2022 External Quality Review

VAYA HEALTH

Submitted: October 20, 2022

Prepared on behalf of
North Carolina Medicaid

Table of Contents

EXECUTIVE SUMMARY

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

Goals of the review are to:

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

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

A. Overall Findings

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

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

Due to the COVID-19 pandemic, CCME implemented a focused review. This decision was based on the issuance by the State of the *COVID-19 flexibilities PIHP Contract Amendment #11*. This PIHP contract amendment stated PIHPs "shall be held harmless for any documentation or other PIHP errors identified through the EQR that are not directly related to member health and safety through the Term of the Amendment."

The focused review included comprehensive evaluation of the PIHP's health systems capabilities and provider credentialing and recredentialing documentation and processes. The review includes validation of the PIHP's PIPs, PMs, and Encounter data. Lastly, a thorough review of the PIHP's Utilization Management, Grievances, and Appeals processes were conducted. The PIHP's network adequacy, availability of services, subcontractual relationships, and Clinical Practice Guidelines (*42 CFR § 438.206, § 438.207, § 438.230, and § 438.236,* respectively*)* were not reviewed.

To access the PIHP's compliance with federal regulations and contract, CCME's review was divided into six areas. The following is a high-level summary of the review results for those areas. Additional information regarding the reviews, including Strengths, Weaknesses, and Recommendations, are included in the narrative of this report.

B. Overall Recommendations

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

Administration

42 CFR § 438.224 and 42 CFR § 438.242

In the 2021 EQR, Vaya met 100% of the Administrative standards and received two Recommendations. These Recommendations centered around limitations of Vaya's Institutional Encounter data submissions into NCTracks.

In the 2022 EQR, Vaya again met 100% of the Administrative standards in the 2022 EQR. However, there was no evidence provided by Vaya demonstrating the 2021 EQR Recommendations were addressed and implemented. During the Onsite, Vaya explained they are in the process of implementing a new system in preparation of going live with the Tailored Care Program in December 2022, and all current system enhancements were put on hold. Therefore, the Recommendations from the 2021 EQR are carried forward in the 2022 EQR to ensure Encounter data capabilities are maximized with Vaya's new system. An additional Recommendation was added to improve turnaround times for the resubmission of denied encounters to NC Medicaid.

Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

In Vaya's 2021 EQR of Credentialing/Recredentialing, there were no items requiring Corrective Action, and one Recommendation, which was an unaddressed Recommendation from the 2020 EQR. In this 2022 EQR, Vaya partially implemented the Recommendation, revising the *Credentialing Committee Charter* but not the relevant language in the *Credentialing Program Description*. There are conflicts in membership lists between the *Credentialing Committee Charter* dated January 27, 2022, the *Credentialing Committee Membership Matrix 20220812*, and the submitted Credentialing Committee meeting minutes.

Although the Recommendation from 2020 and 2021 was only partially implemented and there are conflicts in membership lists in documents, CCME is issuing no Recommendations in the 2022 EQR of Credentialing/Recredentialing, as credentialing and recredentialing are no longer completed by the PIHPs. Vaya met 100% of the Provider Services standards.

Quality Improvement

42 CFR § 438.330

In the 2021 EQR, Vaya met 100% of the Quality standards and received one Recommendation related to the four PIPs validated. One PIP that received a Recommendation in 2021 was no longer active in 2022. Therefore, Vaya's implementation of that Recommendation could not be evaluated in the 2022 EQR.

For the 2022 EQR, Vaya met all standards with no Corrective Actions. All PIPs were validated in the High Confidence range. There was one Recommendation issued regarding the Access to Care PIP to assess the impact of the newest interventions, including additional complex care management and staff education to determine if these improve the services received rate. Vaya was Fully Compliant for (b) Waiver and (c) Waiver PMs, and no Recommendations were issued for the PMs.

Utilization Management

42 CFR § 438.208

In the 2021 EQR, Vaya met 96% of the Utilization Management (UM) standards and received one Corrective Action and one Recommendation to address an issue identified in the Care Coordination enrollee file review. In the 2021 EQR, a Corrective Action was issued to address several issues identified in an Innovations enrollee file submitted by Vaya. The Corrective Action targeted concerns regarding a lack of coordination of services and supports, and assessment of the enrollee's health and safety prior to the enrollee's voluntary termination from the Innovations Waiver. In the 2022 EQR, there was evidence Vaya implemented this Corrective Action. Vaya submitted a new Standard Operating Procedure in draft form, revised the *Care Management Reference Guide*, and

provided training to staff around the required health assessments, support, and notifications when an enrollee is discharged from the Innovations Waiver.

The 2021 enrollee file review found 39% of enrollee contact notes were submitted outside of the 24-hour timeframe required by Vaya Policy. Additionally, enrollee contact notes submitted beyond the 24-hour entry requirement did not follow the late entry process required in Vaya Policy 2340, Administrative Health Record Documentation. CCME recommended Vaya update the current *Complex Care Management Quality Improvement & Monitoring Plan* to include a process to identify late enrollee contact notes and ensure these enrollee contact notes are labelled "late entry" and include the reason for the delay, as required by Policy 2340.

In the 2022 EQR, Vaya met all of the UM standards. However, Vaya was not able to produce any evidence to suggest the 2021 Recommendation was implemented. The *Complex Care Management Quality Improvement & Monitoring Plan* submitted for the 2022 EQR was not revised nor was there evidence Vaya was monitoring for the above compliance issue regarding late enrollee contact notes. Additionally, the files selected by Vaya for the 2022 EQR still showed compliance issues related to late enrollee contact notes, but to a lesser degree than the previous EQR. CCME is again recommending Vaya revise the monitoring plan and routinely review enrollee contact notes for compliance around Vaya's late contact note policy, Policy 2340.

Grievances and Appeals

42 CFR § 438, Subpart F, 42 CFR 483.430

In the 2021 EQR, Vaya met 100% of the Grievance and Appeal standards, resulting in no Corrective Actions. CCME issued one Recommendation in Grievances and two Recommendations in Appeals. The Grievance Recommendation targeted monitoring to ensure timely acknowledgement and resolution notification and was implemented. CCME issued two Appeals Recommendations addressing monitoring practices, which were implemented in the 2022 EQR.

In this 2022 EQR, Vaya met 100% of the Grievance and Appeal standards, resulting in no Corrective Actions or Recommendations.

Program Integrity

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

In the 2021 EQR, Vaya met 100% of Program Integrity standards and received one Recommendation. It was recommended Vaya add language to a PI policy detailing the process and timeframes required by *NC Medicaid Contract, Section 9.8* and *14.2.14* for submission of the monthly report to the State. In the 2022 EQR, it was noted that for a third year Vaya elected not to implement this Recommendation.

For the 2022 EQR, Vaya again met 100% of Program Integrity standards and received two Recommendations. The first Recommendation addresses the need for Vaya to update the *Regulatory Compliance Committee Charter's* membership list, and the second Recommendation addresses the lack of information explaining provider repayment amounts in an *Attachment Y report* within one of the investigation files reviewed.

Encounter Data Validation

The analyses of Vaya's Encounter data showed the data submitted to NC Medicaid is complete and accurate. The only issue noted for Vaya was found with Other Diagnosis codes being frequently absent on both Professional and Institutional encounters.

It is recommended Vaya continue to educate its providers on the importance of complete and accurate coding. Vaya should also continue monitoring the reporting of Diagnosis codes and continue to take appropriate steps to improve both the quality and quantity of the Diagnosis code reporting. This would enable Vaya and NC Medicaid to get a more complete picture of the morbidities within the demographics it serves.

Corrective Actions and Recommendations from Previous EQR

During the 2021 EQR, there was one standard scored as "Partially Met" and no standards scored as "Not Met." Following the 2021 EQR, Vaya submitted a Corrective Action Plan to address the identified deficiencies. CCME reviewed and accepted Vaya's Corrective Action Plan on December 30, 2021.

During the 2022 EQR, CCME assessed the degree to which the PIHP implemented the actions to address these deficiencies and found the Corrective Action Plan was fully implemented. In the 2022, Vaya provided evidence the Corrective Action Plan was implemented by Vaya. Additional details regarding the PIHP's 2021 Corrective Actions Plan, the PIHP's response, and evidence, or lack thereof, of PIHP implementation of the 2021 Corrective Actions are detailed in the Utilization Management section of this report.

Conclusions

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

Figure 1: Annual EQR Comparative Results

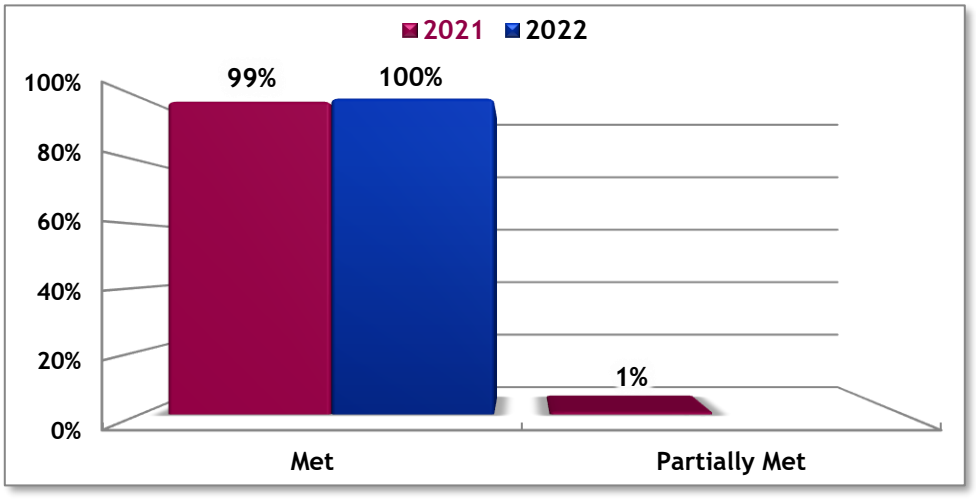


Table 1 provides a summary of key findings and Recommendations or opportunities for improvement. Specific details of Strengths, Weaknesses, and Recommendations can be found in each specific section of this report.

Table 1: Vaya's 2022 Overall Strengths, Weaknesses, Recommendations and Corrective Actions

	Strengths	Weaknesses	Corrective Actions/ Recommendations
Quality	Vaya can capture of up to 22 ICD-10 Diagnosis codes on Institutional claims and 12 ICD-10 Diagnosis codes on Professional claims.	Vaya does not have the ability to submit ICD-10 Procedure codes on Encounter data extracts to NCTracks.	***Recommendation: Update Vaya's encounter data submission process to submit ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks.***
	Vaya can capture the Diagnosis Related Group (DRG) and ICD-10 Procedure codes on Institutional claims on the provider web portal and via HIPAA files.	Vaya does not have the ability to submit more than 12 ICD-10 Diagnosis codes on Institutional encounter data extracts to NCTracks.	***Recommendation: Update Vaya's encounter data submission process to increase the number of ICD-10 Diagnosis codes reported on Institutional encounter data extracts to NCTracks from 12 to 25.***

	Strengths	Weaknesses	Corrective Actions/ Recommendations
	Vaya has the ability to submit DRGs on Institutional Encounter data extracts to NC Medicaid.	For the Access to Care PIP, the most recent remeasurement period shows a rate decline.	***Recommendation: For the Access to Care PIP, assess the impact of newest interventions including additional complex care management and staff education to determine if these improve the services received rate.***
	(b) Waiver Measures included all necessary documentation, and measures were reported according to specifications.	The *Attachment Y Report* for one PI case showed a discrepancy between the identified overpayment amount and the amount of repayment.	***Recommendation: Ensure the Attachment Y reports detail all financial actions taken towards collecting provider overpayments.***
	(c) Waiver Measures met or exceeded State benchmark rates.	One TCLI record reviewed in this year's EQR included the full name of a different enrollee.	***Recommendation: Remove or replace with initials the full name of the other enrollee documented within the TCLI enrollee's record.***
	All PIPs scored in the High Confidence range.		
	Vaya met or exceeded all established targets for the TCLI Super Measure.		
	Vaya can capture of up to 22 ICD-10 Diagnosis codes on Institutional claims and 12 ICD-10 Diagnosis codes on Professional claims.		
	Vaya can capture the DRG and ICD-10 Procedure codes on Institutional claims on the provider web portal and via HIPAA files.		
	Vaya has the ability to submit to NC Medicaid DRGs on Institutional encounter data extracts.		

	Strengths	Weaknesses	Corrective Actions/ Recommendations
Timeliness	Vaya auto-adjudicates 67.13% of Institutional claims and 97.14% of Professional claims.	Vaya stated they have an internal goal to re-submit encounters within two weeks and an external goal of 30 days for resubmission. However, per the information provided in the ISCA, it takes approximately 40 days for Vaya to correct and resubmit an encounter to NC Medicaid.	***Recommendation: Improve turnaround times for resubmission of denied encounters to fall within Vaya's external goal of 30 days.***
	Vaya Implemented a daily huddle in the Grievances department to help staff stay connected and have a group discussion to address high profile Grievances quickly.	There was no evidence Vaya is monitoring enrollee contact notes for compliance with Vaya Policy 2340, Administrative Health Record Documentation.	***Recommendation: Ensure late enrollee contact notes are monitored for compliance with Vaya Policy 2340. Monitoring should check notes are labelled "late entry" and include the reason for the delay when submitted outside of the required 24 hour timeframe.***
	Vaya implemented a bi-monthly standing meeting with their Chief Medical Officer to discuss any Grievances concerning health and safety.	The *Regulatory Compliance Committee Charter* has not been updated to reflect the new committee structure.	***Recommendation: Ensure the Regulatory Compliance Committee Charter list the names and titles of current committee members.***
	The addition of 11 new counties prompted Vaya to develop new methods for timely resolution of potential cases of fraud, waste, and abuse.		
	Vaya auto-adjudicates 67.13% of institutional claims and 97.14% of professional claims.		

	Strengths	Weaknesses	Corrective Actions/ Recommendations
Access to Care	Vaya provides a toll-free Provider Help Line and a separate toll-free line for business calls.		
	Vaya reported that, during the Cardinal transition, they "established a Command Center to escalate, track, and monitor provider-reported issues. This approach was successful and Vaya plans to replicate this model for TP/MD implementation."		
	Vaya reports they have collaborated with local Division of Social Services, hospitals, and the Mountain Area Health Education Center to embed Care Coordinators within these agencies to directly assist enrollees with system navigation, assessments, services and supports.		

METHODOLOGY

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

On July 22, 2022, 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 PIHP to participate in a pre-Onsite conference call with CCME and NC Medicaid for purposes of offering Vaya an opportunity to seek clarification on the review process and ask questions regarding any of the Desk Materials requested by CCME.

The review consisted of two segments. The first was a Desk Review of materials and documents received from Vaya on August 30, 2022 and reviewed by CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. Also included in the Desk Review was a review of Credentialing, Grievance, Utilization, Care Coordination, and Appeal files.

The second segment of the EQR is typically a two-day, Onsite review conducted at the PIHP's offices. However, due to COVID-19, this Onsite was conducted through a teleconference platform on September 22, 2022. This Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the onsite visit, see *Attachment 2*. CCME's onsite activities included:

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

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

FINDINGS

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

A. Administration

42 CFR § 438.208

Information Systems Capabilities Assessment

The review of Vaya's system capabilities involved the use of the Information Systems Capabilities Assessment (ISCA) tool and an evaluation of supporting documentation such as Vaya's claim audit reports, enrollment workflows, and Vaya's Information Technology (IT) staffing patterns. This system analysis is completed as specified in the Centers for Medicare and Medicaid Services (CMS) Protocol. During the Onsite, Vaya staff presented the enrollment and claims systems overview, and additional information regarding the ISCA tool was obtained through discussion with staff.

In the 2021 EQR, Vaya met 100% of the Administration EQR standards, and one Recommendation was issued. Table 2 outlines the Recommendation issued to Vaya in the 2021 EQR and CCME's follow up in the 2022 EQR.

Table 2: 2021 EQR Administration Findings

2021 EQR Administrative Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP has the capabilities in place to submit the State required data elements to NC Medicaid on the Encounter data submission.	***Recommendations: Update Vaya's Encounter data submission process to submit ICD-10 Procedure codes on Institutional Encounter data extracts to NCTracks.*** ***Update Vaya's Encounter data submission process to increase the number of ICD-10 Diagnosis codes reported on Institutional Encounter data extracts to NCTracks from 12 to 25.***	**N**
2022 EQR Follow up: During the 2022 EQR, Vaya confirmed they are in the process of transitioning from the current vendor and working towards implementation of a new system in preparation of going live with the Tailored Care Program in December 2022. Therefore, all enhancements were put on hold, and the prior year Recommendations were not implemented.		

During the 2022 EQR ISCA review it was confirmed Vaya used the AlphaMCS system to process member enrollment and claims, submit encounters, and generate reports. Vaya brought the system inhouse and housed it on their own servers in April 2021.

During the Onsite, Vaya explained the daily and quarterly Global Eligibility Files (GEF) are uploaded to their enrollment system. Vaya also loads the GEF files to a local SQL Server database for reporting and troubleshooting purposes. Encounters for Medicaid, which have been adjudicated, are loaded in batches, and submitted to NCTracks.

Vaya stores the Medicaid identification number received on the GEF. During the ISCA Onsite discussion, Vaya indicated they rarely receive members with multiple IDs but are able to research and merge the information into one Member ID. The historical claims for the member are also merged into one Member ID. During the Onsite, staff displayed the enrollment information to show their system can capture demographic data such as race, ethnicity, and language.

Review of the 2022 ISCA information showed Vaya experienced nearly 62% reduction in enrollment after July 2021. Vaya staff explained this reduction was due to the transition of membership to Standard Plans. Vaya enrollment counts for the past three years is presented in Table 3.

Table 3: Enrollment Counts

2019	2020	2021
144,595	161,570	61,700

Vaya received claims via three methods: 837 electronic file, provider web portal, and paper claims. During the Onsite, Vaya stated they receive claims from out-of-network hospitals and Emergency Departments on paper. Table 4 details the percentage of 2021 claims received via the three methods.

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

Source	HIPAA File	Paper	Provider Web Portal
Institutional	76.72%	0.10%	23.18%
Professional	90.32%	0.00%	9.68%

Vaya adjudicated claims on a nightly basis. Approximately 97.14% of Professional claims and 67.13% of Institutional claims were auto-adjudicated during the period under review. Claims in excess of $5,000 and Emergency Department claims are pended for manual review and reviewed daily.

The review of Vaya's ISCA showed Vaya captured up to 22 ICD-10 Diagnosis codes via the provider web portal and HIPAA files for Institutional claims, which were displayed on the claims screen. For Professional claims, the Vaya system can receive and store up to 12

ICD-10 Diagnosis codes on both the provider web portal and via HIPAA files. Vaya can capture ICD-10 Procedure codes and Diagnosis Related Groups (DRGs), if they were submitted on the claim. In the previous EQR, Recommendations were issued to address these limitations. During the Onsite, Vaya stated they are in the process of testing the submission of ICD-10 Procedure codes and up to 22 ICD-10 Diagnosis codes on Institutional encounters to NCTracks. However, as these Recommendations from the 2021 EQR were not addressed in the past year, they are carried forward in the 2022 EQR.

The breakdown of Encounter data acceptance/denial rates by claim service detail counts was provided for encounters submitted in 2021. Table 5 provides a comparison of 2021 and 2020.

Table 5: Volume of 2021 and 2020 Submitted Encounter Data

2021	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	32,468	1,416	486	34,370
Professional	1,774,065	83,701	18,087	1,875,853
2020	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	34,070	1,766	755	36,591
Professional	1,778,976	120,403	47,182	1,946,561

Vaya has an approximate 99.03% acceptance rate for both Professional and Institutional encounters with dates of service in 2021. Vaya reported the top three denial reasons for encounters submitted in 2021 were:

- Possible Duplicate Same Provider, Same Procedure Code, Overlapping Dates of Service
- Procedure code invalid for billing provider taxonomy
- Procedure code/Revenue code invalid for place of service

On average, Vaya submits an Encounter within three days from the time of adjudication to NC Medicaid. Per the information provided in the ISCA, it takes approximately 40 days to correct and resubmit an Encounter to NC Medicaid. During the Onsite, Vaya clarified the internal goal was to re-submit encounters within two weeks and the external goal is 30 days.

Vaya uses the Adam Holtzman's paid and denied reports and the weekly 835 file to identify encounters that were denied. Vaya explained there was a rate change, and providers re-submitted claims with updated rates. If the timing of the processing of the void files was not conducted before the new claims were processed, it appeared the new claims were duplicates and created duplicate denials. Vaya implemented a temporary process to address this concern. However, it was not consistently applied in 2020 leading to an increase in denials. This was addressed and the denials were reduced in 2021. Vaya exceeds the NC Medicaid standards for encounter submissions and has less than 5% denial rate of their Encounter data submissions.

Table 6 shows Vaya has 486 Institutional and 18,087 Professional encounters with dates of service in 2021 still awaiting resubmission as of August 14, 2022. Vaya exceeds the NC Medicaid standards for encounter submissions and has less than 1% denial rate of their Encounter data submissions. Vaya is submitting up to 12 ICD-10 Diagnosis codes for both Institutional and Professional encounters.

Table 6: Number of Denied Encounters

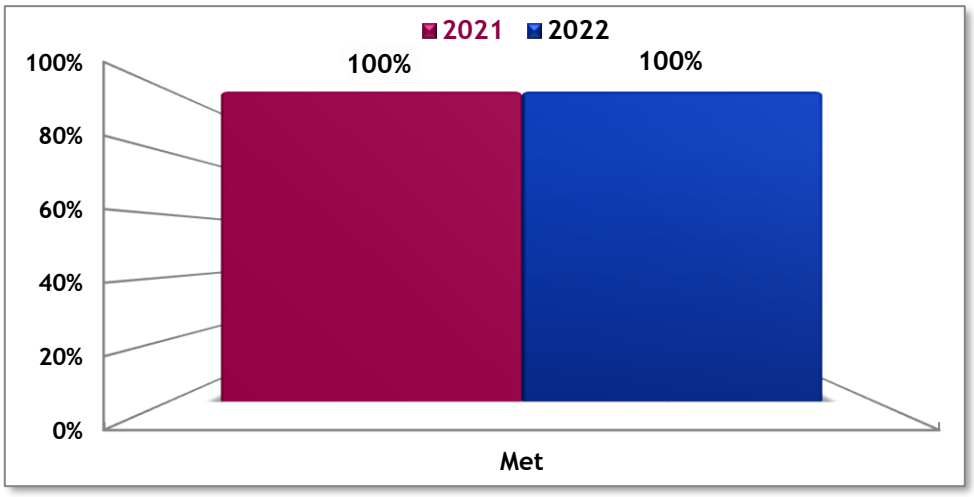
Encounter Type	Number of Denied Encounters	As of Date
Institutional	486*	8/14/2022
Professional	18,087**	8/14/2022

** Per Vaya, this is based on claim headers*

*** Per Vaya, this is based on claim line adjudications*

Figure 2 demonstrates Vaya met all of the Standards in the 2021 and 2022 ISCA EQRs.

Figure 2: Administration Comparative Findings



Strengths

- Vaya auto-adjudicates 67.13% of Institutional claims and 97.14% of Professional claims.
- Vaya can capture of up to 22 ICD-10 Diagnosis codes on Institutional claims and 12 ICD-10 Diagnosis codes on Professional claims.
- Vaya can capture the Diagnosis Related Group (DRG) and ICD-10 Procedure codes on Institutional claims on the provider web portal and via HIPAA files.
- Vaya has the ability to submit DRGs on Institutional Encounter data extracts to NC Medicaid.

Weaknesses

- Vaya stated they have an internal goal to re-submit encounters within two weeks and an external goal of 30 days for resubmission. However, per the information provided in the ISCA, it takes approximately 40 days for Vaya to correct and resubmit an encounter to NC Medicaid.
- Vaya does not have the ability to submit ICD-10 Procedure codes on Encounter data extracts to NCTracks.
- Vaya does not have the ability to submit more than 12 ICD-10 Diagnosis codes on Institutional Encounter data extracts to NCTracks.

Recommendations

- Improve turnaround times for resubmission of denied encounters to fall within Vaya's external goal of 30 days.
- Update Vaya's Encounter data submission process to submit ICD-10 Procedure codes on Institutional Encounter data extracts to NCTracks.
- Update Vaya's Encounter data submission process to increase the number of ICD-10 Diagnosis codes reported on Institutional Encounter data extracts to NCTracks from 12 to 25.

B. Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

The Provider Services EQR for Vaya included Credentialing and Recredentialing as well as a discussion of provider education and network adequacy. CCME reviewed relevant policies and procedures, the *Credentialing Program Description* (*CPD*), the *Credentialing Committee Charter (CCC)*, credentialing/recredentialing files, a sample of Credentialing Committee meeting minutes, and select items on Vaya's website. Vaya's staff provided additional information during an Onsite interview.

During the Onsite, Vaya staff reported the *CCC* dated November 2, 2021 and submitted in the Desk Materials was the "wrong one." Vaya then submitted the *CCC* dated January 27, 2022, and CCME reviewed that document.

In the 2021 EQR, Vaya met 100% of the Credentialing/Recredentialing standards, resulting in no Corrective Actions. CCME issued one Recommendation, focused on revising conflicting language regarding who would chair the Credentialing Committee meetings in the absence of the Chief Medical Officer (CMO). This Recommendation was also issued in the 2020 EQR. Though Vaya revised some language in the *CCC*, the relevant language in the *CPD* was not revised.

The *CCC* dated January 27,2022 was revised to update the Membership List. Dr. Wade's title was revised to "Deputy Chief Medical Director." The *CCC* indicates Dr. Wade is the Vice Chair of the committee and states "The Vice Chair shall serve as the Chair in the Chair's absence."

The relevant language in the *CCPD* continues to state "The Committee is chaired by Vaya's Chief Medical Officer (CMO). The Chair is a permanent member of the Committee. If the CMO is unable to attend the meeting, the Assistant Medical Director or other contracted/employed Psychiatrist attends as the CMO's designee." There is no Assistant Medical Director listed on the *Organizational Chart*. Dr. Wade is not a psychiatrist, and

therefore, would not meet the stipulation in the *Credentialing Program Description* for the "designee" in the absence of the CMO.

In this 2022 EQR, Vaya met 100% of the Credentialing/Recredentialing standards. CCME issued no Corrective Actions. Some differences exist between the Credentialing Committee membership listed on the *Committee Membership Matrix 20220812*, on the *CCC* dated January 27,2022, and on the submitted Credentialing Committee meeting minutes. The Recommendation from the 2020 EQR and the 2021 EQR to "Revise the *Credentialing Committee Charter*, Policy 2891 (designated as the *Credentialing Program Description*), and any other documents that detail credentialing processes, to consistently reflect who will chair the Credentialing Committee meetings in the absence of the CMO" was partially implemented, as presented in *Table 7, 2021 EQR Provider Services Findings*.

Per the direction of the NC DHHS, credentialing has now shifted from the PIHPs completing credentialing and recredentialing to the PIHPs verifying credentialing completed by NCTracks. Vaya completed the in-process credentialing and recredentialing files in June 2022, which is when the Credentialing Committee was dissolved, rendering the existing *CPD* and *CCC* obsolete. Therefore, although the Recommendation from 2020 and 2021 was only partially implemented and there are conflicts in membership lists in documents, CCME is issuing no Recommendations in the 2022 EQR of Credentialing/ Recredentialing.

Table 7 outlines the 2021 findings and CCME's follow up in the 2022 EQR regarding Vaya's implementation of the Corrective Action and Recommendation.

Table 7: 2021 EQR Provider Services Findings

2021 EQR Credentialing/Recredentialing findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	***Recommendation: As per the Recommendation in the 2020 EQR, revise the Credentialing Committee Charter, Policy 2891 (designated as the Credentialing Program Description), and any other documents that detail credentialing processes, to consistently reflect who will chair the Credentialing Committee meetings in the absence of the CMO.***	**N**

2022 EQR Follow up: This issue was discussed during the Onsite Reviews in February 2021 and September 2021 and included as a Recommendation in the reports issued in April 2021 and October 2021.

In this 2022 EQR, as at the 2020 and 2021 EQRs, there is conflicting language regarding who would chair the Credentialing Committee in the absence of the CMO. Vaya revised the *CCC* to indicate Dr. Lorena Wade is the Vice Chair of the committee. The *CCC* states the Vice Chair would chair meetings in the absence of the CMO.

The *CPD* continues to indicate the committee is chaired by the CMO, and states "If the CMO is unable to attend the meeting, the Assistant Medical Director or other contracted/employed Psychiatrist attends as the CMO's designee." As at the 2021 EQR, there is no Assistant Medical Director listed on the *Organizational Chart*. Dr. Wade is not a psychiatrist, and therefore, she does not meet the criterion stipulated in the *CPD* as the "CMO's designee."

Vaya partially implemented the Recommendation, but it will not be reissued in the 2022 EQR, as credentialing and recredentialing are no longer completed by the PIHPs.

Effective January 1, 2022, nine counties transitioned from Cardinal Innovations Healthcare (Cardinal) to Vaya. During the Onsite, Vaya staff reported the addition of "around 800 unduplicated behavioral health providers" as a result of the Cardinal consolidation, with duplicated providers numbering over 1,000. Though contracting "went pretty smoothly", challenges in the consolidation included that, by January 2022, all of the additional providers had to be brought into the Vaya claims system, which was different than Cardinal's claims system. For these new providers, this meant learning a new billing process and new authorization protocols. Then, in April 2022, Vaya transitioned to a new claims system, with providers having to learn how to navigate that system.

Policy 2891 (designated as the *Credentialing Program Description*) and the *CCC* guide the credentialing and recredentialing processes at Vaya. The *Credentialing Program Description* (*CPD*) indicates the CMO chairs the Credentialing Committee and is "responsible for oversight of the clinical aspects of the credentialing program." Section XV of the *CPD* defines the "Scope, Responsibilities and Membership of the Credentialing Committee" and states "In addition to the Chair, the Committee's membership is comprised of no less than five and no more than ten (10) voting members", who are "licensed clinicians and/or Qualified Professionals employed by Vaya, and practitioners directly contracted with Vaya or employed/contracted by a Network Provider."

Four Vaya staff members and four provider representatives comprised the voting membership of the committee during the review period. Dr. Richard Zenn, a board-certified psychiatrist and Vaya's CMO, is "permitted to break a tie vote." A quorum is defined as "a majority of voting members present." A quorum was present at the Credentialing Committee meetings for which minutes were submitted for this EQR. The Credentialing Committee meeting minutes reflect discussion of, and the committee's decisions regarding, the "flagged" applications.

CCME's review showed the credentialing and recredentialing files were organized and contained appropriate information. There was one missing item, which Vaya submitted in response to CCME's request on the Missing Desk Materials list.

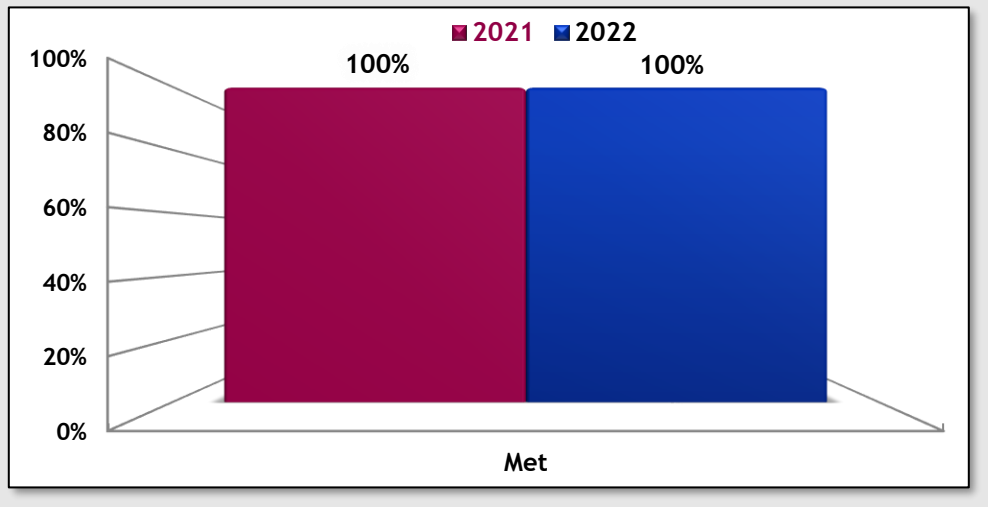
With their contracts, providers receive a letter that includes "Provider Orientation Resources", including links to various materials such as the *Provider Operations Manual*, the Provider Learning Lab, and the Program Integrity webpage with information about fraud, waste, and abuse. The Provider Learning Lab on the Vaya website includes a Provider Events calendar and links to other information for providers, including the *Provider Operations Manual*, the Communication Bulletins Archive, and the Q & A webinars, which are now known as "Provider TouchPoint." Slides from past Provider TouchPoint webinars are posted on the site. There is also a link to the July 2021 Provider and Learning Summit, which included a presentation on fraud, waste, and abuse, as well as other presentations by Vaya staff and external personnel. The Summit presentations are posted on the Vaya website.

Vaya's *2019 Community Mental Health, Substance Use and Developmental Disability Services Network Adequacy and Accessibility Analysis* report is posted on the Vaya website, with the notation that "Due to the COVID-19 pandemic, submission of the FY2020 and FY2021 Community MH/SU/IDD Network Adequacy and Accessibility Analysis reports were delayed by DHHS." The website includes the statement that "Vaya submitted a consolidated report to DHHS on 8/24/2021, and we will update this page once DHHS approves our submission." During the Onsite, Vaya staff confirmed the 2019 report has still not been approved.

Vaya staff reported current gaps analysis is focused on the requirements for the "go live" of the Tailored Plan (TP), scheduled for December 2022. As noted, Vaya "added almost 800 providers" in the consolidation with Cardinal. At the Onsite, Vaya staff reported they "brought over all of the Cardinal In Lieu Of services" and, for TP, "will see new services like Child ACTT addressing some of the same populations as MST, available in all of our counties, but we don't have a choice of two providers in all counties. Some of our real rural counties can't sustain that. We submitted Exception Requests for particular targeted services. We expanded High Fidelity Wrap Around services across all 31 counties. We have two First Episode Psychosis programs for go live. We are required to have access to Clozapine clinics as part of the TP. We have a meeting next week with Facility-Based Crisis/Non-Medical Detox providers to discuss the implementation."

Figure 3, Provider Services Comparative Findings, shows 100% of the standards in the 2022 Credentialing/Recredentialing EQR were scored as "Met" and provides an overview of 2022 scores compared to 2021 scores.

Figure 3: Provider Services Comparative Findings



Strengths

- Vaya provides a toll-free Provider Help Line and a separate toll-free line for business calls.
- Vaya reported that, during the Cardinal transition, they "established a Command Center to escalate, track, and monitor provider-reported issues. This approach was successful and Vaya plans to replicate this model for TP/MD implementation."

C. Quality Improvement

42 CFR § 438.330

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

In the 2021 EQR, Vaya met 100% of the Quality standards and received one Recommendation related to the four PIPs validated. The Recommendation and the status of implementation in the 2022 EQR are presented in Table 8.

Table 8: 2021 EQR PIP Recommendations

Project(s)	Recommendation	Implemented in 2022 (Y/N/NA)
TCLI PN Housing Usage	***Recommendation: Continue to monitor real-time inventory access, communication, and SOP documentation intervention impacts on members housed.***	**N/A: PIP no longer active**

For the 2022 EQR, four active PIPs were submitted and three were validated: Increase Rate of Routine Access to Care Calls Receiving Service Within 14 Days, Increase SF MH FUAD, and TCLI Housing Retention. As the SAR Timeliness PIP was recently implemented by Vaya and little data available, a review was conducted for this PIP in lieu of validation. Three of the four PIPs were new submissions, including SAR Timeliness, Increase Follow-Up After Discharge for Non-Medicaid Mental Health, and TCLI Housing Retention.

Table 9 displays the PIP project titles and interventions for the current review year.

Table 9: 2021 EQR PIP Recommendations

Project(s)	Interventions
Access to Care: Increase Rate of Routine Access to Care Calls Receiving Service Within 14 Days	Mental health specialized probation offices, text message reminders, care management and DPS processes, education for probation and complex care management staff, iPads to DPS for real-time information on members
SAR Timeliness	Data analysis, front-line team member feedback, meeting 8/22/22 for intervention plan
Increase Follow-Up After Discharge for Non-Medicaid Mental Health	Peer Bridger program, crisis services, onsite care management for some facilities, education on Peer Bridger Program
TCLI Housing Retention (Non Clinical)	Weekly huddles, OT and RN skill building follow up, barrier identification, incentive funding to landlords, huddle framework process

Performance Measure Validation

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

Table 10: (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 11: (c) Waiver Measures

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

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

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

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

(b) Waiver Measures Reported Results

In comparing the 2020 and 2021 rates, there were substantial declines for the 30-day Readmission Rates for Mental Health with Inpatient (State Hospital) from 12.5% to 33.3%, which is 20.8% increase. Follow Up After Hospitalization For Mental Illness also declined for the Facility Based Crisis (FBC) 7-day Visit by 16.1% and Psychiatric Residential Treatment Facility (PRTF) 30-day visit by 16.3%. Initiation and Engagement of Alcohol and Other Drug Dependent Treatment Engagement rate declined for 13–17-year-olds by 17.6% and 18-20-year-olds for 15.1%. The Initiation rate improved substantially for 65+ individuals by 10.7%. The current rate in comparison to last year's rate is presented in the Tables 12 through 21.

Table 12: A.1. Readmission Rates for Mental Health

30-day Readmission Rates for Mental Health	FY 2020	FY 2021	Change
Inpatient (Community Hospital Only)	11.8%	11.9%	0.10%
Inpatient (State Hospital Only)	12.5%	33.3%	**20.80%**
Inpatient (Community and State Hospital Combined)	12.2%	12.2%	0.00%
Facility Based Crisis	4.4%	3.3%	-1.10%
Psychiatric Residential Treatment Facility (PRTF)	6.8%	16.7%	9.90%
Combined (includes cross-overs between services)	13.4%	13.1%	-0.30%

Table 13: A.2. Readmission Rate for Substance Abuse

30-day Readmission Rates for Substance Abuse	FY 2020	FY 2021	Change
Inpatient (Community Hospital Only)	10.7%	14.6%	3.90%
Inpatient (State Hospital Only)	1.2%	5.7%	4.50%
Inpatient (Community and State Hospital Combined)	10.1%	13.3%	3.20%
Detox/Facility Based Crisis	5.1%	7.0%	1.90%
Combined (includes cross-overs between services)	13.1%	14.9%	1.80%

Table 14: A.3. Follow-Up after Hospitalization for Mental Illness

Follow-up after Hospitalization for Mental Illness	FY 2020	FY 2021	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	46.5%	46.9%	0.40%
Percent Received Outpatient Visit Within 30 Days	61.1%	60.7%	-0.40%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	75.0%	58.9%	**-16.10%**
Percent Received Outpatient Visit Within 30 Days	81.9%	78.0%	-3.90%
PRTF			
Percent Received Outpatient Visit Within 7 Days	25.0%	26.2%	1.20%
Percent Received Outpatient Visit Within 30 Days	62.5%	46.2%	**-16.30%**
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	47.5%	47.0%	-0.50%
Percent Received Outpatient Visit Within 30 Days	62.3%	61.4%	-0.90%

Table 15: A.4. Follow-Up After Hospitalization for Substance Abuse

Follow-up after Hospitalization for Substance Abuse	FY 2020	FY 2021	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	30.8%	24.2%	-6.60%
Percent Received Outpatient Visit Within 30 Days	41.2%	37.7%	-3.50%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	60.7%	64.7%	4.00%
Percent Received Outpatient Visit Within 7 Days	63.9%	69.1%	5.20%
Percent Received Outpatient Visit Within 30 Days	68.9%	72.1%	3.20%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	36.1%	30.7%	-5.40%
Percent Received Outpatient Visit Within 30 Days	45.6%	43.0%	-2.60%

Table 16: B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2020	FY 2021	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	35.0%	37.7%	2.70%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	30.8%	13.2%	**-17.60%**
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	38.9%	48.3%	9.40%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	33.6%	18.5%	**-15.10%**
Ages 21–34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	48.2%	50.5%	2.30%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	46.2%	40.3%	-5.90%
Ages 35–64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)35.8%	46.2%	50.0%	3.80%
Percent With 2 Or More Services or Visits Within 30 Days After 50.0%Initiation (Engagement)	40.2%	30.6%	-9.60%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	26.0%	36.7%	**10.70%**
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	15.6%	14.2%	-1.40%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	45.0%	48.8%	3.80%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	40.2%	31.7%	-8.50%

Table 17: D.1. Mental Health Utilization-Inpatient Discharges and Average Length of Stay

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3–12	Male	0.4	0.3	-0.1	52.5	54.9	2.4
	Female	0.5	0.4	-0.1	29.0	25.6	-3.4
	Total	0.4	0.4	0	40.5	39.2	-1.3
13–17	Male	1.4	1.2	-0.2	46.2	47.3	1.1
	Female	3.0	2.6	-0.4	20.7	28.2	7.5
	Total	2.2	1.9	-0.3	29.2	34.6	5.4
18–20	Male	1.6	1.5	-0.1	8.4	7.2	-1.2
	Female	2.5	1.7	-0.8	12.4	10.9	-1.5
	Total	2.1	1.6	-0.5	11.0	9.2	-1.8
21–34	Male	6.5	4.7	-1.8	8.7	7.5	-1.2
	Female	2.4	1.8	-0.6	7.2	8.5	1.3
	Total	3.5	2.5	-1	7.9	8.1	0.2
35–64	Male	4.3	3.2	-1.1	8.3	7.9	-0.4
	Female	3.1	2.2	-0.9	8.6	7.7	-0.9
	Total	3.6	2.6	-1	8.4	7.8	-0.6
65+	Male	0.6	0.5	-0.1	13.8	14.0	0.2
	Female	0.5	0.4	-0.1	15.8	18.5	2.7
	Total	0.5	0.5	0	15.0	16.8	1.8
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**	**1.9**	**1.5**	**-0.4**	**17.7**	**18.0**	**0.3**
	Female	**1.8**	**1.4**	**-0.4**	**13.1**	**14.8**	**1.7**
	Total	**1.8**	**1.5**	**-0.3**	**15.2**	**16.2**	**1.0**

Table 18: D.2. Mental Health Utilization -% of Members that Received at Least 1 Mental Health Service in the Category Indicated during the Measurement Period

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3-12	Male	15.59%	11.53%	-4.06%	0.20%	0.13%	-0.07%	0.68%	0.27%	-0.41%	15.49%	11.49%	-4.00%
	Female	12.79%	10.85%	-1.94%	0.20%	0.12%	-0.08%	0.24%	0.14%	-0.10%	12.77%	10.84%	-1.93%
	Total	14.23%	11.20%	-3.03%	0.20%	0.13%	-0.07%	0.46%	0.21%	-0.25%	14.17%	11.18%	-2.99%
13-17	Male	17.01%	13.54%	-3.47%	0.70%	0.63%	-0.07%	1.02%	0.52%	-0.50%	16.88%	13.45%	-3.43%
	Female	21.81%	20.62%	-1.19%	0.99%	0.83%	-0.16%	0.61%	0.41%	-0.20%	21.68%	20.53%	-1.15%
	Total	19.36%	17.00%	-2.36%	0.84%	0.73%	-0.11%	0.82%	0.47%	-0.35%	19.22%	16.92%	-2.30%
18-20	Male	9.93%	7.54%	-2.39%	0.13%	0.05%	-0.08%	0.00%	0.02%	0.02%	9.93%	7.54%	-2.39%
	Female	15.04%	12.87%	-2.17%	0.18%	0.10%	-0.08%	0.12%	0.10%	-0.02%	14.98%	12.87%	-2.11%
	Total	12.63%	10.30%	-2.33%	0.16%	0.08%	-0.08%	0.06%	0.06%	0.00%	12.60%	10.30%	-2.30%
21-34	Male	28.31%	21.27%	-7.04%	0.35%	0.15%	-0.20%	0.12%	0.04%	-0.08%	28.31%	21.27%	-7.04%
	Female	22.85%	19.06%	-3.79%	0.26%	0.14%	-0.12%	0.09%	0.06%	-0.03%	22.85%	19.06%	-3.79%
	Total	24.27%	19.60%	-4.67%	0.28%	0.14%	-0.14%	0.10%	0.05%	-0.05%	24.27%	19.60%	-4.67%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
35-64	Male	22.50%	19.45%	-3.05%	0.25%	0.09%	-0.16%	0.06%	0.03%	-0.03%	22.50%	19.45%	-3.05%
	Female	23.99%	20.69%	-3.30%	0.21%	0.06%	-0.15%	0.09%	0.04%	-0.05%	23.98%	20.69%	-3.29%
	Total	23.39%	20.20%	-3.19%	0.22%	0.07%	-0.15%	0.08%	0.04%	-0.04%	23.38%	20.20%	-3.18%
65+	Male	7.75%	7.14%	-0.61%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.75%	7.14%	-0.61%
	Female	7.57%	6.96%	-0.61%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	7.57%	6.96%	-0.61%
	Total	7.63%	7.02%	-0.61%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	7.63%	7.02%	-0.61%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**Male**	**16.98%**	**13.45%**	**-3.53%**	**0.29%**	**0.20%**	**-0.09%**	**0.48%**	**0.21%**	**-0.27%**	**16.91%**	**13.41%**	**-3.50%**
	Female	**17.45%**	**15.45%**	**-2.00%**	**0.29%**	**0.19%**	**-0.10%**	**0.19%**	**0.12%**	**-0.07%**	**17.42%**	**15.44%**	**-1.98%**
	Total	**17.24%**	**14.58%**	**-2.66%**	**0.29%**	**0.19%**	**-0.10%**	**0.32%**	**0.16%**	**-0.16%**	**17.20%**	**14.56%**	**-2.64%**

Table 19: D.3. Identification of Alcohol and Other Drug Services

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
3–12	Male	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
	Female	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
	Total	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
13–17	Male	0.97%	0.70%	-0.27%	0.04%	0.04%	0.00%	0.05%	0.02%	-0.03%	0.94%	0.65%	-0.29%
	Female	0.66%	0.58%	-0.08%	0.02%	0.04%	0.02%	0.03%	0.05%	0.02%	0.63%	0.57%	-0.06%
	Total	0.82%	0.64%	-0.18%	0.03%	0.04%	0.01%	0.04%	0.03%	-0.01%	0.79%	0.61%	-0.18%
18–20	Male	1.72%	1.61%	-0.11%	0.13%	0.09%	-0.04%	0.11%	0.10%	-0.01%	1.70%	1.58%	-0.12%
	Female	1.98%	1.47%	-0.51%	0.20%	0.13%	-0.07%	0.22%	0.13%	-0.09%	1.94%	1.43%	-0.51%
	Total	1.86%	1.54%	-0.32%	0.17%	0.11%	-0.06%	0.17%	0.12%	-0.05%	1.83%	1.50%	-0.33%
21–34	Male	9.87%	7.75%	-2.12%	0.58%	0.48%	-0.10%	0.54%	0.63%	0.09%	9.85%	7.67%	-2.18%
	Female	9.54%	7.51%	-2.03%	0.46%	0.45%	-0.01%	1.03%	0.84%	-0.19%	9.39%	7.43%	-1.96%
	Total	9.63%	7.57%	-2.06%	0.49%	0.46%	-0.03%	0.90%	0.79%	-0.11%	9.51%	7.49%	-2.02%

2022 External Quality Review

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
35–64	Male	9.48%	7.25%	-2.23%	0.43%	0.22%	-0.21%	0.57%	0.43%	-0.14%	9.33%	7.14%	-2.19%
	Female	7.06%	6.21%	-0.85%	0.25%	0.19%	-0.06%	0.44%	0.43%	-0.01%	6.97%	6.09%	-0.88%
	Total	8.04%	6.62%	-1.42%	0.33%	0.20%	-0.13%	0.49%	0.43%	-0.06%	7.93%	6.50%	-1.43%
65+	Male	1.63%	1.40%	-0.23%	0.04%	0.00%	-0.04%	0.04%	0.07%	0.03%	1.63%	1.40%	-0.23%
	Female	0.43%	0.39%	-0.04%	0.01%	0.01%	0.00%	0.01%	0.01%	0.00%	0.43%	0.39%	-0.04%
	Total	0.83%	0.73%	-0.10%	0.02%	0.01%	-0.01%	0.02%	0.03%	0.01%	0.83%	0.73%	-0.10%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**Male**	**2.95%**	**2.35%**	**-0.60%**	**0.14%**	**0.09%**	**-0.05%**	**0.17%**	**0.15%**	**-0.02%**	**2.91%**	**2.31%**	**-0.60%**
	Female	**3.27%**	**2.93%**	**-0.34%**	**0.14%**	**0.14%**	**0.00%**	**0.27%**	**0.26%**	**-0.01%**	**3.23%**	**2.88%**	**-0.35%**
	Total	**3.13%**	**2.68%**	**-0.45%**	**0.14%**	**0.12%**	**-0.02%**	**0.22%**	**0.21%**	**-0.01%**	**3.09%**	**2.63%**	**-0.46%**

Table 20: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	3-12			13-17			18-20			21-34		
Alexander	0.00%	0.00%	0.00%	0.29%	0.46%	0.17%	1.43%	1.17%	-0.26%	6.37%	6.99%	0.62%
Alleghany	0.00%	0.13%	0.13%	0.93%	0.00%	-0.93%	1.63%	1.60%	-0.03%	6.29%	4.04%	-2.25%
Ashe	0.00%	0.00%	0.00%	1.00%	0.57%	-0.43%	0.93%	1.42%	0.49%	6.12%	5.31%	-0.81%
Avery	0.00%	0.00%	0.00%	0.46%	1.09%	0.63%	1.49%	0.99%	-0.50%	5.08%	2.90%	-2.18%
Buncombe	0.02%	0.03%	0.01%	1.06%	0.70%	-0.36%	2.45%	2.69%	0.24%	8.92%	9.12%	0.20%
Caldwell	0.02%	0.00%	-0.02%	0.62%	0.40%	-0.22%	1.09%	1.08%	-0.01%	6.17%	6.27%	0.10%
Cherokee	0.00%	0.00%	0.00%	0.91%	0.79%	-0.12%	2.54%	1.59%	-0.95%	6.21%	5.48%	-0.73%
Clay	0.00%	0.00%	0.00%	1.86%	1.23%	-0.63%	1.43%	0.68%	-0.75%	8.81%	6.52%	-2.29%
Graham	0.00%	0.00%	0.00%	0.32%	0.64%	0.32%	2.27%	1.78%	-0.49%	7.19%	9.21%	2.02%
Haywood	0.00%	0.00%	0.00%	0.85%	0.77%	-0.08%	2.15%	1.26%	-0.89%	8.93%	7.98%	-0.95%
Henderson	0.00%	0.02%	0.02%	0.54%	0.63%	0.09%	1.76%	1.69%	-0.07%	5.50%	5.04%	-0.46%
Jackson	0.00%	0.00%	0.00%	0.46%	0.36%	-0.10%	2.03%	1.08%	-0.95%	7.06%	6.16%	-0.90%
Macon	0.00%	0.00%	0.00%	1.57%	1.01%	-0.56%	1.23%	0.93%	-0.30%	9.21%	7.29%	-1.92%
Madison	0.00%	0.00%	0.00%	0.35%	1.21%	0.86%	0.97%	3.13%	2.16%	7.34%	8.46%	1.12%
McDowell	0.03%	0.00%	-0.03%	0.90%	1.06%	0.16%	2.29%	2.12%	-0.17%	8.29%	8.90%	0.61%

2022 External Quality Review

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	3-12			13-17			18-20			21-34		
Mitchell	0.00%	0.11%	0.11%	0.52%	1.02%	0.50%	2.66%	0.99%	-1.67%	7.03%	5.20%	-1.83%
Polk	0.00%	0.00%	0.00%	0.88%	0.84%	-0.04%	1.26%	1.60%	0.34%	3.17%	2.81%	-0.36%
Swain	0.00%	0.00%	0.00%	0.49%	0.74%	0.25%	2.61%	0.95%	-1.66%	8.20%	5.20%	-3.00%
Transylvania	0.05%	0.05%	0.00%	0.38%	0.37%	-0.01%	2.85%	3.04%	0.19%	6.37%	4.70%	-1.67%
Watauga	0.07%	0.00%	-0.07%	0.73%	0.50%	-0.23%	0.83%	2.64%	1.81%	6.23%	7.77%	1.54%
Wilkes	0.02%	0.00%	-0.02%	1.08%	0.84%	-0.24%	1.80%	1.89%	0.09%	10.30%	10.26%	-0.04%
Yancey	0.00%	0.00%	0.00%	0.58%	0.39%	-0.19%	1.10%	2.81%	1.71%	8.93%	9.52%	0.59%
	35-64			65+			Unknown			Total		
Alexander	9.23%	7.28%	-1.95%	0.35%	0.50%	0.15%	0.00%	0.00%	0.00%	2.91%	2.63%	-0.28%
Alleghany	4.13%	4.07%	-0.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.93%	1.50%	-0.43%
Ashe	6.79%	6.10%	-0.69%	0.25%	0.39%	0.14%	0.00%	0.00%	0.00%	2.64%	2.30%	-0.34%
Avery	6.41%	5.98%	-0.43%	0.92%	0.23%	-0.69%	0.00%	0.00%	0.00%	1.98%	1.70%	-0.28%
Buncombe	9.53%	9.64%	0.11%	1.71%	1.32%	-0.39%	0.00%	0.00%	0.00%	3.80%	3.80%	0.00%
Caldwell	5.60%	5.31%	-0.29%	0.77%	1.11%	0.34%	0.00%	0.00%	0.00%	2.36%	2.33%	-0.03%
Cherokee	7.70%	4.82%	-2.88%	0.53%	0.94%	0.41%	0.00%	0.00%	0.00%	2.97%	2.17%	-0.80%
Clay	6.65%	5.59%	-1.06%	1.63%	0.34%	-1.29%	0.00%	0.00%	0.00%	2.96%	2.20%	-0.76%

2022 External Quality Review

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	35-64			65+			Unknown			Total		
Graham	6.00%	6.16%	0.16%	0.00%	0.36%	0.36%	0.00%	0.00%	0.00%	2.52%	2.90%	0.38%
Haywood	9.64%	7.15%	-2.49%	1.41%	0.83%	-0.58%	0.00%	0.00%	0.00%	3.80%	3.00%	-0.80%
Henderson	7.71%	6.81%	-0.90%	1.52%	1.84%	0.32%	0.00%	0.00%	0.00%	2.38%	2.24%	-0.14%
Jackson	8.46%	4.58%	-3.88%	1.21%	0.44%	-0.77%	0.00%	0.00%	0.00%	2.99%	2.03%	-0.96%
Macon	8.08%	6.74%	-1.34%	0.83%	0.83%	0.00%	0.00%	0.00%	0.00%	3.09%	2.47%	-0.62%
Madison	8.05%	8.42%	0.37%	0.63%	1.10%	0.47%	0.00%	0.00%	0.00%	3.03%	3.56%	0.53%
McDowell	8.14%	7.99%	-0.15%	0.92%	0.91%	-0.01%	0.00%	0.00%	0.00%	3.31%	3.41%	0.10%
Mitchell	6.53%	8.05%	1.52%	0.48%	0.72%	0.24%	0.00%	0.00%	0.00%	2.65%	2.84%	0.19%
Polk	4.12%	3.44%	-0.68%	0.59%	1.82%	1.23%	0.00%	0.00%	0.00%	1.59%	1.52%	-0.07%
Swain	4.92%	4.98%	0.06%	0.49%	0.27%	-0.22%	0.00%	0.00%	0.00%	2.44%	1.95%	-0.49%
Transylvania	6.52%	5.63%	-0.89%	2.00%	1.57%	-0.43%	0.00%	0.00%	0.00%	2.75%	2.28%	-0.47%
Watauga	6.18%	5.89%	-0.29%	0.57%	1.04%	0.47%	0.00%	0.00%	0.00%	2.31%	2.55%	0.24%
Wilkes	9.24%	9.85%	0.61%	0.47%	0.67%	0.20%	0.00%	0.00%	0.00%	3.72%	3.86%	0.14%
Yancey	9.10%	9.83%	0.73%	0.79%	0.60%	-0.19%	0.00%	0.00%	0.00%	3.37%	3.65%	0.28%

Table 21: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	3-12			13-17			18-20			21-34		
Alexander	10.28%	9.52%	-0.76%	16.25%	14.87%	-1.38%	12.50%	10.70%	-1.80%	9.76%	11.55%	1.79%
Alleghany	12.32%	8.26%	-4.06%	20.74%	18.81%	-1.93%	7.61%	9.57%	1.96%	13.25%	13.66%	0.41%
Ashe	10.77%	10.80%	0.03%	17.05%	20.14%	3.09%	7.74%	7.69%	-0.05%	14.49%	14.38%	-0.11%
Avery	8.04%	6.32%	-1.72%	15.01%	14.57%	-0.44%	9.41%	8.37%	-1.04%	14.92%	14.52%	-0.40%
Buncombe	14.35%	12.06%	-2.29%	21.95%	21.19%	-0.76%	14.92%	16.11%	1.19%	19.98%	20.80%	0.82%
Caldwell	8.29%	7.27%	-1.02%	15.98%	15.18%	-0.80%	9.69%	11.63%	1.94%	10.41%	12.04%	1.63%
Cherokee	10.27%	11.07%	0.80%	17.33%	16.95%	-0.38%	10.85%	11.56%	0.71%	14.23%	14.69%	0.46%
Clay	10.97%	10.81%	-0.16%	21.12%	20.25%	-0.87%	9.29%	6.16%	-3.13%	15.33%	11.23%	-4.10%
Graham	14.71%	14.29%	-0.42%	17.83%	18.79%	0.96%	13.64%	10.65%	-2.99%	16.78%	15.56%	-1.22%
Haywood	13.77%	10.54%	-3.23%	18.76%	16.96%	-1.80%	14.02%	12.20%	-1.82%	17.74%	17.00%	-0.74%
Henderson	10.01%	9.35%	-0.66%	14.71%	14.44%	-0.27%	11.78%	11.65%	-0.13%	13.17%	14.97%	1.80%
Jackson	10.00%	8.30%	-1.70%	16.42%	14.62%	-1.80%	9.24%	11.53%	2.29%	12.57%	13.32%	0.75%
Macon	11.88%	10.53%	-1.35%	19.54%	18.55%	-0.99%	9.58%	8.16%	-1.42%	16.69%	16.18%	-0.51%
Madison	12.19%	10.82%	-1.37%	20.88%	21.03%	0.15%	13.31%	14.06%	0.75%	17.31%	16.92%	-0.39%
McDowell	10.33%	9.66%	-0.67%	18.45%	17.83%	-0.62%	12.69%	10.60%	-2.09%	15.27%	17.73%	2.46%

2022 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		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	3-12			13-17			18-20			21-34		
Mitchell	9.59%	8.89%	-0.70%	16.23%	16.54%	0.31%	9.57%	11.82%	2.25%	12.24%	11.63%	-0.61%
Polk	13.69%	8.30%	-5.39%	17.11%	12.97%	-4.14%	15.55%	9.60%	-5.95%	7.92%	9.29%	1.37%
Swain	7.51%	7.75%	0.24%	16.05%	13.48%	-2.57%	10.46%	9.49%	-0.97%	10.45%	9.36%	-1.09%
Transylvania	11.99%	10.14%	-1.85%	21.88%	18.73%	-3.15%	16.01%	14.52%	-1.49%	13.40%	14.47%	1.07%
Watauga	11.29%	10.49%	-0.80%	18.50%	17.36%	-1.14%	9.54%	16.60%	7.06%	14.40%	12.95%	-1.45%
Wilkes	12.15%	10.91%	-1.24%	20.09%	20.96%	0.87%	11.44%	12.84%	1.40%	14.38%	14.93%	0.55%
Yancey	8.82%	7.75%	-1.07%	13.87%	14.45%	0.58%	8.42%	8.84%	0.42%	8.74%	12.19%	3.45%
	35-64			65+			Unknown			Total		
Alexander	15.02%	14.24%	-0.78%	7.94%	7.82%	-0.12%	0.00%	0.00%	0.00%	12.02%	11.50%	-0.52%
Alleghany	20.41%	22.85%	2.44%	7.75%	6.16%	-1.59%	0.00%	0.00%	0.00%	14.26%	13.16%	-1.10%
Ashe	18.13%	18.29%	0.16%	10.31%	7.71%	-2.60%	0.00%	0.00%	0.00%	13.53%	13.57%	0.04%
Avery	16.55%	14.58%	-1.97%	8.45%	7.98%	-0.47%	0.00%	0.00%	0.00%	11.62%	10.44%	-1.18%
Buncombe	24.79%	23.74%	-1.05%	12.80%	11.95%	-0.85%	0.00%	0.00%	0.00%	18.37%	17.42%	-0.95%
Caldwell	12.99%	13.49%	0.50%	6.89%	7.48%	0.59%	0.00%	0.00%	0.00%	10.69%	10.83%	0.14%
Cherokee	18.21%	14.01%	-4.20%	6.42%	4.03%	-2.39%	0.00%	0.00%	0.00%	13.19%	12.25%	-0.94%
Clay	15.83%	13.20%	-2.63%	6.49%	3.02%	-3.47%	0.00%	0.00%	0.00%	13.21%	11.38%	-1.83%

2022 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		
	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change	FY 2020	FY 2021	Change
	35-64			65+			Unknown			Total		
Graham	12.89%	9.95%	-2.94%	6.06%	3.25%	-2.81%	0.00%	0.00%	0.00%	13.78%	12.54%	-1.24%
Haywood	19.17%	16.08%	-3.09%	10.60%	8.72%	-1.88%	0.00%	0.00%	0.00%	15.88%	13.50%	-2.38%
Henderson	19.44%	19.65%	0.21%	15.10%	14.14%	-0.96%	0.00%	0.00%	0.00%	13.45%	13.36%	-0.09%
Jackson	16.37%	16.03%	-0.34%	7.10%	4.83%	-2.27%	0.00%	0.00%	0.00%	12.26%	11.46%	-0.80%
Macon	19.43%	17.66%	-1.77%	5.25%	4.81%	-0.44%	0.00%	0.00%	0.00%	14.21%	13.00%	-1.21%
Madison	17.13%	19.54%	2.41%	8.95%	7.04%	-1.91%	0.00%	0.00%	0.00%	14.71%	14.62%	-0.09%
McDowell	17.62%	18.17%	0.55%	13.76%	12.13%	-1.63%	0.00%	0.00%	0.00%	14.28%	14.19%	-0.09%
Mitchell	13.64%	13.62%	-0.02%	7.88%	6.02%	-1.86%	0.00%	0.00%	0.00%	11.45%	11.11%	-0.34%
Polk	12.52%	12.95%	0.43%	15.15%	19.15%	4.00%	0.00%	0.00%	0.00%	13.44%	11.29%	-2.15%
Swain	11.81%	11.41%	-0.40%	4.22%	4.01%	-0.21%	0.00%	0.00%	0.00%	9.91%	9.39%	-0.52%
Transylvania	19.90%	18.81%	-1.09%	12.45%	13.11%	0.66%	0.00%	0.00%	0.00%	15.63%	14.40%	-1.23%
Watauga	20.64%	18.75%	-1.89%	12.13%	11.62%	-0.51%	0.00%	0.00%	0.00%	14.51%	13.90%	-0.61%
Wilkes	19.87%	17.90%	-1.97%	6.89%	6.38%	-0.51%	0.00%	0.00%	0.00%	14.63%	14.14%	-0.49%
Yancey	12.22%	15.61%	3.39%	9.26%	9.42%	0.16%	0.00%	0.00%	0.00%	10.24%	11.20%	0.96%

(b) Waiver Validation Results

All measures received a validation score of 100% and were found Fully Compliant. The stored procedures have been updated to address NC Medicaid's most recent changes to the measures. Table 22 contains validation scores for each of the 10 (b) Waiver Performance Measures.

Table 22: (b) Waiver Performance Measure Validation Scores

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

(c) Waiver Measures Reported Results

Five (c) Waiver Measures were chosen for validation. The rates reported by Vaya, and the State benchmarks are displayed in *Table 23: (c) Waiver Measures Reported Results 2021 - 2022*. Documentation on data sources, data validation, source code, and calculated rate for the five measures was provided. Additionally, all rates exceeded the State Performance Benchmarks.

Table 23: (c) Waiver Measures Reported Results 2021-2022

Performance measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	1520/1520 = 100%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	1520/1520 = 100%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	162/180 = 90%	85%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	1951/1955 = 99.8%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	41/41 = 100%	85%

** Latest reported rates are shown in Table from Excel file "C Waiver Reported measures" Excel files.*

All (c) Waiver Measures met the validation requirements and were Fully Compliant as shown in *Table 24, (c) Waiver Performance Measure Validation Scores*. The validation worksheets offer detailed information on validation and calculation steps for (c) Waiver Measures.

Table 24: (c) Waiver Performance Measures Validation Scores

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

Performance Improvement Project (PIP) Validation

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

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

PIP Validation Results

For the 2021 review, four active PIPs were validated, including Assure Consistent Connection to Community Services, TCLI Timeliness Documentation Submission, NC-TOPPS Interview Data Accuracy, and Routine Appointments Kept. Two PIPs showed improvement in their rates, and two PIPs had a decline. Recommendations regarding results presentation and interventions were offered. No Corrective Actions were given. For this year's 2022 EQR, there were three active PIPs submitted and one PIP that was submitted but was still in development. Therefore, it was reviewed in lieu of validating.

The TCL Housing Retention is a new PIP with data for July 2021-June 2022. In the most recent two measurement periods, the number housed showed improvement from 12 housed and 12 lost to 25 housed and 6 lost in June 2022. The goal is to have net gain of 29 housed.

Access to Care Clinical PIP is focused on routine access with service within 14 days for prisoners released from incarceration. The most recent rate showed a decline from 43.2% in Q2 2021/2022 to 40% in the third quarter. The goal is 50% with a routine appointment within 14 days.

Service Authorization Requestion Timeliness for Denials and Partial Denials PIP was initiated in June 2022. Data from July 2021 through April 2022 was reported. No interventions were submitted in the report. The Onsite discussion focused on definition of indicators and planned interventions.

The Increase Follow-up after discharge for non-Medicaid mental health PIP has data for January 2020 to February 2022 monthly. The goal is to attain a 40% follow-up rate. The most recent rate declined from 58% to 56%, although it remains above the goal rate.

Table 25: PIP Summary of Validation Scores

Project Type	Project	2021 Validation Score	2022 Validation Score
Non-Clinical	**TCL Housing Retention**	N/A	79/79=100% High Confidence in Reported Results
	SAR Timeliness	NA	Not Validated- Still in Development
	Increase Follow-Up after Discharge for Mental Health	N/A	79/79=100% High Confidence in Reported Results
Clinical	**Access to Care**	79/79=100% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results

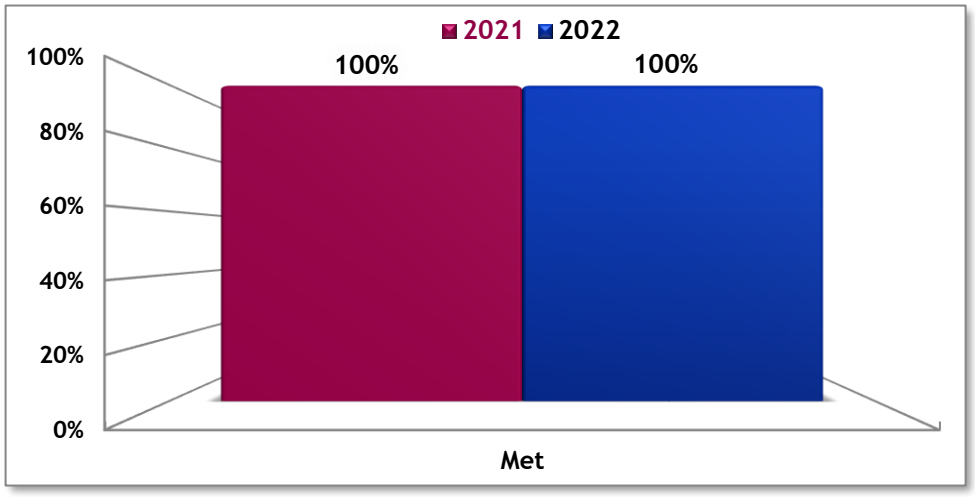
For the Access to Care PIP, there is a Recommendation regarding the assessment of the interventions to improve rates, which showed a decline in the most recent remeasurement period. The project, section, reason, and Recommendation are displayed in Table 26.

Table 26: Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Access to Care (Clinical)	Was there any documented, quantitative improvement in processes or outcomes of care?	The most recent rate showed a decline from 43.2% in Q2 2021/2022 to 40% in third quarter. The goal is 50% with a routine appt within 14 days.	Assess impact of newest interventions including additional complex care management and staff education to determine if these improve the services received rate

There were no Corrective Actions for the three validated PIPs. Details of the validation activities for the PMs and PIPs and specific outcomes related to each activity may be found in *Attachment 3, CCME EQR Validation Worksheets*. As demonstrated in Figure 4, Vaya met all the QI standards in the 2021 and 2022 EQRs.

Figure 4: Quality Improvement Comparative Findings



Strengths

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

Weaknesses

- For the Access to Care PIP, the most recent remeasurement period shows a rate decline.

Recommendations

- For the Access to Care PIP, assess the impact of the newest interventions including additional complex care management and staff education to determine if these improve the services received rate.

D. Utilization Management

42 CFR § 438.208

The EQR of Utilization Management (UM) included a review of the Care Coordination and Transition to Community Living Initiative (TCLI) programs. CCME reviewed relevant policies, Vaya's *Organizational Chart*, *Population Health Program Description*, *Utilization Management Plan and Program Description*, *Population Health Program Description, Complex Care Management Populations, Processes, Roles and Responsibilities, Member and Caregiver Handbook* and *Provider Operations Manual,* and 11 records of enrollees participating in Mental Health/Substance Use Disorder (MH/SUD), Intellectual/Developmental Disability (I/DD), and TCLI Care Coordination.

In the 2021 EQR, Vaya met 96% of the UM standards and received one Corrective Action and one Recommendation to address issues identified in the Care Coordination enrollee record review. Table 27 outlines the 2021 findings and CCME's follow up in the 2022 EQR regarding Vaya's implementation of the Corrective Action and Recommendation.

Table 27: 2021 EQR Utilization Management Findings

2021 EQR Utilization Management Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	**Corrective Action: Enhance the current Care Coordination documentation quality review to include:** • **Routine review of notifications within the enrollee's record and ensure those notifications can be generated outside of the enrollee's electronic record.** • **Routine review of Care Coordination Documentation around any enrollees terminating from Care Coordination or the Innovations Waiver. The review should ensure proper notifications occurred, alternative services were offered, and the enrollee's health and safety were assessed and addressed throughout the termination.**	**Y**

2021 EQR Utilization Management Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
2022 EQR Follow up: In this year's review, Vaya was able to produce all required notifications. Review of the enrollee records submitted for this year's review showed staff were compliant with Vaya policies. Additionally, Vaya drafted a new Standard Operating Procedure detailing the process for terminating enrollees from the Innovations Waiver and revised the *Care management Reference Guide* to include these details. Lastly, Vaya developed training for I/DD Care Coordinators regarding the process of terminating enrollees from the Innovations Waiver.		
The PIHP applies the Care Coordination policies and procedures as formulated.	***Recommendation: Update the current Complex Care Management Quality Improvement & Monitoring Plan to include a process that identifies late progress notes and ensures these progress notes are labelled "late entry", as required by Vaya's Policy 2340, Administrative Health Record Documentation.***	**N**
2022 EQR Follow up: Review of the *Complex Care Management Quality Improvement & Monitoring Plan* submitted by Vaya for this year's EQR shows this Recommendation was not implemented.		

In the 2021 EQR, the review of the enrollee records found 39% of enrollee contact notes were submitted outside of the 24-hour timeframe required by Vaya Policy. Additionally, enrollee contact notes that were submitted beyond the 24-hour entry requirement did not follow the late entry process required in Vaya Policy 2340, Administrative Health Record Documentation. CCME recommended Vaya update the current *Complex Care Management Quality Improvement & Monitoring Plan* to include a process that identifies late enrollee contact notes and ensures these notes are labelled "late entry" and includes the reason for the delay, as required by Policy 2340.

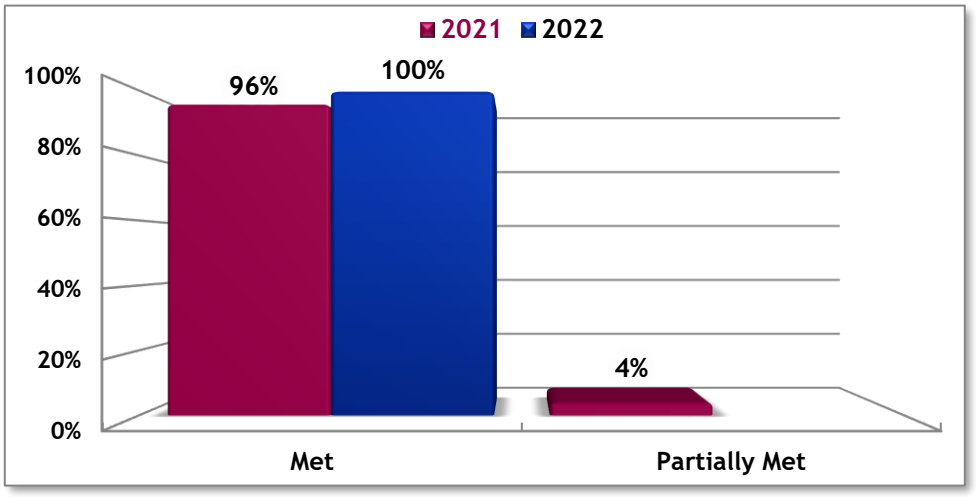
In the 2022 EQR, it was observed there was no revision to the *Complex Care Management Quality Improvement & Monitoring Plan* showing Vaya was checking for compliance issues related to late contact notes. Additionally, the I/DD and TCLI records selected by Vaya for the 2022 EQR still showed compliance issues related to late enrollee contact notes but to a lesser degree than the previous EQR. During the Onsite, Vaya also could not provide any reports or dashboards showing they were monitoring for this issue. CCME is recommending Vaya continue to monitor Care Coordinator contact notes for timeliness and compliance with Vaya Policy 2340.

In one TCLI enrollee record reviewed in this 2022 EQR, another Vaya enrollee's full name was within the enrollee contact notes. Vaya Policy 2340, Administrative Health Record Documentation states, "if another Vaya Member must be referenced in a Member notes, the other Member may be referenced by using his/her initials, record number, or letters/numbers, etc." CCME is recommending Vaya expunge the other enrollee's name from the TCLI enrollee record.

Outside of these minor issues, the MH/SUD, I/DD and TCLI records reviewed in this year's review showed good engagement by Care Coordinators, timely Quality of Life Surveys and monitoring of I/DD services, and overall compliant documentation.

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

Figure 5: Utilization Management Comparative Findings



Strengths

- Vaya met or exceeded all established targets for the TCLI Super Measure.
- Vaya reports they have collaborated with local Division of Social Services, hospitals, and the Mountain Area Health Education Center to embed Care Coordinators within these agencies to directly assist enrollees with system navigation, assessments, services and supports.

Weaknesses

- There was no evidence Vaya is monitoring enrollee contact notes for compliance with Vaya Policy 2340, Administrative Health Record Documentation.
- One TCLI record reviewed in this year's EQR included the full name of a different enrollee.

Recommendations

- Ensure late I/DD enrollee contact notes are monitored for compliance with Vaya Policy 2340. Monitoring should check notes are labelled "late entry" and include the reason for the delay when submitted outside of the required 24 hour timeframe.

- Ensure TCLI late enrollee contact notes are monitored for compliance with Vaya Policy 2340. Monitoring should check notes are labelled "late entry" and include the reason for the delay when submitted outside of the required 24 hour timeframe.

- Remove or replace with initials the full name of the other enrollee documented within the TCLI enrollee's record.

E. Grievances and Appeals

42 CFR § 438, Subpart F

The Grievances and Appeals EQR included a Desk Review of policies, 10 Grievance and 10 Appeal files, the Grievance and Appeal Logs, the *Provider Operations Manual* (Version 4.2), the *Member and Caregiver Handbook* (Version 5.1), and information about Grievances and Appeals available on the Vaya website. There was an Onsite discussion with Grievance and Appeal staff to further clarify the PIHP's documentation and processes.

In the 2021 EQR, Vaya met 100% of the Grievance and Appeal standards, resulting in no Corrective Actions. CCME issued three Recommendations to address concerns noted primarily in the monitoring processes used for ensuring internal processes verify compliance to the *NC Medicaid Contract*, Vaya policies, and federal regulations. In the 2022 EQR, Vaya met 100% of the Grievance and Appeal standards, resulting in no Corrective Actions or Recommendations.

Grievances

In the 2021 EQR, Vaya received one Recommendation targeting monitoring to ensure timely acknowledgement and resolution notification. This Recommendation was implemented. Table 28 outlines CCME's review of the 2021 EQR Grievance Recommendation and how it was addressed by Vaya.

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

2021 EQR Grievance Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP applies the Grievance policy and procedure as formulated.	***Recommendation: Continue to closely monitor all Grievances to ensure all acknowledgement notifications and resolution notifications are timely and to identify problems with processes that contribute to compliance issues.***	**Y**
2022 EQR Follow up: Vaya followed their Grievance and Complaint Monitoring document outlining how they monitor oral notifications, written notifications, Grievance Log and performance metrics, and timeline compliance. Overall improvement in compliance and accuracy of the file review was noted.		

For the 2022 EQR, overall improvement in compliance and accuracy of the file review was noted. The file review included nine standard Grievances and one member-extended Grievance. Two of the standard Grievances were received by Vaya and transferred to the Division of Health Services Regulations (DHSR) because those concerned a facility licensed by DHSR in North Carolina. Vaya staff followed Policy 2607, Member Grievances to acknowledge and resolve all Grievances in a timely manner. The Vaya Grievance Log is consistent with the file review, except for a discrepancy in one Grievance where the date the Grievance was received was off by one day on the Log. During the Onsite discussion, Vaya staff stated this was mislabeled on the Log. Guardianship was verified for each applicable Grievance. Additional release of information documentation was also provided when needed. There are no Corrective Actions or Recommendations issued from CCME.

Appeals

In the 2021 Appeals EQR, Vaya met 100% of the Appeal standards, resulting in no Corrective Actions. CCME issued two Recommendations addressing monitoring practices. Both Recommendations were implemented in the 2022 EQR.

Table 29 outlines CCME's review of the Recommendations and indicates Vaya implemented the Recommendations.

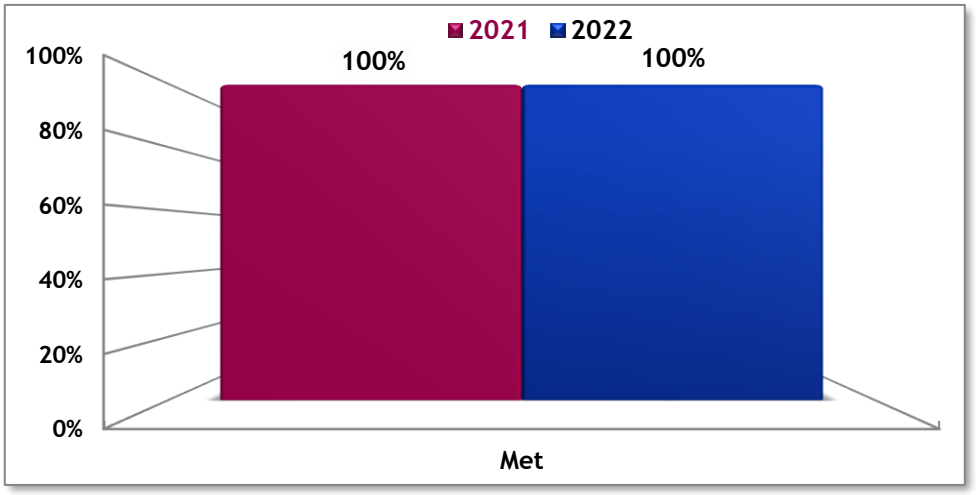
Table 29: Follow up to 2021 EQR Appeals Corrective Actions and Recommendations

2021 EQR Appeals Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP applies the Appeal policies and procedures as formulated.	***Recommendation: Continue to closely monitor Appeals to ensure all acknowledgement notifications and resolution notifications are timely and to identify problems with processes that contribute to compliance issues.***	**Y**
2022 EQR Follow up: Overall improvement in compliance and accuracy was noted with all types of Appeal files when compared to the 2021 EQR. 100% of the Appeals met timeliness requirements.		
Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	***Recommendation: Increase the sample size of the Appeal files reviewed for the Regulatory Compliance Committee and reported in the Vaya UM Audit Summary.***	**Y**
2022 EQR Follow up: During Onsite discussions, Vaya staff explained they increased their sample size, and the file review confirmed the increased level of monitoring.		

In the 2022 EQR, there are no Corrective Actions or Recommendations issued from CCME. Overall improvement in compliance and accuracy was noted with all types of Appeal files when compared to the 2021 EQR. Six standard, three expedited, and one invalid Appeals were reviewed. 100% of the Appeals met timeliness requirements. One file was labeled invalid on the Vaya Appeal Log but was a standard Appeal, and Vaya staff confirmed it was a standard Appeal and mis-labeled on the Log. One file in the Desk Review was missing the acknowledgement notification, resolution notification, adverse benefit determination letter, and the member Appeals contact record. Vaya uploaded those documents before the Onsite as CCME requested. Vaya verified Guardianship in all applicable Appeals and followed confidentiality procedures.

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

Figure 6: Grievances and Appeals Comparative Findings



Strengths

- Vaya implemented a daily huddle in the Grievances department to help staff stay connected and have a group discussion to address high profile Grievances quickly.
- Vaya implemented a bi-monthly standing meeting their Chief Medical Officer to discuss any Grievances concerning health and safety.

F. Program Integrity

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

The 2022 Program Integrity (PI) EQR for Vaya encompassed a thorough Desk Review of Vaya's policies and procedures related to Special Investigative Unit (SIU) investigations, Provider Overpayments, and related aspects of compliance. PI staffing, workflows, reports, training materials, committee minutes, and data mining efforts were also reviewed. Finally, a review of 10 investigative case files were also evaluated for compliance with Vaya's *NC Medicaid Contract*, federal regulations, and Vaya's procedures. During the Onsite, there was a discussion with Vaya Compliance, Program Integrity, Claims, Waiver Programs, Special Investigations staff, and Chief Compliance Officer (CCO) to obtain additional clarification regarding Vaya's PI functions.

In the 2021 EQR, Vaya met 100% of the PI standards. There was one Recommendation and no Corrective Actions issued. Table 30 displays the 2021 findings and evidence presented in the 2022 EQR to demonstrate Vaya addressing this.

Table 30: 2021 EQR Program Integrity Findings

2021 EQR Program Integrity Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month or the next business day if the 10th day is a non-business day (i.e., weekend or State or PIHP holiday). In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to NC Medicaid Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59 p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to NC Medicaid	***Recommendation: Add language to a Vaya PI policy detailing the process and timeframes required by NC Medicaid Contract Section 9.8 and 14.2.14 for submission of the monthly NCID holders/FAMS-users report, the Program Integrity Suspected and Confirmed Cases Report and Network Provider Contract Terminations Report to the State.***	**N**

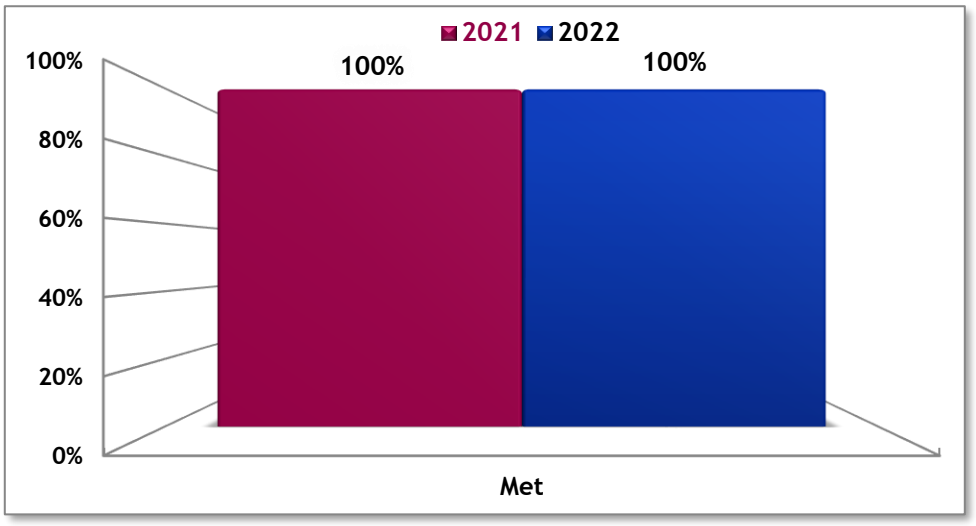
Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.		
2021 EQR Follow up: For this EQR, the review found that for a third year, Vaya has elected not to include language in a policy regarding the timely submission of required monthly and quarterly reports to NC Medicaid. However, Vaya provided evidence they submitted all required reports to NC Medicaid within the required timeframes.		

Since the last EQR, Vaya subsumed 11 counties from another PIHP. To address the needs of these additional counties, the Compliance and PI Departments have been restructured, and the PI staff has expanded. This has caused Vaya to reconsider committee memberships, staff responsibilities, and documentation methods. Vaya implemented a new Internal Investigative Summary and included new staff as FAMS Users. However, discrepancies were found in committee memberships and State-required reports.

The review of the *Regulatory Compliance Committee Charter* (*RCC Charter*) found two members listed who are no longer with Vaya. During the Onsite, Vaya stated they are aware of the inconsistencies and working to resolve the issue. CCME is recommending Vaya ensure the *RCC Charter* includes the names and titles of current committee members. Additionally, the review of the *Attachment Y Report* for one PI case showed a discrepancy between the identified overpayment amount and the amount of repayment. During the Onsite, Vaya explained the repayment amount included a 10% late fee and 8% interest, which is compliant with Vaya's Policy 2595, Identification and Recovery of Overpayments. However, the additional fees were not explained on the *Attachment Y Report June 2022*. CCME is recommending Vaya ensure the *Attachment Y Report* details all actions taken towards collecting provider overpayments.

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

Figure 7: Program Integrity Comparative Findings



Strengths

- The addition of 11 new counties prompted Vaya to develop new methods for timely resolution of potential cases of fraud, waste, and abuse.

Weaknesses

- The *Regulatory Compliance Committee Charter* has not been updated to reflect the new committee structure.
- The *Attachment Y Report* for one PI case showed a discrepancy between the identified overpayment amount and the amount of repayment.

Recommendations

- Ensure the *Regulatory Compliance Committee Charter* list the names and titles of current committee members.
- Ensure the *Attachment Y* reports detail all financial actions taken towards collecting provider overpayments.

G. Encounter Data Validation

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

Guided by the CMS Encounter Data Validation Protocol, the scope of the review focused on measuring the data quality and completeness of claims paid by Vaya for the period of January 2021 through December 2021. All claims paid by Vaya should be submitted and accepted as a valid encounter to NC Medicaid. 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

Results and Recommendations

Issue: Other Diagnosis

Principal Diagnosis codes were populated consistently where appropriate. However, Other Diagnosis codes were infrequently populated with only 16.07% of all encounter records containing at least one Other Diagnosis code. The issue is far more pronounced in Professional encounters, which saw only 13.47% of all Professional encounters billed with at least one Other Diagnosis code. This is well below what is expected to be seen given the comorbidities that are often present in the demographics PIHPs serve.

Resolution:

It is recommended Vaya continue to educate its providers on the importance of complete and accurate coding. Vaya should also continue monitoring the reporting of Diagnosis codes and take appropriate steps to improve both the quality and quantity of the Diagnosis code reporting. This would enable Vaya and NC Medicaid to get a more complete picture of the morbidities within the demographics it serves.

Conclusion

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

ATTACHMENTS

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

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

The Carolinas Center *for* Medical Excellence
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July 22, 2022

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

Dear Mr. Ingraham,

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

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

The CMS EQR protocols can be found at:

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

Due to COVID-19 and the issuance of the contractual flexibilities issued by the State outlined in *NC Medicaid Contract Amendment #11*, the 2022 EQR will be a focused review. The focus of this review will be on Vaya Health's Corrective Actions from the previous EQR and Vaya Health's functions that impact enrollee health and safety. Similarly, for the 2022 EQR, the two-day Onsite previously performed at Vaya Health's offices will conducted during a one-day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **September 22, 2022**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

In preparation for the Desk Review, the items on the enclosed **Desk Materials List** are to be submitted electronically. **Please note that, to facilitate a timely review, there are three items on the Desk Materials List (items 9, 10, and 19.a) that should be submitted no later than July 28, 2022,** and the remaining items are due by no later than **August 30, 2022**. Also, as indicated in item 20 of the Desk Materials List, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted with the other Desk Materials on **August 30, 2022**.

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

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

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 6

Cc: Andrea Hartman, Vaya Health External Review & Delegation Oversight Director
Greg Daniels, NC Medicaid Waiver Contract Manager
Deb Goda, NC Medicaid Associate Director, Behavioral Health and ID
Christean Hunter, NC Medicaid Quality Management Specialist

Focused External Quality Review 2022

MATERIALS REQUESTED FOR DESK REVIEW

**__Please note that the lists requested in items 9, 10, and 19.a must be uploaded by no later than July 28, 2022. The remainder of items must be uploaded by no later than August 30, 2022.__

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

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

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

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

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

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

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

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

9. **By July 28, 2022, a copy of the complete Appeal log for the months of July 2021 through June 2022. Please indicate on the log: the Appeal type (standard, expedited, extended, withdrawn, or invalid), the service appealed, the date the Appeal was received, and the date of the Appeal resolution notification.

10. **By July 28, 2022, a copy of the complete Grievances log for the months of July 2021 through June 2022. Please indicate on the log: the nature of the Grievance, the date received, and the date of the Grievance resolution notification.

11. Copies of all Appeal notification templates used for expedited, invalid, extended, and withdrawn Appeals.
12. For Appeals and Grievances, please submit a description of your monitoring process that reviews compliance of oral and written notifications, completeness of documentation within the Appeal and Grievance records, accuracy of Appeal and Grievance logs, etc. Provide details regarding frequency of monitoring and any benchmarks, performance metrics, and reporting of monitoring outcomes.
13. Please submit a summary of new provider orientation processes and include a list of materials and training provided to new providers.
14. For MH/SU, I/DD, and TCLI Care Coordination, please submit a description of your monitoring plan that reviews compliance of Care Coordinator documentation. Include in the description the elements reviewed (timeliness of progress notes, timeliness of Innovations monitoring, timeliness of Quality of Life surveys, review of quality, completeness of discharge notes, accuracy of documentation, etc.). Provide details regarding frequency of monitoring, and any benchmarks, performance metrics, and reporting of monitoring outcomes.
15. For Care Coordination enrollee files, please provide:
    a. three MH/SU Care Coordination enrollee files (two active since 2020 and one recently discharged)
    b. three I/DD Care Coordination enrollee files (two active since 2020 and one recently discharged)
    c. four TCLI Care Coordination enrollee files (one active since 2020, one who received In-Reach, one who transitioned to the community and recently discharged).

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

16. Information regarding the following selected Performance Measures:

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

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

Required information includes the following for each measure:

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

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

17. Documentation of all Performance Improvement Projects (PIPs) completed or planned in the last year, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e., research question (s), analytic plans, reasons for choosing the topic including how the topic impacts the Medicaid population overall, measurement definitions, qualifications of

personnel collecting/abstracting the data, barriers to improvement and interventions planned or implemented to address each barrier, calculated result, results, etc.)

18. Provide copies of the following files:

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

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

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

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

    b. Insurance:

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

    c. Recredentialing files for the four most recently credentialed practitioners (as listed below)

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

        In addition, please provide one file for a network provider agency.
        Please submit the full recredentialing file, from the date of the application/attestation, to the notification of approval of recredentialing. In addition to the recredentialing application, all recredentialing files should include all of the following:

i. Proof of original credentialing date and all recredentialing dates, including the current recredentialing (this is usually a letter to the provider, indicating the effective date).

ii. Insurance:
   A. Proof of all required insurance, or a signed and dated statement/waiver/attestation from the practitioner/agency indicating why specific insurance coverage is not required.

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

19. Provide the following for Program Integrity:

   a. ****<u>File Review</u>:** Please produce a listing of all active files during the review period (July 2021 through June 2022) by July 28, 2022. The list should include the following information:

      i. Date case opened

      ii. Source of referral

      iii. Category of case (enrollee, provider, subcontractor)

      iv. Current status of the case (opened, closed)

   b. Program Integrity Plan and/or Compliance Plan.

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

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

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

   f. Provider Manual and Provider Application.

   g. Enrollee Handbook.

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

   i. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse.

j. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors, and employees.

k. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other State or Federal agency.

l. Code of Ethics and Business Conduct.

m. Internal and/or external monitoring and auditing materials.

n. Materials pertaining to how the PIHP captures and tracks complaints.

o. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting

    i. NC Medicaid approved reporting templates.

p. Sample Data Mining Reports.

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

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

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

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

a. A completed ISCA.

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

Section	Question Number	Attachment
Enrollment Systems	1b	Enrollment system loading process
Enrollment Systems	1f	Enrollment loading error process reports
Enrollment Systems	1g	Enrollment loading completeness reports
Enrollment Systems	2c	Enrollment reporting system load process
Enrollment Systems	2e	Enrollment reporting system completeness reports
Claims Systems	2	Claim process flowchart

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

c. A copy of the IT Disaster Recovery Plan.

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

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

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

a. Include all adjudicated claims (paid and denied) from January 1, 2021 – December 31, 2021. Follow the format used to submit encounter data to NC Medicaid (i.e., 837I and 837P). If you archive your outbound files to NC Medicaid, you can forward those to CCME 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 CCME.

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

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

B. Attachment 2: EQR Validation Worksheets

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

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

- Performance Improvement Project Validation Worksheet
  - TCLI PN Housing Usage
  - Increase Rate of Routine Access to Care Calls Receiving Service Within 14 Days
  - ADATC VIP

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

NC Medicaid PIHP Reporting Schedule- Innovations Measures
NC Medicaid PIHP Reporting Schedule- Innovations Measures

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

PIHP Name:	**Vaya Health**
Name of PM:	**Percentage of beneficiaries who received appropriate medication**
Reporting Year:	**2021**
Review Performed:	**2022**

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Measure Validation Worksheet

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

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

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME Performance Improvement Project Validation Worksheet

PIHP Name:	**Vaya Health**
Name of PIP:	**TCL HOUSING RETENTION**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data extracted in a systematic manner.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are reported.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Performance reporting analyst
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Monthly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent values are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several months and interpretation of values is provided.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	In the most recent two measurement periods, the number housed showed improvement from 12 housed/ 12 lost to 25 housed and 6 lost in June 2022. The goal is to have net gain of 29 housed.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to have face validity.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not a rate thus no statistical tests were applied or necessary. Indicator is a whole number aggregate value.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME Performance Improvement Project Validation Worksheet

PIHP Name:	**Vaya Health**
Name of PIP:	**INCREASE FOLLOW-UP AFTER DISCHARGE FOR MENTAL HEALTH**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data extracted in a systematic manner.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are reported.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Admin data analyst
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Monthly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for monthly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several months and interpretation of values is provided.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The goal is to attain a 40% follow up rate. The most recent rate declined from 58% to 56%, although it remains above the goal rate.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	No improvement occurred but rate remains above the goal rate thus demonstrating the rates are sustained above goal as a result of the interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No statistical testing required as sampling was not utilized.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME Performance Improvement Project Validation Worksheet

PIHP Name:	**Vaya Health**
Name of PIP:	**ACCESS TO CARE**
Reporting Year:	**2021**
Review Performed:	**2022**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data extracted in a systematic manner.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments are reported.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Performance reporting analyst
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using bar charts and line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters and interpretation of values is provided.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The most recent rate showed a decline from 43.2% in Q2 2021/2022 to 40% in 3rd quarter. The goal is 50% with a routine appt within 14 days. ***Recommendation: Assess impact of newest interventions including additional complex care management and staff education to determine if these improve the services received rate.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No statistical testing required as sampling was not utilized.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**73**
Project Possible Score	**74**
Validation Findings	**99%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

C. Attachment 3: Tabular Spreadsheet

CCME PIHP Data Collection Tool

PIHP Name:	Vaya
Collection Date:	2022

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A Management Information Systems						
1. Enrollment Systems						
1.1 The PIHP capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					Vaya has standard processes in place for enrollment data updates. Vaya uploads the daily and quarterly Global Eligibility Files (GEFs) files to the AlphaMCS enrollment system. Vaya uses the monthly 820 capitation file to reconcile the payment received every month to determine the categories of aid for which payments were received. Demographic data is captured in the AlphaMCS system and patients IDs are unique to members. Historical enrollment information is captured and maintained for all members. Review of the 2022 ISCA information showed Vaya experienced nearly 62% reduction in enrollment after July 2021. Vaya staff explained this reduction was due to the transition of membership to Standard Plans.
1.2 The PIHP is able to identify and review any errors found during, or as a result, of the State enrollment file load process.	X					During the ISCA Onsite discussion, Vaya stated they upload the GEF file to a local database and use the database for troubleshooting purposes by comparing the records to their own inhouse records.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 The PIHP's enrollment system member screens store and track enrollment and demographic information.	X					Vaya demonstrated the enrollment screens and their capability to store the demographic information during the Onsite. The demonstration showed all historical data for members is stored and merged under one member ID.
2. Claims System						
2.1 The PIHP processes provider claims in an accurate and timely fashion.						The majority of claims received are electronic on a HIPAA file (76.72% for Institutional and 90.32%% for Professional) or through the provider web portal (23.18%% for Institutional and 9.68% for Professional). Very few claims are received via paper (approximately less than 1%). For claims received in 2021, 67.13% of Institutional and 97.14% of Professional claims were auto-adjudicated on a nightly basis. Claims in excess of $5,000 and Emergency Department claims are pended for manual review. Pended claims are reviewed daily.
2.2 The PIHP has processes and procedures in place to monitor, review and audit claims staff.	X					Vaya has processes in place to monitor and audit claims staff. Routine audits are performed. Vaya audits a random sample of 3% of all claims processed on a daily basis and also conducts Coordination of Benefits (COBS) and program integrity suspect audits regularly. High dollar claims in excess of $5,000 and paper claims are audited for accuracy and appropriate adjudication. The paper claims are included in the random sample of 3% daily claims audit. Vaya periodically audits new hire claim examiners for the first nine months.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.3 The PIHP has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file. The PIHP has the capability of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	X					During the Onsite, Vaya demonstrated the AlphaMCS claims system and capabilities to receive and store all ICD-10 Diagnosis codes. Vaya indicated ICD-10 Procedure codes, Revenue codes, and DRG codes are captured in the AlphaMCS system electronically and via the provider web portal. The Revenue codes and DRG are also included for Encounter data submission reporting.
2.4 The PIHP's claim system screens store and track claim information and claim adjudication/payment information.	X					Vaya demonstrated their provider web portal, claim system screens, and claim adjudication/payment information during the Onsite. Vaya demonstrated their claim systems ability to completely capture all the ICD-10 Diagnosis codes, Diagnosis Related Groups (DRGs), Revenue codes, CPT/HCPCS, ICD-10 Procedure codes, and adjudication information.
3. Reporting						
3.1 The PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Vaya captures all required ICD-10 Diagnosis codes and is capable of capturing additional Procedure, DRG, and Revenue codes that are submitted on the claims. Vaya stores the DRG and ICD-10 Procedure codes for reporting.
3.2 The PIHP has processes in place to back up the enrollment and claims data repositories.	X					ISCA responses indicate Vaya has processes in place to back up the enrollment and claims data in their inhouse system on a nightly basis. Vaya stated their Disaster Recovery Plan (DRP) is updated when there are infrastructure changes. The DRP was last updated on 7/29/2022.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. Encounter Data Submission						
4.1 The PIHP has the capabilities in place to submit the State required data elements to NC Medicaid on the Encounter data submission.	X					Vaya submits all secondary Diagnosis codes for Professional encounters. Vaya submits only up to 12 Diagnosis codes on Institutional encounters to NCTracks. ICD-10 Procedure codes are captured in the in house enrollment system but are not included on Institutional Encounter data submissions. In the previous EQR, Recommendations were issued to address these limitations. During the Onsite discussion, Vaya stated they are in the process of testing the submission of ICD-10 Procedure codes and up to 22 ICD-10 Diagnosis codes on Institutional encounters to NCTracks. However, as these Recommendations from the 2021 EQR were not addressed in the past year, they are carried forward in the 2022 EQR. ***Recommendations: Update Vaya's Encounter data submission process to submit ICD-10 Procedure codes on Institutional Encounter data extracts to NCTracks.*** ***Update Vaya's Encounter data submission process to increase the number of ICD-10 Diagnosis codes reported on Institutional Encounter data extracts to NCTracks from 12 to 25.***
4.2 The PIHP has the capability to identify, reconcile and track the Encounter data submitted to NC Medicaid.	X					Vaya uses the data from two sources developed by Adam Holtzman to identify and reconcile Encounter data denials: The Encounter Summary by MCO Check Write and Encounter Denial Detail reports. The appropriate departments for investigation and correction work on denied encounters.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.3 PIHP has policies and procedures in place to reconcile and resubmit Encounter data denied by NC Medicaid.	X					Vaya has clear processes in place to address denied Encounter submissions. Encounter denial reports were provided, and ISCA documentation shows flow charts and procedures for Encounter data submissions to NC Medicaid. Vaya has an Encounter acceptance rate of 99.03%.
4.4 The PIHP has an Encounter data team/unit involved and knowledgeable in the submission and reconciliation of Encounter data to NC Medicaid.	X					Vaya's Encounter Team within Vaya's Claims Department are responsible for working on the denied encounters and resubmitting them to NC Medicaid. Vaya staff were able to speak to Encounter data submissions and reconciliation process. On average, Vaya submits an Encounter within three days from the time of adjudication to NC Medicaid. Per the information provided in the ISCA, it takes approximately 40 days to correct and resubmit an Encounter to NC Medicaid. During the Onsite, Vaya clarified the internal goal is to re-submit encounters within two weeks and the external goal is 30 days. ***Recommendation: Improve turnaround times for resubmission of denied encounters to fall within Vaya's external goal of 30 days.***

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, designated as the *Credentialing Program Description(CPD*), and the *Credentialing Committee Charter (CCC)* 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 is chaired by the Chief Medical Officer (CMO), who is responsible for oversight of the clinical aspects of the credentialing program. As was the case at the last EQR, there is conflicting language in the *CCC* and the *CPD* regarding who chairs the committee in the absence of the CMO. This issue was discussed during the Onsite Reviews in February 2021 and September 2021 and included as a Recommendation in the reports issued in April 2021 and October 2021. Vaya partially implemented the Recommendation, revising the *CCC*, but not the relevant language in the *CPD*, which continues to indicate the committee is chaired by the CMO, and states "If the CMO is unable to attend the meeting, the Assistant Medical Director or other contracted/employed Psychiatrist attends as the CMO's designee." As at the 2021 EQR, there is no Assistant Medical Director listed on the *Organizational Chart*. Dr. Wade is not a psychiatrist, and therefore, she does not meet the criterion stipulated in the *CPD* as the "CMO's designee."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						In the 2022 EQR, Vaya met100% of the Credentialing/ Recredentialing standards. There are conflicts in membership lists between the *CCC* dated January 27, 2022, the *Credentialing Committee Membership Matrix 20220812*, and the submitted Credentialing Committee meeting minutes. Although the Recommendation from 2020 and 2021 was only partially implemented and there are conflicts in membership lists in documents, CCME is issuing no Recommendations in the 2022 EQR of credentialing and recredentialing, as credentialing and recredentialing are no longer completed by the PIHPs. The Credentialing Committee meeting minutes indicate which members are "voting" members, which members are present, which member(s) made specific motions, and the outcome of votes cast. The meeting notes contain evidence of the committee discussion and decision-making.
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Credentialing files reviewed for the EQR were organized and contained appropriate information.
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					

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					
3.1.3 Valid DEA certificate; and/or CDS certificate	X					
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	X					
3.1.14 Names of hospitals at which the physician has admitting privileges if any	X					
3.1.15 Ownership Disclosure is addressed.	X					
3.1.16 Criminal background Check	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the PIHP's internal policies.	X					Vaya re-credentialing files reviewed for the EQR were organized and contained appropriate information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
4.2.3 Valid DEA certificate; and/or CDS certificate	X					
4.2.4 Board certification if claimed by the applicant;	X					
4.2.5 Malpractice claims since the previous credentialing event;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.6 Practitioner attestation statement;	X					
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event; and query of the State Exclusion List;	X					
4.2.9 Requery of the SAM.	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (OIG LEIE);	X					
4.2.11 Requery of the Social Security Administration's Death Master File	X					
4.2.12 Requery of the NPPES;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					
4.2.14 Ownership Disclosure is addressed.	X					
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					The *Credentialing Program Description*, Section V. Application Process for Re-Credentialing, item 1. includes the following statement, which addresses provider profiling for recredentialing: "Re-credentialing requires the submission of a currently attested application which updates all categories of required information since the previous application was submitted [N-CR 15], as well as a review of performance data, including but not limited to findings of quality management/quality improvement activities, UM activities, and complaints and grievances [N-CR 5,10, 14(b), 16(c)]."
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 outlines the actions that could be taken 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					

III. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III. Quality Improvement						
III. A Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					All (c) Waiver Measures were above the State benchmark rates. The overall validation scores for all Performance Measures (PMs) were in the Fully Compliant range, with an average validation score of 100% across the 10 (b) Waiver Measures and the five (c) Waiver Measures. Five (b) Waiver measures showed substantial decline and one measure showed improvement.
III. B Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					Vaya submitted three active projects for this 2021 EQR. These three were validated: • TCL Housing Retention – Non-Clinical • Increase Follow-Up after Discharge for Mental Health – Non-Clinical • Access to Care - Clinical • The SAR Timeliness – Non-Clinical PIP was reviewed but not validated, as it is still in development.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					All three validated PIPs scored in the High Confidence range. One PIP had a section with concerns that should be addressed by the Recommendation. For the Access to Care PIP, the most recent remeasurement period shows a rate decline. ***Recommendation: For the Access to Care PIP, assess the impact of the newest interventions including additional complex care management and staff education to determine if these improve the services received rate.***

IV. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. A Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					Vaya's *Utilization Management Plan and Program Description* and Policy 2335, Complex Care Management Populations, Processes, Roles, and Responsibilities outlines the techniques used by the Care Coordination/Management Department to coordinate care for enrollees with complex or high-risk health conditions.
2. The care coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					Vaya reports they have collaborated with local Division of Social Services, hospitals, and the Mountain Area Health Education Center to embed Care Coordinators within these agencies to directly assist enrollees with system navigation, assessments, services and supports.
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					Vaya's Policy 3042, Population Health Program Description describes the use of the Health Risk Assessment and how this tool identifies special health care needs.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					Policy 2324, Development, Implementation and Monitoring of Innovations Enrollee Care Plans explains the development of enrollee treatment plans.
2.5 Quality monitoring and continuous quality improvement;	X					Vaya's *Complex Care Management Quality Improvement & Monitoring Plan* states "the CM Performance Improvement and Outcomes team in collaboration with a small group of Managers reviews for trends and opportunities for improvement. This information is then presented to CM Leadership (i.e., Directors, VP) to develop and implement interventions." Vaya submitted their CCM Performance Dashboard for the month of June 2022. This dashboard showed Vaya is exceeding performance goals in half of their metrics.
2.6 Determination of which Behavioral Health Services are medically necessary;	X					Vaya's *Utilization Management Plan and Program Description* outlines the functions of the UM Department and how services are determined to be medically necessary.
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					In the 2021 EQR, a Corrective Action was issued to address issues identified in an Innovations enrollee record submitted by Vaya. The Corrective Action targeted concerns regarding a lack of coordination of services and supports and assessment of the enrollee's health and safety prior to the enrollee's voluntary termination from the Innovations Waiver. In response to this Corrective Action, Vaya drafted a new procedure, revised the *Care Management Reference Guide*, and provided training to staff around the required health assessments, support, and notifications when an enrollee is discharged from the Innovations Waiver.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					
2.10 Ensure privacy for each Enrollee is protected.	X					
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					Vaya Policy 2324, Development, Implementation and Monitoring of Innovations enrollee Care Plans, outlines the quarterly monitoring of Home and Community Based services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					Vaya Policy 2340, Administrative Health Record Documentation states, "member notes shall be documented within 24 hours of the intervention to ensure accuracy and continuity of care. Notes that cannot be entered within the 24 hours shall be noted as late entries with a reason as to the delay (lack of connectivity, etc.)" In the 2021 EQR, the review of enrollee records found 39% of enrollee contact notes were submitted outside of the 24-hour timeframe. Additionally, enrollee contact notes that were submitted beyond the 24-hour entry requirement did not follow the late entry process. CCME recommended Vaya update the current *Complex Care Management Quality Improvement & Monitoring Plan* to include a process that identifies late enrollee contact notes and ensures these enrollee contact notes are labelled "late entry" and included the reason for the delay, as required by Policy 2340. In the 2022 EQR, the enrollee records submitted contained enrollee contact notes that showed only the date of submission and not the date of contact so timeliness of contact notes could not be discerned. However, of the two notes within an I/DD enrollee record labelled "late entry", neither included a documented reason for the delay and both were submitted nine days after the enrollee contact. Additionally, review of the revised *Complex Care Management Quality Improvement & Monitoring Plan* showed no enhancements regarding the monitoring of compliance of late enrollee contact notes. Outside of this issue, the MH/SUD and I/DD records reviewed in this year's review showed good engagement by Care Coordinators, timely monitoring of I/DD services, and compliant documentation. ***Recommendation: Ensure late enrollee contact notes are monitored for compliance with Vaya Policy 2340. Monitoring should check notes are labelled "late entry" and include the reason for the delay when submitted outside of the required 24-hour timeframe.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. B Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					Vaya Policy 3042, Population Health Program Description outlines the licensures and certifications required for the TCLI specialty team.
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					Vaya Policy 2405, In Reach and Transition describes the required TCLI Care Coordination activities.
2.1 Care Coordination activities occur, as required.	X					
2.2 Person Centered Plans are developed as required.	X					
2.3 Assertive Community Treatment, Peer Support, Supported Employment, Community Support Team, Psychosocial Rehabilitation, and other services as set forth in the DOJ Settlement are included in the individual's transition, if applicable.	X					
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.5 QOL Surveys are administered timely.	X					Vaya Policy 2405, In-Reach and Transition, details the required timelines for completion of the 11 month and 24 month Quality of Life Surveys. Additionally, Vaya reported their overall submission rate for surveys due in the 2020-2021 State Fiscal Year was 89% and included surveys for 94% of all individuals who transitioned to supportive housing during the year, and 86% and 85%, respectively, of individuals in housing at 11 and 24 months.
3. Transition, diversion and discharge processes are in place for TCLI members as outlined in the DOJ Settlement and *DHHS Contract*.	X					
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.	X					Per Vaya report, Vaya met or exceeded all established targets for the TCLI Super Measure.
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	X					Vaya Policy 2340, Administrative Health Record Documentation states, "if another Vaya Member must be referenced in a Member notes, the other Member may be referenced by using his/her initials, record number, or letters/numbers, etc." One TCLI record reviewed in this year's EQR included the full name of a different enrollee. In the 2022 EQR, the enrollee records submitted contained enrollee contact notes that showed only the date of submission and not the date of contact so timeliness of contact notes could not be discerned. However, of the four notes within a TCLI enrollee record labelled "late entry", none included a documented reason for the delay. Outside of this issue, the TCLI records reviewed in this year's EQR showed good engagement by TCLI Care Coordinators, compliant documentation, and timely Quality of Life surveys, In-Reach, and transition activities. ***Recommendation: Remove or replace with initials the full name of the other enrollee documented within the TCLI enrollee's record.*** ***Ensure TCLI late enrollee contact notes are monitored for compliance with Vaya Policy 2340. Monitoring should check notes are labelled "late entry" and include the reason for the delay when submitted outside of the required 24-hour timeframe.***

V. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee Grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy 2607, Member Grievances is the primary policy guiding staff through the Grievance process.
1.1 Definition of a Grievance and who may file a Grievance;	X					
1.2 The procedure for filing and handling a Grievance;	X					
1.3 Timeliness guidelines for resolution of the Grievance as specified in the contract;	X					
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					Documentation of consultations with subject matter experts is captured within the Grievance files and demonstrates compliance with Policy 2607, Member Grievances.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.5 Maintenance of a Grievance log for oral Grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Policy 2607, Member Grievances contains the timeframe for maintenance of Grievance Logs and files. This is required by the *NC Medicaid Contract, Attachment M, Section (B), Recordkeeping and Reporting*.
2. The PIHP applies the Grievance policy and procedure as formulated.	X					In the 2021 EQR, CCME recommended Vaya closely monitor all Grievances to ensure all acknowledgement notifications and resolution notifications are timely and to identify problems with processes that contribute to compliance issues. For the 2022 EQR, Vaya followed their Grievance and Complaint Monitoring document outlining how they monitor oral notifications, written notifications, Grievance Log and performance metrics, and timeline compliance. Overall improvement in compliance and accuracy of the file review was noted. The file review included nine standard Grievances and one member-extended Grievance. Two of the standard Grievances were received by Vaya and transferred to the Division of Health Services Regulations (DHSR) because those concerned a facility licensed by DHSR in North Carolina. Vaya staff followed Policy 2607, Member Grievances to acknowledge and resolve all Grievances in a timely manner. The Vaya Grievance Log is consistent with the file review, except for a discrepancy in one Grievance where the date the Grievance was received was off by one day on the Log. Vaya staff confirmed at the Onsite discussion that it was a standard Grievance and was mislabeled on the Log. Guardianship was verified for each applicable Grievance. Additional release of information documentation was also provided when needed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The staff track Grievances and Complaints by entering them into Navex Global, a component of EthicsPoint. Having the Complaint or Grievance data point on each entry allows staff to run a report of all Medicaid Grievances separately from Complaints. Vaya conducts daily huddles and consults with the performance team about data available to identify provider trends. A bi-monthly standing meeting with their Chief Medical Officer is a new process in the Grievance Department. During the Onsite, Vaya staff stated "We have always had ad hoc meetings with the Chief Medical Officer, but we felt like standing meetings would be helpful. We also work on issues in real time like provider responsiveness or delays in responses. Our Performance Reporting Team runs data and looks for trends and reports to QIC."
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					
V. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider Appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					Policy 2384, Member Appeals of Adverse Decisions is the primary policy guiding staff throughout the Appeals process.
1.1 The definitions an Appeal and who may file an Appeal;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 The procedure for filing an Appeal;	X					
1.3 Review of any Appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited Appeal where the life or health of the enrollee would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the Appeal as specified in the contract;	X					
1.6 Written notice of the Appeal resolution as required by the contract;	X					
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					In the 2021 EQR, there was a Recommendation to continue to closely monitor Appeals to ensure all acknowledgement notifications and resolution notifications are timely and to identify problems with processes contributing to compliance issues. Overall improvement in compliance and accuracy was noted with all types of Appeal files when compared to the 2021 EQR. Six standard, three expedited, and one invalid Appeals were reviewed. 100% of the Appeals met timeliness requirements. One file was labeled invalid on the Vaya Appeal Log but was a standard Appeal. One file in the Desk Review was missing the acknowledgement notification, resolution notification, adverse benefit determination letter, and the member Appeals contact record. Vaya uploaded those before the Onsite as CCME requested. Guardianship was verified in all applicable Appeals.
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					In the 2021 EQR, CCME recommended to increase the sample size of the Appeal files reviewed for the Regulatory Compliance Committee and reported in the Vaya UM Audit Summary. This was implemented in the 2022 EQR. During Onsite discussions, Vaya staff explained they increased their sample size, and the file review confirmed the increased level of monitoring. The Vaya *UM Audit Summary* was not submitted in the Desk Materials of this EQR. It was not required documentation. Quality improvement opportunities were discussed in committees and changes implemented, when needed.
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					Vaya's Policy 2313, Response to Legal Inquiries and Record Requests is referenced in Policy 2384, Member Appeals of Adverse Decisions, to provide guidance to staff when releasing any part of the Appeal record.

VI. PROGRAM INTEGRITY

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of *42 CFR 438.608* and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under *NC Medicaid Contract* and in accordance with *42 CFR § 438.608(a)(1)(iv).*	X					Review of the *Regulatory Compliance Committee Charter* submitted for this review showed discrepancies in membership when compared to Vaya's *Organizational Chart*. For example, the names listed in the charter for the Chief Medicaid Officer and Chief Information and Security Officer, did not match the name listed on the *Organizational Chart* submitted for this year's review. Additionally, job titles listed for one member also did not match the *Organizational Chart*. During the Onsite, Vaya stated they are in the process of organizational restructuring and in the process of determining which staff would best serve on the Regulatory Compliance Committee. ***Recommendation: Ensure the Regulatory Compliance Committee Charter lists the names and title of current committee members.***
3. PIHP shall establish and implement a special investigation or program integrity unit.	X					
4. PIHP's written Compliance Plan shall, at a minimum include:						

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. In accordance with *42 CFR § 438.608 (a)(vii),* PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under *NC Medicaid Contract*, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under *NC Medicaid Contract*; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month.						For this EQR, a review of the *Attachment Y Report* listed all overpayments based on fraud or abuse. The review found the tentative notice of overpayment listed for PI Case file SI-1979 did not match the outstanding amount listed on the *Attachment Y Report*. The difference between to two amounts totaled $6,614.42. During the Onsite, Vaya explained the difference between the amounts included a 10% late fee and 8% interest on the unpaid amount. This was not stated in the comment section of the *Attachment Y Report*. The practice of applying the additional fees and interest, aligns with Policy 2595, Identification and Recovery of Overpayments. ***Recommendation: Ensure the Attachment Y Report detail all financial actions taken towards collecting provider overpayments.***
6. PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					
6.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure.	X					
6.3 In accordance with Attachment Y - Audits/Self-Audits/investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					
6.4 Process for tracking overpayments and collections based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on Attachment Y – Audits/Self-Audits/investigations.	X					Vaya Policy 2595, Identification and Recovery of Overpayments outlines how overpayments are identified and the process for collecting monies from providers.
6.5 Process for handling self-audits and challenge audits.	X					
6.6 Process for using data mining to determine leads.	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
7. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements.	X					
8. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					
9. In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						For this EQR, a review of the *Attachment Y Report* showed Vaya submitted nine cases of potential fraud, waste, and abuse to NC Medicaid's Office of Compliance and Program Integrity (OCPI) Department in the past year.
9.1 Subject (name, Medicaid provider ID, address, provider type);	X					
9.2 Source/origin of complaint;	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9.8.1 Any known Provider connection with any billing entities, other PIHP Network Providers and/or Out-of-Network Providers;	X					
9.8.2 Details that relate to the original allegation that PIHP received which triggered the investigation;	X					
9.8.3 Period of Service Investigated – PIHP shall include the timeframe of the investigation and/or timeframe of the audit, as applicable.;	X					
9.8.4 Information on Biller/Owner;	X					
9.8.5 Additional Provider Locations that are related to the allegations;	X					
9.8.6 Legal and Administrative Status of Case	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template.	X					A review of the SIU Case Log in this year's EQR showed Vaya processed two cases of potential enrollee fraud. Both cases were referred to NC Medicaid's OCPI Department for review.
11. If PIHP uses FAMS, PIHP shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	X					Vaya submitted *FAMS Users Reports* showing a change in superusers beginning January 2022. During the Onsite, Vaya stated the change was due to the onboarding of new staff. The Director of PI remained consistent on all reports.
12. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP.	X					In the last two EQRs, it was recommended that Vaya add language to a Vaya PI policy detailing the process and timeframes required by *NC Medicaid Contract, Section 9.8* and *14.2.14* for timely reporting to NC Medicaid. For another year, this Recommendation was not addressed. During the Onsite, Vaya staff contended all *NC Medicaid Contract* requirements do not need to be captured in Vaya policies. For this EQR, Vaya submitted evidence all State-required monthly and or quarterly reports were submitted to NC Medicaid within the timeframes required by their contract with the State.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII C. Provider Payment Suspensions and Overpayments						
1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, NC Medicaid Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If NC Medicaid determines that a full investigation is warranted, NC Medicaid shall make a referral within five (5) business days of such determination to the MFCU/ MID and will suspend payments in accordance with *42 CFR § 455.23*. At least monthly, NC Medicaid shall provide written notification to PIHP of the status of each such referral. If MFCU/ MID indicates that suspension will not impact their investigation, NC Medicaid may send a payment suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates that payment suspension will impact the investigation, NC Medicaid shall temporarily withhold the suspension notice and notify PIHP. Suspension of payment actions under this *Section 14.3* shall be temporary and shall not continue if either of the following occur: PIHP or the prosecuting authorities determine that there is insufficient 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.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 In the circumstances described in *Section 14.3 (c)* above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.	X					
2. Upon receipt of a payment suspension notice from NC Medicaid Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of NC Medicaid Program Integrity's suspension and lasting until PIHP is notified by NC Medicaid Program Integrity in writing that the suspension has been lifted.	X					
3. PIHP shall provide to NC Medicaid all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid Program Integrity due to allegations of suspected fraud without prior written approval from NC Medicaid Program Integrity or the MFCU/MID.	X					

D. Attachment 4: Encounter Data Validation Report

Table of Contents

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Background

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

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

Overview

The review, guided by the Centers for Medicare and Medicaid Services (CMS) External Quality Review Protocol, focused on measuring the data quality and completeness of claims paid by Vaya for the period of January 2021 through December 2021. All claims paid by Vaya should be submitted and accepted as a valid encounter to NC Medicaid. The 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 focused on Section V, Encounter Data Submission. NC Medicaid requires each PIHP to submit encounter data for all paid claims weekly via 837 Institutional and Professional transactions. The 837 companion guides for encounter submissions follow the standard ASC X12 transaction set with a few modifications to some segments. For example, the PIHP must submit the provider number and paid amount to NC Medicaid in the Contract Information CN104 and CN102 segment of Claim Information Loop 2300.

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

Once NCTracks processes the 837 files, it produces 835 files detailing the results of adjudication and pricing of encounter submissions. The PIHP is required to resubmit encounter records that were denied upon triggering one or more of NC Medicaid's edits marked as "DENY" in Appendix 1.

Vaya has established a team responsible for investigating, correcting, and resubmitting all denied Encounters. The encounters team coordinates denial research and requests corrections from other departments or from the encounter billing provider, depending on the denial reason. Vaya relies on NC Medicaid's "The Encounter Summary by MCO Check write" report and an encounter denial detail report listing the header and line edits, as well as numerous other parameters for all encounter records that deny. Vaya has implemented a detailed reconciliation and correction processes to ensure all denials are reviewed, corrected, and resubmitted to NC Medicaid. 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
- Confirm any changes requested by a provider in NCTracks before updating Vaya systems
- Internal database and reporting tools
- Provider education guidelines
- Providing support to providers in rebilling corrected claims for encounter denials

Based on data provided in the ISCA for claims with dates of service in 2021, Vaya submitted 1,910,223 unique encounters to the State. To date, 0.97% of all 2021 encounters submitted have been corrected and accepted by NC Medicaid.

2021	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
Institutional	34,370	32,468	1,416	486	1.41%
Professional	1,875,853	1,774,065	83,701	18087	0.96%
Total	1,910,223	1,806,533	85,117	18,573	0.97%

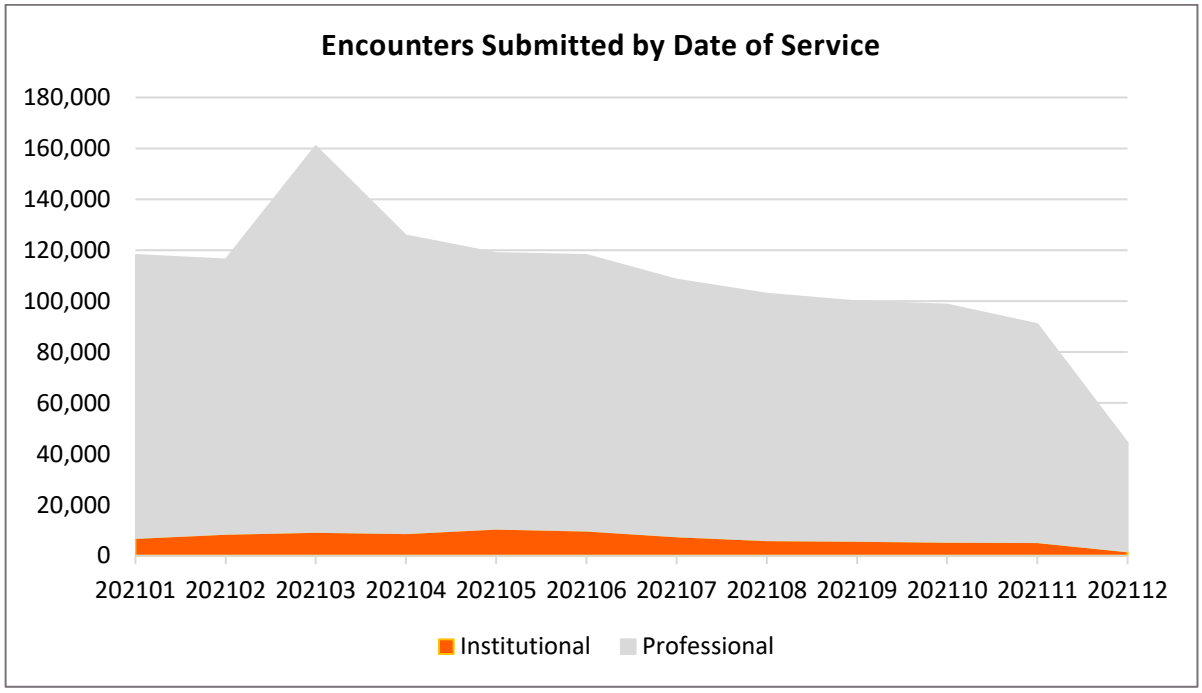
In past year, Vaya has made improvements to their encounter submission process, increasing their acceptance rate and quality of encounter data year over year. In MY 2021, Aqurate noted a decrease in denials from the prior year. The table below shows acceptance rates over the past five (5) years.

Year of Service	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
2021	1,910,223	1,806,533	85,117	18,573	0.97%
2020	1,948,699	1,779,609	102,885	66,205	3.40%
2019	1,850,373	1,810,979	23,841	15,553	0.84%
2018	1,910,482	1,873,781	22,335	14,366	0.75%
2017	1,815,237	1,641,057	79,430	94,750	5.22%

Upon further analyses and based on interviews with Vaya personnel, Aqurate concludes the vast majority of these denials had triggered "duplicate/suspected duplicate" edits within NCTracks As explained by Vaya, most of the denied encounter records were not true duplicates and were related to issues experienced in 2020. The 2020 denials were caused by timing issues when Vaya attempted to adjust previously submitted encounters. Before an adjusted encounter could be processed and accepted by NCTracks a void transaction needed to be processed, essentially removing the prior encounter submission from the system. Any delays in processing or a timing issue with submitting the adjustments resulted in the prior claim still being on NCTracks when an adjustment is submitted, resulting in the latter denying as a duplicate when it is actually meant to be an adjusted encounter. When this occurs, generally the entire batch of adjustments will deny as duplicates, quickly driving up the denial counts. To date, Vaya has resubmitted most of these adjusted encounters.

Analysis of Encounters

The encounter data analyses evaluated whether Vaya submitted complete, accurate, and valid data to NC Medicaid for all claims paid between January 1, 2021, through December 31, 2021. Vaya provided 837I and 837P files submitted to NC Medicaid during the requested audit period to an Excel spreadsheet and submitted to CCME and Aqurate. This included 1,644,023 Professional claim line items and 82,329 Institutional claim line items. These figures include line level detail as well as voids and resubmissions for previously denied claims, including denials prior to 2021. Therefore, these numbers may not match the metrics reported in Vaya's ISCA response for 2021.



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

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Recipient ID	Should be valid ID as found in the State's eligibility file. Can use State's ID unless State also accepts Social Security Number.	100% valid. Medicaid IDs are 9 numeric long followed by 1 alpha.
Recipient Name	Should be captured in such a way that makes separating pieces of name easy. Expect data to be present and of good quality	85% present. Lengths may vary, but there should be at least some last names of >8 digits and some first names of < 8 digits, validating fields have not been truncated.

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Recipient Date of Birth	Should not be missing and should be a valid date.	Existence of a valid date
PIHP ID	Critical Data Element	100% valid for PIHP
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	10 digits
Attending Provider ID	Should be an enrolled provider listed in the provider enrollment file (will accept the MD license number if it is listed in the provider enrollment file).	> 85% match with provider file using either provider ID or MD license number. 10 digits
Provider Location	Minimal requirement is county code, but zip code is strongly advised.	> 95% with valid county code > 95% with valid zip code (if available)
Place of Service	Should be routinely coded, especially for physicians.	> 95% valid for physicians > 80% valid across all providers Standard UB POS
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% non-missing and valid on physician or other applicable provider type claims (e.g., other practitioners). This is the Taxonomy code and is a standard code set.
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid ICD codes for practitioner providers. Codes should be within standard ICD 9 and 10 code sets. ICD-9s have generally stopped appearing on files for current records.

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Other Diagnosis	This is not expected to be coded on all claims even with applicable provider types but should be coded with a fairly high frequency.	90% valid when present. Codes should be within standard ICD 9 and 10 code sets. ICD-9s have generally stopped appearing on files for current records.
Dates of Service	Dates should be evenly distributed across time.	Valid date Dates spread throughout reporting year.
Unit of Service (Quantity)	The number should be routinely coded.	The number should be routinely coded. Current Procedural Terminology (CPT) code is in 99200–99215 or 99241–99291 range.
Procedure Code	Critical Data Element	There should be a wide range of procedures appropriate for the services covered by the PIHP
Procedure Code Modifier	Important to separate out surgical procedures/ anesthesia/assistant surgeon, not applicable for all procedure codes.	Expect a variety of modifiers both numeric (CPT) and Alpha (Healthcare Common Procedure Coding System [HCPCS])
Patient Discharge Status Code (Hospital)	Should be valid codes for inpatient claims, with the most common code being “Discharged to Home.” For outpatient claims, the code can be “not applicable.”	Expect a variety of values, with "Discharge to Home" being most common, and includes "Still-in" and transfers
Revenue Code	If the facility uses a UB04 claim form, this should always be present	Valid code is present

Encounter Accuracy and Completeness

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

Table: Evaluation of Key Fields

Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%
Recipient Name	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%
Recipient Date of Birth	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%
PIHP ID	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%
Provider ID	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%
Attending/Rendering Provider ID	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%
Provider Location	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%
Place of Service	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%
Specialty Code / Taxonomy - Billing	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%
Specialty Code / Taxonomy - Rendering / Attending	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%
Principal Diagnosis	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%

Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Other Diagnosis	330,703	16.07%	330,703	16.07%	330,703	16.07%	330,703	16.07%
Dates of Service	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%	2,058,112	100.00%
Unit of Service (Quantity)	2,029,533	98.61%	2,029,533	98.61%	2,029,533	98.61%	2,029,533	98.61%
Procedure Code	2,001,630	97.26%	2,001,630	97.26%	2,001,630	97.26%	2,001,630	97.26%
Procedure Code Modifier	1,089,741	52.95%	1,089,741	52.95%	1,089,741	52.95%	1,089,741	52.95%
Patient Discharge Status Code Inpatient	97,778	100.00%	97,778	100.00%	97,778	100.00%	97,778	100.00%
Revenue Code	97,778	100.00%	97,778	100.00%	97,778	100.00%	97,778	100.00%

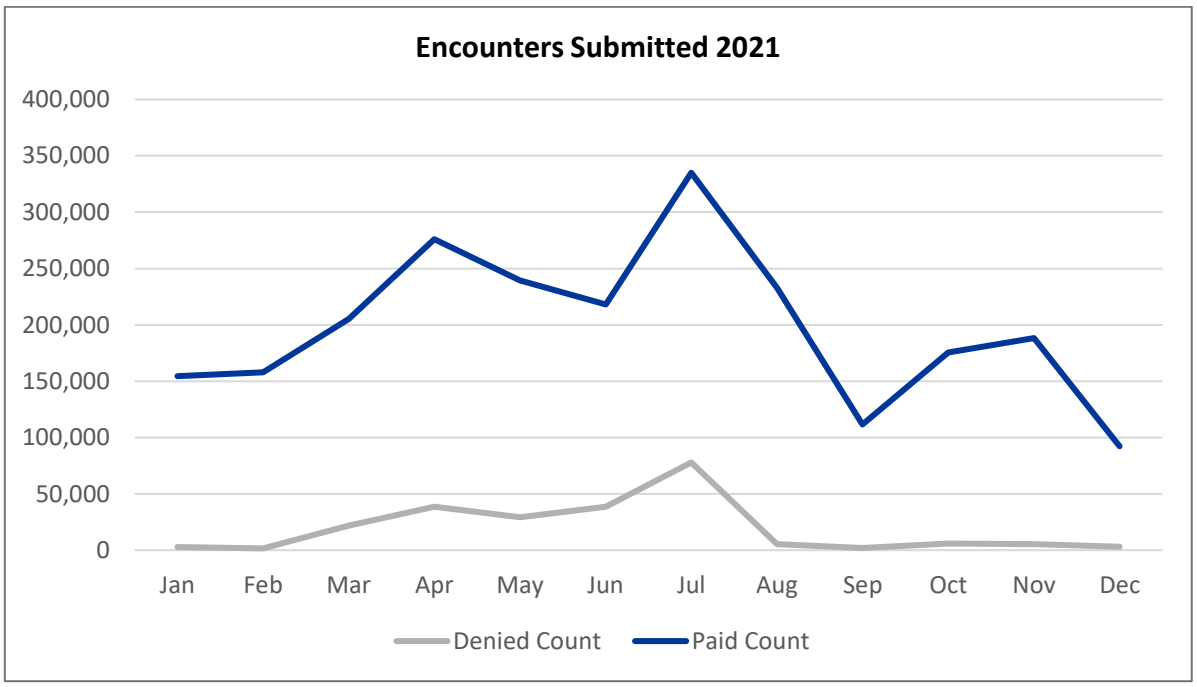
There were very few inconsistencies in the data other than the denial issues highlighted in Vaya's ISCA response and NC Medicaid's encounter acceptance report. Institutional claims contained complete and valid data in 13 of the 17 key fields (76.5%) with noted issues to Procedure codes, Modifiers and Other Diagnosis codes not populated. However, some of the fields may be appropriately blank for certain types of claims.

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

Professional encounter claims submitted contained complete and valid data in 13 of the 15 key Professional fields (86.7%). The primary issue is the infrequent reporting of Other Diagnosis on Professional services. The principal Diagnosis code was populated 100% of the time. Some providers never reported Other Diagnosis codes, but this may be appropriate for certain types of providers. There were also a high number of records without a procedure code modifier, but a review of the files indicated this might be appropriate for certain types of claims.

Encounter Acceptance Report

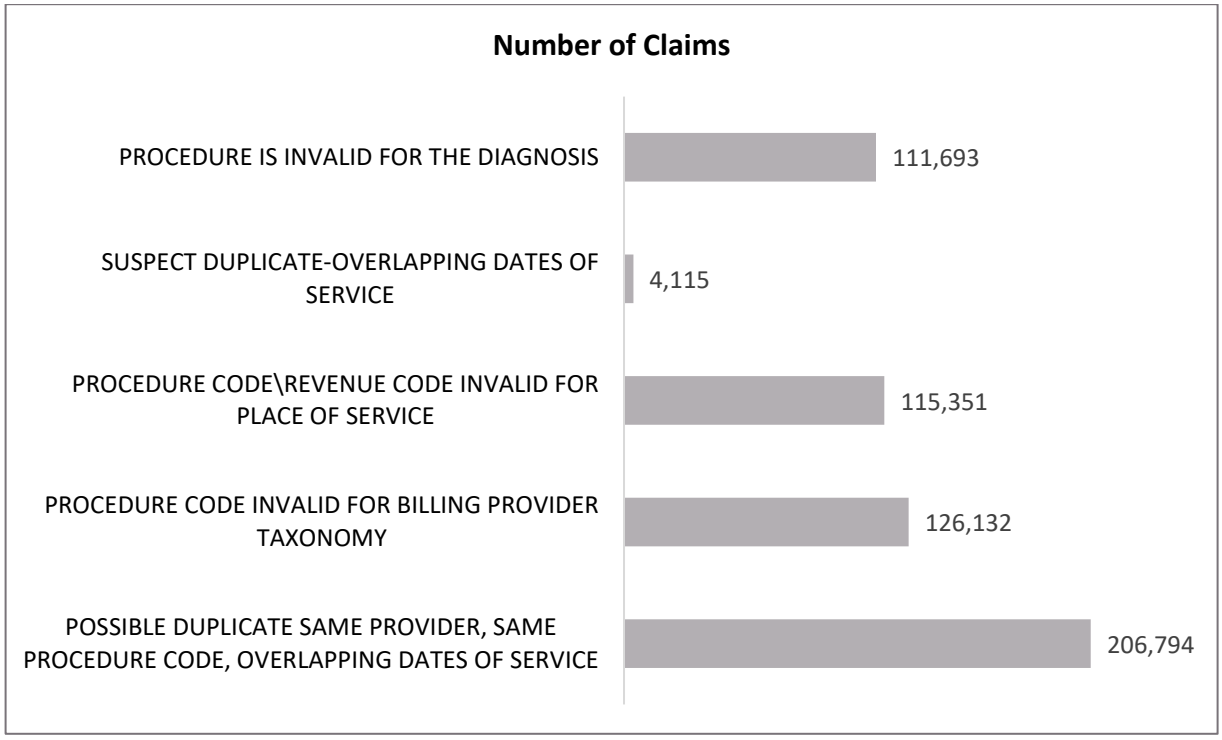
In addition to evaluating the encounter data submitted, Aqurate analysts reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. Since this report is tracked by check write, it was not easy to tie back the metrics to the ISCA response and the converted encounter files submitted since only the Date of Service for each is available. During the 2021 weekly check write schedule, Vaya submitted a total of 2,618,327 encounters to NC Medicaid. On average, 99.03% of all encounters submitted were accepted by NC Medicaid.



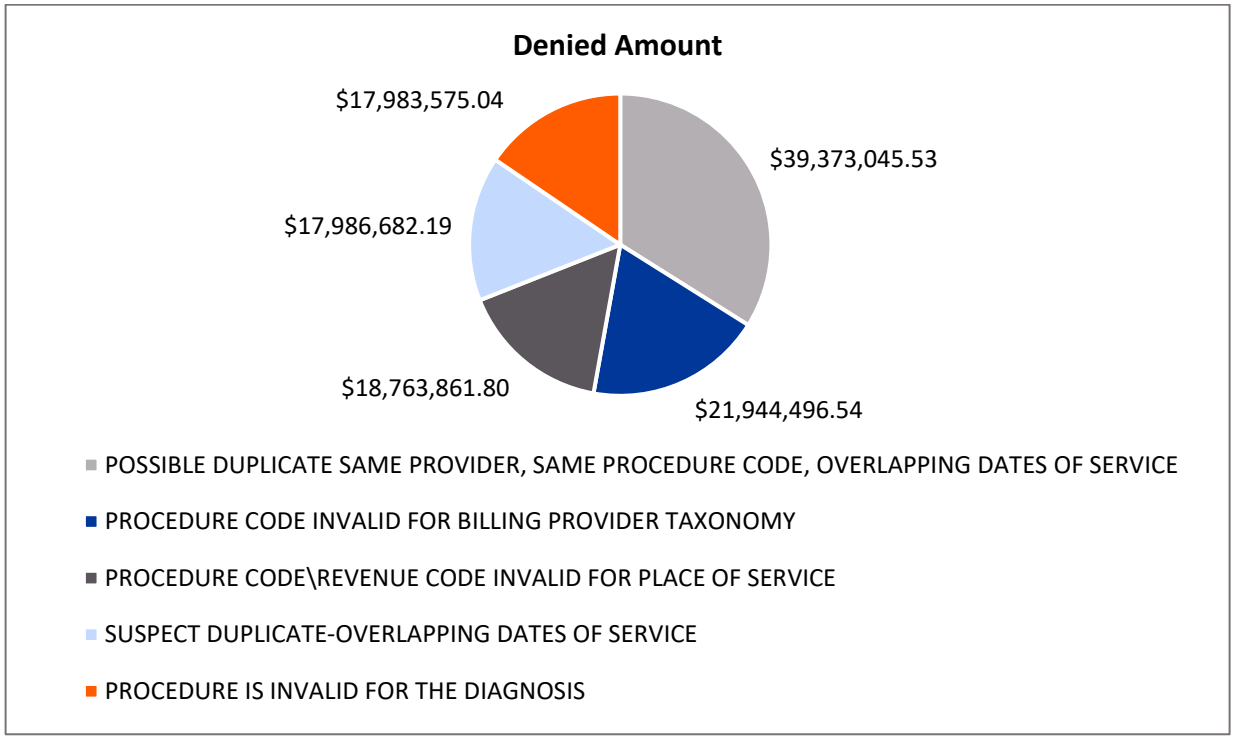
Evaluation of the top denials for Vaya encounters correlates with the data deficiencies identified in the Key Field analysis described previously. The top denials in 2021 were similar to the denial reasons for the dates of service reviewed in the prior year. Encounters were denied primarily for:

- Suspect duplicate-overlapping dates of services
- Procedure code/Revenue code invalid for Place of Service
- Procedure is invalid for the diagnosis
- Procedure code invalid for billing provider taxonomy
- Duplicate service or procedure

The graph below reflects the top five (5) denials by claim volume.



The chart below reflects the top 5 denials by denied amount.



Results and Recommendations

Issue: Other Diagnosis

Principal Diagnosis codes were populated consistently where appropriate. However, Other Diagnosis codes were infrequently populated with only 16.07% of all encounter records containing at least one Other Diagnosis code. The issue is far more pronounced in Professional encounters, which saw only 13.47% of all Professional encounters billed with at least one Other Diagnosis code. This is well below what is expected to be seen given the comorbidities that are often present in the demographics PIHPs serve.

Resolution:

It is recommended Vaya continue to educate its providers on the importance of complete and accurate coding. Vaya should also continue monitoring the reporting of Diagnosis codes and take appropriate steps to improve both the quality and quantity of the Diagnosis code reporting. This would enable Vaya and NC Medicaid to get a more complete picture of the morbidities within the demographics it serves.

Conclusion

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

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