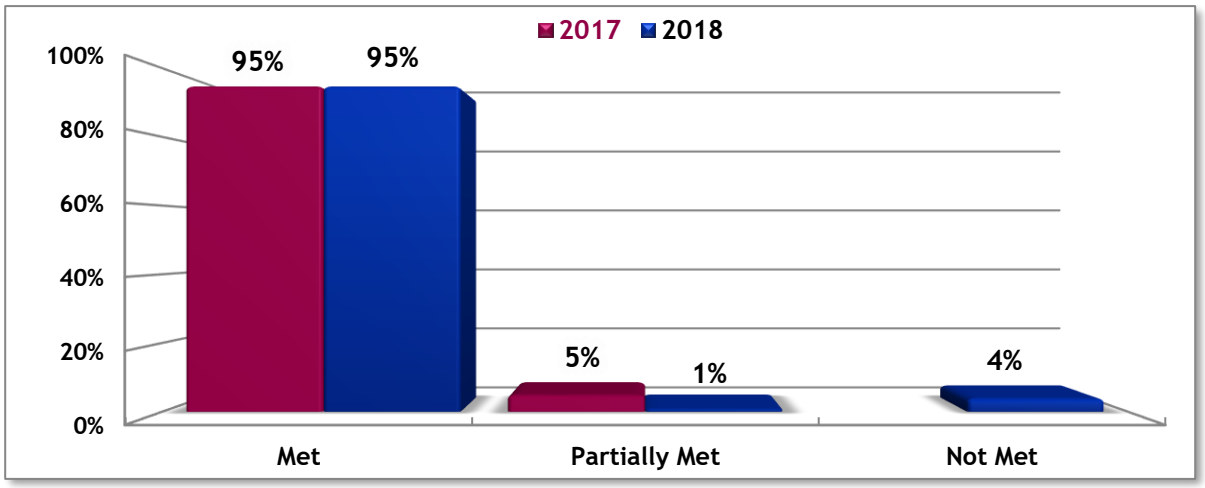


Table 29: Program Integrity

Section	Standard	2018 Review
Fraud and Abuse	Subject (name, Medicaid provider ID, address, provider type)	**Partially Met**
Provider Payment Suspensions and Overpayments	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	**Not Met**
	In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery	**Not Met**

Strengths

- Vaya's PI Department understands the contractual language that governs its work. Evidence of implementation of the contractual requirements is found in Vaya's practices.
- Vaya has an integrated process with appropriate interfaces to compliance, provider, and relevant areas.
- PI files are organized, thorough, and contain all contractual requirements even when the file does not need to be reported to NC Medicaid.
- Vaya's *Investigation Referral Form* is an adequate tool for directing and following the investigation flow, and documenting the steps taken, and the outcome of each investigation.
- Vaya uses Financial Asset Management Systems (FAMS) to identify outliers among providers that warrant further investigation for potential fraud or over utilization.

Weaknesses

- The *Investigation Referral Form* does not capture the Provide NPI number.
- Specific language is missing from Vaya's policies for the following *DMA Contract* requirements:
  - Lifting payment suspensions within three days of notification from NC Medicaid
  - Providing information and personnel access to NC Medicaid needed to defend investigations referred by the PIHP
  - Recouping overpayments or other funds due the Department if instructed by the Department.

Corrective Actions

- Implement changes to the PI referral form in incorporate provider ID number.
- Update policies and procedures to incorporate all contractually required language related to:
  - Lifting payment suspensions within three days of notification from NC Medicaid
  - Recouping overpayments or other funds due to the Department if instructed by the Department.

Recommendation

- Create additional detailed procedures that document the Special Investigations Unit Program Integrity Process.

- Update policies and procedures to incorporate the language regarding Vaya providing information and personnel access to NC Medicaid needed to defend investigations referred by the PIHP.

I. Financial Services

CCME's EQR of Vaya's Financial Services identified two policy enhancements during the financial Onsite visit. CCME recommends that Vaya add the five-business day requirement for Risk Reserve payments to *Policy 2748*. CCME also recommends that Vaya add Medicaid contract requirements and federal regulations to policies.

CCME implemented a Desk Review of the following documentation:

- Financial policies and procedures
- Audited financial statements and footnotes dated June 30, 2017
- Balance sheet and income statements dated March 31, 2018, and April 30, 2018
- Medicaid monthly financial reports for March and April 2018
- 820 and 834 file reconciliation process
- Claims processing aging reports for March and April, as well as claims processing policies
- Accounting Department staffing structure
- Fiscal year budget for 2017-2018
- Budget to actual expenses report for Medicaid during March 2018 and April 2018

After reviewing Vaya's Desk Review materials, CCME conducted an Onsite visit and interview at Vaya's office on October 24, 2018. In reviewing Vaya financial operations, CCME used a standardized EQR Finance Desk Review and an Onsite Administrative Interview guide. CCME also reviewed deficiencies from prior EQRs to determine if they were corrected. In addition to the standardized Desk Review inquiries, CCME asked additional interview questions in the following areas:

- Policies and procedures
- Staffing changes in the Finance Department
- Accounting system
- Claims adjudication and re-adjudication
- Budget variances and development
- Internal audit function
- Board of Directors oversight

Vaya demonstrates ongoing financial stability. Vaya's audit report for June 30, 2017, received an overall unqualified audit opinion on financial statements, and there are no findings in the report about internal control over financial reporting and compliance.

Vaya exceeded the contract benchmarks for current ratio, defensive ratio, and medical loss ratio. Vaya's Medicaid ratio is 3.29 total with a total current ratio of 2.66 in March 2018. The Medicaid current ratio is 3.15 total, with a total current ratio of 2.40 for April 2018 (benchmark is 1.00). Vaya Medicaid defensive interval is 84.90 days in March 2018 and total defensive interval is 52.82 days (the benchmark is 30 days). Vaya's year-to-date medical loss ratio is 90.4% year-to-date as of March 31, 2018, and 90.8% year-to-date as of April 30, 2018 (benchmark is 85%). Medicaid total assets as of March 31, 2018, are $120,151,719 and $120,025,618 for April 30, 2018. Vaya's net assets position is $130,939,959 as of June 30, 2017.

Vaya meets standard *42 CFR § 433.32 (a)* for maintaining an appropriate accounting system (Great Plains). Vaya uses Great Plains financial, purchasing, fixed assets, and bank reconciliation modules. Vaya uses Great Plains version 2015. Vaya uses AlphaMCS for claims processing and ADP for payroll processing.

Vaya meets the minimum record retention of ten years required by standard *DMA Contract, Section 8.3.2*. The PIHP is retaining financial records for ten years from the last date of service, date of activity, or end of reporting period, as applicable. Three fiscal years of finance records are retained onsite. Within Great Plains, records are not purged and remain accessible. *Policy 2314, Record Retention and Management* addresses all types of records retained, access to records, and disposition of the records.

Vaya's updates policies annually. PolicyTech is the software used to update policies and communicate these changes to staff. Policies are published, and staff members are given a deadline via email to read the updated policy. Staff members sign off electronically after reviewing the policy. PolicyTech sends email reminders to staff until they have read and signed off on the policy. CCME recommends Vaya add the five-business day requirement for Risk Reserve payments to *Policy 2748*. CCME also recommends adding Medicaid contract requirements and federal regulations to policies.

Vaya's *Cost Allocation Plan* meets the requirements for allocating the administrative costs between federal, state, and local jurisdictions based on revenue as required by *42 CFR § 433.34*. Vaya has no costs disallowed per the audit report and Onsite interview. Vaya submits a *Cost Allocation Plan* to NC Medicaid annually to determine the percentage of Medicaid's share of administrative costs. This percentage does not differ greatly but is recalculated monthly. The administrative expenses are recorded by expense type in the general ledger, and then allocated to the different funding sources based on a

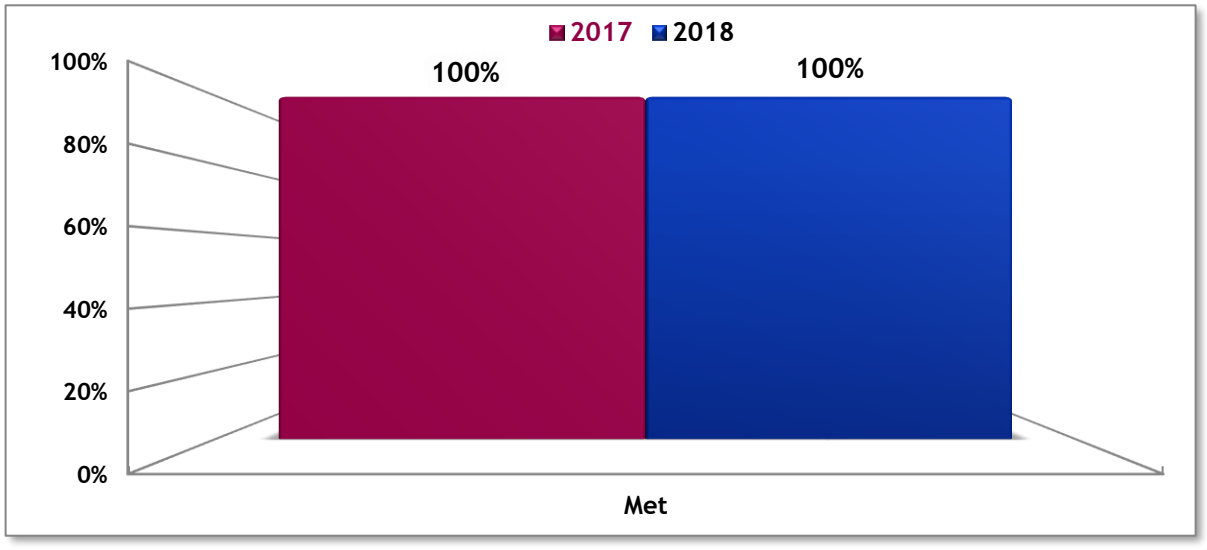
percentage of total year-to-date service revenues received. Vaya's Medicaid funds are properly segregated through the chart of accounts in the general ledger.

Vaya's Medicaid Risk Reserve account meets the minimum requirement of 2% of the capitation payment per month required by *DMA Contract, Section 1.9*. Vaya reached 11.2% of their required percentage of annualized capitation maximum (15%), with a balance of $36,845,480. Once NC Medicaid receives the capitation payment, a data analyst breaks down the payment and the Senior Director of Finance reconciles the payments and pays the risk reserve contribution electronically to the risk reserve account at Wells Fargo. A staff accountant reconciles this account. All deposits are timely and there are no unauthorized withdrawals. Vaya provided CCME with bank statements demonstrating the risk reserve deposit and balance.

A best practices recommendation from the 2017 EQR detailed developing a policy on administrative cost allocation process. Vaya provided CCME with a desk procedure detailing the administrative cost allocation process.

In Figure 10, all the EQR standards receive a "Met" score in the Financial Services section in both 2017 and 2018.

Figure 10: Financial Findings



Strengths

- Vaya's finance policies are organized and have current review dates.
- Medicaid reports are filed timely with no disallowed costs to Medicaid.
- All Vaya's risk reserve payments are timely.

- Vaya holds a strong financial position, as demonstrated by its key Medicaid financial ratios.

Recommendation

- Add the five-business day requirement for Risk Reserve payments to *Policy 2748*. Reference *DMA Contract* and federal regulation requirements in policies.

J. Encounter Data

CCME subcontractor, HMS, has completed a review of the encounter data submitted by Vaya to NC Medicaid, as specified in the CCME agreement with NC Medicaid.

The scope of the review, guided by the CMS EDV Protocol, was focused on measuring the data quality and completeness of claims paid by Vaya for the period of January 2016 through December 2016. All claims paid by Vaya should be submitted and accepted as a valid encounter to NC Medicaid. Our approach to the review included:

- A review of Vaya's response to ISCA
- Analysis of Vaya's converted 837 encounter files
- A review of DMA's encounter data acceptance report

Results and Recommendations

Issue: Procedure Code

The procedure code for Institutional claims should populated 99% of the time. In the encounter files provided, HMS found that the field was populated less than 45% of the time. These fields are required to adjudicate the claim appropriately and should be provided by the provider given the types of services being billed and supporting revenue codes provided.

Resolution:

Vaya should check their claims processing system and data warehouse to ensure the Procedure Code is being captured appropriately. Claims submitted through the portal or an 837 should be denied by Vaya without the proper revenue code and procedure code combination. Vaya should double check their 837 encounter creation process and encounter data extract process to make sure data was not lost or manipulated during transformation.

Issue: Diagnosis Codes

Two items need to be addressed as it relates to diagnosis codes. The secondary diagnosis was not populated less than 8% for professional claims and only the admitting and principal diagnosis was provided for institutional claims. Also, there are never more than 2 diagnosis codes provided/submitted in the encounter data for professional or institutional claims.

Resolution:

The diagnosis issue will require action by Vaya and NC Medicaid. NC Medicaid will need to work with the plans and CSRA to determine what additional non-behavioral health diagnosis codes should be submitted and accepted when available. Currently, NCTracks will deny any encounter with a non behavioral health diagnosis regardless of the position of the diagnosis code value (i.e. primary, secondary, tertiary, etc.). There are behavioral health services provided by the plans that require medical services and medical diagnosis codes. Vaya will need to work collaboratively with the state and Alpha to ensure they can capture and report all diagnosis codes once NCTracks has been updated to accept.

Conclusion

Based on the analysis of Vaya's encounter data, we have concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues were noted with both institutional and professional encounters. Vaya should take corrective action to resolve the issues identified with procedure code and diagnosis codes.

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

The full Encounter Data Validation report can be found in Attachment 5 of this report.

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 and Materials Requested for Desk Review

May 23, 2018

Mr. Brian Ingraham
Chief Executive Officer
Vaya Health
200 Ridgefield Court, Suite 206
Asheville, NC 28806

Dear Mr. Ingraham,

At the request of the Department of Health and Human Services, Division of Medical Assistance (DMA), this letter serves as notification that the 2018 External Quality Review (EQR) of Vaya Health (Vaya) is being initiated. The review will be conducted by us, The Carolinas Center for Medical Excellence (CCME), and is a contractual requirement. The review will include both a desk review (at CCME) and a two-day onsite visit at Vaya's office in Asheville, North Carolina that will address all 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-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

The CCME EQR review team plans to conduct the onsite visit at Vaya on **September 19, 2018** through **September 20, 2018**. For your convenience, a tentative agenda for the two-day review is enclosed.

In preparation for the desk review, the items on the enclosed **Materials Requested for Desk Review** list are to be submitted electronically and are due no later than **June 13, 2018**. As indicated in item 42 of the review list, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted by the aforementioned deadline.

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

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

The location for the file transfer site is:

https://eqro.thecarolinascenter.org

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 5
Cc: Andrea Hartman, Vaya Contract Manager
Greg Daniels, DMA Contract Manager
Renee Rader, DMA EQR Contract Manager
Deb Goda, DMA Behavioral Health Unit Manager

External Quality Review 2018

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy. *(Please do not embed files within word documents)*
2. Organizational chart of all staff members including names of individuals in each position including their degrees and licensure, and include any current vacancies. In addition, please include any positions currently filled by outside consultants/vendors. Further, please indicate staffing structure for Transitions Community Living Initiative (TCLI) program.
3. Current Medical Director, medical staff job descriptions.
4. Job descriptions for positions in the Transitions to Community Living Initiative (TCLI).
5. Description of major changes in operations such as expansions, new technology systems implemented, etc.
6. A summary of the status of all best practice recommendations and corrective action items from the previous External Quality Review.
7. Documentation of all services planning and provider network planning activities (e.g., geographic assessments, provider network adequacy assessments, annual network development plan, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base.
8. List of new services added to the provider network in the past 12 months (June 2017 – May 2018) by provider.
9. List of executed single case agreements by provider and level of care during the past 12 months (June 2017 – May 2018).
10. Network turnover rate for the past 12 months (June 2017 – May 2018) including a list of providers that were terminated by cause and list of providers that did not have their contracts renewed. For five providers termed in the last 12 months (June 2017 – May 2018), who were providing service to enrollees at the time of the termination notice, submit the termination letter to or from the provider, and the notification (of provider termination) letters sent to three consumers who were seeing the provider at the time of the termination notice.
11. List of providers credentialed/recredentialed in the last 12 months (June 2017 – May 2018).
12. A current provider manual and provider directory.

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

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

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

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

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

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

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

19. Copies of the most recent provider profiling activities conducted to measure contracted provider performance.

20. Results of the most recent office site reviews, record reviews and a copy of the tools used to complete these reviews.

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

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

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

24. A copy of the Grievance, Complaint and Appeal logs for the months of June 2017 – May 2018. Please indicate the disability type (MH/SA, I/DD) and whether the enrollee is in the TCLI program for each entry.

25. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

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

27. Practice guidelines developed for use by practitioners, including references used in their development, when they were last updated and how they are disseminated. Also, policies

and procedures for researching, selecting, adopting, reviewing, updating, and disseminating practice guidelines.

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

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

C WAIVER MEASURES	
Proportion of Level of Care evaluations completed at least annually for enrolled participants	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals
Proportion of Level of Care evaluations completed using approved processes and instrument	Proportion of Individual Support Plans that address identified health and safety risk factors
Proportion of New Level of Care evaluations completed using approved processes and instrument	Percentage of participants reporting that their Individual Support Plan has the services that they need

C WAIVER MEASURES	
Proportion of monitored non-licensed/non-certified Innovations providers that successfully implemented an approved corrective action plan	Proportion of individuals for whom an annual plan and/or needed update took place
Proportion of monitored Innovations providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval

Required information includes the following for each measure:

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

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

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

38. Data and/or reports for the Transition to Community Living Initiative (e.g., numbers of in-reach completed, housing slots filled, completed transitions, numbers of enrollees in supported employment, numbers of enrollees assigned to assertive community treatment [ACT], etc.) for the period June 2017 – May 2018.

39. Call performance statistics for the period of June 2017 – May 2018, including average speed of answer, abandoned calls, and average call/handle time for customer service representatives (CSRs).

40. Provide electronic copies of the following files:

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

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

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

The credentialing files should include all of the following:

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

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

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

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

41. Provide the following for Program Integrity:
    a. File Review: Please produce a listing of all active files during the review period (June 2017 – May 2018) including:
        i. Date case opened
        ii. Source of referral
        iii. Category of case (enrollee, provider, subcontractor)
        iv. Current status of the case (opened, closed)
    b. Program Integrity Plan and/or Compliance Plan.
    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.

e. All 'Attachment Y' reports collected during the review period.
f. Provider Manual and Provider Application.
g. Enrollee Handbook.
h. Subcontractor Agreement/Contract Template.
i. Training and educational materials for the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
j. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse.
k. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees.
l. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to DMA or any other State or Federal agency.
m. Code of Ethics and Business Conduct.
n. Internal and/or external monitoring and auditing materials.
o. Materials pertaining to how the PIHP captures and tracks complaints.
p. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
    i. DMA approved reporting templates.
q. Sample Data Mining Reports.
r. DMA Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
s. Monthly reports of NCID holders/FAMS-users in PIHP.
t. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.
u. Corrective action plans including any relevant follow-up documentation.
v. Policies/Procedures for:

    i. Program Integrity
    ii. HIPAA and Compliance
    iii. Internal and external monitoring and auditing
    iv. Annual ownership and financial disclosures
    v. Investigative Process
    vi. Detecting and preventing fraud
    vii. Employee Training
    viii. Collecting overpayments
    ix. Corrective Actions
    x. Reporting Requirements
    xi. Credentialing and Recredentialing Policies
    xii. Disciplinary Guidelines

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

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

c. A copy of the IT Disaster Recovery Plan.

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

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

43. Provide the following for Financial Reporting:

a. Most recent annual audited financial statements.

b. Most recent annual compliance report

c. Most recent two months' State-required DMA financial reports.

d. Most recent two months' balance sheets and income statements including associated balance sheet and income statement reconciliations.

e. Most recent months' capitation/revenue reconciliations.

f. Most recent reconciliation of claims processing system, general ledger, and the reports data warehouse. Provide full year reconciliation if completed.

g. Most recent incurred but not reported claims medical expense and liability estimation. Include the process, work papers, and any supporting schedules.

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

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

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

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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2018

ONSITE MATERIALS REQUESTED FOR REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were uploaded and before 7/13/18.
2. Please submit items missing from credentialing/recredentialing files, for providers identified on the supplemental ***Vaya Credentialing/Recredentialing Documentation list***, for information obtained during the credentialing/ recredentialing process.
    a. Proof of insurance that was in effect at the time the credentialing or recredentialing application was processed, for providers identified on the separate list.
    b. Supervision contract for providers with an "associate" license (such as LCSW-A, LCAS-A, LMFT-A); see separate list for names of providers.
    c. Notification of Credentialing Action for current recredentialing for provider identified on separate list.
    d. Primary Source Verification evidence for the identified indicated queries, completed during the credentialing or recredentialing process, for providers named on the separate list.
    e. Ownership Disclosure for practitioners listed on the separate list; when Licensed Practitioners (LPs) are joining an agency, provide the Ownership Disclosure information from the agency file for managing employees and persons with an ownership or controlling interest of 5% or more.
    f. Site visit report or the PSV/query of DHSR licensure conducted during credentialing/most recent recredentialing process for the applicant identified on the separate list.
    g. PSV of DEA obtained during the recredentialing process for provider identified on the separate list.
    h. Documentation of query of DHHS State Exclusion List, conducted during current/most recent credentialing/recredentialing process, for **all** submitted (practitioner **and** agency/facility) credentialing and recredentialing files.
3. Balanced Score Card TCLI Data submission to DMA for 3rd quarter.
4. A copy of the *TCLI Checklist*.
5. Regulatory Compliance Committee minutes from June 2017 – July 2018.

C. Attachment 3: EQR Validation Worksheets

- Performance Improvement Project Validation Worksheet
  - Behavioral Health-Substance Abuse Follow Up
  - Behavioral Health-Rapid Readmissions
  - Behavioral Health-Integrated Care
  - Behavioral Health-TCLI Housing

- Mental Health 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 Measures Validation Worksheet
  - Innovations Measure: Level of Care Initial Evaluation
  - Innovations Measure: Level of Care Evaluations Completed Using Approved Processes and Instruments
  - Innovations Measure: New Level of Care Evaluations Completed Using Approved Processes and Instruments
  - Innovations Measure: Proportion of Providers That Implemented an Approved Corrective Action Plan
  - Innovations Measure: Proportion of Providers Wherein All Staff Completed Mandated Training
  - Innovations Measure: Proportion of ISPs in which Services and Supports Reflect Participant Assessed Needs and Life Goals
  - Innovations Measure: ISPs Address Identified Health and Safety Risk Factors
  - Innovations Measure: Participants Reporting That ISP Has Services They Need
  - Innovations Measure: Individuals for Whom an Annual ISP and/or Needed Updates Took Place
  - Innovations Measure: New Waiver Participants are Receiving Services According to ISP within 45 Days of Approval

CCME EQR PIP Validation Worksheet

Plan Name:	**VAYA HEALTH**
Name of PIP:	**FOLLOW UP AFTER DISCHARGE FROM INPATIENT SUBSTANCE ABUSE DISORDER TREATMENT- CLINICAL**
Reporting Year:	**2017**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	The available data indicates that Vaya generally has not met the statewide benchmark of 40% seen within seven days of discharge for both Medicaid and state-funded members.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is stated in the report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	One intervention is listed in the project strategies section of the report.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NA**	Analyses were not conducted.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NA**	Results and findings are not presented due to non-availability of data until July 2018.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Analyses were not conducted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NA**	Analyses were not conducted.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Unable to judge due to lack of analyses.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Unable to judge due to lack of analyses.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Analyses were not conducted.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not calculated as sampling is not being utilized.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	62
Project Possible Score	62
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**VAYA HEALTH**
Name of PIP:	**INPATIENT RAPID READMISSION**
Reporting Year:	**2017**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Vaya has observed an overall upward trend in rapid readmissions since 2014, and its rapid readmission rate has consistently been higher than the state average for PIHPs.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is stated in the report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care and functional status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.

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

Component / Standard (Total Points)	Score	Comments
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions are listed in the report in response to barriers.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses were conducted quarterly.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Not Met**	Results and findings are presented using a line chart with percentages. The numerator and denominator for those percentages are not reported. As well, the benchmark comparison rate is not represented in the results, which allow for comparison across timepoints with benchmark. ***Recommendation: Report the numerator and denominator in a table for each measurement period. Include the benchmark rate in the table for comparative purposes.***
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Analysis identified initial and repeated measurements.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Conclusions and recommendations based on findings were included in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	Rate has increased, which is not improvement. ***Recommendation: Initiate new interventions to address increase in readmission rates.***
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement in rates.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not calculated as sampling is not being utilized.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	NA	No improvement in rates.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	74
Project Possible Score	85
Validation Findings	87%

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**VAYA HEALTH**
Name of PIP:	**INTEGRATED CARE FOR INNOVATIONS WAIVER PARTICIPANTS – NON-CLINICAL**
Reporting Year:	**2017**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Partially Met**	Data collected for the period from January 2016 to the present indicates that Innovations beneficiaries are consistently accessing primary and preventive care at a rate between 90 and 91 percent; improvement is needed to reduce the risk of noncompliance. The graph is labeled 2017 although the narrative says 2016. ***Recommendation: Revise the report so that the trend graph data labels are consistent with the narrative.***
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.

Component / Standard (Total Points)	Score	Comments
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is stated in the report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Partially Met**	Measure is defined, although it is difficult to determine if there are two separate rates that will be reported or one rate. ***Recommendation: If there are two separate rates that are reported based on age group, then two indicators should be defined using numerator and denominator in the report.***
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as monthly.

Component / Standard (Total Points)	Score	Comments
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	One intervention is listed in the project strategies section of the report.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Not Met**	Analyses were stated as occurring weekly, whereas the plan was to conduct analyses monthly. ***Recommendation: Include data analysis plan as weekly and monthly if data are being reviewed at both timepoints.***
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Not Met**	Results are presented based on a weekly review, but the dates of these reviews are not documented, nor are the numerator, denominator, and rate for the project results summary. ***Recommendation: The results should include the monthly and/or weekly numerator/denominator and rate for the indicator(s). A table is the best way to present these data, along with the benchmark for comparative purposes.***
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Unable to judge as timepoints of "weekly review of data" are not specified in the report.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis of data is provided and follow up interventions are documented.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Unable to judge due to lack of results presentation.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Unable to judge due to lack of results presentation.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Unable to judge due to lack of results presentation.

Component / Standard (Total Points)	Score	Comments
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not calculated as sampling is not being utilized.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	**56**
Project Possible Score	**78**
Validation Findings	**72%**

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**VAYA HEALTH**
Name of PIP:	**TCLI INCREASE HOUSING- NON-CLINICAL**
Reporting Year:	**2017**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Each LME-MCO has been assigned an annual target for the number of individuals to be housed under this and Vaya has not been meeting this target in prior years.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is stated in the report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Partially Met**	Measure is defined as including a numerator and denominator, although it is not a percentage. It is a numeric value for each month. ***Recommendation: Revise the report so that the definition of the indicator is not a percentage, but a numeric value.***
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.

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

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Unable to judge due to lack of analyses.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Unable to judge due to lack of analyses.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Analyses were not conducted.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical analyses not calculated as sampling is not being utilized.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	57
Project Possible Score	62
Validation Findings	92%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PM Validation Worksheet

Plan Name:	**VAYA HEALTH**
Name of PM:	**READMISSION RATES FOR MENTAL HEALTH**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**VAYA HEALTH**
Name of PM:	**READMISSION RATES FOR SUBSTANCE ABUSE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**VAYA HEALTH**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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 the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
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SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Abstraction was not used.
S2. Sampling	Sample treated all measures independently.	**NA**	Abstraction was not used.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Abstraction was not used.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measure was reported accurately.
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VALIDATION SUMMARY		
Element	**Standard Weight**	**Validation Result**
G1	10	10
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N2	5	5
N3	5	NA
N4	5	NA
N5	5	NA
S1	5	NA
S2	5	NA
S3	5	NA
R1	10	10
R2	5	5

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**VAYA HEALTH**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR SUBSTANCE ABUSE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure denominator adhered to all denominator specifications.

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**VAYA HEALTH**
Name of PM:	**INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**VAYA HEALTH**
Name of PM:	**MENTAL HEALTH UTILIZATION- INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**VAYA HEALTH**
Name of PM:	**MENTAL HEALTH UTILIZATION**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**VAYA HEALTH**
Name of PM:	**IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**VAYA HEALTH**
Name of PM:	**SUBSTANCE ABUSE PENETRATION RATE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**VAYA HEALTH**
Name of PM:	**MENTAL HEALTH PENETRATION RATE**
Reporting Year:	**7/1/2016-6/30/2017**
Review Performed:	**10/18**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N6. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources used to calculate the numerator are complete.
N1. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N2. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N3. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N4. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**VAYA HEALTH**
Name of PM	**INNOVATIONS MEASURE: LEVEL OF CARE EVALUATION**
Reporting Year	**2017**
Review Performed	**10/18**

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**VAYA HEALTH**
Name of PM	**INNOVATIONS MEASURE: LEVEL OF CARE EVALUATIONS COMPLETED USING APPROVED PROCESSES AND INSTRUMENTS**
Reporting Year	**2017**
Review Performed	**10/18**

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**VAYA HEALTH**
Name of PM	**INNOVATIONS MEASURE: NEW LEVEL OF CARE EVALUATIONS COMPLETED USING APPROVED PROCESSES AND INSTRUMENTS**
Reporting Year	**2017**
Review Performed	**10/18**

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**VAYA HEALTH**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF PROVIDERS THAT IMPLEMENTED AN APPROVED CORRECTIVE ACTION PLAN**
Reporting Year	**2017**
Review Performed	**10/18**

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

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

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

VALIDATION SUMMARY3

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**VAYA HEALTH**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF PROVIDERS WHEREIN ALL STAFF COMPLETED MANDATED TRAINING**
Reporting Year	**2017**
Review Performed	**10/18**

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**VAYA HEALTH**
Name of PM	**INNOVATIONS MEASURE: PROPORTION OF ISPS IN WHICH SERVICES AND SUPPORTS REFLECT PARTICIPANT ASSESSED NEEDS AND LIFE GOALS**
Reporting Year	**2017**
Review Performed	**10/18**

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**VAYA HEALTH**
Name of PM	**INNOVATIONS MEASURE: ISPS ADDRESS IDENTIFIED HEALTH AND SAFETY RISK FACTORS**
Reporting Year	**2017**
Review Performed	**10/18**

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**VAYA HEALTH**
Name of PM	**INNOVATIONS MEASURE: PARTICIPANTS REPORTING THAT ISP HAS SERVICES THEY NEED**
Reporting Year	**2017**
Review Performed	**10/18**

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**VAYA HEALTH**
Name of PM	**INNOVATIONS MEASURE: INDIVIDUALS FOR WHOM AN ANNUAL ISP AND OR NEEDED UPDATES TOOK PLACE**
Reporting Year	**2017**
Review Performed	**10/18**

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**NOT MET**	Numerator and Denominator appear to be switched in the Excel file. ***Recommendation: Revise the rate so that numerator, denominator, and rate are accurately presented.***
R2. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications.

VALIDATION SUMMARY

Element	Standard Weight	Validation Result
G1	10	10
G2	2	2
D1	10	10
D2	5	5
N1	10	10
N2	5	5
R1	10	0
R2	3	3

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

Plan's Measure Score	45
Measure Weight Score	55
Validation Findings	82%

CCME EQR Innovations Measures Validation Worksheet

Plan Name	**VAYA HEALTH**
Name of PM	**INNOVATIONS MEASURE: NEW WAIVER PARTICIPANTS ARE RECEIVING SERCICES ACCORDING TO ISP WITHIN 45 DAYS OF APPROVAL**
Reporting Year	**2017**
Review Performed	**10/18**

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

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

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

VALIDATION SUMMARY

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

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

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

VALIDATION PERCENTAGE FOR MEASURES									
MEASURE 1	MEASURE 2	MEASURE 3	MEASURE 4	MEASURE 5	MEASURE 6	MEASURE 7	MEASURE 8	MEASURE 9	MEASURE 10
100%	100%	100%	100%	100%	100%	100%	100%	82%	100%

AVERAGE VALIDATION PERCENTAGE & AUDIT DESIGNATION
98% FULLY COMPLIANT

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

D. Attachment 4: Tabular Spreadsheet

CCME PIHP Data Collection Tool

Plan Name:	**Vaya Health**
Collection Date:	2018

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A. General Approach to Policies and Procedures						
1. The PIHP has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					This year's EQR of Vaya's policies and procedures show considerable effort made by Vaya to bring policies and procedures into compliance with contractual requirements. Vaya is maximizing the policy management features that PolicyTech offers.
I. B. Organizational Chart / Staffing						
1. The PIHP's resources are sufficient to ensure that all health care products and services required by the State of North Carolina are provided to enrollees. At a minimum, this includes designated staff performing in the following roles:						
1.1 A full time administrator of day-to-day business activities;	X					
1.2 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities.	X					Substantial oversight by Vaya's Chief Medical Officer was evident during the Onsite discussion.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Operational relationships of PIHP staff are clearly delineated.	X					The organizational chart provided for this year's EQR does not accurately reflect clinical oversight by the Chief Medical Officer and Assistant Medical Director as described within the job descriptions and Onsite staff discussions. ***Recommendation: Verify the Chief Medical Officer and Assistant Medical Director job descriptions, oversight designations on the organizational chart, and DMA Contract requirements (Sections 6.7.6 and 7.1.3) of the PIHP Medical Director are accurately aligned as a part of an improved process to review and update the organizational chart.***
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all PIHP staff positions, including those that are required by DMA contract.	X					
I. C. Confidentiality						
1. The PIHP formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					
2. The PIHP provides HIPAA/confidentiality training to new employees and existing staff.	X					Vaya's *Privacy Policy 2599* does not specify a timeframe for training new employees on confidentiality, but this training timeframe was defined by staff during the Onsite visit as consistently occurring within 30 days of a new employee hire date.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Add to the Privacy Policy 2599 that new staff members receive training on confidentiality during the new employee orientation, which occurs within 30 days of a new employee hire date.
I D. Management Information Systems						
1. Enrollment Systems						
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Vaya has defined processes for enrollment data updates. Mediware uploads enrollment data received on the daily and quarterly GEF files. Monthly, Vaya uses the monthly capitation file to reconcile the per member/per month payment. Demographic data are captured in the AlphaMCS system and patient IDs are unique to members. Historic enrollment information is captured for all members in the AlphaMCS system.
1.2 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Vaya produces exception reports to verify the completeness of data following the GEF load.
1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.	X					During the Onsite visit, Vaya demonstrated the AlphaMCS enrollment screens and capability to store the demographic information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Claims System						
2.1 The MCO processes provider claims in an accurate and timely fashion.	X					Approximately, 87.85% of institutional and 99.20% of professional claims are auto-adjudicated. Auto-adjudication is performed daily. Claims in excess of $5,000 and Emergency Department claims are pended for manual review.
2.2 The MCO has processes and procedures in place to monitor review and audit claims staff.	X					Vaya audits at least 3% of all claims processed daily. Claims in excess of $5,000 and paper claims are audited for accuracy. 100% of all claims processed by new hires are audited daily for 3-4 months since the date of hire.
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				Vaya captures up to 22 ICD-10 diagnosis codes for institutional and 12 diagnosis codes for professional claims. The Vaya provider web portal captures up to 12 ICD-10 diagnosis codes for both institutional and professional claims. ICD-10 procedure codes and DRG codes received from the provider are not captured. ***Corrective Actions: Update the Vaya system to accept up to 25 ICD-10 diagnosis codes for an 837I.*** ***Update the provider web portal to mirror UB04 claim form for institutional claims and allow up to 18 ICD-10 diagnosis codes.*** ***Update the Vaya system and provider web portal to accept ICD-10 procedure codes and DRG codes.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 The MCO's claim system screens store and track claim information and claim adjudication/payment information.	X					Onsite review of the claim system screens identified the capture of adjudication/payment information for the claims.
3. Reporting						
3.1 The MCO's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Vaya captures all necessary data elements required for enrollment and claims reporting. Historical data are stored in the system from the inception of the PIHP.
3.2 The MCO has processes in place to back up the enrollment and claims data repositories.	X					Vaya has processes to back-up the enrollment and claims data in the AlphaMCS system nightly. The source enrollment and claims files are also compressed and archived. A disaster recovery policy was provided along with the ISCA tool.
4. Encounter Data Submission						
4.1 The MCO has the capabilities in place to submit the State required data elements to DMA on the encounter data submission.		X				Vaya has the capability to submit up to three diagnosis codes on an institutional encounter and up to two ICD-10 diagnosis codes on a professional encounter. 25 ICD-10 diagnosis codes are the maximum number of diagnosis codes that may be submitted on an 837I and the maximum number captured by NCTracks. NCTracks is capable of capturing up to 12 diagnosis codes on an 837P. Vaya indicated that Mediware is currently in the process of testing modifications to submit additional diagnosis codes to NCTracks. After successful testing, the change will be applied to Vaya. Vaya does not have the capability to submit ICD-10 procedure codes and DRG codes to NCTracks. ***Corrective Actions: Update the Vaya encounter data submission process to allow submission of all ICD-10 diagnosis codes present on an 837I and 837P.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Update the Vaya encounter data submission process to allow submission of ICD-10 procedure codes and DRG codes present on an 837I and 837P.
4.2 The MCO has the capability to identify, reconcile and track the encounter data submitted to DMA.	X					Mediware updates and maintains details on encounters that are extracted for encounter data submission on 837 files and also the response 835 files. Vaya receives a copy of the 835 and 837 files from Mediware and loads them into databases to identify and resolve encounter data denials.
4.3 MCO has policies and procedures in place to reconcile and resubmit encounter data denied by DMA.	X					Vaya has clear processes to address denied encounter submissions. Vaya uses Adam Holtzman paid and denied reports to research and verify payment of denied encounters after rebilling. Vaya also uses an internal encounter denial detail report to identify denied encounters for a specific procedure code or provider. Denied encounters are reviewed manually and resubmitted weekly.
4.4 The MCO has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to DMA	X					Communications are established between IT and Claim Departments to address NCTracks encounter denials. Staff members are well-informed and dedicated to improving encounter data submissions and reducing the number of denials.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II. A. Credentialing and Recredentialing						
1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					*Policy 2891 (Credentialing Program), Policy 2909 (Credentialing Committee Policy),* and the *Credentialing Committee Charter* guide the credentialing and recredentialing processes at Vaya.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	X					The *Credentialing Committee Charter* defines the responsibilities of the Credentialing Committee and delegates the authority for approval of "clean" applications to the Chief Medical Officer (CMO). Dr. Craig Martin, CMO, chairs the Credentialing Committee. The *Credentialing Committee Charter* indicates Dr. William Lopez, Assistant Medical Director and the Vice Chairperson of the Credentialing Committee, will chair the committee meeting in the absence of Dr. Martin. Dr. Martin did not attend the June 2017 Credentialing Committee meeting and Dr. John Nicholls, the former Associate Medical Director, chaired the meeting. The Credentialing Committee met monthly between June 2017 and May 2018, with a quorum present for every meeting. Per *Policy 2909, Credentialing Committee*, a list of unflagged applicants and a list of flagged applicants, including details discovered during the application and verification processes, is sent to Credentialing Committee members at least two (2) business days prior to the scheduled committee meeting. Credentialing Committee meeting minutes reflect committee discussion of, and decisions about, "flagged" applications. The committee also votes on the roster of "clean" applications approved by the CMO.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of provider.	X					The credentialing files reviewed are organized and contain appropriate information. Issues regarding the credentialing process or files are discussed in the respective standards that follow.
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					Some of the credentialing files were missing proof of some of the required insurance coverages or the relevant statement from the practitioner about why it is not required, or verification that the individual practitioner is covered under the policies. Item #40 of the *Desk Materials* list includes, "Proof of all insurance coverages. For practitioners joining already-contracted agencies, include copies of the insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies." In response to the CCME *Onsite Request List*, Vaya provided additional insurance information from agency files for licensed practitioners joining the respective agencies. ***Recommendation: Verify credentialing files contain proof of all of the required insurance coverages (or the relevant statement from practitioner about why it is not required), and that the individual practitioner is listed among those covered under the policies. If the practitioner is not named on the Certificate of Insurance, a letter from the agency provider or insurance company indicating that the practitioner is covered under the policy is acceptable. See DMA Contract Attachment B, Section 7.7, DMA Contract, Attachment O, DMA Contract Attachment B, Section 7.9.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					No supervision contract was found in the file of one provider with LCAS-A and in the file of one provider with LMFT-A. CCME requested the supervision contracts via the *Onsite Request List*, but Vaya did not respond nor provide the supervision contracts. Vaya subsequently obtained copies of the supervision contracts and provided them to CCME during the Onsite visit. Vaya has not verified with the licensing boards whether being listed on the licensing board website confirms that the practitioner has a current supervision contract. The NC Psychology Board has confirmed that being listed on its website does not guarantee that the practitioner has a current supervision contract, and PIHPs should obtain the supervision contract from the practitioner. ***Recommendation: Contact licensure boards to confirm if a practitioner (with "associate" licensure) listed on the licensure board website is confirmation of a current supervision contract. Verify credentialing files include supervision contracts for practitioners for whom it is required (Licensed Psychological Associates and practitioners with an "Associate" licensure designation), based on responses from licensure boards. See DMA Contract, Attachment O.***
3.1.3 Valid DEA certificate; and/or CDS certificate	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					
3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.8 Query of the National Practitioner Data Bank (NPDB) ;	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);		X				No evidence of a query of *The North Carolina Medicaid Provider Termination and Exclusion* list (known as the *State Exclusion List*) was found in any submitted credentialing file. During the Onsite visit, Vaya staff confirmed they did not conduct this query as part of the credentialing or monthly verification processes. Vaya staff reported it was an oversight in their process. After Vaya received the *Onsite Request List* and saw this item, Vaya staff started completing the query.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Policy 2891, Credentialing Program, Section XI, Credentialing Verification Process, includes the query of the *State Exclusion List*. ***Corrective Action: Verify all credentialing files include evidence of the query of the State Exclusion List, as required by DMA Contract Attachment B, Sections 1.14.4 and 7.6.4 and Vaya Policy 2891, Credentialing Program.***
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					During the Onsite visit, Vaya staff confirmed the query of the Social Security Death Master File (SSDMF) is conducted for initial credentialing, for recredentialing, and in the monthly checks, via the "SSN Trace/Address Mover" in the Criminal Background Check conducted by Accurate Background. *Policy 2891 Credentialing Program, Section XIII. Continuous Credentialing,* includes the Social Security Death Master File (SSDMF) in the list of items Vaya monitors "on a monthly basis" for "all LPs, LIPs, owners and managing employees credentialed by Vaya." During the Onsite visit, Vaya staff confirmed it is conducting monthly checks of the SSDMF. The current *DMA Contract Attachment B, Section 7.6.4, Exclusions,* does not require monthly checks of the SSDMF.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Ownership Disclosure is addressed.	X					Seven files submitted for Desk Review did not contain the Ownership Disclosure. Vaya submitted the missing Ownership Disclosure from agency files, in response to the *Onsite Request list*. ***Recommendation: Include documentation in the credentialing files to verify Ownership Disclosure is addressed, including by the agency for the employee. If Vaya does not keep a copy of the relevant ownership disclosure information in the individual credentialing file, retrieve copies from the relevant file and upload as part of the credentialing files for the Desk Review. See DMA Contract Attachment B, Section 1.11 -1.13 & Attachment O #5 and #6.***
3.1.16 Criminal background Check	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.	X					One file submitted for Desk Review did not contain the site visit report or PSV of DHSR licensure. In four additional files, the PSV of DHSR licensure is over two years old. ***Recommendation: Verify credentialing files contain all items. If Vaya does not keep a copy of the relevant site visit report or current PSV of the DHSR licensure information in the individual credentialing file, retrieve copies from the relevant file and upload as part of the credentialing files for the Desk Review.***
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Recredentialing files reviewed are organized and contain appropriate information. Issues regarding the recredentialing process are discussed in the respective standards that follow.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					Some of the recredentialing files were missing proof of some of the required insurance coverages or the relevant statement from the practitioner about why it is not required, or verification that the individual practitioner is covered under the policies. Item #40 of the *Desk Materials* list includes, "Proof of all insurance coverages. For practitioners who are employed at already-contracted agencies, include copies of the insurance coverages for the agency, and verification that the practitioner is covered under the plans." In response to CCME's *Onsite Request List*, Vaya provided additional insurance information from agency files for licensed practitioners

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						being recredentialed for the respective agencies. Verification that the practitioner is covered under the agency insurance policies was not provided in some files. ***Recommendation: Verify recredentialing files contain proof of all of the required insurance coverages (or the relevant statement from practitioner about why it is not required), and that the individual practitioner is listed among those covered under the policies. If the practitioner is not named on the Certificate of Insurance, a letter from the agency provider or insurance company indicating that the practitioner is covered under the policy is acceptable. See DMA Contract Attachment B, Section 7.7.***
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					PSV of license was missing from the recredentialing file of two providers. An additional provider has both an LCAS-A license and an LPC license. The PSV of the LCAS-A was in the file, but the PSV of the LPC was not found in the file. In response to CCME's *Onsite Request List*, Vaya uploaded the missing items, though two of the PSVs were dated outside the 180-day timeframe before recredentialing was approved. During the Onsite visit, Vaya provided the current PSVs, both of which fell within the 180 day timeframe. ***Recommendation: Verify recredentialing files contain all items, including the PSV of all relevant clinical licenses, obtained within 180 days of the recredentialing decision. See DMA Contract, Attachment O.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.3 Valid DEA certificate; and/or CDS certificate	X					Vaya submitted recredentialing files for three physicians. Two of the three include the PSV of the DEA certificate. In response to the *Onsite Request List*, Vaya uploaded the missing DEA PSV, though the PSV was outside the 180-day timeframe before recredentialing was approved. During the Onsite visit, Vaya provided the most recent PSV of the DEA certificate, which falls within 180 days requirement of recredentialing. ***Recommendation: Ensure recredentialing files contain all items, including the PSV of the DEA certificates obtained within 180 days of the recredentialing decision. See DMA Contract Attachment O.***
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;		X				CCME found no evidence of a query of the *State Exclusion List* in any submitted recredentialing file. During the Onsite visit, Vaya staff confirmed it had not conducted this query as part of the credentialing, recredentialing or monthly verification processes. Vaya staff reported it was an oversight in their process. Vaya staff reported that, after Vaya received the *Onsite Request List* and saw this item, Vaya staff started completing the query.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Policy 2891, Credentialing Program, Section XI, Credentialing Verification Process, includes the query of the *Exclusion List*. ***Corrective Action: Verify all recredentialing files include evidence of the query of the State Exclusion List, as required by DMA Contract Attachment B, Sections 1.14.4 and 7.6.4 and Vaya Policy 2891, Credentialing Program.***
4.2.9 Requery of the SAM.	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event;	X					
4.2.11 Query of the Social Security Administration's Death Master File	X					
4.2.12 Query of the NPPES;	X					
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.2.14 Ownership Disclosure is addressed.	X					Four files submitted for Desk Review do not contain the Ownership Disclosure. Vaya submitted the missing Ownership Disclosure from agency files, in response to the *Onsite Request list*. ***Recommendation: Include documentation in the recredentialing files to verify Ownership Disclosure is addressed, including by the agency for the employee. If Vaya does not keep a copy of***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						the relevant ownership disclosure information in the individual recredentialing file, retrieve copies from the relevant file and upload as part of the credentialing files for the Desk Review. See DMA Contract Attachment B, Section 1.11 -1.13 & Attachment O #5 and #6.
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					*Policy 2891, Credentialing Program*, indicates the Credentialing Committee review "also includes review of provider performance data, including but not limited to findings of quality management/ quality improvement activities, utilization management activities, and member/provider complaints/grievances. Credentialing Committee meeting minutes include discussion of provider profile information such as "flags" related to legal charges or PIHP audits or other items.
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					*Policy 2577, Provider Sanctions and Administrative Actions*, with a *Last Revision Date* of *05/02/18*, outlines the actions to take against Network Providers "who are found to be noncompliant with applicable federal and state laws, rules, regulations, manuals, policies or guidance, the Vaya *Provider Operations Manual*, contracts between Vaya and the provider, and/or any other applicable payor program requirements."
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					
II B. Adequacy of the Provider Network						
1. The PIHP maintains a network of providers that is sufficient to meet the	X					*Policy 2562, Ensuring Access to Care for Health Plan Members*, states, "At least annually, Vaya assesses the geographic, cultural, ethnic, racial, linguistic and access/ availability needs of its enrollees, through mechanisms such as Member Satisfaction Surveys,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
health care needs of enrollees and is consistent with contract requirements.						Practitioner and ethnicity data reported by practitioners on the Credentialing Initiation Form, and the annual Gaps Analysis and Needs Analysis of the catchment area." The *Network Development Plan* provides strategies for addressing identified service gaps.
1.1 Enrollees have a Provider location within a 30 – mile distance of 30 minutes' drive time of their residence. Rural areas are 45 miles and 45 minutes. Longer distances as approved by DMA are allowed for facility based or specialty providers.	X					*Policy 2562, Ensuring Access to Care for Health Plan Members*, outlines access and availability standards for the Vaya provider network, including, "Two assessment providers within 30 miles / 30 minutes per active enrollee (Urban areas as defined by the U.S. Census Bureau" and "Two assessment providers within 45 miles / 45 minutes per active enrollee (Rural counties as defined by the U.S. Census Bureau)." Page 31 of the *Member and Caregiver Handbook*, states, "Most services will be available within 30 to 45 miles, or 30 to 45 minutes, from your home. However, some specialty providers may be located further away." During the Onsite visit, Vaya staff discussed challenges and barriers in meeting this standard, including the rural nature and low Medicaid population of many of their counties. Vaya filed, and NC Medicaid approved, Exception Requests pursuant to the gaps identified in the *2017 Gaps Analysis*.
1.2 Enrollees have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the enrollee may utilize an out-of-network specialist with no benefit penalty.	X					The *Member and Caregiver Handbook* confirms Vaya will pay for services provided by an out-of-network provider in an emergency or if there's no in-network provider who can meet the need. Vaya will continue to pay the out-of-network provider until the enrollee can be "safely and appropriately transferred to a network provider."
1.3 The sufficiency of the provider network in meeting enrollee demand	X					In accordance with the *DMA Contract Attachment B, Section 6.4*, Vaya conducts an annual gaps and needs analysis. The annual report

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
is formally assessed at least annually.						includes a summary of "Progress and Achievements toward" the "Priorities and Strategies" identified in the previous year's report.
1.4 Providers are available who can serve enrollees with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Page 10 of the *Member and Caregiver Handbook* provides information about communicating with Vaya via the TTY Relay System. Information about TTY availability is also accessed via an icon on the website, in the Member and Caregivers section. *Policy 2578, Network Cultural Competence*, addresses cultural competence. During the Onsite discussion, Vaya staff reported a "cultural competency survey of the entire network last month" was conducted. They plan to present the results and information to the Provider Council and talk with them about next steps, "in an effort to get the Provider Council to own this." The *Credentialing Initiation Form* (*CIF*) includes questions regarding the ability to provide services in non-English languages, including American Sign Language.
1.5 The PIHP demonstrates significant efforts to increase the provider network when it is identified as not meeting enrollee demand.	X					*Policy 2831, Selection and Retention of Providers*, notes, "Vaya will not accept applications for initial enrollment from Applicants unless a service need has been identified… If Vaya cannot identify existing Network Providers to meet the need, Vaya will seek to recruit new provider(s) through a selection or procurement process." Onsite discussion revealed that, especially in Buncombe County, more providers want to join the network than are needed. Vaya uses single case/client specific agreements when needed, and pursues credentialing providers, once there are three to five Out of Network Agreements with a provider.
2. Provider Accessibility						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.1 The PIHP formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					*Policy 2560, Scope of Network Services,* details access standards for the provision of care. *Policy 2416, Interface with Emergency Services Dispatch (911),* addresses emergency situations in which immediate care is needed, including behavioral health or clinical emergencies. *Policy 2912, Member Safety and Quality of Care,* details processes to be used when "a Vaya employee has telephonic or face-to-face contact with a member and reasonably believes a member is at risk of harm to self or others." *Policy 2562, Ensuring Access to Care for Health Plan Members,* includes Availability Standards.
II C. Provider Education						
1. The PIHP formulates and acts within policies and procedures related to initial education of providers.		X				Vaya submitted the *Provider Orientation Letter, new contract* and *Provider Orientation Letter, renewal* in Desk Materials. The "new contract" letter provides high level information and includes references to "Provider Orientation Resources", including a link to the Vaya website, *Communication Bulletins* and archived bulletins and newsletters. Providers are informed the *Provider Operations Manual* can be downloaded from the website. During the Desk Review, and from at least 06/19/18 through 07/27/18, there was no current, approved, final *Provider Operations Manual* available on the website. The draft manual posted on the website was from June 2017, and some icons on the website linked to an old *2015 Smoky Mountain Center Provider Manual*. At the time of the Onsite visit, the current *Provider Operations Manual* as well as several previous *Provider Operations Manuals* were posted on the website. ***Corrective Action: Ensure a current Provider Operations Manual is always available to providers. See DMA Contract Attachment B, Section 7.11.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Initial provider education includes:						
2.1 PIHP purpose and mission;	X					Included on page 5 of the *Provider Operations Manual*.
2.2 Clinical Practice Standards;	X					The *Provider Operations Manual* references Clinical Practice Guidelines. The link on page 62 of the *Provider Operations Manual* navigates to "Coverage Information" in the "Utilization Management" section of the Provider Tab on the Vaya website. At the time of the Desk Review, nothing on that page was named "Clinical Practice Guidelines", but there was a file entitled *Vaya Approved Best Practices* posted on the site. At the time of the Onsite visit, the posted guidelines were updated/replaced and named Clinical Practice Guidelines.
2.3 Provider responsibilities;	X					Provider responsibilities are defined throughout the *Provider Operations Manual*. Page 64 includes a statement that it is an enrollee's right "to receive interpretation and translation services and other reasonable accommodations as needed for accessibility, free of charge." Page 22 of the *Provider Operations Manual* states, "Providers must also ensure that interpreter services are made available by telephone or in-person at no charge to the member or to Vaya."
2.4 PIHP closed network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.5 Access standards related to both appointments and wait times;	X					Page 47 of the *Provider Operations Manual* addresses Access to Care Timeframes for Emergent, Urgent, and Routine levels of care. The "Emergent" section does not include the requirement that the "Provider must provide face-to-face emergency care immediately for life threatening emergencies." Page 127 of the *Provider Operations Manual* lists appointment wait times and the requirements for appointment availability, including "Life-threatening emergencies: Individual must be seen immediately." ***Recommendation: Include the DMA Contract, Attachment S requirement for providers to provide face-to-face emergency care immediately for life-threatening emergencies" in the "Access to Care Timeframes" in the Provider Operations Manual.***
2.6 Authorization, utilization review, and care management requirements;	X					
2.7 Care Coordination and discharge planning requirements;	X					
2.8 PIHP dispute resolution process;	X					
2.9 Complaint investigation and resolution procedures;	X					
2.10 Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.11 Enrollee rights and responsibilities	X					"*Section 7, Member Rights and Empowerment*", starts on page 63 of the *Provider Operations Manual*. The *Provider Operations Manual* does not include the "right of enrollees who live in Adult Care Homes to report any suspected violation of an Enrollee right to the appropriate regulatory authority as outlined in *NCGS §131D-21*." See *DMA Contract Attachment B, Section 6.13.2*. During Onsite discussion, Vaya staff indicated this was added to the *Provider Operations Manual* and CCME staff requested that Vaya upload evidence of the change. The information Vaya uploaded did not include the referenced right of enrollees. ***Recommendation: Add to the Provider Operations Manual the right of enrollees who live in adult care homes to report any suspected violation of an enrollee right to the appropriate regulatory authority as outlined in NCGS §131D-21. See DMA Contract Attachment B, Section 6.13.2.***
2.12 Provider program integrity requirements that include how to report suspected fraud, waste and abuse, training requirements as outlined in the False Claims Act, and other State and Federal requirements.	X					
3. The PIHP provides ongoing education to providers regarding changes and/or additions to its programs, practices, enrollee benefits, standards, policies and procedures.	X					The *"Provider Communications, Training and Technical Assistance"* section in the *Provider Operations Manual* includes links to relevant items on the North Carolina Division of Health and Human Services website and refers providers to the Events and Training Calendar on the Vaya website. Providers are encouraged to sign up for Vaya's Provider Network Bulletins, and a link is provided to "sign up" for Vaya's email list.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II D. Clinical Practice Guidelines for Behavioral Health Management						
1. The PIHP develops clinical practice guidelines for behavioral health management of its enrollees that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					The *Provider Operations Manual* states, "Vaya has adopted or endorsed specific Clinical Practice Guidelines for the treatment of certain conditions and disorders. These guidelines are developed by national organizations…"
2. The PIHP communicates the clinical practice guidelines for behavioral health management and the expectation that they will be followed for PIHP enrollees to providers.	X					The *Provider Operations Manual* informs providers that the (clinical practice) "guidelines identify **required** standards for delivery of care."
II E. Continuity of Care						
1. The PIHP monitors continuity and coordination of care between providers.	X					During Onsite discussion, Vaya reported that this is part of the Post-Payment Reviews. Care Coordinators also are involved in managing Coordination of Care.
II F. Practitioner Medical Records						
1. The PIHP formulates policies and procedures outlining standards for acceptable documentation in the Enrollee medical records maintained by providers.	X					Page 48 of the *Provider Operations Manual* states, "Network Providers are responsible for ensuring that services are delivered and documented in accordance with Controlling Authority outlined in your contract, including, but not limited to, DMA Clinical Coverage Policies and the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2." Page 105 of the *Provider Operations Manual* states, "Innovations providers are required to document services as outlined in DMA Clinical Coverage Policy No. 8-P, the DMH/DD/SAS Records

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Management and Documentation Manual, APSM 45-2, and as specified in this Manual." The "*Documentation and Clinical Coverage Policy Requirements*" section of the *Provider Operations Manual* states, "All Vaya Network Providers are required to strictly adhere to the documentation requirements outlined in the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2." The *Provider Operations Manual* provides a link to the *NCMMIS Provider Claims and Billing Assistance Guide*.
2. The PIHP monitors compliance with medical record documentation standards through formal periodic medical record audit and addresses any deficiencies with the providers.	X					Medical record documentation is monitored via Post Payment Reviews and Investigations. *Policy 2579, Provider Post Payment Reviews,* addresses the post-payment review process, which includes medical record review.
3. The PIHP has a process for handling abandoned records, as required by the contract.	X					*Policy 2617, Provider Closure,* includes the requirements outlined in *DMA Contract Attachment B, Section 8.2.1.*

III. ENROLLEE SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III A. Enrollee Rights and Responsibilities						
1. The PIHP formulates policies outlining enrollee rights and procedures for informing enrollees of these rights.	X					*Policy 2307 Member Rights and Responsibilities* and *Policy 2557, Marketing Materials, Media Relations and Member Notifications* explains the process.
2. Enrollee rights include, but are not limited to, the right:	X					Member rights are listed in *Policy 2307, Member Rights and Responsibilities*. All enrollee rights are outlined in the *Member and Caregiver Handbook*.
2.1 To be treated with respect and due consideration of dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;						
2.3 To participate in decisions regarding health care;						
2.4 To refuse treatment;						
2.5 To be free from any form of restraint of seclusion used as a means of coercion, discipline, convenience or retaliation;						
2.6 To request and receive a copy of his or her medical record, except as set forth in 45 C.F.R. §164.524 and in N.C.G.S. § 122C-53(d), and to request that the medical record be						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
amended or corrected in accordance with 45 CFR Part 164.						
2.7 Of enrollees who live in Adult Care Homes to report any suspected violation of their enrollee rights, to the appropriate regulatory authority as outlined in NCGS§ 131-D21.						
III B. Enrollee PIHP Program Education						
1. Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid waiver managed care program which they are contractually entitled, including:		X				Relevant information is located in the *Member and Caregiver Handbook* or on the Vaya website, unless otherwise indicated. Issues regarding the information provided to enrollees are discussed in the sub-standards that follow.
1.1 A description of the benefits and services provided by the PIHP and of any limitations or exclusions applicable to covered services. These descriptions must have sufficient detail to ensure the Enrollees understand the benefits to which they are entitled and may include a web link to the PIHP Benefit Plan. This includes a descriptions of all Innovations Waiver services and supports;						
1.2 Benefits include access to a 2nd opinion from a qualified health care professional within the network, or arranges for the enrollees to obtain one outside the network, at no cost to the enrollee;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Updates regarding program changes;						
1.4 A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;						
1.5 An explanation of the Enrollee's responsibilities and rights and protection;						Page 45 of the *Member and Caregiver Handbook* has information on member rights and responsibilities.
1.6 An explanation of the Enrollee's rights to select and change Network Providers						*Member and Caregiver Handbook* advises enrollees of the process when they call the Access to Care Line, including the enrollee choosing a provider and of the right to change providers.
1.7 The restrictions, if any, on the enrollee's right to select and change Network Providers						Page 31 of the *Member and Caregiver Handbook explains "Within our provider network, you have the right to change providers for any reason."*
1.8 The procedure for selecting and changing Network Providers						This procedure is explained on page 31, "If you have an assigned core coordinator, you should let him or her know that you are not happy with your current provider and want to discuss options for changing." Or, call the Access to Care Line if no care coordinator is assigned.
1.9 Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request);						The *Provider Directory* uploaded in desk materials is missing fields for "accepting new patients and "provider spoken language." During the Onsite visit, Vaya discovered a more current copy on the website that can be generated and printed. This version has fields for "accepting new patients and "Languages" which are NOT in the *Provider Directory* uploaded in the desk materials. ***Corrective Actions: Verify all forms of the Provider Directory are current. Coordinate desk material uploads so that the most recent documentation is uploaded.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.10 The non-English languages, if any, spoken by each Network Provider;						The printable *Provider Directory* generated online has a field for "Languages" and is not clear if this means languages spoken by the providers or languages that can be interpreted at the provider practice. The online Provider Search has a field for Spoken Languages which is better defined. ***Recommendation: Clarify in every format that the provider directory "Provider spoken Languages" spoken by each network provider.***
1.11 The extent to which, and how, after-hours and emergency coverage are provided, including:						
1.11.1 What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services in accordance with 42 CFR§ 438.114 and EMTALA;						
1.11.2 The fact that prior authorization is not required for emergency services;						
1.11.3 The process and procedures for obtaining Emergency Services, the use of 911 telephone services or the equivalent;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.11.4 The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract;						Detailed information on emergency services is provided in the *Member and Caregiver Handbook*. Within enrollee written materials there are no examples of the locations where providers and hospitals furnish post stabilization services covered under the contract. ***Corrective Action: Within enrollee written materials, Include examples of the locations where providers and hospitals furnish Post Stabilization services covered under the contract.***
1.11.5 A statement that, subject to the provisions of the DMA this contract, the Enrollee has a right to use any hospital or other setting for Emergency care;						
1.12 The PIHP's policy on referrals for Specialty Care to include cost sharing, if any, and how to access Medicaid benefits that are not covered under this Contract;						
1.13 Any limitations that may apply to services obtained from Out-of Network Providers, including disclosures of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of Network Providers, and the procedures for obtaining authorization for such services.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.14 How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost-sharing;						
1.15 Procedures for obtaining out-of-area or out-of-state coverage of or services, if special procedures exist;						
1.16 Information about medically necessary transportation services by the department of Social Services in each country;						
1.17 Identification and explanation of State laws and rules Policies regarding the treatment of minors;						
1.18 The enrollee's right to recommend changes in the PIHP's policies and procedures						
1.19 The procedure for recommending changes in the PHIP's policies and procedures;						
1.20 The Enrollee's right to formulate Advance Directives;						
1.21 The Enrollee's right to file a grievance concerning non-actions, and the Enrollee's right to file an appeal if PIHP takes an action against an Enrollee;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.22 The accommodations made for non-English speakers, as specified in 42 CFR §438.10(c)(5);						
1.23 Written information shall be made available in the non-English languages prevalent in the PIHP's services area.						
1.24 The availability of oral interpretation service for non-English languages and how to access the service;						The *Member and Caregiver Handbook* is available in Spanish and large print. Several brochures are available in Spanish (posted on the website). A statement in English and Spanish at the bottom of each page of the website informs readers to "call the toll-free # 24/7 to obtain services and support for mental health, developmental disabilities and substance abuse. Members can request materials in Spanish or English."
1.25 The availability of interpretation of written information in prevalent languages and how to access those services						
1.26 Information on how to report fraud and abuse; and						
1.27 Upon an Enrollee's request, the PIHP shall provide information on the structure and operation of the agency and any physician incentive plans.						Page 35 of The *Member and Caregiver Handbook* states, "We also do not offer physician incentive plans."
1.28 Information on grievance, appeal and fair hearing procedures and information specified in CFR §438.10 (g) and CFR §438.10 (f) (6).						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.	X					Once per year Vaya's mass mailing vendor sends a letter that informs members they can request additional information about the PIHP and member rights and responsibilities. *Policy 2557, Marketing Materials, Media Relations and Member Notifications* explains the annual mailing procedure.
3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in CFR 438.10 (f) (61) and 438.10 (g) at least 30 days before calendar days before the intended effective date of the change; and (2) . termination of their provider within fifteen (15) calendar days after PIHP receives notice that DMA or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.	X					Only one provider that was terminated (with cause terminated by Vaya) had associated enrollees to whom Vaya sent notifications. Vaya terminated 16 providers because of because they were "non-renewals," and 13 providers terminated because of "closure, withdrawal, merger." During the Onsite interview, Vaya explained that the providers terminated because of "non-renewal, closure, withdrawal, merger" do not have any enrollees who had claims submitted in the past 60 days which excludes the PIHP from sending an enrollee notification. Reports are run to ascertain if these providers had a claim within the past 60 days.
4. Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation of prevalent non-English languages as required by the contract.	X					
5. The PIHP maintains and informs Enrollees of how to access a toll-free vehicle for 24-hours Enrollee access to coverage information from the PIHP, including the availability of free oral translation services for all languages and care management services such as crisis interventions.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III C. Behavioral Health and Chronic Disease Management Education						
1. The PIHP enables each enrollee to choose a Provider upon enrollment and provide assistance as needed.	X					
2. The PIHP informs enrollees about the behavioral health education services that are available to them and encourages them to utilize these benefits.	X					
3. The PIHP tracks the participation of enrollees in the behavioral health education services.	X					
III D. Call Center						
1. The PIHP provides customer services that are responsible to the needs of the Enrollees and their families. Services include:	X					Vaya maintains a toll-free 24/7 Access to Care Line that can be used for any need or question from a member or caregiver. The Vaya Customer Services Representatives and Clinicians follow the Customer Services policies and procedures including *Policy 2422, Customer Services Clinical Decision Making and Triage*. This policy ensures the enrollee is directed to correct level of care.
1.1 Respond appropriately to inquiries by enrollees and their family members (including those with limited English proficiency);	X					
1.2 Connect enrollees, family members and stakeholders to crisis services when clinically appropriate;	X					
1.3 Provide information to enrollees and their family members on where and how to access behavioral health services;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.4 Train its staff to recognize third-party insurance issues, recipient appeals, and grievances and to route these issues to the appropriate individual;	X					
1.5 Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;	X					
1.6 Process referrals twenty-four (24) hours per day, seven (7) days per week; 365 days per year; and	X					
1.7 Process Call Center linkage and referral requests for services twenty-four (24) hours per day, seven (7) days per week, 365 days per year.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV A. The Quality Improvement (QI) Program						
1. The PIHP formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to enrollees.	X					Vaya's Quality Management (QM) Program Description defines all aspects of a formal QI program.
2. The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.	X					In QM Program Description on page 7, Vaya identifies a Quality Assurance activity of "Provider compliance with clinical practice guidelines: Rate of compliance with guidelines for selected services."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Page 33 of the *QI Program Evaluation 2017-18* evaluates two Clinical Practice Guidelines monitored this year from July 2017 – June 2018. • Supported Employment (SE) as promulgated by Substance Abuse and Mental Health Services Administration (SAMHSA) • Best Practice Treatment of Opioid Dependence as promulgated by the National Institute of Drug Abuse (NIDA) – Opioid Only the guideline for Best Practice Treatment of Opioid Dependence was monitored this fiscal year.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Vaya has a policy for detecting over and underutilization: *Policy 2385 Detecting Over and Under-Utilization of MH/SU/IDD Services*. The desk materials folder contains a presentation of the utilization services presented to the QIC in April 2018. Services presented include engagement for mental health and substance use, inpatient admissions, length of stay, readmissions, and ED admits. Data are presented as quarterly or monthly rates. Committee minutes display monitoring and analysis of utilization and recommendations based on analysis.
4. The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.	X					The *QM Program Description* on page 9 states "The Quality Improvement Advisory Team (QIAT) carries out critical QM functions under the direction of the QM Director. The QIAT analyzes the data and prepares a summary of the survey results to be presented to the Vaya Board of Directors, RCQC, the CFAC, and QIC, as well as internally throughout Vaya." The Onsite interview confirmed Vaya follows this practice and no measures are identified by the QIAT for improvement from the 2017 enrollee surveys. Vaya presents no evidence of discussing lower scoring measures in a formal committee like the QIC to allow QIC members to weigh in and vote for or against improving low scoring measures.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Bring lower scoring enrollee survey items to QIC for discussion and decisions on the need for quality improvement actions on those lower scoring items.
5. The PIHP reports the results of the enrollee satisfaction survey to providers.	X					Enrollee Surveys are presented in Provider Council, QIC, ELT, and to the BOD.
6. The PIHP reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					ECHO and Perception of Care are presented at the April 2018 WIC Meeting.
7. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, time frame for implementation and completion, and the person(s) responsible for the project(s).	X					Vaya changed the format of the workplan to shorten it and have it fit on a few pages as recommended in the prior year's EQR.
IV B. Quality Improvement Committee						
1. The PIHP has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					
2. The composition of the QI Committee reflects the membership required by the contract.	X					QIC consists of Vaya staff, CFAC members, and providers.
3. The QI Committee meets at regular intervals.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".		X				Two of the four PIPS validated are not in the "High Confidence" validation. PIPs that have specific items for correction include: • Inpatient Rapid Readmission • Integrated Care for Innovations Waiver Participants • TCLI- Increasing Housing ***Corrective Action: Correct specific PIP errors, by project. See Tables 22, 23, and 24 for corrections.***
IV E. Provider Participation in Quality Improvement Activities						
1. The PIHP requires its providers to actively participate in QI activities.	X					Providers are asked to do QIPs and the Vaya monitoring team looks for the existence of QIP during onsite routine monitoring. The monitoring team is not equipped to offer suggestions for the QIP process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					During the Onsite interview Vaya described including providers in several PDSA cycles for the Integrated care QIP and Emergency Department Value-Based Payments project. Other measures are discussed at Provider Council Meetings, but no specific examples of providers receiving interpretation of QI performance data and feedback regarding QI activities. ***Recommendation: Begin providing more feedback for provider's individual QI activities. Examples include:*** • ***Select B and C Waiver measures for individual providers.*** • ***Involve QI/QA staff in the process for Individual QIPs so that providers can receive feedback on their QIPs as they work toward their desired outcome.***
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					The *Quality Improvement Program Evaluation 2017-2018* contains information about all Quality Assurance and Quality Improvement activities. It begins with a summary of the QI program and major accomplishments during the year. For QI and QA activities, it provides the activity, lead staff, goals, project dates, progress notes, recommendations, and when the activity was last updated, including staff who updated it. The document ends addressing adequacy of resources, training, scope and content specific to Vaya. This is a comprehensive program evaluation that gives any reader insight into the QM program at Vaya.
2. The annual report of the QI program is submitted to the QI Committee and to the PIHP Board of Directors.	X					The Program Evaluation was reviewed by the QIC, the BOD, and the Marketing Department.

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. The Utilization Management (UM) Program						
1. The PIHP formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					*Policy 3004, Utilization Management Plan and Program Description* defines the UM's program purpose, scope, structure components, and staffing qualifications.
1.1 structure of the program;	x					
1.2 lines of responsibility and accountability;	x					
1.3 guidelines / standards to be used in making utilization management decisions;	x					Vaya has an *Approved Clinical Guidelines List* available for providers; it is posted on the Vaya website and is available in print.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	x					
1.5 consideration of new technology;	x					
1.6 the appeal process, including a mechanism for expedited appeal;	x					*Policy 2384, Members Appeals of Adverse Decisions* provides the process and mechanisms for expedited appeals,
1.7 the absence of direct financial incentives to provider or UM staff for denials of coverage or services;	x					
1.8 mechanisms to detect underutilization and overutilization of services.	X					*Policy 3004, Detecting Over and Under-Utilization of MH/SU/I/DD Services*, provides the procedures regarding the mechanisms for monitoring overutilization and outliers of service. During the Onsite

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						interview, Vaya clarified the data analysis process used to identify over utilizers and underutilizers.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Dr. Martin oversees the UM Department and supervises UM leadership. He chairs four committees; *Quality Improvement Committee, Credentialing Committee, Clinical Advisory Committee and Clinical Incident Review Committee*. He is involved in the day-to-day activities of the UM Department.
3. The UM program design is reevaluated annually, including Provider input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					*Policy 3004, Vaya Health Utilization Management Program Description*, indicates that this plan is reviewed and updated at least annually by the Chief Medical Officer, the UM Director, and Member Appeals Director with input from the Executive Leadership Team. This annual appraisal assesses Vaya adherence to the *Clinical Plan* and identifies any need for changes.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Vaya has UM standards available for providers; they are posted on the Vaya website and are available in print. *The Children's Assessment of Needs and Strengths (CANS)* practice guidelines for *Applied Behavioral Analysis (ABA)* and *Autism Disorder Syndrome Guidelines* are identified for use with young children.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.						*Policy 2377, UM Department Training, Staffing and Supervision*, identifies clinical and medical staff positions and qualification requirements, including education requirements and brief descriptions of roles and responsibilities.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					UM review staff are master level/ licensed clinicians and PhD staff. *Policy 2373, Service Authorization Review, Decisions and Notification*, provides specific guidance regarding each level of review, roles, and responsibilities.
4. Utilization management standards/criteria are consistently applied to all enrollees across all reviewers.	X					Vaya targets an 80% benchmark/concordance rate for UM staff and completes the IRR process quarterly. CCME's Onsite discussion of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Vaya's IRR process revealed that the MH/SU and I/DD teams consistently average a concordance rate of 90-100%. The peer reviewer IRR process measures the rate of agreement between UM adverse benefit determinations and their appeal outcomes. This measure, as was reported during the Onsite discussion, has proven to not measure concordance. Per staff report, disagreement in clinical decisions is primarily due to the presence of new information. ***Recommendation: The use of vignette-based IRR process for all peer reviewers would improve the validity and reliability of the IRR process for peer reviewers and create consistency with UM IRR processes.***
5. Emergency and post stabilization care are provided in a manner consistent with contract and federal regulations.	X					
6. Utilization management standards/criteria are available for Providers.	X					
7. Utilization management decisions are made by appropriately trained reviewers						Utilization management decisions are made by appropriately trained staff as indicated in *Policy 2377, UM Department training, Staffing, Monitoring and Supervision*.
8. Initial utilization decisions are made promptly after all necessary information is received	X					
9. Denials						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.1 A responsible effort that is not burdensome on the enrollee or the provider is made to obtain all pertinent information prior to making the decisions to deny services	X					
9.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					*Policy 2374, Service Authorization Request Review, Decision and Notification*, states that all denial decisions based on medical necessity are reviewed by appropriately licensed peer reviewer.
9.3 Denial decisions are promptly communicated to the provider and enrollee and include the basis for the denials of service and the procedure for appeal	X					Only 1 of the 25 UM denial files reviewed showed late notification of the adverse benefit determination
V C. Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					Rhonda Cox MA, HSP-PA and Chief Population Health Officer oversees the *Care Coordination Program*. Sara Wilson, MSW, LCSW, is the Senior Director and three regional Care Coordinators support the program. *Policy 2335, Care Coordination Populations, Processes, Roles and Responsibilities,* provides information about care coordination and the role of care coordination with members who have complex healthcare needs. Over the past year, Vaya implemented the Incedo platform and staff is learning the system and its capabilities.
2. The case coordination program includes:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					Customer Service *Policy 2415, Access to Care Monitoring* and *Policy 2422, Customer Services Clinical Decision Making and Triage,* addresses 24/7 coverage, providing telephonic assessment, and crisis intervention.
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					
2.4 Develop treatment plans for enrollees that meet all requirements;	X					*Policy 2335, Care Coordination Populations, Processes, Roles and Responsibilities,* includes monitoring coordination, linking services, and discharges of the I/DD and MH/SU populations. This includes providing follow-up activities for enrollees.
2.5 Quality monitoring and continuous quality improvement;	X					
2.6 Determine of which Behavioral Health Services are medically necessary;	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					Vaya has Care Coordinators who coordinate discharge planning, are integrated with 10 hospitals in the region.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.8 Coordinate care with each Enrollee's provider;	x					*Policy 2335, Care Coordination, Populations, Processes, Roles and Responsibilities* describes the process that the Care Coordinators take to link and coordinate services for members are provided.
2.9 Provide follow-up activities for Enrollees;	X					*Policy 2335, Care Coordination Populations, Processes, Roles and Responsibilities,* includes monitoring coordination, linking services and discharges of the I/DD and MH/SU populations. The policy includes providing follow-up activities for enrollees. This policy also includes Section VII. Discharge from Care Coordination criteria and process.
2.10 Ensure privacy for each Enrollee is protected.	X					
3. The PIHP applies the Care Coordination policies and procedures as formulated.		X				The care coordination notes showed that, in three of five files where care coordination members were not following up with care coordination, care coordinators attempted two phone calls and sent a letter. This action is not consistent with *Policy 2335, Care Coordination Populations, Processes, Roles*. ***Corrective Action: Monitor care coordination notes to ensure follow up activities, including attempts to contact members who are not following up with care coordination, are compliant with Policy 2335.***
V. D Transitions to Community Living Initiative						
1. Transition to Community Living functions are performed by appropriately licensed, or certified, and trained staff.	X					*Policy 2405, Transitions to Community Living* explains licensure and certification requirements for the TCLI staff.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements includes all required elements.	X					
2.1 Care Coordination activities occur as required.		X				*There is no reference to the required In-Reach/TCLI Transition tool in Policy 2405, Transitions to Community Living.* ***Corrective Action: Add details to Policy 2405, Transitions to Community Living regarding the requirements around the completion of In-Reach/TCLI Transition Tool.***
2.2 Person Centered Plans are developed as required.	X					There is no reference in *Policy 2405, Transitions to Community Living* to person centered planning activities, as is described in DMA Contract, Section 15.3. ***Recommendation: Add details to Policy 2405, Transitions to Community Living regarding person centered planning activities, as is described in DMA Contract, Section 15.3.***
2.3 Assertive Community Treatment, Peer Support Services, and Supported Employment services are included in the individual's transition, if applicable.	X					
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					Vaya has a mechanism in place for providing One Time Transition Year Supports (TYS) as described in *Policy 2447*.
2.5 QOL Surveys are administered timely.	X					Limited QOL surveys are present in the TCLI files. During the Onsite interview, Vaya indicated that, Vaya Transition staff members have monitored and ensured completion of *QOL* surveys since September 2017.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. A diversion process is in place for individuals considering admissions into an Adult Care Home (ACH).	X					
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to DMA within the timeframes determined by DMA.	X					Vaya regularly submits the required TCLI reporting data and provided the *DMA TCLI Data Dashboard* as part of the review process.
5. The PIHP will develop a TCLI communication plan that includes materials and training about crisis hotline, services for enrollees with limited English proficiency and also to for external and internal stakeholders providing information on the TCL initiative, resources, and system navigation tools, etc.	X					Vaya has a TCLI flier and recently updated the flier with additional information. Training is provided to external stakeholders and community members about TCLI initiatives.
6. A review of files demonstrates the PIHP is following appropriate TCL policies, procedures and processes, as required by NC DMA, and developed by the PIHP.		X				Policy 2405, Transitions to Community Living does reference a mechanism for Transition Year Funds; however, CCME found no documentation within the TCLI files reviewed showing discussions with TCLI members regarding the purpose and access to these funds. The *In-Reach/TCLI Transition Tool* is not included in eight of the files reviewed where this tool would be required. ***Corrective Action: Enhance Vaya's current TCLI monitoring processes to ensure TCLI care coordinators complete an In-Reach/TCLI Transition Tool, when appropriate, and that discussions with TCLI member regarding the purpose and access of Transition Year Funds are occurring.***

VI. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					The Grievance Department is within the Customer Services Department. Vaya has one overarching policy, *Policy 2607, Complaints and Grievances*, which states the term grievance is for use of Medicaid members. The use of Complaint is for non-Medicaid members. The grievance procedure has a process for registering, filing, and responding to a grievance.
1.1 Definition of a grievance and who may file a grievance;	X					*Policy 2607, Complaints and Grievances* provides the definition of a grievance and it is consistent with the definition in the *DMA Contract*.
1.2 The procedure for filing and handling a grievance;	X					*Policy 2607, Complaints and Grievances* provides the definitions of a complaint and a grievance. The grievance definition is consistent with the *DMA Contract, Attachment M*. The procedure uses the term grievance thought out the policy when referencing the Medicaid grievance process. The procedure is unambiguous, and the procedural steps are easily understood and logical. Vaya uses a *Grievance Worksheet* to document the grievance investigation process. The *Grievance Worksheet* includes the procedural steps for handling a grievance and supports the procedure in *Policy 2607*. Vaya has 8 files where the worksheet is missing. In an additional 9 files, the worksheet contains incomplete information. Including the use of the *Grievance Worksheet* in *Policy 2607* will ensure the procedural steps for handling a grievance are followed consistently. ***Recommendation: Include the use and steps of the Grievance Worksheet in Policy 2607, Complaints and Grievances, to ensure***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						procedures for handling grievances are followed and completed consistently.
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					Vaya indicates in *Policy 2607* that it has 90 days to resolve a grievance; in the policy it states that Vaya strives to resolve grievances in 30 days. In *Policy 2607* the correct process to extend a grievance is stated on page 5 item 17, " If Vaya determines to or a grievant request to extend the timeframe for resolution, the Grievance Team will notify the grievant in writing." Per *42 CFR 438.402,* the notification letter is mailed within 2 days from the decision. ***Recommendation: Include in Policy 2607, that when Vaya extends the grievance process, the Notice of Extension letter is sent within 2 days per 42 CFR § 438.402.***
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					*Policy 2607* includes the CMO or designee's involvement in grievances; however, of the policy does not state the CMO's involvement in the resolution process clearly. The policy references the "Grievance Team." The members of the "Grievance Team" are not defined in the policy. During the Onsite interview, Vaya clarified that the Grievance Team membership includes the CMO. Including the definition of the Grievance Team and that its membership roster includes the CMO will clarify the grievance resolution process. ***Recommendation: In the Definitions section of Policy 2607, Complaints and Grievances, include the "Grievance Team" and define the membership of the team and the CMO's involvement in the grievance resolution process.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					*Policy 2314, Records Retention and Management* references the retention time frame of grievance logs.
2. The PIHP applies the grievance policy and procedure as formulated.	X					CCME's review of the *Grievance Files* reflects that the grievance policies are applied as formulated.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The Vaya *Grievance Log* includes both grievances and complaints. During the Onsite interview, Vaya stated that it does separate the complaint from the grievance data and submits only grievances in the *Grievance Log* to the state. Grievances are monitored monthly for potential patterns and opportunities for improvement.
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					
VI. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to enrollee and/or provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					*Policy 2384, Member Appeals of Adverse Decisions* is clear and thorough.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;		X				Vaya's *Policy 2384* defines an appeal as "Medicaid Appeal means a request for a new consideration of an authorization request that resulted in an ABD." The definition of an appeal within the *DMA Contract Section, Attachment M G(1)* and *42 CFR § 438.400(b)*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						define an appeal as "the request for review of an adverse benefit determination." ***Corrective Action: Change the definition of an appeal within Policy 2384 to "the request for review of an adverse benefit determination."***
1.2 The procedure for filing an appeal;		X				Per *Policy 2384*, appellants must submit Vaya's *Reconsideration Request Form*. Similarly, the *Member and Caregiver Handbook* states, "To request a reconsideration of a Medicaid adverse benefit determination, you must complete and return the Vaya *Reconsideration Request Form*." Neither the *DMA Contract* nor the federal regulations governing appeals require a specific form. Appeal rights exist regardless of whether Vaya's form is submitted, and individuals should be able to file appeals in any format so long as they are providing sufficient information to Vaya to consider the appeal. ***Corrective Action: Revise the language within Policy 2384 and the Member and Caregiver Handbook to clarify that any written request can initiate the first level appeal process, so long as the request provides sufficient information for Vaya to consider the appeal.*** *The Provider Operations Manual (pg. 61)* and the *Member and Caregiver Handbook (pg. 57)* state an acknowledgment letter is sent once an appeal request is received. This statement contradicts Vaya's appeals policy that states a written acknowledgement is not required when filing an expedited appeal. ***Recommendation: Clarify in the Provider Operations Manual and Member and Caregiver Handbook that Vaya is not required to***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						send a written acknowledgement when an expedited appeal is filed. The *Member and Caregiver Handbook*, page 61, erroneously says appellants can request an extension to the "60-day timeframe." The appeal resolution timeframe is 30 days. ***Recommendation: Correct the typographic error on pg. 61 of the Member and Caregiver Handbook to say appellants can request an extension to the "30-day timeframe."***
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					All of the appeals files reviewed show decisions are rendered within the required timeframes and by appropriate appeal peer reviewers.
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;		X				Vaya's appeal policy, *Member and Caregiver Handbook*, and *Provider Operations Manual* have missing or incorrect information regarding the required notification process when an expedited appeal is requested and denied. The *DMA Contract* requires PIHPs to "give the Enrollee prompt oral notice for the denial (make reasonable efforts) and a written notice within two (2) calendar days." This requirement is in *DMA Contract, Attachment M 9.b.* ***Corrective Action: Revise the Policy 2384, the Provider Operations Manual, and the Member and Caregiver Handbook to include information that states enrollees are given prompt oral notice and a written notice within 2 calendar days when Vaya denies a request for an expedited appeal.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The 2017 EQR recommended Vaya add the process for denying a request for expedited appeal to policy. During the Onsite discussion, staff described the process for review and denial of a request for expedited appeal, including review by the CMO. CCME recommended that Vaya describes this process in policy and note that the CMO is involved. ***Recommendation: Add detail to Policy 2384 that describes the process Vaya uses when reviewing and denying a request for an expedited appeal, including Chief Medical Officer involvement.***
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				Per *Policy 2384*, "If a signed and completed *Reconsideration Request Form* is received more than 20 days after the oral request, the date of receipt of the written request is considered to be the Reconsideration Request date for the purpose of issuing the Notice of Resolution." This practice allows Vaya to extend the appeal resolution timeframe up to 50 days. *42 CFR 438.406(b)(3)* states PIHPs must "Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal)." Further, *42 CFR 438.408(b)(2)* and the *DMA Contract, Attachment G.4* require standard appeals to be resolved and notification provided within 30 days. The only exception to this timeframe is if a written request is never received or an extension to the appeal resolution timeframe is issued. ***Corrective Action: Revise Policy 2384 to reflect that all oral requests are treated as appeals and begin the 30 day timeframe for Vaya to resolve the appeal. The only exception is when, following an oral appeal request, a written request is not submitted within the 60 days of the mailing date of the Notice of Adverse Benefit Determination.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Vaya's appeals *Policy 2384*, the *Provider Operations Manual*, and the *Member and Caregiver Handbook* do not clarify that if Vaya extends an appeal resolution timeframe, the enrollee is notified of the extension within 2 calendar days and informed of the right to file a grievance if disagreeing with the extension. This notification requirement is in *DMA Contract*, *Attachment M, G.6 i* and *ii*. ***Corrective Actions: Revise Policy 2384, the Provider Operations Manual, and the Member and Caregiver Handbook to clarify that if Vaya extends an appeal resolution timeframe, Vaya will make reasonable efforts to give the enrollee prompt oral notice of the delay. Also, include that the enrollee must be notified in writing of the extension within 2 calendar days and informed of the right to file a grievance if they disagree with the extension.***
1.6 Written notice of the appeal resolution as required by the contract;	X					*Policy 2384* guides staff through the required steps of notifying appellants of an appeal decision. Within this process description, steps 13 and 14 use the terms "partially overturned" and "partially upheld." The policy only indicates additional appeal rights are offered via a decision notice when an appeal is "partially upheld." Given a decision that is partially overturned is not wholly in favor of the appellant, notification to appellants of appeal rights is required. ***Recommendation: Correct the language in Policy 2384 to clarify that any appeal decision that is not wholly in favor of the appellant requires notification of appeal rights.***
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					Five of the 20 first level appeal files show notifications by appeal staff are inconsistent with *DMA Contract* and Vaya procedural requirements. Vaya staff explained that each appeal is reviewed for compliance, but bolstering Vaya's appeals monitoring will ensure better compliance with appeal requirements. ***Recommendation: Increase or improve the current monitoring process of all written and oral notifications, including invalid notifications, acknowledgements, and resolution notifications. Ensure monitoring also reviews all notifications for timeliness.***
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Vaya provided evidence in the Quality Improvement Committee minutes that the PIHP analyzes appeal trends by number, type, percentage of UM denial decisions that are appealed, funding source, outcome and appeal level. The appeal data are discussed by this committee quarterly, with one exception in the second quarter of the 2018 calendar year.
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					The file review shows efforts by staff to confirm guardianship prior to disclosing information to legal.

VII. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. Delegation						
1. The PIHP has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Vaya has a delegation agreement with Prest for Peer Review/ Utilization Management, and a delegation agreement with Partners Behavioral Health for call roll-over.
2. The PIHP conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the PIHP if the PIHP were directly performing the delegated functions.	X					Vaya conducted annual oversight and completed monitoring tools for the two delegates during the current review period. The *Delegation Assessment* form for Partners Behavioral Health does not include the timeframe covered by the assessment, the date the form was completed, or the date signed. *Policy 2303, Delegation and Subcontracting,* includes a reference to "a mechanism for reporting delegation oversight no less than annually to the Quality Improvement Committee (QIC)." The QIC meeting minutes do not include reporting of delegation oversight for Prest and Associates or Partners. ***Recommendations:*** • ***Report delegation oversight in a QIC meeting annually as referenced in Vaya Policy 2303, or revise the policy to eliminate the reference to annual reporting in QIC.*** • ***For Delegation Assessments, include the timeframe covered by the assessment, the date the assessment was completed, and the date signed by the Vaya staff member.***

VIII. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII A. General Requirements						
1. PIHP shall be familiar and comply with Section 1902(a)(68) of the Social Security Act, 42 C.F.R. Parts 438,455 and 1000 through 1008, as applicable, including proper payments to Providers and methods for detection of fraud and abuse.	X					This requirement is addressed in the *Compliance Program Plan* and *Workplan FY 17-18*.
2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents' and subcontractors,' compliance with the requirements of this Section 14.	X					This requirement is address in the *Compliance Program Plan and Workplan FY 17-18*. This is addressed in the *Code of Ethics and Conduct*, pg.6-10
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					This is addressed in the *Provider Operations Manual*, pages 12, 55, 67, and 118-121.
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					This requirement is addressed in the *Compliance Program Plan and Workplan FY 17-18*.
VIII B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with 42 C.F.R. 438.608 that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the DMA Contract Administrator on an annual basis.	X					This requirement is addressed in the *Compliance Program Plan and Workplan FY 17-18*.
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of 42 C.F.R. 438.608 and who retains authority to report directly to	X					This requirement is addressed in the *Compliance Program Plan and Workplan FY 17-18 pg. 7*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 DMA Contract in accordance with 42 CFR 438.608(a)(1)(iv).						Vaya provides evidence (course outlines, registration confirmation, and training PowerPoint presentations) of training Special Investigations Unit (SIU) staff and general training for staff in other departments.
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 DMA. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator.	X					This requirement is addressed in the *Compliance Program Plan and Workplan FY 17-18,* pg. 19. Vaya provided an organizational chart for its Performance and Quality Improvement function with the Director of Special Investigations reporting to a Senior Director of Performance and Quality Improvement, and ultimately the Chief Compliance Officer. ***Recommendation: Create additional detailed procedures to document the Special Investigations Unit Program Integrity Process.***
4. PIHP shall participate in quarterly Program Integrity meetings with DMA Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID)	X					This requirement is addressed in the quarterly PI meeting minutes.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
of the N.C. Department of Justice ("MFCU/ MID').						
5. PIHP shall participate in monthly meetings with DMA Program Integrity, in the most productive setting, either telephonically or in person at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.	X					This requirement is addressed in the monthly PI meeting minutes.
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					This requirement is addressed in the quarterly PI meeting minutes. The SIU director and Regulatory Affairs Director are in attendance at meetings.
7. PIHP shall also make Regulatory Compliance minutes and Program Integrity minutes, redacted as deemed appropriate by PIHP, available for review upon request by DMA.	X					This requirement is addressed in the quarterly PI meeting minutes.
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 and procedures and the False Claims Act as identified in Section 1902(a)(66) of the Social Security Act;	X					This requirement is addressed in the *Compliance Program Plan and Workplan FY 17-18*, pg. 13. Vaya provided curriculum for training staff, the Board of Directors (BOD), and providers.
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing and	X					This requirement is addressed in the *Compliance Program Plan and Workplan FY 17-18*, pg. 14. Vaya provides external and internal reporting options.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
development of corrective action initiatives;						
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					This requirement is addressed in the *Compliance Program Plan and Workplan FY 17-18*, page. 16. Vaya provides new hire training that details adherence to guidelines and fraud reporting procedures.
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 DMA or MFCU/MID, and including promptly supplying all data and information requested for their respective investigations.	X					This requirement is addressed in the *Code of Ethics and Conduct*, page 7. This requirement is also addressed in Provider Agreements, Section 2.16.
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 DMA 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 DMA Contract; and making documentation of	X					Vaya provided an organizational chart for its Performance and Quality Improvement functions and indicates a staff of 8 (including the Director) dedicated to monitoring fraud.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
investigations and compliance available as requested by the State.						
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					This requirement is met in the *Compliance Program Plan* and *Workplan FY17-18*.
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse.	X					This requirement is met in the *Compliance Program Plan* and *Workplan FY17-18*.
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	X					This requirement is addressed in the *SI Workflow 20180605*. The workflow includes procedures for logging, determination of validity, and assignment to a SIU investigator. It includes sub-routines for cases of Fraud versus Abuse. The process flow includes recovery of overpayments and reconsideration of findings. There are workflows for provider self-audits and onsite audits (announced and unannounced). This requirement is also supported through the *Program Integrity Instructions*. While not a visual workflow, this instructional document addresses recoveries clearly.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.						
10.3 In accordance with Attachment Y - Audits/Self-Audits/Investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an· overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					This is addressed in the *DMA Contract, Section 2.16.7.*
10.4 Process for tracking overpayments and collections, and reporting on Attachment Y – Audits/Self-Audits/Investigations.	X					Vaya provided *Attachment Y* for the months June 2017-May 2018.
10.5 Process for handling self-audits and challenge audits.	X					This requirement is met in *Policy 2622 Internal Audits & Investigations.*
10.6 Process for using data mining to determine leads.	X					This requirement is addressed in the *Compliance Program Plan and Workplan FY 17-18,* pg. 19.
10.7 Process for informing PIHP employees, subcontractors and providers regarding the False Claims Act.	X					This requirement is addressed in the *Compliance Program Plan and Workplan FY 17-18,* pg. 13.
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,	X					This requirement is addressed in *Policy 2487, Code of Ethics and Conduct.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains DMA-standardized elements or a DMA-approved template;	X					This requirement is addressed in SIU audits tools including Agency Billing, Residential, and Provider Audit. Vaya supplied Explanation Of Benefits (EOB) letters and tracking.
10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available database or other search mechanism.	X					This is addressed in the *DMA Contract Section 2.16.7.*
11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.	X					This is addressed in the *DMA Contract Section 2.16.7.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to DMA within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					The requirement for initial investigation is addressed in *Policy 2622, Internal Audits and Investigations*.
13. In each case where PIHP refers to DMA an allegation of fraud involving a Provider, PIHP shall provide DMA Program Integrity with the following information on the DMA approved template:						
13.1 Subject (name, Medicaid provider ID, address, provider type);		X				This requirement is partially met on the *Investigation Referral Form*. There is no provider ID on form. 13 of 15 files contain the required documentation (provider ID was either on the claims run or other document). For two files there is no NPI evidence in the supporting documents provided. ***Corrective Action: Incorporate the provider ID number into the PI referral form.***
13.2 Source/origin of complaint;	X					This requirement is met on the *Investigation Referral Form*. 15 of 15 files contain the required documentation.
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					This requirement is met on the *Investigation Referral Form*. 15 of 15 files contain the required documentation.
13.4 Description of suspected intentional misconduct, with specific details	X					This requirement is met on the *Investigation Referral Form*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations or policies violated; and dates of suspected intentional misconduct;						15 of 15 files contain the required documentation.
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					This requirement is addressed in the *SI Workflow Visio diagram*. The *Investigation Referral Form* does not include a specific field for paid amounts. It is addressed when applicable in notes and comments. In addition, Vaya provided claims runs from internal systems. This element is not applicable in 3 of 15 files. 12 of 12 files contain the required documentation.
13.6 All communications between PIHP and the Provider concerning the conduct at issues, when available.	X					This requirement is met on the *Investigation Referral Form*. 14 of 15 contain the required documentation. One of 15 files is labeled as closed in error. Communication took place after the review period. This requirement is Not Applicable for the file.
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					This requirement is met on the *Investigation Referral Form*. 15 of 15 files contain the required documentation.
13.8 Sample/exposed dollar amount, when available.	X					*The Investigation Referral Form* does not include a specific field for exposure amounts. It is addressed, when applicable, in notes and comments. This element is not applicable in 2 of 15 files. 13 of 13 files contain the required documentation.
14. In each case where PIHP refers suspected Enrollee fraud to DMA, PIHP shall provide						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
DMA Program Integrity with the following information on the DMA approved template:						
14.1 The Enrollee's name, birth date, and Medicaid number;	X					This requirement is partially met on the *Investigation Referral Form*.
14.2 The source of the allegation;	X					This requirement is met on the *Investigation Referral Form*.
14.3 The nature of the allegation, including the timeframe of the allegation in question;	X					This requirement is met on the *Investigation Referral Form*.
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	X					This requirement is met on the *Investigation Referral Form*.
14.5 Contact information for PIHP staff persons with practical knowledge of the allegation;	X					This requirement is met on the *Investigation Referral Form*.
14.6 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation; and	X					This requirement is met on the *Investigation Referral Form*.
14.7 The legal and administrative status of the case.	X					
15. PIHP and DMA 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					Vaya provided multiple letters, reports, and tools. NC Medicaid indicated during the Onsite interview that it approved Vaya's tool and letters.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
16. PIHP shall use the DMA Fraud and Abuse Management System (FAMS) or a DMA approved alternative data mining technology solution to detect and prevent fraud, waste and abuse in managed care.	X					This requirement is partially addressed in the *SIU Initiative 2 Project Plan* for using FAMS to identify provider billing outliers. Vaya provided samples of outlier reports within some of the PI case files reviewed.
17. If PIHP uses FAMS, PIHP shall work with the DMA designated Administrator to submit appropriate claims data to load into the DMA Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the DMA designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	X					There are no user changes to report during the review period.
18. PIHP shall submit to the DMA 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. In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to DMA 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 DMA Program Integrity all Network Provider contract terminations and non-renewals initiated by	X					Vaya provided a list of NCID FAMS superusers. Vaya provide copies of monthly *Attachment Y* reports.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						
19. On a quarterly basis, DMA shall review a sample of cases where the PIHP's Special Investigation Unit has identified overpayments, investigated or audited a provider. The results of these reviews will be discussed during the PIHP monthly Program Integrity meetings to assure that DMA is providing consistent guidance on expectations with regard to referrals for potential cases of fraud. DMA shall also determine what additional technical assistance may be available to PIHP to support PIHP's efforts in making referrals.	X					Vaya submitted monthly PI meeting minutes with evidence of discussion with NC Medicaid about open cases.
VIII C. Provider Payment Suspensions and Overpayments						
1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, DMA Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If DMA determines that a full investigation is warranted, DMA shall make a referral						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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, DMA shall provide written notification to PIHP of the status of each such referral. If MFCU/ MID indicates that suspension will not impact their investigation, DMA may send a payment suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates that payment suspension will impact the investigation, DMA shall temporarily withhold the suspension notice and notify PIHP. Suspension of payment actions under this Section 14.3 shall be temporary and shall not continue if either of the following occur: PIHP or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider; or Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.						
1.1 In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.			X			Vaya provided *Policy 2595 Identifications and Recovery of Overpayments*. This document does not contain the required language. ***Corrective Action: Add the required language to Vaya's policies and procedures.***
2. Upon suspension notice from DMA Program Integrity, PIHP shall suspend	X					This requirement is addressed in *Policy 2610, Provider Dispute Resolution*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
payment of Medicaid funds to the identified Provider beginning the effective date of DMA Program Integrity's suspension and lasting until PIHP is notified by DMA Program Integrity in writing that the suspension has been lifted.						Communication of this requirement is addressed in the sample provider contract provided.
3. PIHP shall provide to DMA all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					The required language is not in Vaya's policies and procedures. During Onsite interviews, Vaya stated not all contract language is incorporated into policies. Further, during Onsite interviews Vaya described its ongoing cooperation with MID and offered this as proof of compliance with this requirement. Post interview, Vaya provided examples of correspondence, other material support, and cooperation with MID investigations. ***Recommendation: Add the required language to the Vaya's policies and procedures.***
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to DMA Program Integrity due to allegations of suspected fraud without prior written approval from DMA Program Integrity or the MFCU/MID.	X					This requirement is addressed in the *Provider Operations Manual*.
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,	X					This requirement is addressed in *Policy 2610, Provider Dispute Resolution.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 DMA, 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 DMA, MFCU/MID or other oversight agency.						
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.			X			No wording directly related to remittance of reimbursement amounts to NC Medicaid and notification to provider of such mandates is found in the policies. During the Onsite interviews, Vaya stated that there is no mutual indemnification in its contract with NC Medicaid and therefor it cannot act in a collections capacity without exposure to liability. Vaya is researching contract language with the State that allows it to perform this function. ***Corrective Action: Add the required language to Vaya's policies and procedures.***
7. The MFCU/MID reserves the right to prosecute or seek civil damages regardless of payments made by the Provider to PIHP. The Parties shall work collaboratively to develop a plan for the disbursement of the						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
share of monies that are recovered and returned to the state by the MFCU/MID for fraudulent claims paid by PIHP. DMA will examine options to refund returned funds to PIHP and/or to appropriately account for these recoveries in the rate setting process.						
8. The MFCU/MID reserves the right to prosecute or seek civil damages regardless of payments made by the Provider to PIHP. The Parties shall work collaboratively to develop a plan for the disbursement of the share of monies that are recovered and returned to the state by the MFCU/MID for fraudulent claims paid by PIHP. DMA will examine options to refund returned funds to PIHP and/or to appropriately account for these recoveries in the rate setting process.						

IX. FINANCIAL SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IX. Financial						
1. The PIHP has policies and systems in-place for submitting and reporting financial data.	X					Vaya's policy review is conducted annually. All reports are submitted on time to NC Medicaid. ***Recommendations: Add the five-business day transfer requirement after capitation payment of risk reserve payment to Policy 2748, Medicaid Funds Management.*** ***Revise policies to add Medicaid contract requirements and federal regulations to policies.***
2. The PIHP has and adheres to a cost allocation plan that meets the requirements of 42 CFR 433.34.	X					Vaya recalculates its administrative cost allocation by spreadsheet monthly, based on year-to-date service revenues.
3. PIHP maintains detailed records of the administrative costs and expenses incurred as required by the DMA contract. (DMA Contract, Section 8.3).	X					The administrative costs are captured by the general ledger in Great Plains and allocated to Medicaid via the monthly NC Medicaid report.
4. Maintains an accounting system in accordance with 42 CFR 433.32 (a).	X					Vaya uses Great Plains, version 2015 as its accounting system and AlphaMCS for claims processing.
5. The PIHP follows a record retention policy of retaining records for ten years.	X					Vaya retains records for 10 years, with 3 fiscal years onsite, and 7 fiscal years offsite.
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution.	X					Wells Fargo maintains the restricted risk reserve account, and it is federally guaranteed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
7. The required minimum balance of the Risk Reserve Account meets the requirements of the DMA contract. (DMA Contract, Section 1.8 Restricted Risk Reserve Account)	X					The Financial Reporting Director and the Senior Director-Finance monitor the monthly contribution. They stated all deposits were made on time and are no unauthorized withdrawals were made.
8. All funds received by PIHP are accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as required by the DMA contract (DMA Contract, Section 1.9).	X					The segregation of Title XIX (Medicaid) funds is done by funding source. All reports and systems separately identify Title XIX funds, as well as the NC Medicaid reports separating Medicaid funds.
9. The Medical Loss Ratio (MLR) meets the requirements of 42 CFR 438.8 and the DMA contract (Amendment 2, Section 12.3 Item k).	X					The medical loss ratio is calculated monthly within the NC Medicaid report and is published monthly on the dashboard. The year-to-date MLR percentage is 90.8%, exceeding the 85% requirement.

E. Attachment 5: Encounter Data Validation Report

Vaya Health

Encounter Data Validation Report

performed on behalf of

North Carolina Medicaid

November 14, 2018

Prepared By:

hms

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

Table of Contents

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Background

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

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

Overview

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

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

Review of Vaya's ISCA response

The review of Vaya's 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 MMIS. Utilizing existing Medicaid pricing methodology, using the billing or rendering provider accordingly, the appropriate Medicaid allowed amount is calculated for each encounter claim in order to shadow price what was paid by the PIHP.

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

Looking at claims with dates of service in 2017, Vaya submitted 1,815,237 unique encounters to the state. To date, less than 5% of all encounters submitted have not been corrected and accepted by NC Medicaid.

2017	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	44,650	42,121	154	2,375	5%
Professional	1,770,587	1,598,936	79,276	92,375	5%
Total	1,815,237	1,641,057	79,430	94,750	5%

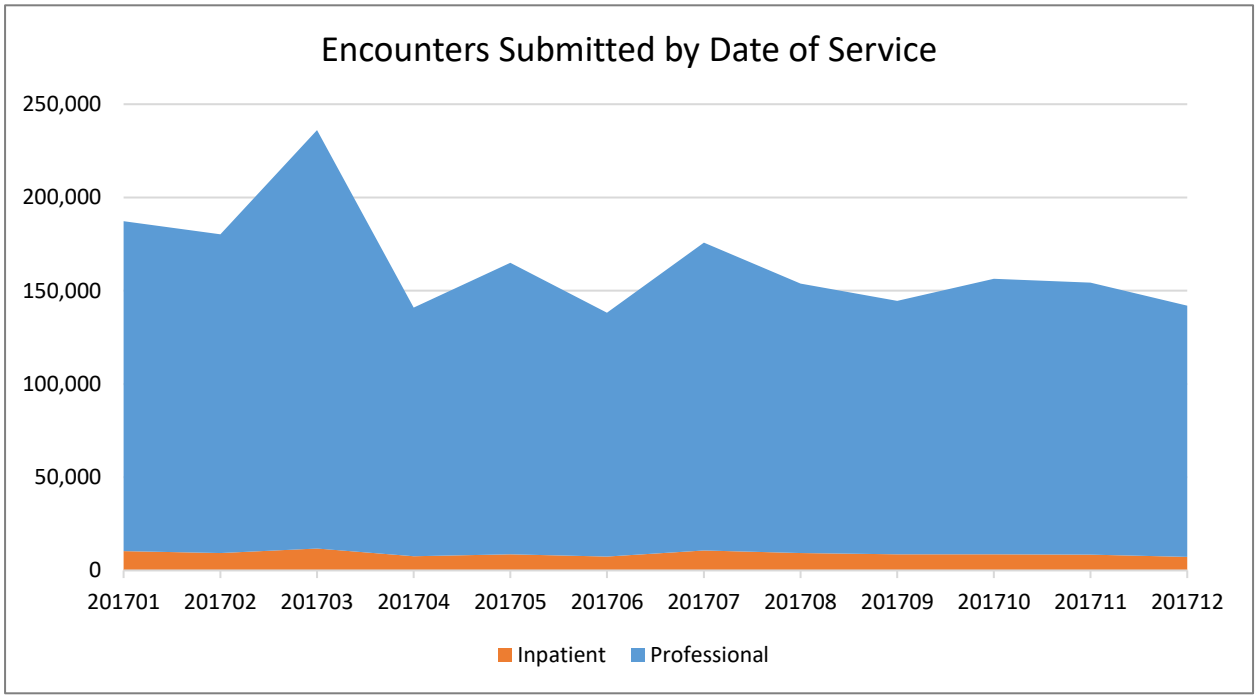
Compared to claims submitted in 2016, Vaya has decreased the number of initial denials and total number of outstanding denials for claims submitted in 2017. The PIHP has also done a great job cleaning up outstanding denials from 2016 with less than 1% still in error. According to Vaya's response and review of NC Medicaid's acceptance report, 36% of all outstanding and ongoing denials are still related to invalid taxonomy codes for the billing and rendering provider or invalid combination of procedure code and taxonomy. Vaya's strategy to continue to reduce, correct and resubmit encounter denials includes the following steps:

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

As a result of their strategy, denied claims from 2016 that were reported in the EDV review last year has decreased from 9% (109,983 claims) to less than 1% (1,614 claims).

Analysis of Encounters

The analysis of encounter data evaluated whether Vaya submitted complete, accurate, and valid data to NC Medicaid for all claims paid between January 1, 2017 through December 31, 2017. Vaya pulled all claims adjudicated and submitted to NC Medicaid during 2017 and sent to HMS via SFTP. This included more than 2.4 million professional claims and just over 327,000 institutional claims. Data transmitted included voids and resubmissions for previously denied claims, so the numbers do not reconcile back to the metrics reported in the ISCA response.



In order to evaluate the data, HMS ingested the 837I and 837P data extracts, and loaded them to a consolidated database. After data onboarding was completed, HMS applied proprietary, internally designed data analysis logic within SAS to review each data element, focusing on the data elements defined as required. Our logic evaluates the presence of data in each field within a record as well as whether the value for the field is within accepted standards. Results of these checks were compared with general expectations for each data field and to the CMS standards adopted for encounter data. The table below depicts the specific data expectations and validity criteria applied.

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

Data Element	*Expectation*	*Validity Criteria*
Recipient ID	Should be valid ID as found in the State's eligibility file. Can use State's ID unless State also accepts Social Security Number.	100% valid
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

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

Data Element	*Expectation*	*Validity Criteria*
		of names should have at least a middle initial.
Recipient Date of Birth	Should not be missing and should be a valid date.	< 2% missing or invalid
MCO/PIHP ID	Critical Data Element	100% valid
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	95% valid
Attending Provider ID	Should be an enrolled provider listed in the provider enrollment file (will accept the MD license number if it is listed in the provider enrollment file).	> 85% match with provider file using either provider ID or MD license number
Provider Location	Minimal requirement is county code, but zip code is strongly advised.	> 95% with valid county code > 95% with valid zip code (if available)
Place of Service	Should be routinely coded, especially for physicians.	> 95% valid for physicians > 80% valid across all providers
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% nonmissing and valid on physician or other applicable provider type claims (e.g., other practitioners)
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid codes (using International Statistical Classifications of Diseases, Ninth Revision, Clinical Modification [ICD-10-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 table below outlines the key fields that were reviewed to determine if information was present, whether the information was the correct type and size, and whether or not the data populated was valid. Although we looked at the complete data set and validated all data values, the fields below are key to properly pricing for the services paid by Vaya.

Table: Evaluation of Key Fields

Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%
Recipient Name	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%
Recipient Date of Birth	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%
MCO/PIHP ID	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%
Provider ID	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%
Attending/Renderring Provider ID	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%
Provider Location	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%
Place of Service	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%
Specialty Code / Taxonomy - Billing	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%
Specialty Code / Taxonomy - Rendering / Attending	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%
Principal Diagnosis	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%
Other Diagnosis	221,138	7.94%	221,138	7.94%	221,138	7.94%	221,138	7.94%
Dates of Service	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%
Unit of Service (Quantity)	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%	2,784,352	100.00%
Procedure Code	2,601,086	93.42%	2,601,086	93.42%	2,601,086	93.42%	2,601,086	93.42%
Procedure Code Modifier	669,907	24.06%	669,907	24.06%	669,907	24.06%	669,907	24.06%
Patient Discharge Status Code Inpatient	327,261	100.00%	324,071	99.03%	324,071	99.03%	324,071	99.03%
Revenue Code	327,261	100.00%	324,071	99.03%	324,071	99.03%	312,183	95.39%

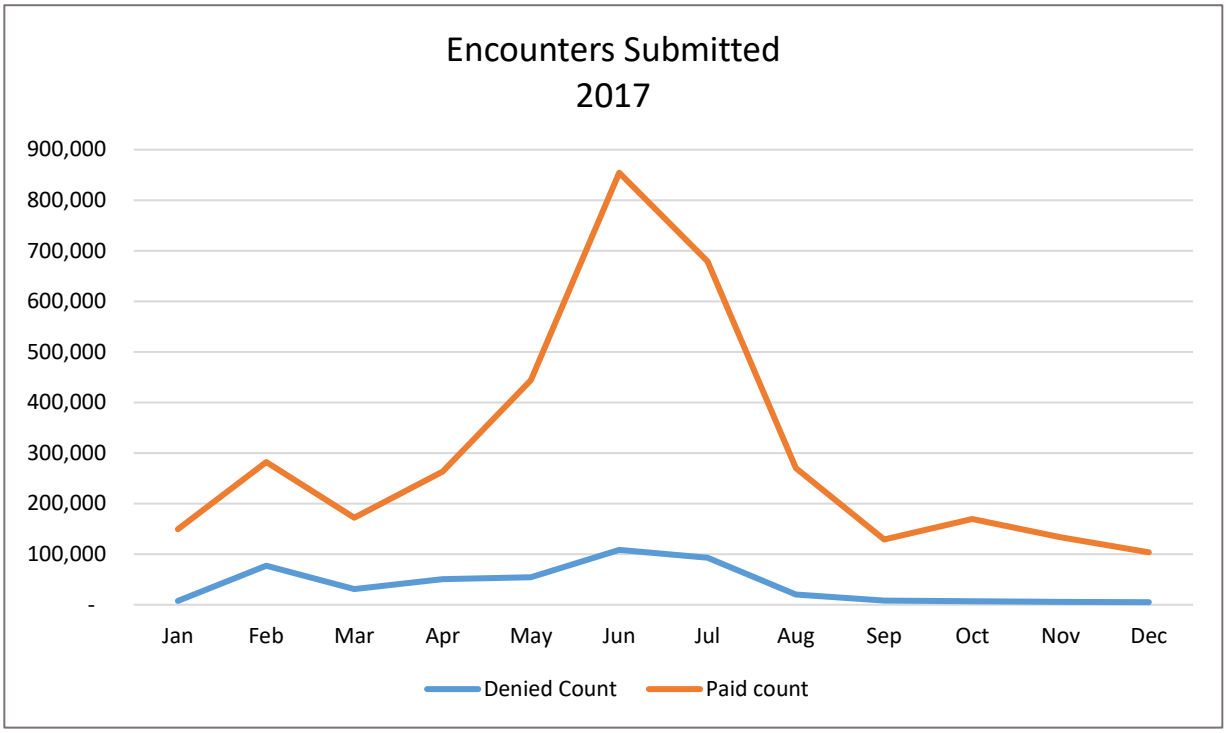
Overall, Vaya has significantly improved the quality and accuracy of the encounter data submitted compared to last year's review of 2016 claims. Institutional claims contained complete and valid data in 16 of the 18 key fields (89%) with noted issues for procedure code and diagnosis codes. The procedure code was only populated 50% of the time. Give the services provided and revenue codes submitted, the procedure code should have been more consistently populated. Also, only the admitting and principal diagnosis were provided -- a secondary diagnosis was never submitted.

Professional encounter claims submitted contained complete and accurate data in 14 of the 15 key professional fields (93%). Only the principal and secondary diagnosis codes were reported in the data. Although this is common across each of the PIHPs, only 7% of the encounters had the secondary diagnosis code populated.

Encounter Acceptance Report

In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write which made it difficult to tie back to the ISCA response and submitted encounter files since only the

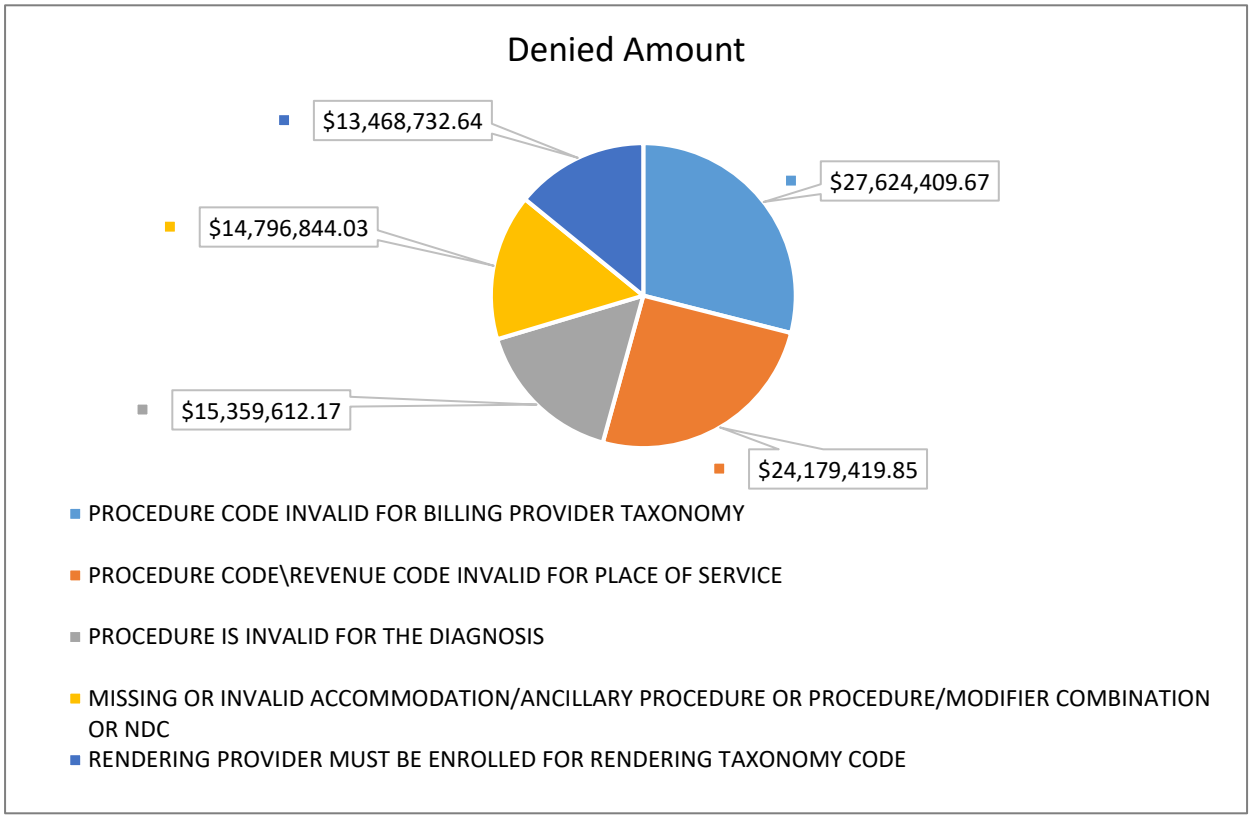
Date of Service for each is available. During the 2017 weekly check write schedule, Vaya submitted a total of 3,651,032 encounters to NC Medicaid. On average, 13% of all encounters submitted were initially denied. Less than 5% of claims denied are still outstanding -- the rest have been reviewed, resubmitted, and accepted by NC Medicaid.

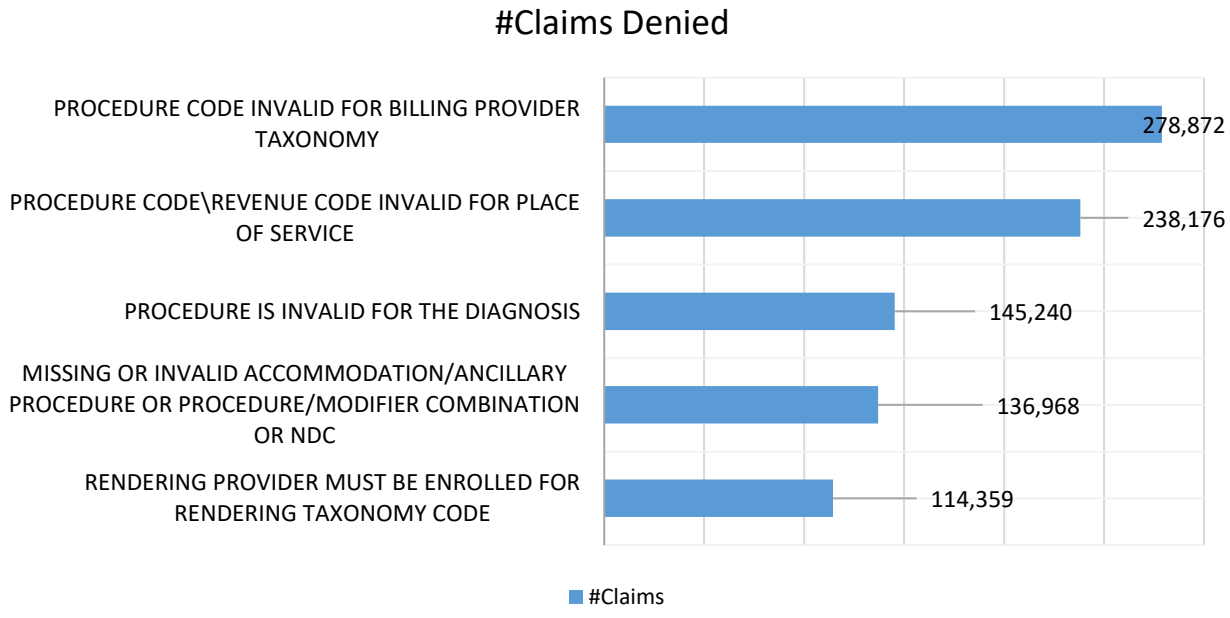


Evaluation of the top denials for Vaya encounters correlates with the some of the data deficiencies identified by the HMS analyst in the Key Field analysis above. Encounters were denied primarily for:

- Procedure code invalid for billing provider taxonomy
- Procedure code\revenue code invalid for place of service
- Procedure is invalid for the diagnosis
- Missing or invalid accommodation/ancillary procedure or procedure/modifer combination
- Rendering provider must be enrolled for rendering taxonomy code

The charts below reflect the top 5 denials by paid amount and the number of claims impacted by each denial reason.


Denied Amount
$13,468,732.64
$27,624,409.67
$14,796,844.03
$15,359,612.17
$24,179,419.85
PROCEDURE CODE INVALID FOR BILLING PROVIDER TAXONOMY
PROCEDURE CODE\REVENUE CODE INVALID FOR PLACE OF SERVICE
PROCEDURE IS INVALID FOR THE DIAGNOSIS
MISSING OR INVALID ACCOMMODATION/ANCILLARY PROCEDURE OR PROCEDURE/MODIFIER COMBINATION OR NDC
RENDERING PROVIDER MUST BE ENROLLED FOR RENDERING TAXONOMY CODE


#Claims Denied
PROCEDURE CODE INVALID FOR BILLING PROVIDER TAXONOMY
278,872
PROCEDURE CODE\REVENUE CODE INVALID FOR PLACE OF SERVICE
238,176
PROCEDURE IS INVALID FOR THE DIAGNOSIS
145,240
MISSING OR INVALID ACCOMMODATION/ANCILLARY PROCEDURE OR PROCEDURE/MODIFIER COMBINATION OR NDC
136,968
RENDERING PROVIDER MUST BE ENROLLED FOR RENDERING TAXONOMY CODE
114,359
#Claims

Results and Recommendations

Issue: Procedure Code

The procedure code for Institutional claims should populated 99% of the time. In the encounter files provided, HMS found that the field was populated less than 45% of the time. These fields are required to adjudicate the claim appropriately and should be provided by the provider given the types of services being billed and supporting revenue codes provided.

Resolution:

Vaya should check their claims processing system and data warehouse to ensure the Procedure Code is being captured appropriately. Claims submitted through the portal or an 837 should be denied by Vaya without the proper revenue code and procedure code combination. Vaya should double check their 837 encounter creation process and encounter data extract process to make sure data was not lost or manipulated during transformation.

Issue: Diagnosis Codes

Two items need to be addressed as it relates to diagnosis codes. The secondary diagnosis was not populated less than 8% for professional claims and only the admitting and principal diagnosis was provided for institutional claims. Also, there are never more than 2 diagnosis codes provided/submitted in the encounter data for professional or institutional claims.

Resolution:

The diagnosis issue will require action by Vaya and NC Medicaid. NC Medicaid will need to work with the PIHPs and CSRA to determine what additional non-behavioral health diagnosis codes should be submitted and accepted when available. Currently, NCTracks will deny any encounter with a non behavioral health diagnosis regardless of the position of the diagnosis code value (i.e. primary, secondary, tertiary, etc.). There are behavioral health services provided by the PIHPs that require medical services and medical diagnosis codes. Vaya will need to work collaboratively with the state and Alpha to ensure they can capture and report all diagnosis codes once NCTracks has been updated to accept.

Conclusion

Based on the analysis of Vaya's encounter data, we have concluded that the data submitted to NC Medicaid is not complete and accurate. Minor issues were noted with both institutional and professional encounters. Vaya should take corrective action to resolve the issues identified with procedure code and diagnosis codes.

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

Appendix 1

R_CLM_EDT_CD	R_EDT_SHORT_DESC	DISPOSITION
00001	HDR BEG DOS INVLD/ > TCN DATE	DENY
00002	ADMISSION DATE INVALID	DENY
00003	HDR END DOS INVLD/ > TCN DATE	DENY
00006	DISCHARGE DATE INVALID	PAY AND REPORT
00007	TOT DAYS CLM GTR THAN BILL PER	PAY AND REPORT
00023	SICK VISIT BILLED ON HC CLAIM	IGNORE
00030	ADMIT SRC CD INVALID	PAY AND REPORT
00031	VALUE CODE/AMT MISS OR INVLD	PAY AND REPORT
00036	HEALTH CHECK IMMUNIZATION EDIT	IGNORE
00038	MULTI DOS ON HEALTH CHECK CLM	IGNORE
00040	TO DOS INVALID	DENY
00041	INVALID FIRST TREATMENT DATE	IGNORE
00044	REQ DIAG FOR VITROCERT	IGNORE
00051	PATIENT STATUS CODE INVALID	PAY AND REPORT
00055	TOTAL BILLED INVALID	PAY AND REPORT
00062	REVIEW LAB PATHOLOGY	IGNORE
00073	PROC CODE/MOD END-DTE ON FILE	PAY AND REPORT
00076	OCC DTE INVLD FOR SUB OCC CODE	PAY AND REPORT
00097	INCARCERATED - INPAT SVCS ONLY	DENY
00100	LINE FDOS/HDR FDOS INVALID	DENY
00101	LN TDOS BEFORE FDOS	IGNORE
00105	INVLD TOOTH SURF ON RSTR PROC	IGNORE
00106	UNABLE TO DETERMINE MEDICARE	PAY AND REPORT

00117	ONLY ONE DOS ALLOWED/LINE	PAY AND REPORT
00126	TOOTH SURFACE MISSING/INVALID	IGNORE
00127	QUAD CODE MISSING/INVALID	IGNORE
00128	PROC CDE DOESNT MATCH TOOTH #	IGNORE
00132	HCPCS CODE REQ FOR REV CODE	IGNORE
00133	HCPCS CODE REQ BILLING RC 0636	IGNORE
00135	INVL POS INDEP MENT HLTH PROV	PAY AND REPORT
00136	INVLD POS FOR IDTF PROV	PAY AND REPORT
00140	BILL TYPE/ADMIT DATE/FDOS	DENY
00141	MEDICAID DAYS CONFLICT	IGNORE
00142	UNITS NOT EQUAL TO DOS	PAY AND REPORT
00143	REVIEW FOR MEDICAL NECESSITY	IGNORE
00144	FDOS AND TDOS MUST BE THE SAME	IGNORE
00146	PROC INVLD - BILL PROV TAXON	PAY AND REPORT
00148	PROC\REV CODE INVLD FOR POS	PAY AND REPORT
00149	PROC\REV CD INVLD FOR AGE	IGNORE
00150	PROC CODE INVLD FOR RECIP SEX	IGNORE
00151	PROC CD/RATE INVALID FOR DOS	PAY AND REPORT
00152	M/I ACC/ANC PROC CD	PAY AND REPORT
00153	PROC INVLD FOR DIAG	PAY AND REPORT
00154	REIMB RATE NOT ON FILE	PAY AND REPORT
00157	VIS FLD EXAM REQ MED JUST	IGNORE
00158	CPT LAB CODE REQ FOR REV CD	IGNORE
00164	IMMUNIZATION REVIEW	IGNORE
00166	INVALID VISUAL PROC CODE	IGNORE

00174	VACCINE FOR AGE 00-18	IGNORE
00175	CPT CODE REQUIRED FOR RC 0391	IGNORE
00176	MULT LINES SAME PROC, SAME TCN	IGNORE
00177	HCPCS CODE REQ W/ RC 0250	IGNORE
00179	MULT LINES SAME PROC, SAME TCN	IGNORE
00180	INVALID DIAGNOSIS FOR LAB CODE	IGNORE
00184	REV CODE NOT ALLOW OUTPAT CLM	IGNORE
00190	DIAGNOSIS NOT VALID	DENY
00192	DIAG INVALID RECIP AGE	IGNORE
00194	DIAG INVLD FOR RECIP SEX	IGNORE
00202	HEALTH CHECK SHADOW BILLING	IGNORE
00205	SPECIAL ANESTHESIA SERVICE	IGNORE
00217	ADMISSION TYPE CODE INVALID	PAY AND REPORT
00250	RECIP NOT ON ELIG DATABASE	DENY
00252	RECIPIENT NAME/NUMBER MISMATCH	PAY AND REPORT
00253	RECIP DECEASED BEFORE HDR TDOS	DENY
00254	PART ELIG FOR HEADER DOS	PAY AND REPORT
00259	TPL SUSPECT	PAY AND REPORT
00260	M/I RECIPIENT ID NUMBER	DENY
00261	RECIP DECEASED BEFORE TDOS	DENY
00262	RECIP NOT ELIG ON DOS	DENY
00263	PART ELIG FOR LINE DOS	PAY AND REPORT
00267	DOS PRIOR TO RECIP BIRTH	DENY
00295	ENC PRV NOT ENRL TAX	IGNORE
00296	ENC PRV INV FOR DOS	IGNORE

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

00374	DRG PAY ON FIRST ACCOM LINE	DENY
00375	DRG CODE NOT ON PRICING FILE	PAY AND REPORT
00378	DRG RCC CODE NOT ON FILE DOS	PAY AND REPORT
00439	PROC\REV CD INVLD FOR AGE	IGNORE
00441	PROC INVLD FOR DIAG	IGNORE
00442	PROC INVLD FOR DIAG	IGNORE
00613	PRIM DIAG MISSING	DENY
00628	BILLING PROV ID REQUIRED	IGNORE
00686	ADJ/VOID REPLC TCN INVALID	DENY
00689	UNDEFINED CLAIM TYPE	IGNORE
00701	MISSING BILL PROV TAXON CODE	DENY
00800	PROC CODE/TAXON REQ PSYCH DX	PAY AND REPORT
00810	PRICING DTE INVALID	IGNORE
00811	PRICING CODE MOD REC M/I	IGNORE
00812	PRICING FACTOR CODE SEG M/I	IGNORE
00813	PRICING MOD PROC CODE DTE M/I	IGNORE
00814	SEC FACT CDE X & % SEG DTE M/I	IGNORE
00815	SEC FCT CDE Y PSTOP SEG DT M/I	IGNORE
01005	ANTHES PROC REQ ANTHES MODS	IGNORE
01060	ADMISSION HOUR INVALID	IGNORE
01061	ONLY ONE DOS PER CLAIM	IGNORE
01102	PRV TAXON CHCK - RAD PROF SRV	IGNORE
01200	INPAT CLM BILL ACCOM REV CDE	DENY
01201	MCE - ADMIT DTE = DISCH DTE	DENY
01202	M/I ADMIT AND DISCH HRS	DENY

01205	MCE: PAT STAT INVLD FOR TOB	DENY
01207	MCE - INVALID AGE	PAY AND REPORT
01208	MCE - INVALID SEX	PAY AND REPORT
01209	MCE - INVALID PATIENT STATUS	DENY
01705	PA REQD FOR CAPCH/DA/CO RECIP	PAY AND REPORT
01792	DME SUPPLIES INCLD IN PR DIEM	DENY
02101	INVALID MODIFIER COMB	IGNORE
02102	INVALID MODIFIERS	PAY AND REPORT
02104	TAXON NOT ALLOWED WITH MOD	PAY AND REPORT
02105	POST-OP DATES M/I WITH MOD 55	IGNORE
02106	LN W/ MOD 55 MST BE SAME DOS	IGNORE
02107	XOVER CLAIM FOR CAP PROVIDER	IGNORE
02111	MODIFIER CC INTERNAL USE ONLY	IGNORE
02143	CIRCUMCISION REQ MED RECS	IGNORE
03001	REV/HCPCS CD M/I COMBO	IGNORE
03010	M/I MOD FOR PROF XOVER	IGNORE
03012	HOME HLTH RECIP NOT ELG MCARE	IGNORE
03100	CARDIO CODE REQ LC LD LM RC RI	IGNORE
03101	MODIFIER Q7, Q8 OR Q9 REQ	IGNORE
03200	MCE - INVALID ICD-9 CM PROC	DENY
03201	MCE INVLD FOR SEX PRIN PROC	PAY AND REPORT
03224	MCE-PROC INCONSISTENT WITH LOS	PAY AND REPORT
03405	HIST CLM CANNOT BE ADJ/VOIDED	DENY
03406	HIST REC NOT FND FOR ADJ/VOID	DENY
03407	ADJ/VOID - PRV NOT ON HIST REC	DENY

04200	MCE - ADMITTING DIAG MISSING	DENY
04201	MCE - PRIN DIAG CODE MISSING	DENY
04202	MCE DIAG CD - ADMIT DIAG	DENY
04203	MCE DIAG CODE INVLD RECIP SEX	PAY AND REPORT
04206	MCE MANIFEST CODE AS PRIN DIAG	DENY
04207	MCE E-CODE AS PRIN DIAG	DENY
04208	MCE - UNACCEPTABLE PRIN DIAG	DENY
04209	MCE - PRIN DIAG REQ SEC DIAG	PAY AND REPORT
04210	MCE - DUPE OF PRIN DIAG	DENY
04506	PROC INVLD FOR DIAG	IGNORE
04507	PROC INVLD FOR DIAG	IGNORE
04508	PROC INVLD FOR DIAG	IGNORE
04509	PROC INVLD FOR DIAG	IGNORE
04510	PROC INVLD FOR DIAG	IGNORE
04511	PROC INVLD FOR DIAG	IGNORE
07001	TAXON FOR ATTND/REND PROV M/I	DENY
07011	INVLD BILLING PROV TAXON CODE	DENY
07012	INVLD REND PROV TAXONOMY CODE	DENY
07013	INVLD ATTEND PROV TAXON CODE	PAY AND REPORT
07100	ANESTH MUST BILL BY APPR PROV	IGNORE
07101	ASC MODIFIER REQUIREMENTS	IGNORE
13320	DUP-SAME PROV/AMT/DOS/PX	DENY
13420	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
13460	POSSIBLE DUP-SAME PROV/PX/DOS	PAY AND REPORT
13470	LESS SEV DUPLICATE OUTPATIENT	PAY AND REPORT

13480	POSSIBLE DUP SAME PROV/OVRLAP	PAY AND REPORT
13490	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13500	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13510	POSSIBLE DUP/SME PRV/OVRLP DOS	PAY AND REPORT
13580	DUPLICATE SAME PROV/AMT/DOS	PAY AND REPORT
13590	DUPLICATE-SAME PROV/AMT/DOS	PAY AND REPORT
25980	EXACT DUPE. SAME DOS/ADMT/NDC	PAY AND REPORT
34420	EXACT DUP SAME DOS/PX/MOD/AMT	PAY AND REPORT
34460	SEV DUP-SAME PX/PRV/IM/DOS/MOD	DENY
34490	DUP-PX/IM/DOS/MOD/$$/PRV/TCN	PAY AND REPORT
34550	SEV DUP-SAME PX/IM/MOD/DOS/TCN	PAY AND REPORT
39360	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
39380	EXACT/LESS SEVERE DUPLICATE	PAY AND REPORT
49450	PROCDURE CODE UNIT LIMIT	PAY AND REPORT
53800	Dupe service or procedure	PAY AND REPORT
53810	Dupe service or procedure	PAY AND REPORT
53820	Dupe service or procedure	PAY AND REPORT
53830	Dupe service or procedure	PAY AND REPORT
53840	Limit of one unit per day	PAY AND REPORT
53850	Limit of one unit per day	PAY AND REPORT
53860	Limit of one unit per month	PAY AND REPORT
53870	Limit of one unit per day	PAY AND REPORT
53880	Limit of 24 units per day	DENY
53890	Limit of 96 units per day	DENY
53900	Limit of 96 units per day	DENY