CCME

2019 External Quality Review

VAYA HEALTH

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

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EXECUTIVE SUMMARY

The *Balanced Budget Act of 1997* requires State Medicaid Agencies that contract with Prepaid Inpatient Health Plans (PIHPs) to evaluate their compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358 (42 CFR § 438.358)*. This review determines the level of performance demonstrated by the Vaya Health (Vaya). This report contains a description of the process and the results of the 2019 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the North Carolina Medicaid (NC Medicaid).

Goals of the review are to:

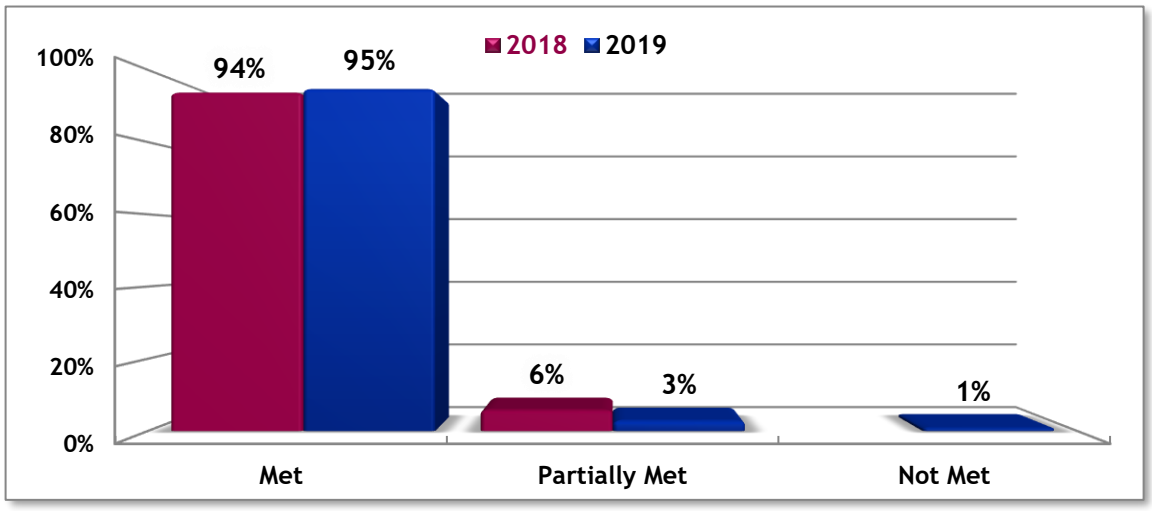
- Determine if Vaya complies with service delivery as mandated by their *NC Medicaid Contract*
- Provide feedback for potential areas of further improvement
- Verify the delivery and determine the quality of contracted health care services

The process used for the EQR was based on the Centers for Medicare & Medicaid Services (CMS) protocols for EQR of Medicaid Managed Care Organizations (MCOs) and PIHPs. The review includes a desk review of documents, a two-day Onsite visit (Onsite), 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

The 2019 Annual EQR reflects that Vaya achieved a “Met” score for 95% of the standards reviewed. As *Figure 1* indicates, 3% of the standards were scored as “Partially Met.” 1% of the standards were scored as “Not Met.” *Figure 1* provides a comparison of Vaya’s 2018 review results to 2019 results.

Figure 1: Annual EQR Comparative Results



B. Overall Recommendations

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

Administration

The 2019 Vaya EQR reflects Vaya met 90% of the Administrative standards. Vaya made considerable efforts in the past two years to bring policies and procedures into compliance with contractual requirements. The documentation submitted for this year's EQR shows all policies and procedures are accounted for and submitted in final, approved format.

CCME's review of Vaya's current organizational staffing reflects that none of the current vacancies are affecting Vaya's core functions. Interim coverage has been in place to cover the vacancies of the Chief Financial Officer and Utilization Management Director. CCME recommends again this year that Vaya's *Organizational Chart* accurately reflects the oversight and job duties of the Medical Director and Assistant Medical Director.

The EQR of Vaya's confidentiality policies and practices show that Vaya continues to maintain a complete set of policies that address both state and federal requirements for preserving enrollee confidentiality and protecting health information. Vaya's *Privacy Policy 2599* does not specify a timeframe for training new employees on confidentiality. There is evidence that Vaya has an established timeframe for confidentiality training of new staff and staff have reported this training occurs within 30 days of a new staff's hire

date. For the past three years, CCME has recommended Vaya specify this timeframe in *Privacy Policy 2599*.

Vaya received two Corrective Actions in the previous year. Vaya partially resolved the Corrective Action from last year requiring they update their provider web portal to capture up to 22 ICD-10 diagnosis codes for Institutional claims. Vaya can capture up to 22 ICD-10 diagnosis codes for Institutional and up to 12 diagnosis codes for Professional claims.

Vaya has partially resolved the other Corrective Action from last year's review and can now submit up to 12 diagnosis codes on Institutional and Professional encounter data files to NC Tracks. Approximately 44% of the Institutional encounters submitted to NC Tracks only have the admitting and primary diagnosis codes populated. Even though Vaya is capturing up to 22 diagnosis codes on an Institutional claim in AlphaMCS, Vaya is only submitting up to 12 diagnosis codes to NC Tracks on Institutional encounter data files.

Provider Services

Vaya met 100% of the Provider Services standards in the current EQR. Several items that were issues at the last EQR were addressed by Vaya. In this year's EQR, four Recommendations were issued to improve areas within the Credentialing/Recredentialing and Provider Education areas. One of the Recommendations in the Provider Education area was an unaddressed Recommendation from the previous year's EQR.

Enrollee Services

Vaya met 100% of the Enrollee Services standards in the current EQR. CCME provided one Recommendation for the *Member and Caregiver Handbook* to be more accessible on the website and one Recommendation concerning *NC Medicaid Contract, Section 6.10* that states, "PIHP shall give written notice of the termination to all Enrollees, who have been receiving services from the terminated Provider within the sixty (60) calendar day period immediately preceding the date of the notice of termination."

Quality Improvement (QI)

Vaya met 83% of the Quality Improvement standards in the current EQR. 6% of the standards were scored "Partially Met" and 11% of the standards scored a "Not Met."

Two standards scored a "Not Met" this EQR. The first standard is "the scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines." During the prior year's EQR, Vaya monitored the Clinical Practice Guideline for "Best Practice Treatment of Opioid Dependence" and included the monitoring results in the *Quality Improvement Program Evaluation 2017-2018*. This EQR, Vaya did not include this within the quality program for this EQR. The other standard that scored a "Not Met" were related to Vaya's enrollee survey. The results of this survey were not reported to the

quality committee nor were lower scoring survey items identified or discussed within the committee, including implementing measures to address identified quality problems. Lastly, one standard was scored as "Partially Met". Review of Vaya's Performance Improvement Projects (PIPs) showed two of the four PIPs were validated in the "Confidence" level. A Corrective Action was issued to correct the errors in these two PIPs in hopes of improving the validation score to "High Confidence".

Utilization Management (UM)

Vaya met 96% of the Utilization Management standards in the current EQR. One Corrective Action was given to address incorrect information within Vaya's EPSDT policy. For the Care Coordination EQR, Vaya was unable to identify and produce complete enrollee records requested for the file review. What could be discerned was a pattern of documentation by Care Coordinators that was outside of the requirements detailed in Vaya's policies. As a result, one Corrective Action was given to address issues noted within the UM, Care Coordination, and Transition to Community Living Initiative file reviews. CCME also recommends Vaya develop a report or process that ensures Vaya can identify, access and produce enrollees records from the AlphaMCS and Incedo Care Coordination platforms.

Grievances and Appeals

Vaya met 90% of the grievance and appeal standards for this year's EQR. One Corrective Action and one Recommendation resulted from the grievance Review. The Corrective Action is related to the missing time frame within a policy for the maintenance of the *Grievances Logs*. The Recommendations is related to ensuring consultation with subject matter experts, such as the Medical Director, are captured within the grievance record.

One Corrective Action and six Recommendations resulted in the Appeal EQR. In the previous year's EQR, CCME provided five Corrective Actions and four Recommendations to address missing or incorrect information in Vaya's appeal policy, *Policy 2384, Member Appeals of Adverse Decisions, Provider Operations Manual*, and *Member and Caregiver Handbook*. While the policy was revised to reflect compliance with the NC Medicaid Contract, information is still missing or incorrect in the Member and Caregiver Handbook made available to enrollees during the year in review.

Review of the 25 appeal files and Vaya's *Appeal Log* showed a portion of Vaya appeals were processed outside of the timeframes required by Vaya's policies and the *NC Medicaid Contract*. This was a concern noted in last year's EQR, and it was recommended last year that Vaya enhance the appeal monitoring to ensure appeals and all notifications are compliant with requirements. Corrective Action is needed this year to target noncompliance with requirements within Vaya's policies, contract with NC Medicaid and federal regulations governing Medicaid appeals regarding timely appeal notifications.

Delegation

Vaya met 100% of the Delegation standards for this year's EQR, with no items requiring Corrective Action. In the last EQR, Vaya received two Recommendations in the area of delegation oversight. An unaddressed Recommendation from the last EQR is to report delegation oversight in a Quality Improvement Committee (QIC) meeting annually, as referenced in *Policy 2303*, or revise the policy to eliminate the reference to annual reporting by the QIC. The supplied QIC meeting minutes do not include reporting of delegation oversight of Partners, with whom the Delegation Agreement ended on June 30, 2019. The Prest delegation report was presented at the September 10, 2019 meeting, which is outside the review period for the current EQR. The second Recommendation for the current EQR is to include in the Delegation Assessments the time frame covered by the assessment. This was included in a Recommendation at the last EQR and was partially addressed by Vaya in the current EQR.

Program Integrity (PI)

Vaya met 95% of the standards within the PI EQR. Review of the PI documentation showed there is still opportunity for improvement in the area of updating policies to reflect the complete contract language. This is particularly true of contractual timeliness requirements for providing information to NC Medicaid and ensuring continuity of care for enrollees while investigating or taking action against providers. Vaya's policies are sometimes limited to a high-level overview of the contractual requirements and, therefore, do not go into the depth needed to assure that all employees using these documents know the exact requirements. The file review also showed inconsistency by staff in capturing elements required by the NC Medicaid Contract within the PI record. As a result, three Corrective Actions focused on bolstering PI policies, Vaya's Compliance Plan, and PI referral form.

Financial Services

100% of the Financial standards were met as a result of this year's EQR. Per the review of Vaya's financial records, Vaya demonstrates ongoing financial stability. The 2018 EQR of Vaya's Financial Services identified one policy enhancement related to adding the five-business day requirement for Risk Reserve payments to *Policy 2748*. This revision was not implemented as of this year's EQR and CCME again recommends that this timeframe is added to *Policy 2748*, as it is required per *NC Medicaid Contract, Section 1.8.1*.

Encounter Data Validation

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

Their biggest issue was noted with the number of diagnosis codes being reported to NC Medicaid for both Professional and Institutional claims. Although the additional diagnosis

codes do not impact adjudication, the codes are key for reporting, evaluating member health, and factors that will be used in a value-based payment model. Vaya should review and revise their 837 mapping immediately.

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, HMS. Additionally, as required by CCME's contract with NC Medicaid, an ISCA Audit and Medicaid program integrity (PI) review of the PIHP was conducted by CCME's subcontractor, IPRO.

On August 20, 2019, 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 September 11, 2019 and reviewed in the offices of CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. Also included in the Desk Review was a review of credentialing, grievance, utilization, care coordination, case management, and appeal files.

The second segment was a two-day, Onsite review (Onsite) conducted on October 9, 2019 and October 10, 2019, at Vaya's corporate office in Asheville, North Carolina. CCME's Onsite focused on areas not covered in the Desk Review, and areas needing clarification. For a list of items requested for the Onsite, see *Attachment 2*. CCME's Onsite activities included:

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

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

FINDINGS

The findings of the EQR are summarized in 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

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

Policies & Procedures

Administrative review of Vaya's policies and procedures includes review of the individual policies and procedures and the *Policy and Procedure Index*. In 2017, over 30% of Vaya's policies and procedures were either missing from the Desk Materials requested by CCME or submitted in draft format. Since that time, Vaya made considerable effort to consolidate their policy and procedure set. In this year's EQR, all policies and procedures were accounted for and demonstrated annual review or revisions occurred. During the Onsite, Vaya staff explained that in addition to the creation of several new policies and procedures, Vaya continues to retire, combine, split, and move policies and procedures to ensure effective and efficient governance over agency functions.

Organizational Staffing/ Management

Current clinical and medical oversight is led by Vaya's Chief Medical Officer (CMO), Dr. Craig Martin. CCME's review of Dr. Martin's job description shows that he is active in the activities required by his job description and *NC Medicaid Contract*. Based on a Recommendation in last year's EQR, Vaya revised the Organizational Chart to reflect Dr. Martin's oversight of Care Coordination. However, his oversight of Customer Service, now located within the Business Integrity Department, is still not reflected on the Organizational Chart.

The duties of the Assistant Medical Director (AMD), Dr. William Lopez, are also unclear in the Organizational Chart and Associate Medical Director (AMD) job description. Vaya clarified during the Onsite discussion that Dr. Lopez's involvement is with the Utilization Management Department, and he is available to back up Dr. Martin in his absence. However, the current job description, signed in August of 2019, also states 20% of Dr. Lopez's time is spent providing consultation to the Access Unit, Care Coordination,

Community Collaboration, and Provider Network Departments, as well as participating in four committees, and reviewing and approving policies and procedures.

For the past three EQRs, CCME has provided feedback in the form of Corrected Actions or Recommendations so that Vaya will have consistent documentation of the Medical Director's involvement and oversight as required by *NC Medicaid Contract, Sections 6.7.6 and 7.1.3*. In response to last year's EQR Recommendation addressing this need, Vaya provided the following statement "Thank you for making the suggestion, but this item is not a requirement."

Confidentiality

Vaya is a Covered Entity under the Health Insurance Portability and Accountability Act (HIPAA). CCME reviewed Vaya policies and procedures regarding the management and protection of enrollee confidentiality. Vaya's policies address both state and federal requirements for preserving enrollee confidentiality and protecting health information with one exception. Vaya's *Privacy Policy 2599* does not specify a timeframe for training new employees on Vaya's confidentiality practices. This policy states new employees are trained "within a reasonable period of time," and that "best efforts will be made to ensure that all staff receive training before accessing PHI." There is evidence that Vaya has an established timeframe for confidentiality training of new staff and staff have reported this training occurs within 30 days of a new employee hire date. CCME has recommended Vaya specify this timeframe in *Privacy Policy 2599* for the past three years.

Information Systems Capabilities Assessment

As required by their contract with the CCME, IPRO conducted a review of Vaya's information system capabilities using the *Information Systems Capabilities Assessment* (*ISCA*), as specified in the CMS protocol.

Upon receipt of the completed ISCA tool and supporting documentation from Vaya, IPRO reviewed the responses and followed up on areas requiring clarification via Onsite interviews. Additionally, staff conducted a member and claims systems review upon request during the Onsite and were prepared to speak about existing processes and reports during the Onsite. Questions regarding the ISCA tool and follow-up on last year's findings were discussed with Vaya.

Vaya, like many other behavioral health managed care organizations in North Carolina, uses the AlphaMCS, a hosted system environment produced by WellSky (formerly known as Mediware). The AlphaMCS system is used to process member enrollment, claims, submit encounters and generate reports. WellSky modifies the user interface and conducts backend programming updates to the system.

Enrollment Systems

As demonstrated in *Table 1*, Vaya has experienced a small decrease in enrollment over the past three years.

Table 1: Enrollment Counts

2016	2017	2018
170,784	166,286	160,660

During the ISCA Onsite, Vaya provided a demonstration of the AlphaMCS enrollment system. The system maintains a member's enrollment history. The Global Eligibility File (GEF) file is imported into the AlphaMCS daily. The quarterly GEF file is imported quarterly when received. The daily and quarterly eligibility files are compared to existing eligibility in the AlphaMCS. The member enrollment records are processed and checked against the existing data in the database. An edit code that identifies if the member record needs to be added or changed or deleted is applied. The AlphaMCS system is able to capture demographic data like race, ethnicity, and language

During the Onsite, Vaya stated a process is in place to generate error reports when errors are encountered during the GEF load process. An enrollment completeness report is generated quarterly to check the full GEF file and assess any divergence from the data that is loaded in AlphaMCS. Vaya stated that errors do not occur often, and typically encounter errors relate to invalid enrollment dates.

Vaya identifies enrollees by the Medicaid Identification number (MID) that is received on the GEF. An enrollee retains the same MID in case the enrollee is re-enrolled after a disenrollment. If the enrollee is assigned a new MID, then Vaya's system is able to track the prior MID and link the historical enrollment records to the new MID. Vaya has the capability to track historical claim and encounter data for an enrollee.

During the Onsite, Vaya indicated it is rare to find members with multiple MIDs, but Vaya is able to research and merge the information into one MID. The historical claims for the member are also merged into one MID. Vaya providers have the capability to confirm a member's eligibility in the AlphaMCS Provider Portal. Member deaths are also captured through the GEF file. Each month Vaya uses the 820 Capitation file to reconcile with their Per Member Per Month (PMPM) payments to identify the payments made by category of aid.

Claims System

Vaya's authorizations and claims are processed in the AlphaMCS system. The ISCA tool and supporting documentation for claims processes for receiving, adjudicating, and auditing claims are defined clearly. A demonstration of the Vaya's Provider web claims

entry portal and the AlphaMCS claims processing system was performed during the Onsite. Vaya also provided an overview of the processes for receiving, adjudicating, and auditing claims.

Vaya receives claims from three methods; 837 electronic file, provider web portal, and paper claims. During the Onsite, Vaya stated paper claims are accepted from out of network providers and emergency room claims only. *Table 2* details the percentage of 2018 claims received via the three methods.

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

Source	HIPAA File	Paper	Provider Web Portal
Institutional	73.2%	<.01%	26.8%
Professional	87.6%	<.01%	12.3%

Vaya processes claims within 18 days of receipt of a claims, and approved claims are paid within 30 days of receipt. If a required field is missing from a claim, the provider portal will not allow the claim to be submitted to Vaya. If the claim is being submitted electronically via an electronic 837 file and one or more required fields are missing, the provider will receive a 999 response file advising the provider of the claim submission failure. Vaya's claims processors do not change any information on the claims.

Vaya adjudicates claims nightly. Approximately 96.80% of Professional claims and 84.43% of Institutional claims are auto-adjudicated. On an average, Vaya pays 90% of all clean claims within 30 days from the date of approval. Approximately 98.65% of all claims are processed and complete within three months of the date of service.

Vaya conducts audits of claims processed daily. Vaya staff conduct random audits of at least 3% of all claims processed during the day. High dollar claims (above $5,000) and paper claims are audited daily. Vaya staff and managers review 100% of claims examined by new hire claim examiners. Per Vaya's Claims Adjudication policy, staff correct claims that have been identified as being adjudicated incorrectly. Vaya also refers claims that are suspected of fraud, waste, or abuse to the Vaya Special Investigations Unit for further investigation.

Vaya has partially addressed last year's corrective action to capture all ICD-10 Diagnosis codes in their claims system for Institutional claims. Vaya has updated their provider web portal to capture up to 22 ICD-10 Diagnosis codes for Institutional claims and is compliant

with the UB04 form. Vaya can capture only up to 22 ICD-10 Diagnosis codes on the HIPAA 837I file. Vaya does not have the capability to store all possible Diagnosis codes submitted on an 837I file. The maximum number of ICD-10 Diagnosis codes that may be submitted on an 8371 is 25. For Professional encounters, Vaya has the ability to receive and store up to 12 ICD-10 Diagnosis codes on both the provider web portal and HIPAA 837P file. During the Onsite, Vaya staff explained Diagnosis Related Groups (DRG) and ICD-10 Procedure codes are captured from the HIPAA 837I file. Vaya does not have the ability to capture the DRG and ICD-10 Procedure codes through the provider web portal.

As discussed during the Onsite, Vaya has the capability to capture and submit Healthcare Common Procedure Coding System (HCPCS) codes along with required revenue codes for specific claims regarding lab, drug, or radiology services. Vaya clarified that if the provider does not submit the HCPCS codes along with required revenue codes, Vaya denies the claim and advises the provider to resubmit along with the required codes.

Vaya pends claims that have a claim header amount of $5,000 or more and Emergency Department (ED) Institutional and Professional claims. The pended claims are manually reviewed daily.

Reporting

Vaya uses an internal reporting database and data warehouse to generate reports. The backup of the AlphaMCS database is used to refresh the reporting database and data warehouse daily. Vaya has automated jobs in place to restore and monitor the data refresh of the reporting database and data warehouse. The automated jobs send success or failure notifications to system administrators and also monitor record counts of the AlphaMCS database and the data warehouse to identify errors. Vaya also compares the data in the reporting data warehouse to the data in the reporting database to verify completeness of data.

During the Onsite, Vaya indicated that all enrollment and claims history since 2012 are available in the AlphaMCS system. Enrollment and claims data prior to 2012 is available in a separate database that can be accessed when required. Vaya mentioned that both Vaya and WellSky maintain backups of the enrollment and claims data. The data is also replicated in the data centers for disaster recovery. The reporting database and data warehouse are backed up daily.

Vaya uses the stored procedures in the AlphaMCS database for performance measure reporting. Vaya also uses Microsoft Transact Structured Query Language (T-SQL) programming language that is run from the SQL Server Management Studio or from within stored procedures to extract data from the reporting database.

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

Each PIHP uploads their *Disaster Recovery Plan* (*DRP*) as a standard ISCA Desk Material reviewed for each EQR. In lieu of submitting this form this year, Vaya uploaded a statement, "Vaya Health's Disaster Recovery Plan contains very detailed information related to the architecture and technical & security configuration of our network. Due to the sensitive nature of the details of the plan, we do not typically send this document outside of our organization, and request to present the plan for review during the onsite visit as we have done in all previous EQR reviews." It should be noted that Vaya uploaded their *DRP*, albeit in draft form, for last year's EQR without comment. During the Onsite, staff explained the DRP was recently revised on 09/30/2019. As this update was not during the year in review and the DRP is approximately 70 pages, CCME could not conduct a thorough review during the Onsite discussion. A thorough review of the DRP submitted for last year's EQR was completed along with Vaya *Policy 2536, Disaster Recovery*.

Encounter Data Submissions

Vaya has a defined process in place for encounter data submission, with 837 files submitted to NC Medicaid, and 835 files received back from NC Medicaid through the NCTracks system. Vaya uses Chiapas, an Electronic Data Interchange (EDI) translator software, to extract encounter data. Encounters that are approved by Vaya are submitted to NCTracks. Vaya has the ability to track claims from the adjudication process to encounter submissions status. Vaya uses the 835 file from NCTracks to review denials. The extraction and submission of encounter data are fully automated. The reconciliation of encounter data is performed manually.

Table 3 shows the breakdown of encounter data acceptance/denial rates for the dates of service in 2018, with a 2017 year comparison.

Table 3: Volume of Submitted Encounter Data with dates of service in 2017 and 2018

2018	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	42,110	287	390	42,787
Professional	1,831,671	22,048	13,976	1,867,695

2017	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	40,787	11	163	40,961
Professional	1,630,781	76,774	78,810	1,786,365

Vaya has over 99% acceptance rate for both Professional and Institutional encounters for dates of service in 2018. Last year's audit findings indicated that the encounter data acceptance rate was approximately 95%. During the Onsite, Vaya mentioned that their most recent encounter data denial rate was approximately 0.2%. Vaya indicated that the three top denial reason codes were:

1. Provider Licensure
2. Provider Taxonomy
3. Provider site

During the Onsite discussion, CCME subcontractor HMS noted that encounters submitted by Vaya were being denied due to duplicate services recently. It was discussed that this could be due to new encounters being processed prior to recoupment. This issue could be avoided by submitting the recoupment on a separate file prior to submitting the new encounter. Vaya indicated that they would submit the recoupment encounter in a separate batch of files prior to submitting the new encounter.

On average, Vaya submits an encounter to NCTracks within 7.2 days from the time of adjudication. It takes approximately 47 days to correct and resubmit an encounter to NCTracks. Vaya uses the *Adam Holtzman's paid and denied report* and *DMA Outstanding Denials Tracker* developed in-house to identify encounters that were denied. The Tracker is used to track an encounter from the adjudication process to the submission to NCTracks and the response received on the 835.

As stated in the ISCA, Vaya has 1,513 Institutional and 18,544 Professional encounters still awaiting resubmission as of 08/22/2019. During the Onsite, Vaya stated that their most recent encounter data denial rate was approximately 0.2%. Vaya exceeds the NC Medicaid standards for encounter data submission.

During the Onsite, Vaya advised their system was updated in December 2018 to submit up to 12 ICD-10 Diagnosis codes for Institutional and Professional encounters. Though Vaya is

submitting up to 12 ICD-10 Diagnosis codes for Institutional encounters, HMS indicated that approximately 44% of the Institutional encounters only have the admitting and primary Diagnosis codes. Vaya clarified that they have the capability to submit additional Diagnosis codes if NCTracks can accept them. NC Medicaid confirmed that twenty-five ICD-10 Diagnosis codes for Institutional encounters and 12 ICD-10 Diagnosis codes for Professional encounters are the maximum number of Diagnosis codes that may be submitted on an 837I and 837P, respectively.

As of August 12, 2019, Vaya updated their system to start submitting DRG codes to NCTracks. Vaya does not submit the ICD-10 Procedure codes to NCTracks. Vaya mentioned that as of October 7, 2019, they are in the process of testing a new system build to submit the ICD-10 Procedure codes to NCTracks.

During the Onsite discussion, Vaya stated that they can submit lab, drug, or radiologic services that have revenue codes along with the Healthcare Common Procedure Coding System (HCPCS) Procedure code on the encounter data extracts. It was also noted in the discussion that encounters submitted by Vaya usually have revenue codes populated, but do not have Procedure codes populated.

Figure 2, Administrative Comparative Findings shows 90% of the standards in the Administrative section are scored as "Met" for the current EQR. Several Corrective Actions and Recommendations address identified "Weaknesses", some of which were also identified at the last EQR.

Figure 2: Administration Comparative Findings

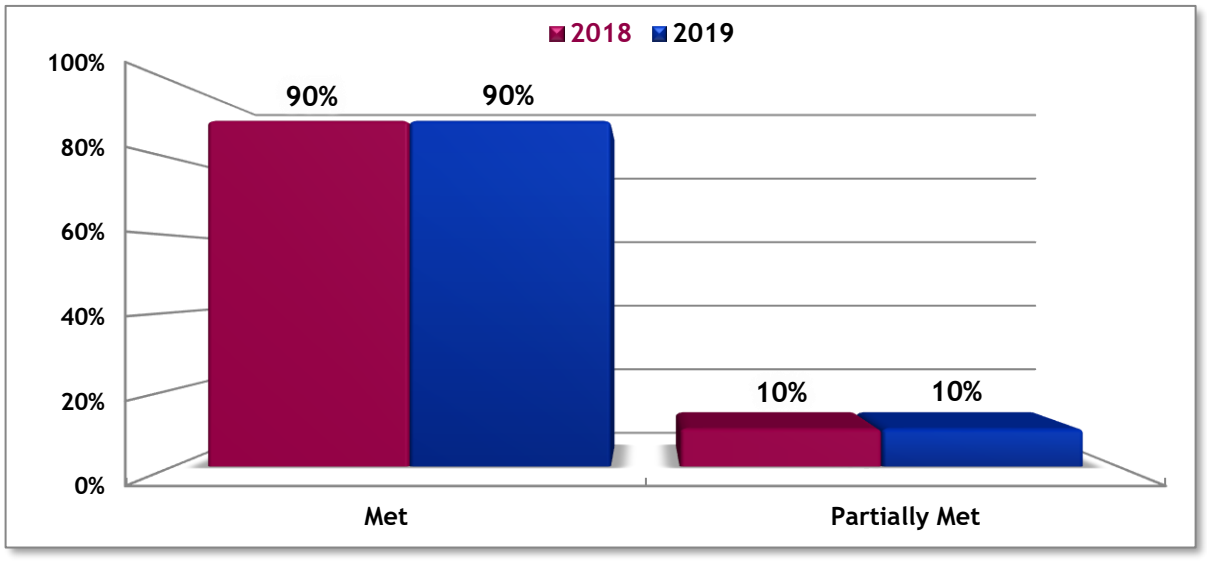


Table 4: Administration

Section	Standard	2019 Review
Management Information Systems	The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file capabilities of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	Partially Met
	The MCO has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	Partially Met

Strengths

- Over the past two years, Vaya has made considerable effort to consolidate their policy and procedure set.
- Substantial involvement by the Chief Medical Officer was evident during the Onsite discussion.
- Vaya auto-adjudicates clean claims; 84.43% of Institutional claims and 96.80% of Professional claims.
- Vaya has the capability to accept 22 ICD-10 Diagnosis codes on their provider web portal on Institutional claims that are compliant with the UB04 form.
- Vaya has the capability to store and report on the DRG and ICD-10 Procedure codes that are submitted on the HIPAA files.
- Vaya has the capability to submit DRG codes on encounter data submissions to NCTracks.
- Vaya's current NCTracks encounter data acceptance rate is approximately 99%. Vaya's most recent encounter data denial rate is approximately 0.2%. The PIHP has made significant improvements in the acceptance rate of encounter data submissions.

Weaknesses

- The Organizational Chart and job descriptions of the CMO and AMD do not align with the oversight and duties as described during the Onsite discussion.
- Vaya's *Privacy Policy 2599* does not specify a timeframe for training new employees on Vaya's confidentiality practices.

- Vaya does not have the ability to receive, store, and report all the ICD-10 Diagnosis codes for Institutional claims.
- Vaya does not capture DRG and ICD-10 Procedure codes on the provider web portal.
- Vaya submits only up to 12 ICD-10 Diagnosis codes on Institutional encounter data extracts to NCTracks. 44% of the Institutional encounters only have up to two Diagnosis codes populated.
- Vaya does not have the ability to submit ICD-10 Procedure codes on encounter data extracts to NCTracks.
- Vaya does not include Procedure codes on all encounters that require Procedure code along with the revenue code on encounter data extracts to NCTracks.

Corrective Action

- Update Vaya's system to be able to accept up to 25 ICD-10 Diagnosis codes.
- Update Vaya's provider web portal to be able to capture the DRG and ICD-10 Procedure codes.
- Update Vaya's encounter data submission process to allow all ICD-10 Diagnosis codes submitted on an Institutional claim to be submitted to NCTracks. Twenty-five ICD-10 Diagnosis codes are the maximum number of Diagnosis codes that may be submitted on an 837I and the maximum number captured by NCTracks.
- Update Vaya's encounter data submission process to allow ICD-10 Procedure codes to be submitted on encounter data extracts to NCTracks.

Recommendations

- Ensure the Chief Medical Officer (CMO) and Assistant Medical Director (AMD) job descriptions and oversight designations on the Organizational Chart, align with the *NC Medicaid Contract* requirements (Sections 6.7.6 and 7.1.3) and actual duties being performed by the CMO and AMD.
- Specify in *Privacy Policy 2599*, the timeframe by which new staff are trained on Vaya's confidentiality practices.
- Vaya does not include the Procedure codes along with revenue codes to NCTracks for services that require them. CCME recommends that Vaya update their encounter data submission process to include Procedure codes along with revenue codes on encounter data extracts to NCTracks.

B. Provider Services

The Provider Services review is comprised of Credentialing and Recredentialing, Network Adequacy, Provider Accessibility, Provider Education, Clinical Practice Guidelines for Behavioral Health Management, Continuity of Care, and Practitioner Medical Records. CCME reviewed relevant policies and procedures, the *Provider Operations Manual*, provider network information, credentialing/recredentialing files, the *Credentialing Committee Charter*, Credentialing Committee meeting minutes, the *Vaya Health 2019 Community Mental Health, Substance Use and Developmental Disabilities Services Network Adequacy and Accessibility Analysis* ("Gaps Analysis"), the *Member and Caregiver Handbook*, and the Vaya website. CCME also conducted an Onsite interview with relevant staff.

Three items required Corrective Action in the Provider Services area during the last EQR. During that Desk Review, and from at least June 19, 2018 through July 27, 2018, there was no current, approved, final *Provider Operations Manual* available on the Vaya website. This was addressed, and the current *Provider Operations Manual* is posted on the website, along with archived manuals. Also requiring Corrective Action at the last EQR was Vaya's failure to query the *State Exclusion List* as part of the credentialing and recredentialing processes. Vaya staff reported that was an oversight, and they started conducting the query when they received the Onsite Request List from CCME.

At the last EQR, there were two Recommendations in the Credentialing/Recredentialing section. Vaya addressed both Recommendations.

Vaya addressed one of the two Recommendations in the Provider Education area. Still unaddressed is the failure to include the requirement for providers to "provide face-to-face emergency care immediately for life-threatening emergencies" in the "Access to Care Timeframes" in the *Provider Operations Manual*, although this is referenced in other sections of the *Provider Operations Manual*.

The Credentialing Committee is chaired by Dr. Craig Martin, the Chief Medical Officer (CMO), and in his absence, the Assistant Medical Director. Voting membership is comprised of licensed clinicians and Qualified Professionals employed by Vaya and provider members. The *Committee Membership List-09192019 Approved Version* indicates current voting membership is four provider representatives and three Vaya staff members. The Chair breaks a tie vote. The Credentialing Committee meeting minutes reflect committee discussion of and decisions about "flagged" applications. The committee also votes on the roster of "clean" applications approved by the CMO.

During the Onsite Review, CCME discussed the area of potential conflict of interest of Credentialing Committee members regarding applications being reviewed/voted on by the Credentialing Committee. Vaya staff indicated committee members abstain/recuse

themselves from votes when there is a potential conflict of interest. Nothing regarding conflict of interest/abstaining from votes was found in *Policy 2891* (*Credentialing Program*), *Policy 2909* (*Credentialing Committee Policy*), or in the *Credentialing Committee Charter*.

Further, CCME discussed with Vaya staff one specific situation regarding a recredentialing applicant and whether a relevant Vaya staff member abstained from voting. Though the Credentialing Committee meeting minutes reflect other situations in which committee members abstained, the minutes regarding that specific recredentialing application did not reflect that the Vaya staff member abstained. Vaya staff reported that this staff member received redacted information (that excluded information regarding that application), and the staff member actually left the room before the vote. However, the meeting minutes do not reflect this, and, in fact, state, "All members approved… unanimously", regarding approval of the applicant's recredentialing.

Vaya stated that, sometime after the minutes from that particular meeting were approved, Vaya staff discovered the omission (that the minutes didn't reflect the staff member left the room before the application was discussed/voted on). Vaya indicated they couldn't change the minutes "because they were already approved;" however, committee meeting minutes can be revised, especially to correct omissions or errors.

The credentialing and recredentialing file review showed the files are organized and contain appropriate information with a few exceptions as outlined in the following "Weaknesses" section and in the Tabular Spreadsheet. Several items that were issues during the last EQR were corrected in the files submitted for the current EQR.

Newly contracted providers receive a letter that provides orientation information, including a link to the Vaya website, with the statement "the *Provider Operations Manual* can be downloaded from our website." An Events Calendar on the Vaya website includes information about available trainings. The Provider Learning Lab on the Provider Central section of the website offers some online training and provides access to the Communication Bulletins Archive. Vaya is beginning a process of creating a training library, including a "robust orientation" for providers.

Policy 2427, Development of Clinical Guidelines, states the guidelines are "selected, adopted, developed, reviewed, and updated through the Clinical Practices Committee, Clinical Advisory Committee and with the involvement of practicing clinicians." The *Provider Operations Manual* informs providers about the Clinical Practice Guidelines posted on the Vaya website.

As required by NC Medicaid, Vaya conducts the annual *Network Adequacy and Accessibility Analysis* (Gaps Analysis), which includes obtaining feedback from members, providers and other stakeholders, as well as Geo-Access studies. The Vaya *2019*

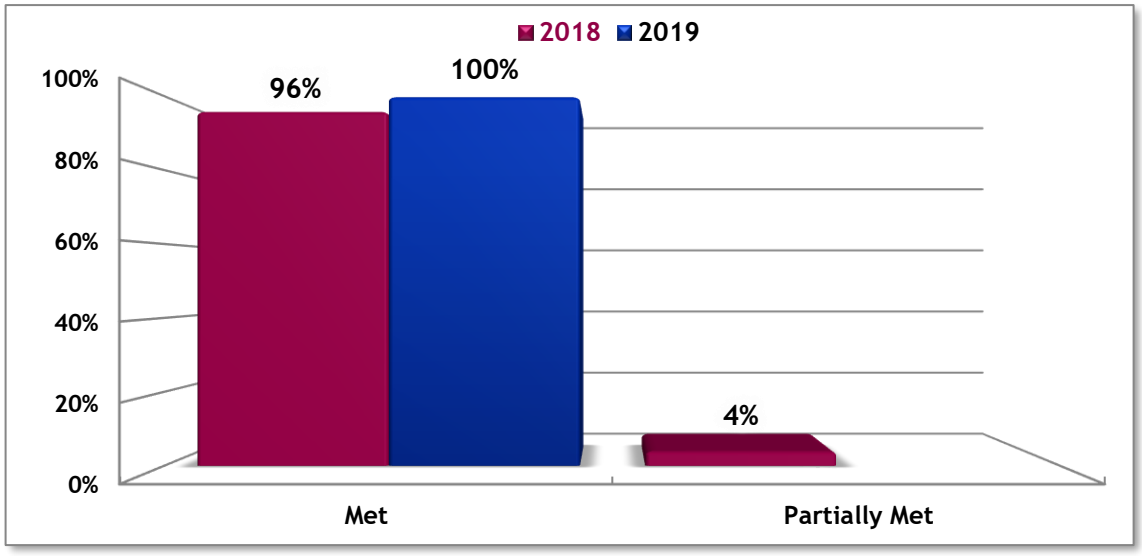
Community Mental Health, Substance Use and Developmental Disability Services Network Adequacy and Accessibility Analysis (Gaps Analysis) annual report lists ten services for which Vaya did not meet choice/access standards. Vaya submitted *Exception Requests* for these ten services, and NC Medicaid approved nine of them.

As in previous years, Vaya identified barriers to meeting the standards that require two providers within 30 minutes/30 miles, especially the rural location and low population of many of the counties in the catchment area. Vaya has expanded some services and acknowledges that expansion of others is unlikely due to economies of scale. Vaya indicates it will "enter into single case agreements with out-of-network providers who can provide the level of service required by the member."

During the Onsite visit, Rhonda Cox, MA, HSP-PA, Chief Population Health Officer, highlighted several initiatives. A community inclusion supportive living grant has provided additional resources, enabling those who have traditionally been institutionalized to, instead, remain in the community. Vaya has been working with a clinic in the Mission Health System to address the needs of children with complex needs and has been working with the Mountain AHEC to increase the knowledge and clinical expertise of primary care residents in addressing the needs of individuals with intellectual/developmental disabilities.

Figure 3, Provider Services Findings shows 100% of the standards in the Provider Services section are scored as "Met" for the current EQR. Several Recommendations address identified "Weaknesses", some of which were also identified at the last EQR.

Figure 3: Provider Services Comparative Findings



Strengths

- The *Provider Operations Manual* has a chart titled "Important Contacts" with contact information for Vaya departments or teams.
- Vaya provides a toll-free Provider Help Line and a separate toll-free line for business calls.
- The Vaya website includes a chart with instructions and links to the correct forms for providers requesting network enrollment.
- Vaya is in the process of developing a provider training library that will include a "robust orientation" for new providers.
- Vaya is working on a number of initiatives with the goal of improving service delivery.

Weaknesses

- No information regarding conflict of interest/abstaining from votes was found in *Policy 2891* (*Credentialing Program*), *Policy 2909* (*Credentialing Committee Policy*), or in the *Credentialing Committee Charter*.
- Credentialing and recredentialing files uploaded for Desk Review were missing some items including, for example, some files missing proof of some of the required types of insurance or an explanation/attestation of why it would not be required. In response to the *Onsite Request List*, Vaya provided additional documentation or clarification. This was also an issue at the last EQR.
- Though other sections of the *Provider Operations Manual* include it, the "Emergent" section of the Access to Care Timeframes in *the Provider Operations Manual* does not include the requirement that the "Provider must provide face-to-face emergency care immediately for life threatening emergencies." This was also an issue at the last EQR. Office Wait Times are found in "Health and Safety Site Reviews" section of Section 16-Audits/Monitoring/Investigations in the *Provider Operations Manual*, but the information is not included in the "Access to Care Timeframes" of the *Provider Operations Manual*.
- Section IX: Records Management Obligations of Closing Providers section of *Policy 2617, Provider Closure*, addresses abandoned records, but does not include creating an "inventory log" of the records. See *NC Medicaid Contract Attachment B, Section 8.2.1.*

Recommendations

- Include, in a policy, procedure, or the Credentialing Committee Charter information about Vaya's protocol regarding potential conflicts of interest for Credentialing Committee members. Vaya should also ensure committee meeting minutes accurately

reflect those committee members that abstained/recused themselves from votes or left the meeting.

- Verify credentialing and recredentialing files contain all required information and Primary Source Verifications (PSVs).
- Note: If Vaya does not keep a copy of the relevant information in the individual credentialing or recredentialing files, retrieve or print copies from the relevant files and upload as part of the credentialing/recredentialing files for the EQR desk review. See *NC Medicaid Contract Attachment B, Section 7.7*, *NC Medicaid Contract Attachment O*, and *NC Medicaid Contract Attachment B, Section 7.9*.
- Include the *NC Medicaid Contract*, *Attachment S* requirements for providers to provide face-to-face emergency care immediately for life-threatening emergencies, and the Office Wait Times requirements in the "Access to Care Timeframes" in the *Provider Operations Manual*.
- Revise *Policy 2617, Provider Closure*, to include the requirement for the PIHP to complete an inventory log of the records, per *NC Medicaid Contract Attachment B*, Section 8.2.1.

C. Enrollee Services

The Enrollee Services External Quality Review (EQR) encompasses review of Enrollee Services including Enrollee Rights and Responsibilities, policies and procedures, the *Member and Caregiver Handbook*, the submitted enrollee educational materials, the Member Service Center training materials, and a variety of items on the Vaya website.

Policy 2307 Member Rights and Responsibilities and *Policy 2557, Marketing Materials, Media Relations and Member Notifications* explains the process Vaya uses to inform enrollees of their rights.

All enrollee rights are outlined in the *Member and Caregiver Handbook June 2018*. This version of the *Member and Caregiver Handbook* was effective during the review period, and it covered all required information within the EQR review. *The Member and Caregiver Handbook* is located five layers deep on the Vaya website. From the home screen, one must hover over the "Get Involved" link at the top, then hover over "Member Rights and Responsibilities," then click on "Member Handbook," then scroll to the bottom of this page and click on the link *Vaya Health Member and Caregiver Handbook 2019-2020*. Finally, one must click on the image of the cover page of the handbook to download. CCME recommends relocating the *Vaya Health Member and Caregiver Handbook 2019-2020* to a more accessible location on the website.

Vaya submitted an attestation signed by the Senior Director of Provider Network Operations that states, "There were no provider closures during the requested time

period that required a letter to members. All providers terminations occurred when no Vaya members were receiving services from the terminating providers." This attestation was related to the standard, "Enrollees are informed promptly in writing of … (2) termination of their provider within fifteen (15) calendar days after PIHP receives notice that NC Medicaid or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider."

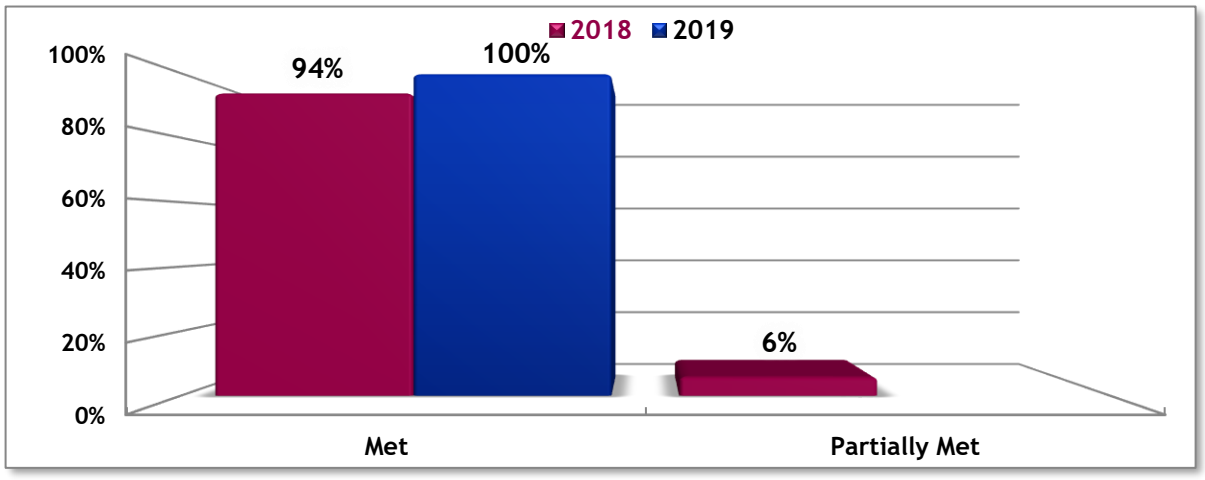
During the Onsite, CCME asked Vaya to share written or emailed correspondence between the providers and Vaya for the providers terminated "with cause." CCME also requested the report used to verify there were no members being seen by the provider 60 days prior to the notice of termination. CCME and Vaya agreed to use one example from the 10 "with cause" terminations. For that example, Vaya used the 60-day lookback period, looking back from the termination date of March 31, 2019. The look back period shown during the Onsite was February 1 - March 31, 2019. The look back date should begin with the date the notice of termination was sent to the provider, which was February 19, 2019. The correct lookback period should have been December 21, 2018 - February 19, 2019.

Vaya's *Policy 2617, Provider Closure,* addresses steps taken when there is a provider leaving the network for any reason. It does not include details found in *NC Medicaid Contract 6.10* that states "PIHP shall give written notice of the termination to all Enrollees who have been receiving services from the terminated Provider within the sixty (60) calendar day period immediately preceding the date of the notice of termination." This requires Vaya to update *Policy 2617, Provider Closure* with details from *NC Medicaid Contract 6.10*.

Vaya maintains a toll-free 24/7 Access to Care Line that can be used for any need or question from a member or caregiver. The Vaya Customer Services Representatives and Clinicians follow the Member Services policies and procedures including *Policy 2422, Member Services Clinical Decision Making and Triage*. This policy ensures the enrollee is directed to correct level of care. Call metrics remain adequate with average speed of answer and average abandoned call rates meeting Vaya's goals *in Policy 2411, Member Services Telephone Performance Standard and Monitoring*.

Figure 4 provides a comparison of the 2018 scores versus the 2019 scores. The 2019 review shows 100% of the standards were scored as "Met".

Figure 4: Enrollee Services Comparative Findings



Strengths

- The newly designed website has detailed information about locations for Emergency and Post Stabilization Care including Crisis Walk-in Centers in each county, Urgent Care options, and facility-based crisis centers.
- One calendar is used for all training, including members and providers. The Provider Central webpage has an "Event Calendar" that goes to the same calendar as the "Get Involved" tab "Calendar of Events" page.

Weaknesses

- The *Member and Caregiver Handbook* is located five layers deep on the Vaya website. From the home screen, hover over the "Get Involved" link at the top, hover over "Member Rights and Responsibilities", then click on "Member Handbook," then scroll to the bottom of this page and click on the link *Vaya Health Member and Caregiver Handbook 2019-2020*. Finally, click on the image of the cover page of the handbook to download.
- *Policy 2617, Provider Closure* addresses steps Vaya takes when there is a provider leaving the network for any reason. It does not address details included in *NC Medicaid Contract 6.10* that states, "PIHP shall give written notice of the termination to all Enrollees who have been receiving services from the terminated Provider within the sixty (60) calendar day period immediately preceding the date of the notice of termination."

Recommendations:

- Update *Policy 2617, Provider Closure*, with details that address *NC Medicaid Contract 6.10* that states "PIHP shall give written notice of the termination to all Enrollees who

have been receiving services from the terminated Provider within the sixty (60) calendar day period immediately preceding the date of the notice of termination."

- Relocate the *Vaya Health Member and Caregiver Handbook 2019-2020* to a more accessible location on the website.

D. Quality Improvement

The Quality Improvement (QI) section covers the QI Program, QI Committees, provider participation in QI, the QI Annual Evaluation, over/under-utilization, performance measures, and Performance Improvement Projects (PIPs).

The Quality Management Program Description 2019-2020 contains the formal structure of Vaya's Quality Management Program including defined goals, structure, and scope of the program.

As outlined on page 11 of the *Quality Management Program Description 2019-2020*, provider compliance with clinical practice guidelines is a quality assurance activity. Vaya looks at the "rate of compliance with guidelines for selected services." From Onsite discussions and Desk Review, Vaya did not present any selected services over the review period that looked at the rate of compliance with selected guidelines. During the last EQR Review, Vaya monitored the Clinical Practice Guideline for "Best Practice Treatment of Opioid Dependence" and included the monitoring results in the *Quality Improvement Program Evaluation 2017-2018*.

Policy 2385, Detecting Over and Under-Utilization is in place for detecting over- and under-utilization of Medicaid funded Services. At the April 2018 meeting, the Quality Improvement Committee (QIC) reviewed several reports focused on service utilization.

Starting in 2018, Vaya initiated an Organizational Quality Improvement Committee (O-QIC) and Internal Quality Improvement Committee (I-QIC). Although minutes are documented at the I-QIC and O-QIC meetings, the minutes do not capture discussion from the meeting topics. CCME recommends including discussion that happens on each agenda item in the I-QIC and O-QIC meeting minutes.

Vaya had two standards related to enrollee surveys scoring "Not Met" for this EQR. These two standards were also scored as "Not Met" or "Partially Met" in the 2016 EQR and 2017 EQR. A Recommendation for the 2018 EQR that was not implemented was "Bring lower scoring enrollee survey items to QIC for discussion and decisions on the need for quality improvement actions on those lower scoring items."

Adult and Child ECHO Survey results were prepared in December 2018 and available to Vaya by February 2019, but not reported in the I-QIC or O-QIC meetings during the review period. The draft September 2019 I-QIC minutes include documentation of a PowerPoint

presentation titled, *State Surveys 2018*. The PowerPoint presentation includes highlights of Provider, Perception of Care, and ECHO Survey results. The Child ECHO Survey results were not included in the PowerPoint. There was no discussion from I-QIC on next steps after the PowerPoint was presented. The Recommendation for this review is to report both the Adult and Child ECHO Survey results to I-QIC and O-QIC and facilitate discussion at both committees around measures to be taken to address quality problems that are identified within Adult and Child Survey results. Committee Minutes of both committees should reflect this discussion.

No significant measures were implemented to address quality problems identified though the ECHO Surveys. CCME identified "Key Strengths" and "Opportunities for Improvement" in the Adult ECHO Survey and Child ECHO Survey reports prepared by CCME in December 2018. In Vaya's PowerPoint presentation titled *State Surveys 2018*, the same "Opportunities for Improvement" from their Adult ECHO Survey results were included on a slide. The PowerPoint documented that "the sample is not statistically significant and therefore, further action will not be taken based on survey responses." This response addresses the response rate and not the survey results. The Recommendation is to implement significant measures to address problems identified in the Adult and Child ECHO Surveys and show discussion in I-QIC and O-QIC meeting minutes of significant measures that are implemented.

Adult and Child Echo Survey results are found on the Vaya website. The meeting minutes did not reflect that the survey results were shared with a Vaya provider attended committee/group such as Clinical Advisory Committee or O-QIC during the review period. CCME recommends sharing enrollee satisfaction survey results with providers during the appropriate in-person provider committees/forums.

The last EQR recommended that Vaya "Begin providing more feedback for provider's individual QI activities." This Recommendation was not followed and for the current EQR there was no evidence of providers receiving interpretation of their QI performance data and feedback regarding QI activities. During the Onsite, Vaya gave the example of providers participating in Vaya's PIP for Alcohol Drug Abuse Treatment Center (ADATC) and the Assertive Community Treatment Team (ACTT) Learning Network. There was no evidence or example of the feedback given. The Corrective Action is to provide evidence as required per *NC Medicaid Contract section 7.1.4 (h)* "Provide performance feedback to Providers, including detailed discussions of clinical standards and the expectations of PIHP."

The Quality Management Program Evaluation FY 2019-2020 was included in the Desk Materials for review. The year was mislabeled. Onsite discussion determined it was supposed to be FY 2018-2019. The Program Evaluation did not include information about enrollee and provider survey results. CCME recommends Vaya correct the year on the

Quality Management Program Evaluation to FY 2018-2019. CCME also recommends including information about all provider and enrollee survey results in the Quality Management Program Evaluation annually to show effectiveness of the significant measures Implemented to address problems identified in the provider and enrollee survey results.

Performance Measure Validation

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

Table 5: (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 6: (c) Waiver Measures

(c) WAIVER MEASURES	
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals. IW D1 ISP	Percentage of level 2 and 3 incidents reported within required timeframes. IW G2
Proportion of Individual Support Plans that address identified health and safety risk factors. IW D2 ISP	Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required. IW G3
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need. IW D3 ISP	Percentage of medication errors resulting in medical treatment. IW G4

(c) WAIVER MEASURES	
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Percentage of beneficiaries who received appropriate medication. IW G5
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8

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

- Performance measure documentation
- Denominator data quality
- Validity of denominator calculation
- Data collection policies and 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

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

The measure rates for 2017 and 2018 are presented for all (b) Waiver measures. Substantial declines of >10% occurred for the 30 day follow up after hospitalization for substance abuse for detox and Facility Based Crisis subpopulation and Initiation and Alcohol and Other Drug Dependence (initiation of treatment) for 13 to 17-year old individuals. There was a substantial increase in the Alcohol and Other Drug Dependence (engagement) for 18 to 20-year old population. The current rate in comparison to last year's rate is presented in *Table*s 7 through *16*.

Table 7: A.1. Readmission Rates for Mental Health

30-day Readmission Rates for Mental Health	2017	2018	Change
Inpatient (Community Hospital Only)	10.6%	11.0%	0.4%
Inpatient (State Hospital Only)	0.0%	0.0%	0.0%
Inpatient (Community and State Hospital Combined)	10.8%	10.9%	0.1%
Facility Based Crisis	7.5%	4.1%	-3.4%
Psychiatric Residential Treatment Facility (PRTF)	13.1%	18.3%	5.2%
Combined (includes cross-overs between services)	12.2%	12.9%	0.7%

Table 8: A.2. Readmission Rate for Substance Abuse

30-day Readmission Rates for Substance Abuse	2017	2018	Change
Inpatient (Community Hospital Only)	10.1%	13.1%	3.0%
Inpatient (State Hospital Only)	0.0%	0.0%	0.0%
Inpatient (Community and State Hospital Combined)	9.7%	12.7%	3.0%
Detox/Facility Based Crisis	5.5%	6.0%	0.5%
Combined (includes cross-overs between services)	11.1%	11.7%	0.6%

Table 9: A.3. Follow-Up after Hospitalization for Mental Illness

Follow-up after Hospitalization for Mental Illness	2017	2018	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	48.4%	52.2%	3.8%
Percent Received Outpatient Visit Within 30 Days	66.3%	68.7%	2.4%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	59.5%	56.5%	-3.0%
Percent Received Outpatient Visit Within 30 Days	73.8%	69.6%	-4.2%
PRTF			
Percent Received Outpatient Visit Within 7 Days	25.0%	30.4%	5.4%
Percent Received Outpatient Visit Within 30 Days	56.3%	62.0%	5.7%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	48.4%	51.4%	3.0%
Percent Received Outpatient Visit Within 30 Days	66.2%	68.4%	2.2%

Table 10: A.4. Follow-Up After Hospitalization for Substance Abuse

Follow-up after Hospitalization for Substance Abuse	2017	2018	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	32.2%	30.0%	-2.2%
Percent Received Outpatient Visit Within 30 Days	43.6%	38.0%	-5.6%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	46.9%	40.9%	-6.0%
Percent Received Outpatient Visit Within 7 Days	53.1%	46.4%	-6.7%
Percent Received Outpatient Visit Within 30 Days	66.7%	53.6%	-13.1%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	37.3%	35.3%	-2.0%
Percent Received Outpatient Visit Within 30 Days	49.2%	42.9%	-6.3%

**NR = Denominator is equal to zero.*

Table 11: B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2017	2018	Change
Ages 13-17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	46.7%	36.6%	-10.1%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	27.2%	36.6%	9.4%
Ages 18-20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	42.7%	40.7%	-2.0%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	26.1%	36.7%	10.6%
Ages 21-34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	58.4%	50.6%	-7.8%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	47.8%	50.2%	2.4%
Ages 35-64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	49.4%	46.7%	-2.7%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	34.3%	41.6%	7.3%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	43.2%	33.7%	-9.5%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	21.1%	25.8%	4.7%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	51.8%	46.5%	-5.3%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	37.8%	43.3%	5.5%

Table 12: D.1. Mental Health Utilization-Inpatient Discharges and Average Length of Stay

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		2017	2018	Change	2017	2018	Change
3-12	Male	0.4	0.4	0.0	44.4	39.2	-5.2
	Female	0.3	0.4	0.1	34.3	29.1	-5.2
	Total	0.3	0.4	0.1	40.7	34.7	-6.0
13-17	Male	1.4	1.7	0.3	37.8	34.6	-3.2
	Female	2.5	2.9	0.4	24.2	26.0	1.8
	Total	1.9	2.3	0.4	29.2	29.3	0.1
18-20	Male	1.7	1.9	0.2	14.9	10.2	-4.7
	Female	1.7	2.2	0.5	5.9	13.4	7.5
	Total	1.7	2.1	0.4	10.1	12.0	1.9
21-34	Male	5.3	5.1	-0.2	9.3	9.9	0.6
	Female	2.1	2.1	0.0	8.0	7.1	-0.9
	Total	2.9	2.9	0.0	8.6	8.3	-0.3
35-64	Male	4.0	3.6	-0.4	9.6	10.1	0.5
	Female	3.0	2.8	-0.2	8.8	8.9	0.1
	Total	3.4	3.1	-0.3	9.2	9.5	0.3
65+	Male	0.5	0.6	0.1	10.1	8.9	-1.2
	Female	0.4	0.4	0.0	11.7	14.5	2.8
	Total	0.5	0.5	0.0	11.1	12.3	1.2
Unknown	Male	0.0	0.0	0.0	0.0	0.0	0.0
	Female	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0
Total	**Male**	**1.8**	**1.7**	**-0.1**	**17.1**	**17.2**	**0.1**
	Female	**1.6**	**1.7**	**0.1**	**12.8**	**14.2**	**1.4**
	Total	**1.7**	**1.7**	**0.0**	**14.8**	**15.5**	**0.7**

Table 13: D.2. Mental Health Utilization -% of Members that Received at Least 1 Mental Health Service in the Category Indicated during the Measurement Period

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
3-12	Male	16.62%	17.17%	0.55%	0.38%	0.39%	0.01%	1.22%	1.22%	0.00%	16.54%	17.05%	0.51%
	Female	12.71%	13.15%	0.44%	0.25%	0.30%	0.05%	0.45%	0.33%	-0.12%	12.67%	13.12%	0.45%
	Total	14.72%	15.22%	0.50%	0.32%	0.35%	0.03%	0.84%	0.79%	-0.05%	14.66%	15.14%	0.48%
13-17	Male	18.42%	18.90%	0.48%	1.29%	1.56%	0.27%	1.51%	1.51%	0.00%	18.13%	18.58%	0.45%
	Female	22.53%	23.15%	0.62%	2.34%	2.72%	0.38%	0.94%	0.87%	-0.07%	22.20%	22.86%	0.66%
	Total	20.42%	20.97%	0.55%	1.80%	2.13%	0.33%	1.24%	1.20%	-0.04%	20.11%	20.67%	0.56%
18-20	Male	10.92%	11.02%	0.10%	1.56%	1.48%	-0.08%	0.10%	0.06%	-0.04%	10.67%	10.90%	0.23%
	Female	14.28%	14.07%	-0.21%	1.58%	1.71%	0.13%	0.03%	0.05%	0.02%	13.95%	13.84%	-0.11%
	Total	12.69%	12.62%	-0.07%	1.57%	1.60%	0.03%	0.06%	0.06%	0.00%	12.40%	12.44%	0.04%
21-34	Male	29.93%	28.65%	-1.28%	4.01%	3.55%	-0.46%	0.06%	0.00%	-0.06%	29.63%	28.47%	-1.16%
	Female	23.50%	22.59%	-0.91%	1.74%	1.62%	-0.12%	0.04%	0.02%	-0.02%	23.33%	22.40%	-0.93%
	Total	25.12%	24.15%	-0.97%	2.31%	2.11%	-0.20%	0.05%	0.02%	-0.03%	24.91%	23.97%	-0.94%

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Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
35-64	Male	23.82%	23.13%	-0.69%	2.94%	2.37%	-0.57%	0.01%	0.01%	0.00%	23.48%	22.84%	-0.64%
	Female	27.57%	26.40%	-1.17%	2.50%	2.02%	-0.48%	0.01%	0.01%	0.00%	27.31%	26.22%	-1.09%
	Total	26.07%	25.08%	-0.99%	2.67%	2.16%	-0.51%	0.01%	0.01%	0.00%	25.78%	24.86%	-0.92%
65+	Male	7.65%	6.42%	-1.23%	0.51%	0.19%	-0.32%	0.00%	0.00%	0.00%	7.40%	6.32%	-1.08%
	Female	7.98%	7.34%	-0.64%	0.44%	0.16%	-0.28%	0.00%	0.01%	0.01%	7.82%	7.25%	-0.57%
	Total	7.88%	7.05%	-0.83%	0.47%	0.17%	-0.30%	0.00%	0.01%	0.01%	7.69%	6.96%	-0.73%
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**	**18.26%**	**18.18%**	**-0.08%**	**1.41%**	**1.28%**	**-0.13%**	**0.77%**	**0.76%**	**-0.01%**	**18.05%**	**17.99%**	**-0.06%**
	Female	**18.61%**	**18.23%**	**-0.38%**	**1.38%**	**1.28%**	**-0.10%**	**0.26%**	**0.22%**	**-0.04%**	**18.43%**	**18.09%**	**-0.34%**
	Total	**18.46%**	**18.21%**	**-0.25%**	**1.39%**	**1.28%**	**-0.11%**	**0.48%**	**0.46%**	**-0.02%**	**18.27%**	**18.05%**	**-0.22%**

Table 14: D.3. Identification of Alcohol and Other Drug Services

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
3-12	Male	0.01%	0.02%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.02%	0.01%
	Female	0.01%	0.01%	0.00%	0.01%	0.00%	-0.01%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
	Total	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
13-17	Male	1.23%	1.31%	0.08%	0.09%	0.06%	-0.03%	0.12%	0.13%	0.01%	1.13%	1.23%	0.10%
	Female	0.99%	1.11%	0.12%	0.10%	0.07%	-0.03%	0.06%	0.10%	0.04%	0.91%	1.03%	0.12%
	Total	1.11%	1.21%	0.10%	0.09%	0.06%	-0.03%	0.09%	0.12%	0.03%	1.02%	1.13%	0.11%
18-20	Male	2.95%	2.52%	-0.43%	0.37%	0.45%	0.08%	0.33%	0.35%	0.02%	2.83%	2.36%	-0.47%
	Female	2.78%	2.40%	-0.38%	0.43%	0.39%	-0.04%	0.19%	0.25%	0.06%	2.64%	2.28%	-0.36%
	Total	2.86%	2.45%	-0.41%	0.40%	0.42%	0.02%	0.26%	0.30%	0.04%	2.73%	2.32%	-0.41%
21-34	Male	12.03%	11.76%	-0.27%	1.44%	1.07%	-0.37%	0.58%	0.74%	0.16%	11.67%	11.53%	-0.14%
	Female	10.36%	10.83%	0.47%	0.87%	0.84%	-0.03%	0.86%	1.10%	0.24%	10.11%	10.56%	0.45%
	Total	10.78%	11.07%	0.29%	1.01%	0.90%	-0.11%	0.79%	1.00%	0.21%	10.50%	10.81%	0.31%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
35-64	Male	9.04%	9.42%	0.38%	1.44%	1.32%	-0.12%	0.59%	0.63%	0.04%	8.62%	9.00%	0.38%
	Female	6.87%	7.48%	0.61%	0.70%	0.69%	-0.01%	0.52%	0.60%	0.08%	6.56%	7.22%	0.66%
	Total	7.74%	8.26%	0.52%	1.00%	0.94%	-0.06%	0.55%	0.61%	0.06%	7.38%	7.94%	0.56%
65+	Male	1.07%	0.95%	-0.12%	0.11%	0.07%	-0.04%	0.09%	0.03%	-0.06%	0.98%	0.95%	-0.03%
	Female	0.28%	0.31%	0.03%	0.02%	0.02%	0.00%	0.00%	0.00%	0.00%	0.25%	0.30%	0.05%
	Total	0.52%	0.52%	0.00%	0.05%	0.03%	-0.02%	0.03%	0.01%	-0.02%	0.48%	0.51%	0.03%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**Male**	**3.21%**	**3.21%**	**0.00%**	**0.44%**	**0.39%**	**-0.05%**	**0.21%**	**0.23%**	**0.02%**	**3.07%**	**3.08%**	**0.01%**
	Female	**3.62%**	**3.75%**	**0.13%**	**0.35%**	**0.33%**	**-0.02%**	**0.28%**	**0.34%**	**0.06%**	**3.49%**	**3.63%**	**0.14%**
	Total	**3.44%**	**3.51%**	**0.07%**	**0.39%**	**0.35%**	**-0.04%**	**0.25%**	**0.29%**	**0.04%**	**3.30%**	**3.39%**	**0.09%**

Table 15: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Alexander	0.00%	0.00%	0.00%	0.29%	0.29%	0.00%	0.80%	1.63%	0.83%	10.41%	9.64%	-0.77%
Alleghany	0.00%	0.00%	0.00%	1.40%	0.58%	-0.82%	2.26%	1.19%	-1.07%	7.77%	4.44%	-3.33%
Ashe	0.00%	0.00%	0.00%	0.56%	0.29%	-0.27%	1.48%	0.58%	-0.90%	6.62%	5.90%	-0.72%
Avery	0.00%	0.00%	0.00%	1.95%	0.69%	-1.26%	0.00%	2.39%	2.39%	5.77%	5.29%	-0.48%
Buncombe	0.01%	0.01%	0.00%	1.04%	1.00%	-0.04%	3.01%	3.09%	0.08%	9.21%	9.39%	0.18%
Caldwell	0.00%	0.00%	0.00%	0.90%	1.38%	0.48%	1.75%	1.30%	-0.45%	9.03%	8.30%	-0.73%
Cherokee	0.00%	0.05%	0.05%	1.37%	1.59%	0.22%	2.94%	1.41%	-1.53%	8.07%	6.64%	-1.43%
Clay	0.00%	0.00%	0.00%	0.65%	1.65%	1.00%	1.50%	1.49%	-0.01%	9.82%	5.45%	-4.37%
Graham	0.00%	0.00%	0.00%	0.84%	0.30%	-0.54%	3.01%	1.64%	-1.37%	7.19%	2.92%	-4.27%
Haywood	0.00%	0.08%	0.08%	2.32%	1.76%	-0.56%	3.44%	2.58%	-0.86%	11.36%	11.93%	0.57%
Henderson	0.01%	0.00%	-0.01%	0.69%	0.90%	0.21%	2.01%	1.46%	-0.55%	5.57%	7.06%	1.49%
Jackson	0.08%	0.00%	-0.08%	1.57%	1.15%	-0.42%	3.01%	4.44%	1.43%	8.68%	8.10%	-0.58%

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County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Macon	0.04%	0.00%	-0.04%	1.49%	1.36%	-0.13%	2.60%	2.96%	0.36%	8.21%	7.43%	-0.78%
Madison	0.00%	0.00%	0.00%	0.63%	0.99%	0.36%	1.58%	3.15%	1.57%	8.03%	8.58%	0.55%
McDowell	0.00%	0.00%	0.00%	0.74%	1.53%	0.79%	2.58%	2.49%	-0.09%	9.90%	8.46%	-1.44%
Mitchell	0.00%	0.00%	0.00%	0.51%	0.27%	-0.24%	1.46%	2.31%	0.85%	9.25%	5.84%	-3.41%
Polk	0.00%	0.00%	0.00%	0.81%	0.00%	-0.81%	0.44%	1.65%	1.21%	5.04%	4.30%	-0.74%
Rutherford	0.00%	0.02%	0.02%	0.41%	0.76%	0.35%	1.26%	2.22%	0.96%	6.57%	6.37%	-0.20%
Swain	0.00%	0.00%	0.00%	2.48%	1.63%	-0.85%	4.07%	3.13%	-0.94%	6.34%	6.14%	-0.20%
Transylvania	0.00%	0.00%	0.00%	1.81%	2.06%	0.25%	3.23%	3.06%	-0.17%	7.69%	9.58%	1.89%
Watauga	0.00%	0.00%	0.00%	1.42%	1.60%	0.18%	3.48%	1.21%	-2.27%	5.08%	5.70%	0.62%
Wilkes	0.02%	0.02%	0.00%	0.63%	0.98%	0.35%	1.51%	1.19%	-0.32%	10.08%	11.52%	1.44%
Yancey	0.00%	0.00%	0.00%	0.18%	0.55%	0.37%	1.20%	1.00%	-0.20%	5.75%	7.24%	1.49%
TOTAL	0.01%	0.01%	0.00%	1.01%	1.08%	0.07%	2.27%	2.21%	-0.06%	8.44%	8.33%	-0.11%

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	35-64			65+			Unknown			Total		
Alexander	5.76%	7.90%	2.14%	0.33%	0.00%	-0.33%	0.00%	0.00%	0.00%	2.80%	3.16%	0.36%
Alleghany	5.53%	3.06%	-2.47%	0.00%	0.81%	0.81%	0.00%	0.00%	0.00%	2.55%	1.46%	-1.09%
Ashe	5.75%	5.53%	-0.22%	0.41%	0.52%	0.11%	0.00%	0.00%	0.00%	2.40%	2.17%	-0.23%
Avery	6.56%	6.16%	-0.40%	0.24%	0.91%	0.67%	0.00%	0.00%	0.00%	2.37%	2.28%	-0.09%
Buncombe	8.74%	9.34%	0.60%	1.10%	1.12%	0.02%	0.00%	0.00%	0.00%	3.75%	3.87%	0.12%
Caldwell	5.16%	5.48%	0.32%	0.71%	0.70%	-0.01%	0.00%	0.00%	0.00%	2.81%	2.80%	-0.01%
Cherokee	7.32%	8.50%	1.18%	0.42%	0.41%	-0.01%	0.00%	0.00%	0.00%	3.23%	3.19%	-0.04%
Clay	7.59%	8.25%	0.66%	0.34%	0.00%	-0.34%	0.00%	0.00%	0.00%	3.23%	2.83%	-0.40%
Graham	5.60%	5.08%	-0.52%	0.00%	0.34%	0.34%	0.00%	0.00%	0.00%	2.43%	1.70%	-0.73%
Haywood	12.91%	12.13%	-0.78%	1.13%	1.19%	0.06%	0.00%	0.00%	0.00%	5.41%	5.12%	-0.29%
Henderson	6.04%	7.32%	1.28%	0.74%	1.11%	0.37%	0.00%	0.00%	0.00%	2.10%	2.53%	0.43%
Jackson	9.79%	10.06%	0.27%	0.77%	0.90%	0.13%	0.00%	0.00%	0.00%	3.83%	3.79%	-0.04%
Macon	8.34%	9.94%	1.60%	0.88%	0.28%	-0.60%	0.00%	0.00%	0.00%	3.30%	3.44%	0.14%

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County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	35-64			65+			Unknown			Total		
Madison	5.89%	6.34%	0.45%	0.89%	0.61%	-0.28%	0.00%	0.00%	0.00%	2.85%	3.14%	0.29%
McDowell	8.78%	8.77%	-0.01%	0.71%	0.51%	-0.20%	0.00%	0.00%	0.00%	3.76%	3.62%	-0.14%
Mitchell	5.01%	6.09%	1.08%	0.24%	0.23%	-0.01%	0.00%	0.00%	0.00%	2.62%	2.41%	-0.21%
Polk	3.45%	3.90%	0.45%	0.54%	0.84%	0.30%	0.00%	0.00%	0.00%	1.61%	1.55%	-0.06%
Rutherford	5.27%	5.18%	-0.09%	0.42%	0.43%	0.01%	0.00%	0.00%	0.00%	2.42%	2.48%	0.06%
Swain	4.68%	4.58%	-0.10%	0.98%	0.25%	-0.73%	0.00%	0.00%	0.00%	2.57%	2.31%	-0.26%
Transylvania	9.52%	9.18%	-0.34%	2.04%	1.65%	-0.39%	0.00%	0.00%	0.00%	3.91%	4.03%	0.12%
Watauga	8.42%	7.81%	-0.61%	1.00%	0.96%	-0.04%	0.00%	0.00%	0.00%	2.84%	2.70%	-0.14%
Wilkes	8.40%	9.41%	1.01%	0.33%	0.46%	0.13%	0.00%	0.00%	0.00%	3.39%	3.86%	0.47%
Yancey	6.83%	6.00%	-0.83%	0.82%	0.39%	-0.43%	0.00%	0.00%	0.00%	2.44%	2.45%	0.01%
Total	**7.58%**	**7.96%**	**0.38%**	**0.75%**	**0.75%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**3.22%**	**3.27%**	**0.05%**

Table 16: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Alexander	10.96%	9.54%	-1.42%	15.98%	16.10%	0.12%	9.56%	8.33%	-1.23%	9.35%	9.44%	0.09%
Alleghany	11.27%	9.24%	-2.03%	15.92%	15.56%	-0.36%	3.95%	6.55%	2.60%	16.18%	13.97%	-2.21%
Ashe	10.72%	10.87%	0.15%	17.21%	16.98%	-0.23%	9.47%	8.67%	-0.80%	11.37%	10.77%	-0.60%
Avery	7.91%	8.85%	0.94%	18.83%	21.10%	2.27%	10.95%	11.48%	0.53%	13.12%	11.14%	-1.98%
Buncombe	14.00%	14.59%	0.59%	22.00%	22.60%	0.60%	15.34%	15.87%	0.53%	19.44%	18.44%	-1.00%
Caldwell	9.14%	9.16%	0.02%	15.85%	15.34%	-0.51%	9.87%	8.97%	-0.90%	10.59%	9.96%	-0.63%
Cherokee	12.34%	12.37%	0.03%	20.41%	20.34%	-0.07%	9.80%	13.35%	3.55%	15.44%	14.13%	-1.31%
Clay	12.27%	14.26%	1.99%	16.23%	15.51%	-0.72%	8.27%	11.94%	3.67%	15.79%	11.67%	-4.12%
Graham	7.59%	8.98%	1.39%	12.61%	14.55%	1.94%	10.24%	7.10%	-3.14%	14.04%	11.68%	-2.36%
Haywood	15.35%	17.02%	1.67%	20.39%	23.38%	2.99%	14.32%	13.26%	-1.06%	18.14%	18.88%	0.74%
Henderson	9.94%	10.52%	0.58%	13.91%	15.66%	1.75%	10.66%	9.86%	-0.80%	14.56%	13.09%	-1.47%
Jackson	12.01%	12.06%	0.05%	19.96%	22.36%	2.40%	13.23%	13.71%	0.48%	14.25%	12.35%	-1.90%

2019 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		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	3-12			13-17			18-20			21-34		
Macon	12.98%	14.65%	1.67%	21.22%	21.69%	0.47%	13.20%	13.83%	0.63%	14.69%	15.39%	0.70%
Madison	10.55%	11.38%	0.83%	18.94%	20.03%	1.09%	12.66%	11.99%	-0.67%	16.50%	16.72%	0.22%
McDowell	12.65%	13.63%	0.98%	19.42%	19.69%	0.27%	13.02%	12.84%	-0.18%	14.24%	14.72%	0.48%
Mitchell	11.02%	11.48%	0.46%	14.76%	19.78%	5.02%	11.65%	14.35%	2.70%	13.00%	11.46%	-1.54%
Polk	19.08%	15.47%	-3.61%	28.51%	25.10%	-3.41%	11.40%	12.35%	0.95%	11.51%	11.46%	-0.05%
Rutherford	9.48%	10.22%	0.74%	17.50%	18.51%	1.01%	10.98%	10.06%	-0.92%	14.22%	14.82%	0.60%
Swain	8.41%	7.80%	-0.61%	16.98%	17.97%	0.99%	10.17%	9.40%	-0.77%	9.27%	8.91%	-0.36%
Transylvania	14.82%	15.88%	1.06%	21.86%	25.00%	3.14%	11.21%	13.27%	2.06%	16.76%	14.67%	-2.09%
Watauga	11.40%	11.35%	-0.05%	20.96%	19.40%	-1.56%	11.85%	10.48%	-1.37%	11.64%	11.22%	-0.42%
Wilkes	12.00%	12.36%	0.36%	15.56%	16.35%	0.79%	8.40%	8.88%	0.48%	11.47%	10.63%	-0.84%
Yancey	10.59%	9.90%	-0.69%	11.58%	14.55%	2.97%	9.56%	9.70%	0.14%	9.58%	8.38%	-1.20%
Total	11.91%	12.32%	0.41%	18.49%	19.34%	0.85%	11.79%	11.79%	0.00%	14.79%	14.03%	-0.76%

2019 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		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	35-64			65+			Unknown			Total		
Alexander	16.67%	15.87%	-0.80%	9.83%	7.59%	-2.24%	0.00%	0.00%	0.00%	12.34%	11.52%	-0.82%
Alleghany	24.18%	22.32%	-1.86%	13.57%	14.63%	1.06%	0.00%	0.00%	0.00%	15.00%	13.75%	-1.25%
Ashe	19.52%	18.36%	-1.16%	10.61%	8.78%	-1.83%	0.00%	0.00%	0.00%	13.57%	12.93%	-0.64%
Avery	15.94%	16.43%	0.49%	8.03%	6.14%	-1.89%	0.00%	0.00%	0.00%	12.03%	12.21%	0.18%
Buncombe	24.92%	24.65%	-0.27%	16.03%	10.02%	-6.01%	0.00%	0.00%	0.00%	18.59%	18.13%	-0.46%
Caldwell	16.51%	14.61%	-1.90%	12.00%	7.48%	-4.52%	0.00%	0.00%	0.00%	12.16%	11.14%	-1.02%
Cherokee	20.27%	20.19%	-0.08%	5.19%	6.15%	0.96%	0.00%	0.00%	0.00%	14.74%	14.83%	0.09%
Clay	17.32%	19.32%	2.00%	7.07%	5.79%	-1.28%	0.00%	0.00%	0.00%	13.50%	13.93%	0.43%
Graham	18.05%	15.85%	-2.20%	5.63%	4.10%	-1.53%	0.00%	0.00%	0.00%	11.32%	10.86%	-0.46%
Haywood	25.72%	22.14%	-3.58%	16.05%	8.52%	-7.53%	0.00%	0.00%	0.00%	18.79%	18.12%	-0.67%
Henderson	21.47%	20.70%	-0.77%	20.12%	17.29%	-2.83%	0.00%	0.00%	0.00%	14.18%	14.01%	-0.17%
Jackson	19.93%	17.83%	-2.10%	9.82%	4.78%	-5.04%	0.00%	0.00%	0.00%	14.89%	14.12%	-0.77%
Macon	21.87%	21.79%	-0.08%	7.52%	7.48%	-0.04%	0.00%	0.00%	0.00%	15.71%	16.38%	0.67%

2019 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		
	2017	2018	Change	2017	2018	Change	2017	2018	Change	2017	2018	Change
	35-64			65+			Unknown			Total		
Madison	18.77%	17.36%	-1.41%	10.22%	4.15%	-6.07%	0.00%	0.00%	0.00%	14.53%	13.70%	-0.83%
McDowell	18.80%	19.13%	0.33%	12.73%	7.16%	-5.57%	0.00%	0.00%	0.00%	15.19%	15.16%	-0.03%
Mitchell	17.52%	16.43%	-1.09%	6.44%	7.03%	0.59%	0.00%	0.00%	0.00%	12.66%	13.16%	0.50%
Polk	16.40%	14.45%	-1.95%	17.52%	8.12%	-9.40%	0.00%	0.00%	0.00%	18.24%	15.15%	-3.09%
Rutherford	23.91%	21.87%	-2.04%	12.46%	6.02%	-6.44%	0.00%	0.00%	0.00%	14.95%	14.37%	-0.58%
Swain	13.10%	11.62%	-1.48%	3.43%	3.55%	0.12%	0.00%	0.00%	0.00%	10.20%	9.76%	-0.44%
Transylvania	20.66%	21.12%	0.46%	14.11%	11.52%	-2.59%	0.00%	0.00%	0.00%	17.04%	17.51%	0.47%
Watauga	23.51%	22.60%	-0.91%	10.98%	14.18%	3.20%	0.00%	0.00%	0.00%	14.96%	14.86%	-0.10%
Wilkes	20.19%	17.39%	-2.80%	10.94%	6.98%	-3.96%	0.00%	0.00%	0.00%	13.81%	12.96%	-0.85%
Yancey	17.39%	13.21%	-4.18%	8.23%	6.31%	-1.92%	0.00%	0.00%	0.00%	11.66%	10.57%	-1.09%
Total	**21.21%**	**19.96%**	**-1.25%**	**12.59%**	**8.63%**	**-3.96%**	**0.00%**	**0.00%**	**0.00%**	**15.28%**	**14.76%**	**-0.52%**

(b) Waiver Validation Results

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

Table 17 contains validation scores for each of the 10 (b) Waiver Performance Measures.

Table 17: (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

For reviews of 2018 (c) Waiver measures, there were changes made to the measures that were validated. Seven new measures were chosen, and three previously validated measures were retained. Documentation was included for all ten (c) Waiver measures. The rates reported by Vaya are displayed in *Table 18*.

Table 18: (c) Waiver Measures Reported Results 2018

Performance Measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals. IW D1 ISP	Annual	2309/2309=100%	85%
Proportion of Individual Support Plans that address identified health and safety risk factors. IW D2 ISP	Semi Annually	831/831=100%	85%
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need. IW D3 ISP	Annually	2309/2309=100%	85%
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	1539/1539=100%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	1539/1539=100	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	58/63=92.1%	85%
Number and Percentage of deaths where required PIHP follow-up interventions were completed as required. IW G3	Quarterly	5/5=100%	85%
Percentage of medication errors resulting in medical treatment. IW G4	Quarterly	0/3=0%	15%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	1554/1557= 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	6/6=100%	85%

** Latest reported rates are shown in Table.*

(c) Waiver Validation Results

Validation scores are fully compliant with an average validation score of 100% across the ten measures. The validation scores are shown in *Table 19*, (c) Waiver Performance Measure Validation Scores. Documentation on data sources, data validation, source code, and calculated rate for the ten (c) Waiver measures was provided. All rates met or exceeded state performance benchmarks. The validation worksheets offer detailed information on point deduction when validating each (c) Waiver measure.

Table 19: C Waiver Performance Measures Validation Scores

Measure	Validation Score Received
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals. IW D1 ISP	100%
Proportion of Individual Support Plans that address identified health and safety risk factors. IW D2 ISP	100%
Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need. IW D3 ISP	100%
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%
Number and Percentage of deaths where required PIHP follow-up interventions were completed as required. IW G3	100%
Percentage of medication errors resulting in medical treatment. IW G4	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**

Note: Documentation used from Vaya C Waiver Excel Datasheets

Performance Improvement Project (PIP) Validation

The validation of the PIPs was conducted in accordance with the protocol developed by CMS titled, *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012*. The protocol validates components of the project and relative 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 policies and procedures
- Improvement strategies

PIP Validation Results

During the 2018 EQR, four projects were validated: Integrated Care for Innovations Waiver Participants, Inpatient Rapid Readmission, TCLI Housing, and Substance Abuse Follow Up. Two were in the high confidence range of 90 to 100% and two were in the confidence range of 70 to 89%. Recommendations were made regarding measure definitions, results presentation, documentation of data analysis plan, and clarification of interventions.

For the 2019 EQR, Vaya submitted five PIPs. The Incident Report Timely Filing was documented as completed in Oct. 2019, and the primary metric rate has remained above the target of 85% since April 2019. This PIP was not validated since the end date is October 2019. There were four new PIPs that were validated: TCLI PN Housing Usage, Access to Care: Routine, ADATC VIP, and Community Crisis Management. Scores for the previous review year and current review year are shown in *Table 20* with a summary of the validation scores for each Project.

Table 20: PIP Summary of Validation Scores

Project Type	Project	2018 Validation Score	2019 Validation Score
Non-Clinical	Integrated Care for Innovations Waiver Participants	56/78=72% Confidence in Reported Results	Not Validated
Clinical	Follow-up after discharge from inpatient substance abuse disorder treatment	62/62=100% High Confidence in Reported Results	Not Validated
Clinical	Inpatient Rapid Readmission	74/85=87% Confidence in Reported Results	Not Validated
Clinical	Increase rate of routine access to care calls receiving service within 14 days	Not Validated	74/85=87% Confidence in Reported Results
	Community crisis management	Not Validated	57/67=85% Confidence in Reported Results
	ADATC VIP	Not Validated	90/90=100% High Confidence in Reported Results
Non-Clinical	TCLI- Increasing Housing	57/62=92% High Confidence in Reported Results	95/95=100% High Confidence in Reported Results

Two PIPs scored in the Confidence range and two PIPs scored in the High Confidence range, resulting in a "Partially Met" score for this standard. *Table 21* below displays the two PIPs scoring in the Confidence range and the required Corrective Action. The ADATC VIP and TCLI- Increasing Housing PIPs were validated at 100% and have no Recommendations or Corrective Actions. The PIP Validation Worksheets in *Attachment 3* show complete scoring for each PIP along with the specific Corrective Actions.

Table 21: Performance Improvement Project Errors and Corrective Actions

Project	Section	Reason	Corrective Action
Increase rate of routine access to care calls receiving service within 14 days	Was/were the study question(s) stated clearly in writing	Research question is not clearly stated in workbook	Add study question to workbook report.
	Was there any documented, quantitative improvement in processes or outcomes of care?	Rates are below goal.	Continue to initiate new interventions or adjust ongoing interventions to improve rates.
Community Crisis Management	Was/were the study question(s) stated clearly in writing	Research question is not clearly stated in workbook	Add study question to workbook report.

Figure 5 provides a comparison of the 2018 scores versus the 2019 scores. The 2019 review shows 83% of the standards were scored as "Met," and 6% of the standards were scored as "Partially Met." 11% of the standards scored "Not Met."

Figure 5: Quality Improvement Comparative Findings

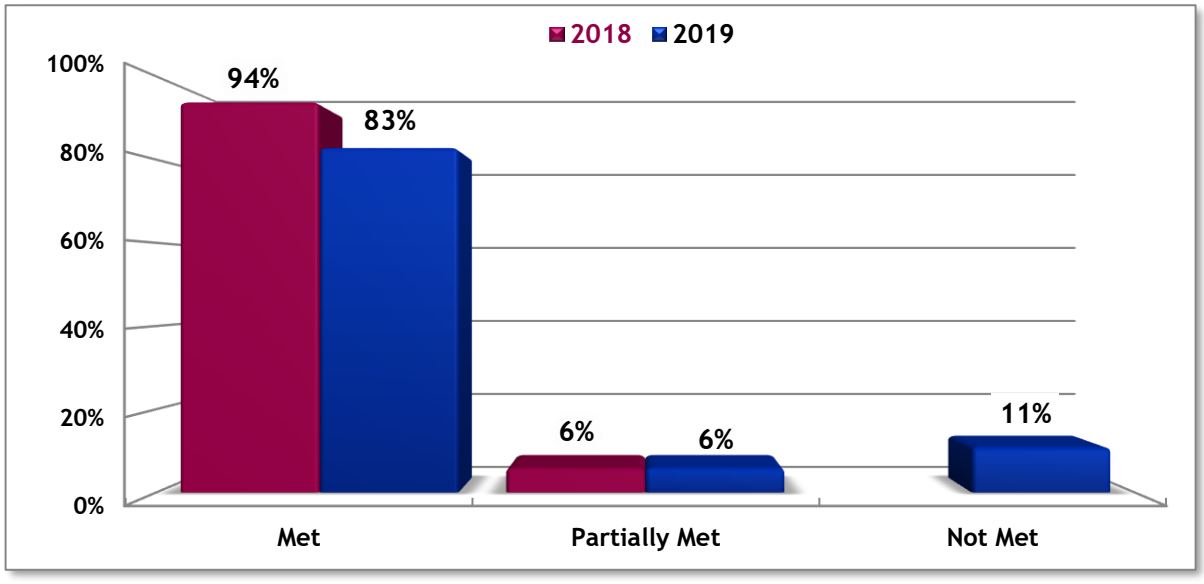


Table 22: Quality Improvement

Section	Standard	2019 Review
The Quality Improvement (QI) Program	The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.	Not Met
	The PIHP reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified.	Not Met
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	Partially Met

Strengths

- Validation scores for (b) Waiver and (c) Waiver measures are fully compliant with an average validation score of 100%.

Weaknesses

- There were no selected services over the review period that looked at the rate of compliance with selected Clinical Practice Guidelines.
- No significant measures were implemented to address quality problems identified though the ECHO Survey.
- Adult and Child Echo Survey results are found on the Vaya website. The meeting minutes did not reflect that the survey results were shared with a Vaya provider attended committee/group such as Clinical Advisory Committee or O-QIC during the review period.
- Adult and Child ECHO survey results were not reported to the I-QIC or O-QIC committee meetings during the review period.
- Although Minutes are taken at the I-QIC and O-QIC meetings, the minutes do not capture discussion from the meeting topics.
- The following two PIPs scored in the Confidence range resulting in a Partially Met score: Increase rate of routine access to care calls receiving service within 14 days and Community Crisis Management.
- There is no evidence of providers receiving interpretation of their QI performance data and feedback regarding QI activities.
- The *Quality Management Program Evaluation FY 2019-2020* was included in the Desk Materials for review. The year was mislabeled. Onsite discussion determined the correct year is FY 2018-2019.

- The Quality Management Program Evaluation did not include information about Enrollee and Provider Survey Results.

Corrective Action

- Follow the QM Program Description for provider compliance with Clinical Practice Guidelines. Select practice guidelines and monitor the rate of compliance with the selected guidelines. Include the monitoring results in the Quality Management Program Evaluation at the end of each fiscal year when preparing this document.
- Implement significant measures to address problems identified in the Adult and Child ECHO Surveys and show discussion in I-QIC and O-QIC meeting minutes.
- Report both the Adult and Child ECHO Survey results to I-QIC and O-QIC. Facilitate discussion in both committees around measures to be taken to address quality problems that are identified within Adult and Child Survey Results. Committee Minutes of both committees should reflect this discussion.

Recommendations

- Share Enrollee Satisfaction Survey results with providers at the appropriate in-person provider committees/forums.
- Include discussion that happens on each agenda item in the I-QIC and O-QIC meeting minutes.
- Correct the year on the Quality Management Program Evaluation FY 2019-2020. The year is FY 2018-2019.
- Include information about all Survey Results in the Quality Management Program Evaluation annually.
- Correct the errors in the two PIPs scoring Partially Met: Increase rate of routine access to care calls receiving service within 14 days and Community Crisis Management. *Table 21* displays both PIPs and the specific Corrective Action. The specific corrections are also displayed on the PIP Worksheets in *Attachment C*.
- Provide evidence as required per *NC Medicaid Contract section 7.1.4 (h)* "Provide performance feedback to Providers, including detailed discussions of clinical standards and the expectations of PIHP."

E. Utilization Management

The Utilization Management (UM) EQR included review of Vaya's UM service authorization decisions, Care Coordination program and Transition to Community Living Initiative (TCLI) functions. Included in the review process are Desk Review of relevant policies, the Utilization Management Plan and Program Description SY2019-2020, the Provider

Operations Manual, the Member and Caregiver Handbook, Vaya's website, service authorization decisions, and Care Coordination files.

The Chief Medical Officer (CMO) currently oversees the UM functions. However, Vaya has hired a Clinical Director who will be responsible for the UM program. Others involved with the oversight of Care Coordination and Transition to Community Living include the Chief Population Health Officer and the Senior Care Coordination Director.

The Utilization Management Program Description describes the program structure and policies are in place. One correction needed is regarding a cost limitation related to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits described in a Vaya policy. *Policy 2382, EPSDT* states "Any Innovations waiver participant can receive both waiver services and EPSDT services. However, the total cost of the beneficiary's care must not exceed the waiver cost limit ($135,000 annually)." This information is not in line with NC Medicaid Contract 7.4.6 which states, "any service that is covered under Section 1905(a) of the Social Security Act which is medically necessary to treat or ameliorate a defect, physical illness, or condition identified through screening must be provided to Children", and does not state that PIHPs can impose a cost limit. Additionally, *Medicaid Clinical Coverage Policy 8P, Appendix C-4 – Budget Levels by Level of Support* states, "Budget Guidelines by Level of Support: The only individual budget limit is $135,000 per year in Innovations waiver services". Vaya's *Policy 2382, EPSDT* needs to be corrected to ensure no cost limit is placed on enrollees who qualify for both Innovations and EPSDT benefits.

In reviewing the UM service authorization files, it was noted that the decisions were rendered by appropriate staff and notifications provided within the required 14-day timeframe. During the Onsite, Vaya stated that the UM reviewers spend additional time educating and requesting additional information from providers in order to process the authorizations timely.

The EQR of Care Coordination included review of a sample of 35 records of enrollees participating in Mental Health/Substance Use (MH/SU), Intellectual/Developmental Disability (IDD), and Transition to Community Living Initiative (TCLI) Care Coordination. Upon review of the Care Coordination records submitted with the desk materials, CCME contacted Vaya to ensure the Care Coordination records were complete, as submitted. Vaya initially confirmed that the records submitted were complete.

Four days prior to the Onsite, Vaya informed CCME that the Care Coordination records were not complete. The second upload of Care Coordination records provided some additional documents; however, this new set of documents proved mostly to be duplicative to the first upload and did not complete the files for the majority of the sampled enrollees. Additionally, the submitted documentation clearly demonstrated documentation errors by Care Coordinators that were noncompliant with Vaya's *Policy*

2335, Complex Care Management Populations, Processes Roles and Responsibilities. For example, in one file, six progress notes were labelled as TCLI interventions, but the enrollee was a child that was not part of the initiative.

Also, Vaya's *Policy 2335 Complex Care Management Populations, Processes Roles and Responsibilities states*, "Care managers must enter CCM activities, tasks and follow ups (interventions) into the member's administrative health record (AHR) within one business day of the intervention to ensure continuity of care and accuracy." However, at least 5% of the progress notes were noted as "late entry" by the Care Coordinator.

Similarly, there was evidence in the files reviewed that Care Coordinators were not in compliance with the steps and required timeframes of those steps when attempting to contact a member who is unable to be reached. *Policy 2335* requires, "Prior to discharging a member from CCM because they are unable to be reached (UTR), during the outreach and engagements process or thereafter, the care manager attempts to engage the member/LRP a minimum of three times. These attempts should occur over a two-week period and include at least two of the following methods: telephonic, regular mail, email, or fax." However, files without gaps in progress notes showed a lack of adherence to this policy.

In the previous year's EQR, CCME recommended that increased monitoring occur to ensure compliance with Vaya's documentation requirements outlined in their policies. While blank monitoring tools were provided during the Onsite this year and their frequency and intent explained by staff, there continues to be concern with Vaya's ability to identify and produce each enrollee's complete Care Coordination record and ensure continuity of care by Care Coordination. Based on Care Coordination and TCLI file review, Corrective Action is needed by Vaya.

In the 2018 EQR of Vaya's TCLI functions, a deficiency was noted by CCME regarding Vaya's use of a TCLI tool that was not the State required, TCLI In-Reach Tool. This deficiency was disputed by Vaya with NC Medicaid during the Corrective Action Review process in 2018. Vaya provided an email between Vaya and the Department of Health and Human Services (DHHS) that showed DHHS agreed in 2016 for Vaya to use a different tool as a part of a pilot project. As of September of 2019, Vaya and DHHS have agreed Vaya will start using the State required TCLI In-Reach tool, effective November 1, 2019.

Figure 6 provides a comparison of the 2018 EQR UM scores versus the 2019 scores. The 2019 UM review shows 96% of the standards were scored as "Met," and 4% of the standards were scored as "Partially Met." There were no standards scored "Not Met."

Figure 6: Utilization Management Comparative Findings

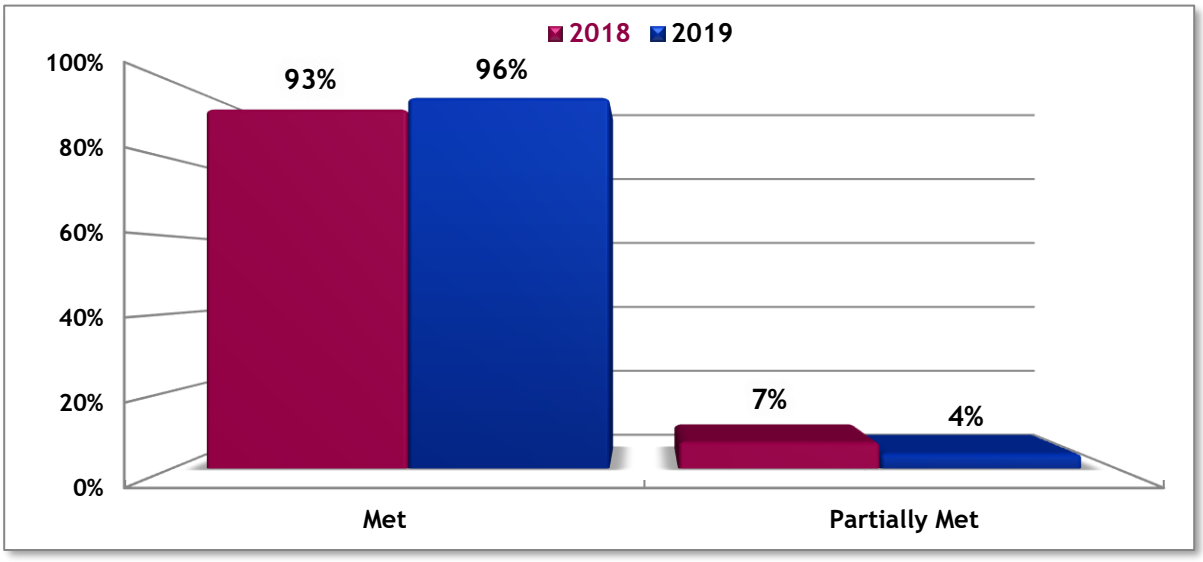


Table 23: Utilization Management

Section	Standard	2019 Review
Utilization Management	The PIHP formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: guidelines / standards to be used in making utilization management decisions;	**Partially Met**
Transition to Community Living Initiative	A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures and processes, as required by NC Medicaid, and developed by the PIHP.	**Partially Met**

Strengths

- UM decision timeframes are included within policies and procedure and the file review indicated timely review of the requests.

Weaknesses

- The cost limitation described in In *Policy 2382, EPSDT* does not align with the *NC Medicaid Contract* and *Medicaid Clinical Coverage Policy 8P*.
- Vaya was unable to identify and produce each enrollee's, complete Care Coordination record that was selected for this year's EQR.
- Within the Care Coordination and TCLI files reviewed there was a pattern of late progress notes and gaps in engagement by Care Coordinators.

Corrective Action

- Revise Vaya's *Policy 2382, EPSDT* to align with the language within the *NC Medicaid Contract* and *Medicaid Clinical Coverage Policy 8P*, which does not allow a cost limit for enrollee's accessing services through Innovations and EPSDT.
- Enhance the current monitoring process to ensure documentation by Care Coordinators is complete, accurate and compliant with documentation requirements set forth by Vaya's *Policy 2335 Complex Care Management Populations, Processes Roles and Responsibilities*.

Recommendation:

- Develop a report or process that ensures an enrollee's complete record can be identified, accessed and produced from the AlphaMCS and Incedo platforms.

F. Grievances and Appeals

Grievances

The Grievance EQR includes a Desk Review of policies and procedures, the *Grievance Log*, the *Provider Operations Manual,* the *Member and Caregiver Handbook,* 20 grievance files, and an Onsite discussion with staff to further understand Vaya's grievance process.

CCME's process to select grievances for the review involves identifying 20 grievances from the *Grievance Log* submitted by Vaya. After CCME identified 20 grievances and requested the files from Vaya, Vaya responded by stating one of the files selected was not a grievance but a "compliance issue." On the *Grievance Log* provided, this grievance was labeled as a grievance and categorized as a "LME-MCO Functions (excluding Authorization/Payment/ Billing)." Vaya's *Grievance and Complaint Workflow 9.4.19* also shows that, if any concern comes into the call center that is not a grievance, staff would still send an acknowledgment letter and a resolution notice stating the concern had been referred to an appropriate department. This was true in several files that were provided by Vaya that showed the grievance was actually an "appeal", and another that involved a HIPAA violation by Vaya staff. During the Onsite discussion, staff reiterated that this was an "external concern" and that the compliance issue had mistakenly been labelled grievance. Vaya was unable to clearly explain the difference in how this external call would have been handled differently and why the file was not provided.

The review of the grievance files showed files did not always contain documentation as described in *Policy 2607, Complaints and Grievances*. Per this policy, "Documentation of all actions taken in efforts to resolve the grievance, including dates, time and summaries of contacts made, materials reviewed, requests for information, and information received" is required to be documented in "AlphaMCS and/or other platforms". During the Onsite, Vaya clarified some internal consultations with internal subject matter

experts, such as the Chief Medical Officer, are captured in emails and not necessarily within the grievance record. As no consultations were evident in the files provided, even in situations that warranted consultation, it is assumed documentation was not submitted or consultations did not occur.

Policy 2314, Record Retention Management states, "Maintenance of records relating to complaints and grievances are maintained as specified in *Policy 2607*." *Policy 2607, Complaints and Grievances* does not include the timeframe to maintain grievance logs as specified in the *NC Medicaid Contract, Attachment M, Section B. Record Keeping*.

Appeals

The EQR of Vaya's appeal process includes reviewing governing policies and procedures, the *Member and Caregiver Handbook*, the *Provider Operations Manual*, the *Vaya Appeal log-Aug 2018 thru July 2019*, Vaya's website, and 25 appeal files.

In the previous year's EQR, five Corrective Actions and four Recommendations were aimed at correcting or bolstering information within Vaya's *Policy 2384, Member Appeals of Adverse Decisions,* the *Provider Operations Manual,* and the *Member and Caregiver Handbook*. Vaya addressed these areas of concerns in the policy and *Provider Operations Manual*, but did not revise the *Member and Caregiver Handbook* available to enrollees and providers. These revisions are still needed and are detailed in the Recommendations listed below and on the Tabular Spreadsheet (*Attachment 4*).

One item requiring Corrective Action relates to the timely processing of appeals. In the year in review, the *Vaya Appeal Log-Aug 2018 thru July 2019 (Appeal Log*) showed Vaya processed and resolved approximately 150 first level appeals. Of the required written notifications for those appeals, approximately 5% of the acknowledgement notifications and written resolutions were outside of the required timeframes. The files Vaya provided followed this trend with four of the twenty first level appeals containing late acknowledgements and appeal resolution notifications. This trend was approximated as the *Appeal Log* contained some errors (e.g., appeals not identified as extended, missing resolution notification dates, typos in dates, etc.) and half of the files provided were missing evidence of appeal receipt date and time.

This trend was noted in last year's EQR, and staff reported they had identified a barrier to timeliness and would resolve it. CCME recommended that Vaya "Increase or improve the current monitoring process of all written and oral notifications, including invalid notifications, acknowledgements, and resolution notifications. Ensure monitoring also reviews all notifications for timeliness." In this year's EQR and in response to this Recommendation from last year, Vaya stated, "We have increased oversight of denial and appeal notifications and decision and notification timeliness through revising the audit tool and increasing internal audits." As a result of the continued trend, Corrective Action

is required to ensure all appeals notifications are compliant with *Vaya's Policy 2384, Member Appeals of Adverse Decisions, NC Medicaid Contract, Attachment M,* and *42 CFR § 438.408 (b).* It was discussed during the Onsite that any monitoring efforts could include validation of the data within the Appeal Log and using that log to create data-driven internal audits.

In one of the 20 first level appeal files reviewed it was noted that appeal #19 appeared to have been processed outside of the allowable timeframe for standard appeal resolution of 30 days. Following the appeals Onsite discussion, Vaya submitted a timeline, labeled "Additional Information appeal #19 10 9 19." This documentation confirmed that this appeal was resolved, and notification provided in 74 days.

During a subsequent discussion with appeal staff, CCME acknowledged the timing of the oral and written appeal requests placed Vaya in a predicament and attempted to provide technical assistance regarding other steps that could have been taken by staff. In the end, CCME highlighted that further guidance from the State could help Vaya address any other appeals with a similar timing issue.

It was highlighted during the Onsite that the file review also showed Vaya uses checklists and forms to capture required internal steps by staff such as providing oral resolution notifications. Staff maximize the use of these forms and checklists by comprehensively documenting all internal steps like obtaining guardianship documentation and following up on the enrollee submission of additional appeal documentation. This comprehensive documentation provides a thorough overview of the workflow staff followed in processing each appeal.

Figure 7, Grievances and Appeals Comparative Findings shows 90% of the standards in are scored as "Met" for the current EQR. Several Corrective Actions and Recommendations address identified "Weaknesses", some of which were also identified at the last EQR.

Figure 7: Grievances and Appeals Comparative Findings

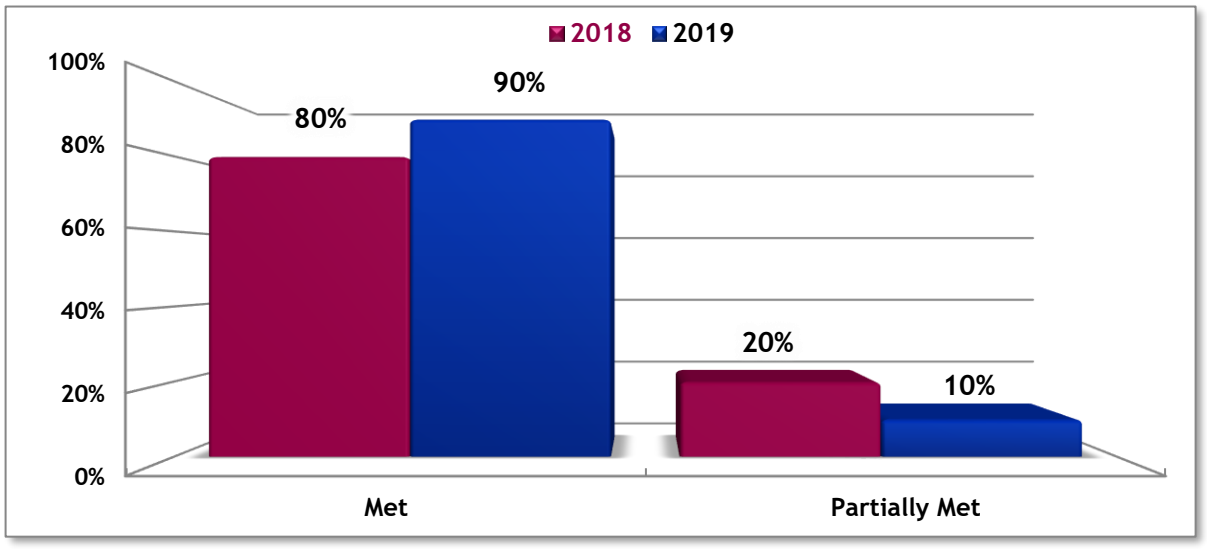


Table 24: Grievances and Appeals

Section	Standard	2019 Review
Grievances	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.	Partially Met
Appeals	The PIHP applies the appeal policies and procedures as formulated.	Partially Met

Strengths

- The Chief Medical Officer is well-versed in the grievance process.
- Staff maximize the use of forms and checklists by comprehensively documenting all internal steps when processing appeals.

Weaknesses

- *Policy 2607, Complaints and Grievances* does not include the timeframe to maintain grievance logs as specified in *Policy 2314* and the *NC Medicaid Contract*.
- There was no documentation of consultation with subject matter experts within the grievance files reviewed, even in grievance files with situations that warranted consultations.

- The *Member and Caregiver Handbook* states, "you must complete and return the Vaya reconsideration form." This statement is not compliant with Vaya's *Policy 2384, Member Appeals of Adverse Decisions.*
- The *Member and Caregiver Handbook* (pg. 57) states, "We will send you a written acknowledgement within one business day when we receive your request." This statement contradicts Vaya's appeals policy that states, "Requests for Expedited Appeal that are accepted do not require written acknowledgement."
- Vaya must give prompt oral notice and a written notice within two calendar days when a request to expedite and appeal is denied. However, the *Member and Caregiver Handbook* (pg. 58) continues to not include the timeframes of these notifications.
- The *Member and Caregiver Handbook* states, "we will notify you in writing within three business days," when Vaya extends an appeal resolution timeframe. This information is not in line with Vaya's appeal policy and the *NC Medicaid Contract* requirements. Enrollees are also not informed of their right to file a grievance when Vaya extends the standard or expedited timeframe to resolve and appeal.
- Page 58 of the *Member and Caregiver Handbook* states, "You or your provider can request an expedited reconsideration review if the 60-day timeframe will jeopardize your health and safety." However, the appeals resolution timeframe that can be extended is 30 days.
- The appeal files and *Appeal Log* showed a portion of the appeals processed in the past year had appeal acknowledgements and appeal resolution notifications sent outside of the required timeframes.
- One appeal within the file review was resolved outside of the required 30-day timeframe for standard appeals and notification was provided in 74 days.

Corrective Action

- Include the timeframe to maintain grievance logs within *Policy 2607*, as specified in Vaya *Policy 2314*, and per the *NC Medicaid Contract*.
- Develop and document an enhanced monitoring process to ensure all appeals are acknowledged and processed within the timeframes required by *Policy 2384, Member Appeals of Adverse Decisions*, *NC Medicaid Contract, Attachment M,* and *42 CFR § 438.408.*

Recommendations

- Ensure consultations with subject matter experts are captured within the grievance file to demonstrate compliance with *Policy 2607.*
- Revise the *Member and Caregiver Handbook* to state that any written request can initiate the first level appeal process. The *Vaya Reconsideration Form* is not required.

- Clarify in the *Member and Caregiver Handbook* that members may not receive written acknowledgement when an expedited appeal is filed. The handbook currently says all appeals receive written acknowledgment.
- Add to the *Member and Caregiver Handbook* that enrollees are given prompt oral notice and a written notice within two calendar days when Vaya denies a request for an expedited appeal.
- Correct to the Member and Caregiver Handbook to explain that reasonable efforts are made to give enrollees prompt oral notice, and a written notice within two calendar days when Vaya extends the expedited or standard appeal resolution timeframe. Ensure members are also informed they have the right to file a grievance against Vaya if they disagree with the decision to delay resolution.
- Correct the *Member and Caregiver Handbook* to state that the "30 day" timeframe for appeal resolution can be expedited.
- Seek guidance from NC Medicaid on how to accommodate the timeline requirements outlined in Vaya's *Policy 2384, Member Appeals of Adverse Decisions*, and the *NC Medicaid Contract, Attachment M, G. 2., G.3.a.,* and *G.4.*

G. Delegation

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

At the last EQR, there were no Corrective Action items and two Recommendations. During the current EQR review period, Vaya did not address one Recommendation and partially addressed one Recommendation. Details regarding the status of the Recommendations are provided in the information that follows.

During the period covered by the current EQR, Vaya had two delegated entities, as evidenced in *Table 25*. Vaya's contract with Partners Behavioral Health for call roll-over coverage ended as of June 30, 2019. Vaya conducted a pre-delegation assessment of Alliance Health before the inception of a contract for call roll-over coverage effective July 1, 2019.

Table 25: Delegated Entities

Delegated Entities	Service
Prest and Associates (Prest)	Peer Review/ Utilization Management
Partners Behavioral Health (Partners)	Call roll over

Policy 2303, Delegation and Subcontracting outlines the process for delegating administrative functions to another entity and includes the requirements for ongoing oversight. The referenced policy states "the Vaya department with primary responsibility for the delegated function(s) shall provide ongoing oversight of the delegation agreement and the delegated entity's performance of those functions. This oversight shall include development and implementation of an oversight delegation plan approved by the Regulatory Compliance Manager or designee that includes the following elements," including "E. A mechanism for reporting delegation oversight no less than annually to the Quality Improvement Committee (QIC)."

At the last EQR, the QIC meeting minutes did not include reporting of delegation oversight of Prest and Associates or of Partners, resulting in the Recommendation that Vaya "report delegation oversight in a QIC meeting annually, as referenced in Vaya *Policy 2303,* or revise the policy to eliminate the reference to annual reporting by the QIC."

The QIC meeting minutes for the timeframe covered by the current EQR also do not include reporting of delegation oversight of Prest or Partners. When asked for evidence of the annual delegation oversight reports to QIC, Vaya staff reported "Delegation oversight had not been built into the QIC schedule when the 2018 EQR Review was finalized. Delegation oversight has been built into the QIC schedule for the current fiscal year and moving forward." For the Onsite, Vaya provided minutes of the September 10, 2019 Internal QIC (I-QIC) meeting, at which Stephen Puckett, PhD, HSP-P, Member Appeals Director, presented the "Annual Prest Delegation Evaluation". However, the meeting date is outside the review period covered by the current EQR.

The EQR Desk Materials Request includes "30. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used. Include annual evaluations, if applicable, and indicate to which committees delegate monitoring is reported." In response, Vaya submitted information regarding Alliance (whose contract started outside of the review period covered by the current EQR) and Prest, but nothing for Partners. The Prest *FY 2019 Peer Review Delegation Oversight Report 8 30 19* states, "All internal and external Peer Reviews are reviewed for completeness and adherence to review standards prior to implementation." During the Onsite, Vaya staff confirmed this by stating it reviews "every review completed by Prest", and also receive monthly and quarterly statistics. No issues were found in a Vaya-conducted audit of Prest Peer Reviews for Quarters 1, 2, and 3 of FY 2019. Concordance rates for FY19 ranged from 90% (Quarter 1) to 100% (Quarters 3 and 4).

On the *Onsite Request List*, CCME requested "Delegation monitoring, including call metrics, of Partners Behavioral Health for timeframe of July 2018 through June 2019." In response, Vaya submitted *Call Monitoring* reports for calls answered by Partners, a

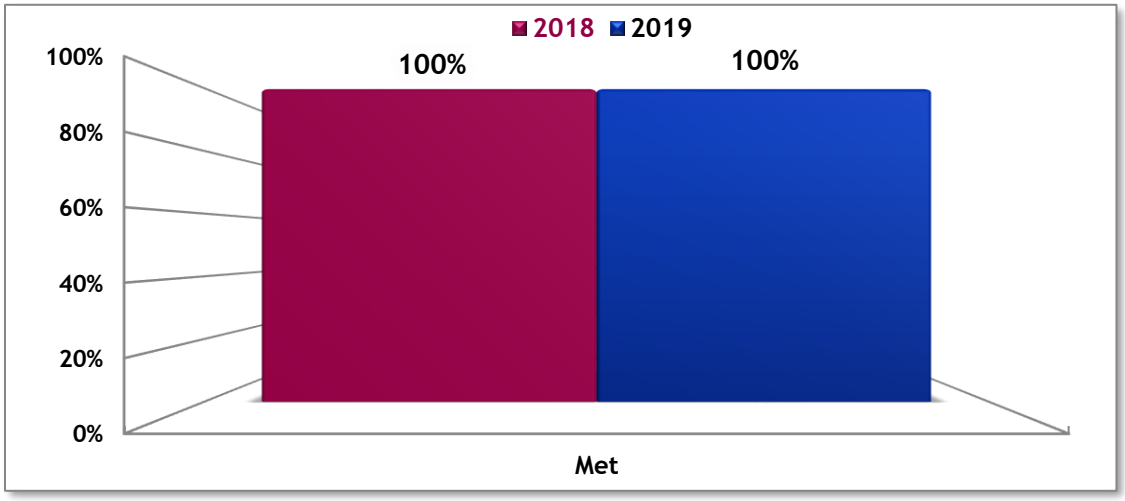
Delegation Audit Tool completed in July 2018, and a *Delegation Assessment* completed by Karla Mensah, MBA, Vaya's Senior Director of Customer Services.

Though the contract with Partners ended on June 30, 2019, the *Delegation Assessment* was completed on October 7, 2019, after Vaya received the *Onsite Request List* from CCME. This *Delegation Assessment* of Partners occurred outside the review period covered by this EQR, and three-and-a-half months after the end of the Partners contract. The Partners *Delegation Assessment* does not include the timeframe covered by the Delegation Assessment, which was also an issue resulting in a Recommendation in the 2018 EQR.

Vaya reported Partners met call metrics for the calls answered by Partners. Ms. Mensah reported that she met regularly with the relevant staff member from Partners to monitor calls and complete the *Call Monitoring Checklist*. During the Onsite interview, Vaya staff indicated there were no quality of care or other concerns that led to ending the contract with Partners and switching to another vendor.

As noted in *Figure 8*, 100% of the standards in the 2019 Delegation review received a "Met" score. *Figure 8* also provides a comparison of the 2019 scores versus the 2018 scores.

Figure 8: Delegation Comparative Findings



Strengths

- Vaya has an executed contract, including a Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement, with each delegate.
- Vaya conducted the required annual monitoring for each delegate.

- Vaya held regular meetings with Partners staff to monitor calls and to discuss and resolve any issues.
- Vaya staff reviews all reviews conducted by Prest.

Weaknesses

- The supplied QIC meeting minutes do not include reporting of delegation oversight of Prest and Associates or of Partners until the Prest delegation report at the September 10, 2019 meeting, which is outside the review period for the current EQR. This was also an issue, resulting in a Recommendation, at the last EQR. See Vaya *Policy 2303, Delegation and Subcontracting*.
- The *Delegation Assessment* form completed for Partners Behavioral Health, signed by Ms. Mensah on October 7, 2019, does not include the timeframe covered by the assessment. This was also an issue at the last EQR, when the *Delegation Assessment* did "not include the timeframe covered by the assessment, the date the assessment was completed, or the date it was signed by the Vaya staff member." During the current EQR review period, Vaya partially addressed the Recommendation from the 2018 EQR, in that the submitted *Delegation Assessment* (of Partners) included the date the form was completed by Ms. Mensah.

Recommendation

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

H. Program Integrity

As required by contract with CCME, IPRO is tasked with assessing PIHP compliance with federal and state regulations regarding program integrity functions. IPRO analyzed the Program Integrity (PI) files and documentation submitted for the Desk Review, and then facilitated discussions with Vaya staff during the Onsite.

File Review

IPRO requested the universe of PI files from Vaya for August 1, 2018 through July 31, 2019, and selected a random sample of 15 files with a two file oversample for a total of 17 files. Review of these files was to ensure Vaya, in each case where the PIHP investigates a credible allegation of fraud, provided NC Medicaid Program Integrity with the following information on a NC Medicaid approved template:

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

All of the files contained the above requirements with one exception. All but one of the fifteen files were missing additional contact information for PIHP staff persons with practical knowledge of the working of the relevant programs.

Additionally, files were reviewed to ensure that, in each case of suspected enrollee fraud, the PIHP shall provide NC Medicaid program integrity with:

- The enrollee's name, birth date, and Medicaid number
- The source of the allegation
- The nature of the allegation
- Copies of all communications between the PIHP and the provider concerning the conduct at issue
- Contact information for PIHP staff persons with practical knowledge of the allegation
- The date reported to the State
- The legal and administrative status of the case

The two cases of suspected enrollee fraud contained all of the required information.

Documentation

The EQR of PI documentation included review of Vaya's policies, procedures, training materials, organizational charts, job descriptions, committee meeting minutes and reports, provider agreements, enrollment application, workflows, provider manual,

employee handbook, newsletters, conflict of interest forms, and the *Compliance Program Plan*. This information was reviewed under three topic areas: General Requirements, Fraud and Abuse, and Provider Payment Suspensions. Onsite interviews were conducted on October 10, 2019, with the Program Integrity staff to review the Desk Review findings. Missing from the documentation was explicit language pertaining to the following areas:

- Supplying all investigation data to NC Medicaid in a uniform format and within the timeliness requirement.
- Timeliness requirements for the provision of a monthly report to NC Medicaid Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse.

Regarding Provider Payment Suspensions and Overpayments, the documentation was missing explicit language pertaining to the lifting of payment suspensions within three days of notification from NC Medicaid and the requirement by Vaya to ensure, during any ongoing investigation, that nothing will interfere with Enrollee access to care.

Figure 9, Program Integrity Comparative Findings shows 95% of the standards in the PI section are scored as "Met" for the current EQR.

Figure 9: Program Integrity Comparative Findings

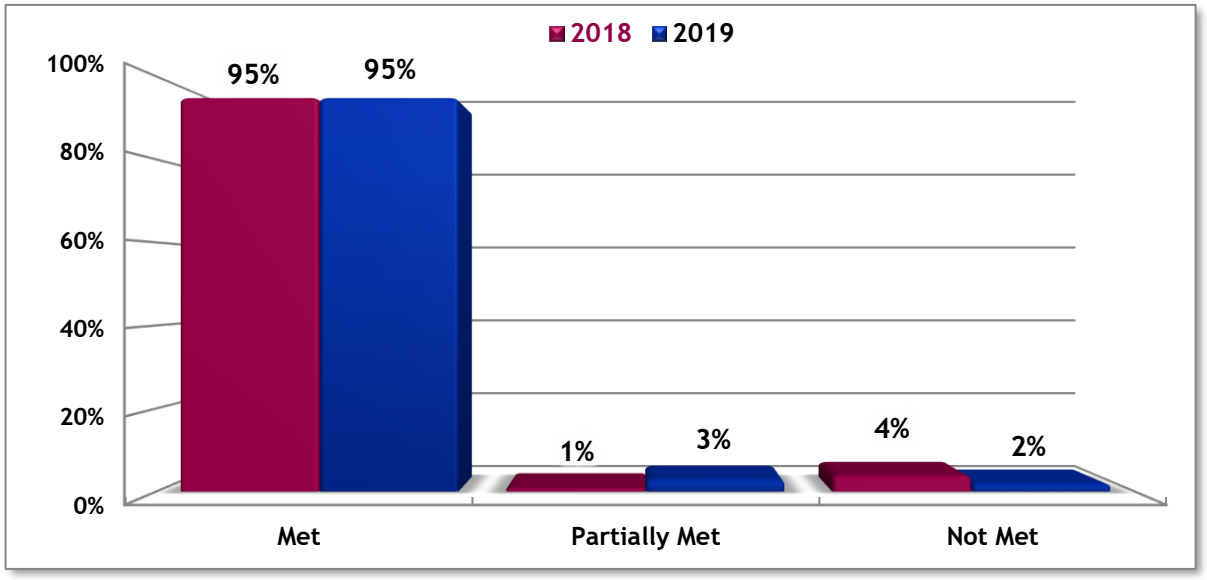


Table 26: Program Integrity

Section	Standard	2019 Review
Fraud and Abuse	Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any	Partially Met

Section	Standard	2019 Review
	investigation conducted by Federal or State authorities, including NC Medicaid or MFCU/MID, and including promptly supplying all data in a uniform format provided by DHB and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by Division as provided in Section 13.2 – Monetary Penalties.	
	Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	Not Met
	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.	Partially Met

Strengths

- Vaya is undertaking an initiative working on predictive modeling to help deter and avoid Fraud, Waste, and Abuse on the front end, in addition to their efforts in identifying cases on the back end with the integration of the Coordination of Benefits (COB) review.
- Vaya shows its commitment to educating staff, providers, and enrollees about Fraud, Waste, and Abuse through numerous training events and materials.

Weaknesses

- The *Investigation Referral Form* does not capture the contact information for PIHP staff persons with practical knowledge of the workings of the relevant programs. All but one of the fifteen files reviewed were missing this required information.
- The *Compliance Program Plan FY2019-20* does not make reference to the timeliness or format requirement for supplying investigation data to NC Medicaid.
- Vaya's polices do not contain specific information about the timeliness requirement for the provision of a monthly report to NC Medicaid Program Integrity.
- Vaya's policies do not contain specific information about the timeliness requirement for the lifting of payment suspensions within three days of notification from NC Medicaid.
- Vaya's policies do not contain specific information about the requirement by Vaya to ensure nothing will interfere with Enrollee access to care during any investigation.

Corrective Actions

- Incorporate contact information for PIHP staff persons with practical knowledge of the working of the relevant programs into the PI referral form to ensure PI files contain this information required per *NC Medicaid Contract, 4.2.9.*
- Include in policy the timeliness requirement for providing information to NC Medicaid, as outlined in *NC Medicaid Contract, 21.d*, which states, "supplying all data in a uniform format provided by DHB and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by Division as provided in Section 13.2 – Monetary Penalties."
- Include in policy the timeliness requirement in *NC Medicaid Contract, 14.3.d* which states, "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."

Recommendations:

- Include in policy the timeliness requirement, as outlined in *NC Medicaid Contract Section 9.8* and *25* of *Amendment 4.*
- Include in a Vaya policy the requirement in *NC Medicaid Contract, 14.3.4* regarding Vaya's obligation to ensure there is no interference with Enrollee's access to care during any investigation.

I. Financial Services

In reviewing Vaya financial operations, CCME used a standardized *EQR Finance Desk Review* and an *Onsite Administrative Interview* guide. CCME also reviewed deficiencies from prior EQRs to determine if they were corrected.

CCME implemented a Desk Review of the following documentation:

- Financial policies and procedures
- Audited financial statements and footnotes dated June 30, 2018
- Balance sheet and income statements dated June 30, 2019, and July 31, 2019
- Medicaid monthly financial reports for June and July 2019
- Claims processing aging reports for June and July, as well as claims processing policies
- Accounting Department staffing structure
- Fiscal year budget for 2019-2020
- Risk reserve account reporting and bank statements

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

- Policies and procedures
- Staffing changes in the Finance Department
- Accounting system
- Budget variances and development
- Incurred But Not Reported (IBNR) calculation
- Medical Loss Ratio (MLR) reporting

Per the EQR of Vaya's financial records, Vaya demonstrates ongoing financial stability. Vaya's audit report for June 30, 2018 showed an unqualified audit opinion on financial statements, which indicated the auditors did not report any compliance or internal control findings in their testing of federal and state programs.

Vaya exceeded the contract benchmarks for current ratio, defensive ratio, and MLR. Vaya's Medicaid ratio is 2.8 total with a total current ratio of 2.26 in June 2019. The Medicaid current ratio is 3.01 total, with a total current ratio of 2.09 for July 2019 (benchmark is 1.00). Vaya's total defensive interval in June 2019 is 42.81 days (the benchmark is 30 days). Vaya's year-to-date MLR is 93.8% year-to-date as of June 30, 2019, and 95.61% year-to-date as of July 31,2019 (benchmark is 85%). Medicaid total assets as of June 30, 2019, are $123,320,536 and $121,319,191 for July 31, 2019. Vaya's net assets position was $78,695,155 as of June 30, 2018.

Vaya meets standard *42 CFR § 433.32 (a)* for maintaining an appropriate accounting system (Great Plains). Vaya uses Great Plains financial, purchasing, fixed assets, and bank reconciliation modules. Vaya uses Great Plains version 2015 and is planning to upgrade to version 2018 during the current fiscal year. Vaya uses AlphaMCS for claims processing and ADP for payroll processing.

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

Vaya's updates policies annually. PolicyTech is the software used to update policies and communicate these changes to staff. Policies are published, and staff members are given a deadline via email to read the updated policy. Staff members sign off electronically

after reviewing the policy. PolicyTech sends email reminders to staff until they have read and signed off on the policy.

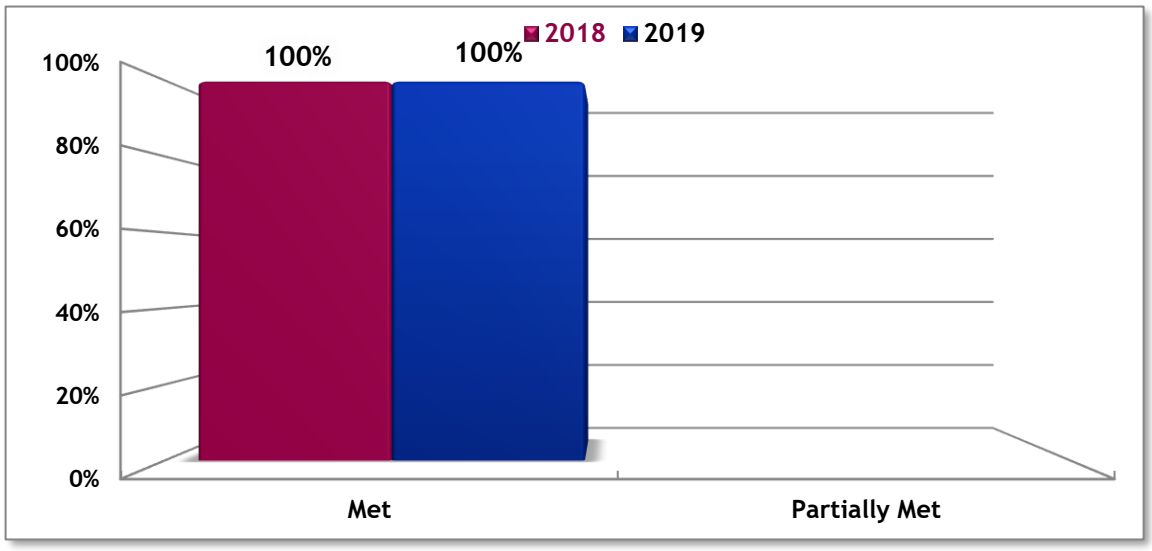
Vaya's *Cost Allocation Plan* meets the requirements for allocating the administrative costs between federal, state, and local jurisdictions based on revenue as required by *42 CFR § 433.34.* Vaya has no costs disallowed per the audit report and Onsite interview. Vaya submits a *Cost Allocation Plan*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

Vaya's Medicaid Risk Reserve account meets the minimum requirement of contributing 2% of the capitation payment per month required by the *NC Medicaid Contract, Section 1.9.* During the period in review, Vaya reached 13.8% of their required percentage of annualized capitation maximum (15%), with a balance of $45,106,653. Once NC Medicaid receives the capitation payment, a data analyst breaks down the payment by Category of Aid, and the Deputy Director of Finance reconciles the payments and pays the risk reserve contribution electronically to the risk reserve account at Wells Fargo. A staff accountant reconciles this account. All deposits are timely and there are no unauthorized withdrawals. Vaya provided CCME with bank statements demonstrating the risk reserve deposit and balance.

The 2018 EQR of Vaya's Financial Services identified one policy enhancement related to adding the five-business day requirement for Risk Reserve payments to *Policy 2748*. This revision was not implemented as of this year's EQR. CCME recommends Vaya add to Policy 2748 the timeframe required by *NC Medicaid Contract, Section 1.8.1.*

Figure 10 shows a comparative of the Financial standards scored as a "Met" in the 2018 and 2019 EQRs.

Figure 10: Financial Services Comparative Findings



Strengths

- *Policy 2748* has a detailed process describing the IBNR calculation.
- Vaya provided a thorough demonstration of reconciliations between AlphaMCS claims, system, data warehouse, and the general ledger.
- Vaya's Financial Department staff were well-versed when describing the various departmental functions.

Weaknesses

- *Policy 2748* does not contain the five-business day requirement for Risk Reserve payments.

Corrective Action

- Add the five-business day transfer requirement after capitation payment of risk reserve payment to *Policy 2748, Medicaid Funds Management*.

J. Encounter Data Validation

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

The scope of the review, guided by the CMS EDV Protocol, was focused on measuring the data quality and completeness of claims paid by Vaya for the period of January 2018 through December 2018. All claims paid by Vaya should be submitted and accepted as a valid encounter to NC Medicaid. Our approach to the review included:

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

Results and Recommendations

Issue: Other Diagnosis

Principal and admitting diagnosis was populated consistently where appropriate, however, additional diagnosis codes were not populated consistently for Institutional or Professional claims. Institutional claims were not transmitted with any additional diagnosis codes other than principal and admitting. This issue was present in the 2017 review. The Professional claims contained up to ten diagnosis codes which is an improvement from the 2017 review, in which only the principal and secondary diagnosis was provided. Vaya noted in their ISCA response that up to twelve diagnosis codes were being provided which is the maximum number that can be accepted by NCTracks; however, that did not prove true in our review of the encounter data. Vaya should be capturing up to the maximum allowed and submitting to NC Medicaid.

Resolution

Vaya should expand the number of diagnosis codes being captured in their system. This update will also require Vaya to modify their 837 mapping to ensure all diagnosis codes captured are sent to NC Medicaid moving forward for both Institutional and Professional claims.

Conclusion

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

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

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

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

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet
- Attachment 5: Encounter Data Validation Report

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

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

August 20, 2019

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 2019 External Quality Review (EQR) of Vaya Health (Vaya) is being initiated. The review will be conducted by us, The Carolinas Center for Medical Excellence (CCME), and is a contractual requirement. The review will include both a desk review (at CCME) and a two-day onsite visit at Vaya's office in Asheville, North Carolina that will address all contractually required services.

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

The CMS EQR protocols can be found at:

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

The CCME EQR review team plans to conduct the onsite visit at Vaya on **October 9, 2019** through **October 10, 2019**. For your convenience, a tentative agenda for the two-day review is enclosed.

In preparation for the desk review, the items on the enclosed **Desk Materials List** are to be submitted electronically, and are due no later than **September 11, 2019**. As indicated in item 40 of the Desk Materials List, a completed Information Systems Capabilities Assessment (ISCA) for Behavioral Health Managed Care Organizations is required. The enclosed ISCA document is to be completed electronically and submitted by the aforementioned deadline.

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

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

The location for the file transfer site is:

https://eqro.thecarolinascenter.org

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 5
Cc: Greg Daniels, NC Medicaid Contract Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager

External Quality Review 2019

MATERIALS REQUESTED FOR DESK REVIEW

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

2. Organizational Chart of all staff members including names of individuals in each position including their degrees, licensure, and any certifications required for their position. Include any current vacancies. In addition, please include any positions currently filled by outside consultants/vendors. Further, please indicate staffing structure for Transitions Community Living Initiative (TCLI) program.

3. Current Medical Director and Medical Staff job descriptions.

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

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

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

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

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

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

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

11. A current provider manual and provider directory.

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

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

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

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

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

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

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

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

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

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

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

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

23. A copy of the complete Grievances log for the months of August 2018 through July 2019. Please indicate on the log the nature of the grievance, the date received, and the date

resolved. If the grievance resolution timeframe was extended, please include who requested the extension.

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

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

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

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

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

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

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

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

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

33. Information regarding the following selected Performance Measures:

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 Individual Support Plans in which the services and supports reflect participant assessed needs and life goals
Proportion of beneficiaries reporting they have a choice between providers.	Proportion of Individual Support Plans that address identified health and safety risk factors
Percentage of level 2 and 3 incidents reported within required timeframes.	Percentage of participants reporting that their Individual Support Plan has the services that they need
Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.	Percentage of beneficiaries who received appropriate medication.
Percentage of medication errors resulting in medical treatment.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.

Required information includes the following <u>for each measure</u>:

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

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

c. Reporting frequency and format;

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

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

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

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

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

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

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

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

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

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

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

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

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

       i. Insurance:

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

          B. For practitioners joining already-contracted agencies, include copies of the proof of insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement

from the provider agency, confirming the practitioner is covered under the agency insurance policies.

ii. All PSVs conducted during the current process, including current supervision contracts for all LPAs and all provisionally-licensed practitioners (*i.e.*, LCAS-A, LCSW-A).

iii. Ownership disclosure information/form.

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

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

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

ii. Insurance:

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

B. For practitioners joining already-contracted agencies, include copies of the proof of insurance coverages for the agency, and verification that the practitioner is covered under the plans. The verification can be a statement from the provider agency, confirming the practitioner is covered under the agency insurance policies.

iii. All PSVs conducted during the current process, including current supervision contracts for all LPAs and all provisionally-licensed practitioners (*i.e.*, LCAS-A, LCSW-A).

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

v. Ownership disclosure information/form.

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

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

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

39. Provide the following for Program Integrity:
    a. File Review: Please produce a listing of all active files during the review period (August 2018 through July 2019) including:
        i. Date case opened
        ii. Source of referral
        iii. Category of case (enrollee, provider, subcontractor)
        iv. Current status of the case (opened, closed)
    b. Program Integrity Plan and/or Compliance Plan.
    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.
    e. All 'Attachment Y' reports collected during the review period.
    f. All 'Attachment Z' reports collected during the review period.
    g. Provider Manual and Provider Application.
    h. Enrollee Handbook.
    i. Subcontractor Agreement/Contract Template.
    j. Training and educational materials for the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse and the False Claims Act.
    k. Any communications (newsletters, memos, mailings etc.) between the PIHP's Compliance Officer and the PIHP's employees, subcontractors and providers as it pertains to fraud, waste, and abuse.
    l. Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees.
    m. Financial information on potential and current network providers regarding outstanding overpayments, assessments, penalties, or fees due to NC Medicaid or any other State or Federal agency.
    n. Code of Ethics and Business Conduct.
    o. Internal and/or external monitoring and auditing materials.
    p. Materials pertaining to how the PIHP captures and tracks complaints.
    q. Materials pertaining to how the PIHP tracks overpayments, collections, and reporting
        i. NC Medicaid approved reporting templates.
    r. Sample Data Mining Reports.
    s. NC Medicaid Monthly Meeting Minutes for entire review period, including agendas and attendance lists.
    t. Monthly reports of NCID holders/FAMS-users in PIHP.
    u. Any program or initiatives the plan is undertaking related to Program Integrity including documentation of implementation and outcomes, if appropriate.

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

w. Policies/Procedures for:

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

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

a. A completed ISCA.

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

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

c. A copy of the IT Disaster Recovery Plan.

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

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

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

42. Provide the following for Encounter Data Validation (EDV):
    a. Include all adjudicated claims (paid and denied) from January 1, 2018 – December 31, 2018. Follow the format used to submit encounter data to NC Medicaid (i.e., 837I and 837P). If you archive your outbound files to NC Medicaid, you can forward those to HMS for the specified time period. In addition, please convert each 837I and 837P to a pipe delimited text file or excel sheet using an EDI translator. If your EDI translator does not support this functionality, please reach out immediately to HMS.
    b. Provide a report of all paid claims by service type from January 1, 2018 – December 31, 2018. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2019

MATERIALS REQUESTED FOR REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were uploaded and before 9/11/19.

2. Please submit items missing from credentialing/recredentialing files, for providers identified on the separate list, for information obtained during the credentialing/ recredentialing process. Please upload into folder 38 (into subfolder 38a. for Credentialing or 38b. for Recredentialing).

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

4. Network Development Plan (as referenced in Policy/Procedure *2562 Ensuring Access to Care for Health Plan Members*). Please upload into folder 7.

5. Pre-delegation assessment conducted prior to delegation to Alliance Behavioral Health. Please upload into folder 30.

6. Delegation agreement with Partners Behavioral Health, in effect from July 2018 through June 30, 2019. Please upload into folder 29.

7. Delegation monitoring, including call metrics, of Partners Behavioral Health for timeframe of July 2018 through June 2019. Please upload into folder 30.

8. QIC meeting minutes for meeting(s) in which delegation oversight was reported, during timeframe of July 2018 through June 2019. Please upload into folder 30.

9. Any monitoring tool used by MH/SU and TCLI Care Coordination managers or supervisors that reviews timelines of progress notes, Quarterly monitoring, Quality of Life surveys, etc. Please upload into folder 31.

C. Attachment 3: EQR Validation Worksheets

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

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

- Performance Improvement Project Validation Worksheet
    - ADATC (Alcohol and Drug Abuse Treatment Center) VIP
    - Community Crisis Management
    - Increase Rate of Routine Access to Care Calls Receiving Service Within 14 Days
    - TCLI Housing Usage

CCME EQR PM Validation Worksheet

PIHP Name	**Vaya Health**
Name of PM	**READMISSION RATES FOR MENTAL HEALTH**
Reporting Year	7/1/2017-6/30/2018
Review Performed	10/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Vaya Health**
Name of PM:	**READMISSION RATES FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	10/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Vaya Health**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	10/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Vaya Health**
Name of PM:	**FOLLOW-UP AFTER HOSPITALIZATION FOR SUBSTANCE ABUSE**
Reporting Year:	7/1/2017-6/30/2018
Review Performed:	10/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Calculation of the performance measure numerator adhered to all numerator specifications.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Abstraction was not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Abstraction was not used.

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name	**Vaya Health**
Name of PM	**INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT**
Reporting Year	7/1/2017-6/30/2018
Review Performed	10/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name	**Vaya Health**
Name of PM	**MENTAL HEALTH UTILIZATION- INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY**
Reporting Year	7/1/2017-6/30/2018
Review Performed	10/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name	**Vaya Health**
Name of PM	**MENTAL HEALTH UTILIZATION**
Reporting Year	7/1/2017-6/30/2018
Review Performed	10/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name	**Vaya Health**
Name of PM	**IDENTIFICATION OF ALCOHOL AND OTHER DRUG SERVICES**
Reporting Year	7/1/2017-6/30/2018
Review Performed	10/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name	**Vaya Health**
Name of PM	**SUBSTANCE ABUSE PENETRATION RATE**
Reporting Year	7/1/2017-6/30/2018
Review Performed	10/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name	**Vaya Health**
Name of PM	**MENTAL HEALTH PENETRATION RATE**
Reporting Year	7/1/2017-6/30/2018
Review Performed	10/19

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
DMA Specifications Guide

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

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

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

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

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

VALIDATION SUMMARY

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM Validation Worksheet

PIHP name	**Vaya Health**
Name of PM	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals.
Reporting Year	2018-2019
Review Performed	10/19

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	Data sources used to calculate the numerator (e.g., claims files, case records, etc.) are complete and accurate.	**MET**	Data sources were accurate.
N2. Numerator (5)	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Specifications were followed.
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting (10)	Was the measure reported accurately?	**MET**	Numerator and Denominator and Rate is in SHC_C Waiver Excel file
R4. Reporting (3)	Was the measure reported according to State specifications?	**MET**	Measure was reported using State specifications

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Vaya Health**
Name of PM	Proportion of Individual Support Plans that address identified health and safety risk factors
Reporting Year	2018-2019
Review Performed	10/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Vaya Health**
Name of PM	Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need.
Reporting Year	2018-2019
Review Performed	10/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Vaya Health**
Name of PM	Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available
Reporting Year	2018-2019
Review Performed	10/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Vaya Health**
Name of PM	Proportion of beneficiaries reporting they have a choice between providers
Reporting Year	2018-2019
Review Performed	10/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Vaya Health**
Name of PM	Percentage of level 2 and 3 incidents reported within required timeframes
Reporting Year	2018-2019
Review Performed	10/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Vaya Health**
Name of PM	Number and Percentage of deaths where required LME/PIHP follow-up interventions were completed as required.
Reporting Year	2018-2019
Review Performed	10/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Vaya Health**
Name of PM	Percentage of medication errors resulting in medical treatment
Reporting Year	2018-2019
Review Performed	10/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**Vaya Health**
Name of PM	Percentage of beneficiaries who received appropriate medication
Reporting Year	2018-2019
Review Performed	10/19

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

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

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

VALIDATION SUMMARY

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

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

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

CCME EQR Innovations Measures Validation Worksheet

PIHP Name	**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	2018-2019
Review Performed	10/19

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

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

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

VALIDATION SUMMARY

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

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

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

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

AVERAGE VALIDATION PERCENTAGE & AUDIT DESIGNATION
100% FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

PIHP Name	**Vaya Health**
Name of PIP	**ADATC (Alcohol and Drug Abuse Treatment Center) VIP**
Reporting Year	2018
Review Performed	2019

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Vaya has been relatively successful with meeting the benchmark except for those members receiving state funding with a substance use diagnosis and most specifically being discharged from ADATC. Goal is to increase the follow-up after discharge rate from 20% to 50% by January 1, 2020.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The PIHP addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is clearly stated in workbook on page 12, although the Table of Contents says it occurs on page 6.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures are defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care and health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as monthly with weekly interim rates as well.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions are documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses are conducted according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Initial and repeat measurements are reported.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis of intervention effects are noted in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology is similar across remeasurement periods.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Rates have mostly improved since interventions were implemented.

Component / Standard (Total Points)	Score	Comments
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement appears to be a result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not applicable as sampling is not utilized.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Goal rates not yet consistently met.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	**90**
Project Possible Score	**90**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name	**Vaya Health**
Name of PIP	**COMMUNITY CRISIS MANAGEMENT**
Reporting Year	2018
Review Performed	2019

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	In every measure Vaya rates are above the state average for LME/MCOs and in most cases the rates are trending up.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The PIHP addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Not Met**	Research question is not clearly stated in workbook. ***Corrective Action: Add study question to workbook report.***
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures are defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care and health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling used.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**NA**	Barriers and interventions are documented as not yet selected. Project start date was July 9, 2019.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses are conducted according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Initial and repeat measurements are reported, although interventions have not yet been implemented, thus, comparison of pre and post rates is not yet available.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NA**	Only pre-intervention data are reported. No interventions have been implemented.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Only pre-intervention data are reported. No interventions have been implemented.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Rates will be examined after interventions are implemented.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Unable to judge.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not applicable.

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

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	57
Project Possible Score	67
Validation Findings	85%

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name	**Vaya Health**
Name of PIP	**INCREASE RATE OF ROUTINE ACCESS TO CARE CALLS RECEIVING SERVICE WITHIN 14 DAYS**
Reporting Year	2018
Review Performed	2019

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Vaya is consistently below the State defined benchmark for routine service request (75% of service request received within 14 days) for both Non-Medicaid and Combined Calls.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The PIHP addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Not Met**	Research question is not clearly stated in workbook. ***Corrective Action: Add study question to workbook report.***
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures are defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were well documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses are conducted according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Initial and repeat measurements are reported.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Rates are analyzed and follow-up activities reported.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology is consistent.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	Rates are below goal. ***Corrective Action: Continue to initiate new interventions or adjust ongoing interventions to improve rates.***
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Improvement did not occur for either outcome.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not applicable.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Goal rates have not yet been achieved; unable to assess.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	74
Project Possible Score	85
Validation Findings	87%

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name	**Vaya Health**
Name of PIP	**TCLI Housing Usage**
Reporting Year	2018
Review Performed	2019

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	During state fiscal year 17-18 TCLI housed 8 members per month. Based upon the state requirement of an annual net gain of 61, TCLI determined it was necessary to house 10 members per month.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The PIHP addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is clearly stated in workbook on page 6.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures are defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care and health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions are documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses are conducted according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Initial and repeat measurements are reported.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis of interventions' effects are noted in the report.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology is similar across remeasurement periods.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Rates have mostly improved since interventions were implemented.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvement appears to be a result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not applicable as sampling is not utilized.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**Met**	Goal rates consistently met.

ACTIVITY 2: VERIFYING STUDY FINDINGS

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

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	**95**
Project Possible Score	**95**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

D. Attachment 4: Tabular Spreadsheet

CCME PIHP Data Collection Tool

PIHP Name:	Vaya
Collection Date:	2019

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. A. General Approach to Policies and Procedures						
1. The PIHP has in place policies and procedures that impact the quality of care provided to Enrollees, both directly and indirectly.	X					Administrative review of Vaya's policies and procedures includes review of the individual policies and procedures and the *Policy and Procedure Index*. In 2017, over 30% of Vaya's policies and procedures were either missing from the submitted Desk Materials or submitted in draft format. Since that time, Vaya made considerable effort to consolidate their policy and procedure set. In this year's EQR, all policies and procedures were accounted for and demonstrated annual review or active revision. During the Onsite, Vaya staff also explained that in addition to the creation of several new policies and procedures, Vaya continues to retire, combine, split, and move policies and procedures to ensure effective and efficient governance over agency functions.
I. B. Organizational Chart / Staffing						
1. The PIHP's resources are sufficient to ensure that all health care products and services required by the State of North Carolina are provided to enrollees. At a minimum, this includes designated staff performing in the following roles:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 A full time administrator of day-to-day business activities;	X					
1.2 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities.	X					
2. Operational relationships of PIHP staff are clearly delineated.	X					Based on a Recommendation in last year's EQR, the Organizational Chart was revised to reflect the oversight by Dr. Martin of Care Coordination. However, his oversight of Customer Service and the grievance process is still not reflected on the Organizational Chart. The duties of the Assistant Medical Director (AMD), Dr. William Lopez, are also unclear in the AMD job description. Vaya clarified during the Onsite discussion that Dr. Lopez's involvement is with the Utilization Management Department, and he is also available to back up Dr. Martin in his absence. However, the current job description, signed in August of 2019, states 20% of Dr. Lopez's time is spent providing consultation to the Access Unit, Care Coordination, Community Collaboration, and Provider Network Departments, as well as participating in four committees, and reviewing and approving policies and procedures. These are not duties currently performed by Dr. Lopez. ***Recommendation: Ensure the Chief Medical Officer (CMO) and Assistant Medical Director (AMD) job descriptions and oversight designations on the Organizational Chart, align with the NC Medicaid Contract requirements (Sections 6.7.6 and 7.1.3) and actual duties being performed by the CMO and AMD.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all PIHP staff positions, including those that are required by NC Medicaid.	X					
I. C. Confidentiality						
1. The PIHP formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					
2. The PIHP provides HIPAA/confidentiality training to new employees and existing staff.	X					Vaya's policies address both state and federal requirements for preserving enrollee confidentiality and protecting health information with one exception. Vaya's *Privacy Policy 2599* does not specify a timeframe for training new employees on Vaya's confidentiality practices. This policy states new employees are trained "within a reasonable period of time," and that "best efforts will be made to ensure that all staff receive training before accessing PHI." There is evidence that Vaya has an established timeframe for confidentiality training of new staff, and CCME has recommended Vaya specify this timeframe in *Privacy Policy 2599* for the past three years. ***Recommendation: Specify the timeframe by which new staff are trained on Vaya confidentiality practices in Privacy Policy 2599.***
I D. Management Information Systems						
1. Enrollment Systems						
1.1 The PIHP capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification	X					Vaya has standard processes in place for enrollment data updates. WellSky uploads the daily and quarterly GEF files to the AlphaMCS enrollment system. Vaya uses the monthly 820 capitation file to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.						reconcile the payment received every month to the GEF to determine the categories of aid for which payments were received.
1.2 The PIHP is able to identify and review any errors identified during, or as a result, of the State enrollment file load process.	X					Demographic data is captured in the AlphaMCS system and patients IDs are unique to members. Historical enrollment information is captured and maintained for all members.
1.3 The PIHP's enrollment system member screens store and track enrollment and demographic information.	X					Vaya produces an enrollment completeness report to verify the completeness of data following the quarterly GEF load.
2. Claims System						
2.1 The PIHP processes provider claims in an accurate and timely fashion.	X					The majority of claims received are electronic or through the provider web portal. Less than 1% of claims that are submitted by out-of-network providers and emergency room claims are received via paper. Approximately, 84.43% of Institutional and 96.80% of Professional claims are auto-adjudicated. Auto-adjudication is performed daily. Claims in excess of $5,000 and all Institutional and Professional Emergency Department claims are pended for manual review. Manual review of claims is performed 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. Vaya audits a random sample of 3% of all claims processed daily. Paper claims are included in the random sample of 3% and audited daily. For the first couple of months, 100% of claims processed by new-hire claim examiners are audited by experienced staff and managers.

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				Onsite review of the AlphaMCS claims system shows partial compliance with this listed element. ICD-10 Procedure codes, revenue codes, and DRG codes are captured in the AlphaMCS system. DRG and ICD-10 Procedure codes cannot be submitted via the provider web portal. The revenue codes and DRG are also included for encounter data submission reporting. Up to 22 ICD-10 Diagnosis codes are captured for Institutional claims received via the web portal and electronically. For Professional encounters, up to 12 ICD-10 Diagnosis codes are captured electronically and via the web portal. Three Corrective Actions were given in last year's EQR to address some of the above issues; however, Vaya fully implemented and maintained only one of the Corrective Actions. ***Corrective Action: Update Vaya's system to be able to accept up to 25 ICD-10 Diagnosis codes for electronic Institutional claims.*** ***Corrective Action: Update Vaya's provider web portal to be able to capture the DRG and ICD-10 Procedure codes.***
2.4 The PIHP's claim system screens store and track claim information and claim adjudication/payment information.	X					Onsite review of the claim system screens identified the capture of adjudication/payment information for the claims.
3. Reporting						
3.1 The PIHP's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Vaya receives a backup of the AlphaMCS database from WellSky that is restored into a local database daily. Vaya maintains a reporting database and data warehouse to generate reports. Stored procedures from the backup copy of the AlphaMCS database are also used for creating reports.
3.2 The PIHP has processes in place to back up the enrollment and claims data repositories.	X					Vaya's reporting database contains enrollment and claims data since 2012. Data prior to 2012 is available on a separate database.

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				Currently, Vaya submits up to 12 ICD-10 Diagnosis codes on Institutional and Professional encounters to NCTracks. Approximately 44% of the Institutional encounters submitted to NCTracks only have up to two Diagnosis codes populated. Vaya should update their encounter data submission process to submit all ICD-10 secondary Diagnosis codes captured in the AlphaMCS from an Institutional claim to be submitted to NCTracks. Twenty-five ICD-10 Diagnosis codes are the maximum number of Diagnosis codes that may be submitted on an 837I and the maximum number captured by NCTracks. Vaya includes DRG codes on encounter data submissions. ICD-10 Procedure codes are captured in the AlphaMCS system but are not included for encounter data submissions. During the Onsite, Vaya indicated that they are testing a new system build to start submitting the ICD-10 Procedure codes. Vaya does not include Procedure codes and revenue codes for certain lab, drug, or radiology services on all encounter data submissions. Two Corrective Actions were given in last year's EQR to address the issues around compliance with this standard. Neither Corrective Action was fully implemented. ***Corrective Action: Update Vaya's encounter data submission process to be able to submit all ICD-10 Diagnosis codes present on an 837I.*** ***Corrective Action: Update Vaya's encounter data submission process to be able to submit ICD-10 Procedure codes present on an 837I.*** ***Recommendation**: Update Vaya's encounter data submission process to include Procedure codes along with revenue codes on encounter data extracts to NCTracks.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 the Adam Holtzman's paid and denied reports and the 835 response files to identify and reconcile encounter data denials. The data from the Adam Holtzman's reports are uploaded into cumulative databases that are used to verify if the encounters were resubmitted and approved.
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. ISCA documentation shows flow charts and policies for encounter data submissions to NC Medicaid. A *DMA Outstanding Claims Tracker* report was also provided.
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 has an Encounters Team within the Claims Department that is responsible for working on the denied encounters. The Encounter Team works with other Vaya departments and with the billing provider to resolve encounter data denial issues. The encounter data process has improved significantly over the years, and staff is able to speak to encounter data submissions and reconciliation process.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II. A. Credentialing and Recredentialing						
1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					*Policy 2891 (Credentialing Program), Policy 2909 (Credentialing Committee Policy),* and the *Credentialing Committee Charter (CCC)* guide the credentialing and recredentialing processes at Vaya. During the Onsite Review, CCME discussed the area of potential conflict of interest of Credentialing Committee members regarding applications being reviewed/voted on by the Credentialing Committee. Vaya staff indicated committee members abstain from votes when there is a potential conflict of interest. No information regarding conflict of interest/abstaining from votes was found in *Policy 2891 (Credentialing Program), Policy 2909 (Credentialing Committee Policy), or in the Credentialing Committee Charter.* ***Recommendation: Include, in a policy, procedure, or the Credentialing Committee Charter information about Vaya's protocol regarding potential conflicts of interest for Credentialing Committee members. Vaya should also ensure committee meeting minutes accurately reflect the committee members that abstained/recused themselves from votes or left the meeting.***
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					Both the *CCC* and *Policy 2909* delegate the authority for approval of "clean" applications to the CMO. *Policy 2909* defines "flag" and indicates the Credentialing Committee "retains final authority to approve or disapprove all flagged and Applicants for participation in the closed Network." The Credentialing Committee met monthly between August 2018 and July 2019, with a quorum present for every meeting. The Credentialing Committee meeting minutes reflect committee discussion of and decisions about "flagged" applications. The

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						committee also votes on the roster of "clean" applications approved by the CMO. The Credentialing Committee meeting minutes designate which are voting members. Based on that information, provider representative member meeting attendance ranged from 58% to 75% of the meetings at which they were a member. Voting members of the Vaya staff attended 75% or more of meetings at which they were listed as members. Dr. Martin was not present at the May 23, 2019 meeting, and the meeting was chaired by Dr. Will Lopez, the Assistant Medical Director/Alternate Chair.
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					The credentialing files reviewed are organized and contain appropriate information. Issues regarding the credentialing process or files are discussed in the respective standards that follow.
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					As was the case at the last EQR, some of the credentialing files were missing proof of some of the required insurance coverages or the relevant statement from the practitioner about why it is not required, or the verification that the individual practitioner is covered under the policies. In response to CCME's *Onsite Request List*, Vaya provided additional insurance information. Verification that the practitioner is covered under the agency insurance policies was not provided for one file, and the proof of insurance (or relevant attestation) was not received for some of the insurance for another practitioner joining an agency. ***Recommendation: Verify credentialing files contain proof of all of the required insurance coverages (or the relevant statement from practitioner about why it is not required), and that the***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						individual practitioner is listed among those covered under the policies. If the practitioner is not named on the Certificate of Insurance, a letter from the agency provider or insurance company indicating that the practitioner is covered under the policy is acceptable. See NC Medicaid Contract Attachment B, Section 7.7, NC Medicaid Contract, Attachment O, NC Medicaid Contract Attachment B, Section 7.9.
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					
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	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
disciplinary action, the accuracy and completeness of the application;						
3.1.8 Query of the National Practitioner Data Bank (NPDB) ;	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); and query of the State Exclusion List;	X					*Policy 2891, Credentialing Program, Section XI, Credentialing Verification Process* includes the query of the "DHHS Exclusion List". Credentialing files submitted in the Desk Materials lack evidence of a query of *The North Carolina Medicaid Provider Termination and Exclusion* list (known as the *State Exclusion List*). At the Onsite, Vaya credentialing staff clarified the process for checking the *State Exclusion List* for all applicants. A quality review is completed on all credentialing files, and the *State Exclusion List* is part of that check. *Policy 2891 Credentialing Program, Section XIII. Continuous Credentialing* does not include the *State Exclusion List* in the list of items Vaya monitors "on a monthly basis" for "all LPs, LIPs, owners and managing employees credentialed by Vaya." At the Onsite, Vaya Credentialing staff confirmed this is part of the monthly queries.
3.1.10 Query for the System for Awards Management (SAM);	X					
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Recredentialing files reviewed are organized and contain appropriate information. Issues regarding the recredentialing process are discussed in the respective standards that follow.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					As was the case at the last EQR, some of the recredentialing files were missing proof of some of the required insurance coverages or the relevant statement from the practitioner about why it is not required, or verification that the individual practitioner is covered under the policies.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						In response to CCME's *Onsite Request List*, Vaya provided additional insurance information. Verification that the practitioner is covered under the agency insurance policies was not provided for one file. ***Recommendation: Verify recredentialing files contain proof of all of the required insurance coverage (or the relevant statement from practitioner about why it is not required), and that the individual practitioner is listed among those covered under the policies. If the practitioner is not named on the Certificate of Insurance, a letter from the agency provider or insurance company indicating that the practitioner is covered under the policy is acceptable. See NC Medicaid Contract Attachment B, Section 7.7, NC Medicaid Contract, Attachment O, NC Medicaid Contract Attachment B, Section 7.9.***
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					
4.2.3 Valid DEA certificate; and/or CDS certificate	X					
4.2.4 Board certification if claimed by the applicant;	X					
4.2.5 Malpractice claims since the previous credentialing event;	X					
4.2.6 Practitioner attestation statement;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Recredentialing files submitted in the Desk Materials lack evidence of a query of *The North Carolina Medicaid Provider Termination and Exclusion* list (known as the *State Exclusion List*). At the Onsite, Vaya credentialing staff clarified the process for checking the *State Exclusion List* for all applicants. A quality review is completed on all credentialing files, and the *State Exclusion List* is part of that check. *Policy 2891 Credentialing Program, Section XIII. Continuous Credentialing,* does not include the *State Exclusion List* in the list of items Vaya monitors "on a monthly basis" for "all LPs, LIPs, owners and managing employees credentialed by Vaya." At the Onsite, Vaya Credentialing staff confirmed this is part of the monthly queries.
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 Query of the Social Security Administration's Death Master File	X					
4.2.12 Query 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					*Policy 2909, Credentialing Committee Policy* and *Policy 2891, Credentialing Program,* state re-credentialing includes "a review of provider performance data, including but not limited to findings of quality management/quality improvement activities, utilization management activities, and member/provider complaints/ grievances. (URAC N-CR 3, 14c). (DMA Att. B 7.6). (DHHS Att. I 5.4.3)" *Policy 2891, Section VI. Application Process for Re-Credentialing,* outlines the process for collecting the referenced performance data, which includes distribution of a questionnaire form to various Vaya internal departments, "requesting information about the provider's performance and quality of care within the previous credentialing period." Results of these inquiries were in the six LIP recredentialing files, but not in the recredentialing files of LPs joining already contracted agencies. During the Onsite, Vaya staff clarified that information regarding LPs would be included in the relevant agency review, rather than in the practitioner (LP) review. Credentialing Committee meeting minutes include discussion of provider profile information such as "flags" related to legal charges or PIHP audits or other items.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. The PIHP formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the PIHP for serious quality of care or service issues.	X					*Policy 2577, Provider Sanctions and Administrative Actions,* outlines the actions to take against Network Providers "who are found to be noncompliant with applicable federal and state laws, rules, regulations, manuals, policies or guidance, the Vaya *Provider Operations Manual*, contracts between Vaya and the provider, and/or any other applicable payor program requirements."
6. Organizational providers with which the PIHP contracts are accredited and/or licensed by appropriate authorities.	X					
II B. Adequacy of the Provider Network						
1. The PIHP maintains a network of providers that is sufficient to meet the health care needs of enrollees and is consistent with contract requirements.	X					*Policy 2562, Ensuring Access to Care for Health Plan Members*, states, "it is the policy of Vaya Health to monitor and ensure that Vaya Health Plan members have adequate access to care and treatment." *Policy 2386, Out of Network Authorizations and Contracting* directs the process for obtaining medically necessary services when an in-network provider is not available.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 Enrollees have a Provider location within a 30 – mile distance of 30 minutes' drive time of their residence. Rural areas are 45 miles and 45 minutes. Longer distances as approved by NC Medicaid are allowed for facility based or specialty providers.	X					*Policy 2562, Ensuring Access to Care for Health Plan Members*, outlines access and availability standards for the Vaya provider network, including, "Two assessment providers within 30 miles / 30 minutes per active enrollee (Urban areas as defined by the U.S. Census Bureau" and "Two assessment providers within 45 miles / 45 minutes per active enrollee (Rural counties as defined by the U.S. Census Bureau)." During the Onsite, Vaya staff discussed challenges and barriers in meeting this standard, including the rural nature and low Medicaid population of many of the counties they serve. Vaya filed, and NC Medicaid approved, *Exception Requests* for nine of the ten gaps identified in the *Vaya Health 2019 Community Mental Health, Substance Use and Developmental Disabilities Services Network Adequacy and Accessibility Analysis*. NC Medicaid did not approve one Exception Request related to Substance Use services.
1.2 Enrollees have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the enrollee may utilize an out-of-network specialist with no benefit penalty.	X					The *Member and Caregiver Handbook* confirms Vaya will pay for services provided by an out-of-network provider in an emergency or if there's no in-network provider who can meet the need. Vaya will continue to pay the out-of-network provider until the enrollee can be "safely and appropriately transferred to a network provider."
1.3 The sufficiency of the provider network in meeting enrollee demand is formally assessed at least annually.	X					As required by NC Medicaid, Vaya conducts an annual gaps and needs analysis. The *2019 Community Mental Health, Substance Use and Developmental Disabilities Services Network Adequacy and Accessibility Analysis* ("Gaps Analysis"), includes "Current Progress on 2018 Identified Medicaid Service Gaps."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.4 Providers are available who can serve enrollees with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					The "Call for Help" section of the home page of the Vaya website lists the tollfree 800 number and the NC Relay phone number (for the hearing impaired). Information about TTY availability is available in the TTY/TTD Services section of the website. Detailed information about communicating with Vaya via the TTY Relay System is on page 10 of the *Member and Caregiver Handbook*. The *Credentialing Initiation Form* (*CIF*) includes questions regarding the ability to provide services in non-English languages, including American Sign Language. Providers are also asked to identify "Culturally diverse populations you feel competent to treat", and, if they choose to answer, their own "Gender/Race/Ethnic Background". The *Provider Operations Manual* has an "Accessibility and Cultural Competence" section focused on provider responsibility to deliver culturally competent services. Page 23 of the 2019 Gaps Analysis report addresses services for "Members with Visual and/or Hearing Impairment". Vaya has a three-year *Cultural Competency Plan*.
1.5 The PIHP demonstrates significant efforts to increase the provider network when it is identified as not meeting enrollee demand.	X					*Policy 2831, Selection and Retention of Providers*, notes "Vaya does not accept applications for initial enrollment from Applicants unless a service need has been identified… If Vaya cannot identify existing Network Providers to meet the need, Vaya will seek to recruit new provider(s) through a selection or procurement process." The *2019 Network Access Plan*, included in the 2019 Gaps Analysis, outlines "Current Progress on 2018 Identified Medicaid Services Gaps." During the Onsite, Vaya staff indicated they use Requests for Proposals (RFPs) if needed, but are able to typically fill service needs via their existing contracted provider network (providers adding services at Vaya's request). Single Case Agreements are used as needed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Provider Accessibility						
2.1 The PIHP formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					*Policy 2560, Scope of Network Services,* details access standards for the provision of care. *Policy 2416, Interface with Emergency Services Dispatch (911),* addresses emergency situations in which immediate care is needed. The *Provider Operations Manual* provides access standards and notes "Failure to meet these timeframes may result in referral for investigation and administrative action or sanction, up to and including termination of your contract with Vaya."
II C. Provider Education						
1. The PIHP formulates and acts within policies and procedures related to initial education of providers.	X					*Policy 2588, Network Provider Relations Program*, addresses provider training and orientation. The "new contract" letter provides high level information and includes references to "Provider Orientation Resources", including a link to the Vaya website, *Communication Bulletins,* and archived bulletins and newsletters. Providers are informed the *Provider Operations Manual* can be downloaded from the website.
2. Initial provider education includes:						During the Onsite, Vaya staff reported it is developing a full provider training library that will be available to providers via the Vaya website.
2.1 PIHP purpose and mission;	X					Included on page 5 of the *Provider Operations Manual*.
2.2 Clinical Practice Standards;	X					The *Provider Operations Manual* references the Clinical Practice Guidelines. The "Clinical Practice Guidelines, Leveling Tools and HEDIS Measures" are on the Vaya website.
2.3 Provider responsibilities;	X					Provider responsibilities are defined throughout the *Provider Operations Manual*. Page 66 includes a statement that it is an enrollee's right "to receive interpretation and translation services and other reasonable accommodations as needed for accessibility,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						free of charge." Page 21 of the *Provider Operations Manual* states, "Providers must also ensure that interpreter services are made available by telephone or in-person at no charge to the member or to Vaya."
2.4 PIHP closed network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability.	X					
2.5 Access standards related to both appointments and wait times;	X					Page 47 of the *Provider Operations Manual* addresses "Access to Care Timeframes" for Emergent, Urgent, and Routine levels of care. As was the case at the last EQR, the "Emergent" section does not include the requirement that the "Provider must provide face-to-face emergency care immediately for life threatening emergencies." Though Vaya's *EQR CAP 2018 Recommendations-tjh* document submitted for the current EQR states, "This item has been added to the Provider Operations Manual", it was not added to the "Access to Care Timeframes" list. During the Onsite, Vaya staff repeatedly referenced page 129 of the *Provider Operations Manual*, which lists appointment wait times and the requirements for appointment availability, including "Life-threatening emergencies: Individual must be seen immediately." However, that information is located in the "Health and Safety Site Reviews" section of Section 16-Audits/Monitoring/Investigations in the *Provider Operations Manual*. It is not included in the only list named "Access to Care Timeframes" in the *Provider Operations*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Manual, which is likely the source where providers would first look for information. Since the Vaya *Provider Operations Manual* has a specific list named "Access to Care Timeframes", that list should include both the Office Wait Times and the requirement for providers to "provide must provide face-to-face emergency care immediately for life threatening emergencies." ***Recommendation: Include the NC Medicaid Contract, Attachment S requirements for providers to provide face-to-face emergency care immediately for life-threatening emergencies, and the Office Wait Times requirements in the "Access to Care Timeframes" in the Provider Operations Manual.***
2.6 Authorization, utilization review, and care management requirements;	X					
2.7 Care Coordination and discharge planning requirements;	X					
2.8 PIHP dispute resolution process;	X					Section 17 of the *Provider Operations Manual* covers Dispute Resolution.
2.9 Complaint investigation and resolution procedures;	X					
2.10 Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements;	X					Section 5 of the *Provider Operations Manual* addresses Billing and Reimbursement.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.11 Enrollee rights and responsibilities	X					Section 7, Member Rights and Empowerment, starts on page 65 of the *Provider Operations Manual*.
2.12 Provider program integrity requirements that include how to report suspected fraud, waste and abuse, training requirements as outlined in the False Claims Act, and other State and Federal requirements.	X					Section 15, Compliance/Quality Management, of the *Provider Operations Manual* includes detailed information about fraud, waste, and abuse, including how to report potential fraud, waste, or abuse. Information about the False Claims Act is also provided in Section 15. The phone number and email address for the 24/7 Compliance Hotline (which includes reporting fraud, waste or abuse or suspicious billing) is listed in the Important Contacts chart on page 1 of the *Provider Operations Manual*.
3. The PIHP provides ongoing education to providers regarding changes and/or additions to its programs, practices, enrollee benefits, standards, policies and procedures.	X					Links to relevant items on the North Carolina Division of Health and Human Services website are included in the "Provider Communications, Training and Technical Assistance" section of the *Provider Operations Manual*. Providers are encouraged to sign up for Vaya's Provider Network Bulletins and to check the Events and Training Calendar on the Vaya website.
II D. Clinical Practice Guidelines for Behavioral Health Management						
1. The PIHP develops clinical practice guidelines for behavioral health management of its enrollees that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Page 64 of the *Provider Operations Manual* addresses clinical practice guidelines, including "all guidelines are adopted through a Clinical Advisory Committee that includes provider and CFAC participation." The *Clinical Advisory Committee Meeting Minutes* of February 19, 2019, include the "endorsement and annual review" of the Clinical Practice Guidelines.
2. The PIHP communicates the clinical practice guidelines for behavioral health management and the expectation that	X					The *Provider Operations Manual* states, "Providers are expected to maintain or advance the quality of services through the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
they will be followed for PIHP enrollees to providers.						demonstration of practice consistent with the adopted clinical practice guidelines and suggested best practices."
II E. Continuity of Care						
1. The PIHP monitors continuity and coordination of care between providers.	X					During Onsite discussion, Vaya reported that this is part of the Post-Payment Reviews and that it also must provide data to the State regarding access to primary care.
II F. Practitioner Medical Records						
1. The PIHP formulates policies and procedures outlining standards for acceptable documentation in the Enrollee medical records maintained by providers.	X					Page 49 of the *Provider Operations Manual* states "Network Providers are responsible for ensuring that services are delivered and documented in accordance with Controlling Authority outlined in your contract, including, but not limited to, DMA Clinical Coverage Policies and the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2." Page 105 of the *Provider Operations Manual* states, "Innovations providers are required to document services as outlined in DMA Clinical Coverage Policy No. 8-P, the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2, and as specified in this Manual." The "*Documentation and Clinical Coverage Policy Requirements*" section of the *Provider Operations Manual* states "All Vaya Network Providers are required to strictly adhere to the documentation requirements outlined in the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2."
2. The PIHP monitors compliance with medical record documentation standards through formal periodic medical record audit and addresses any deficiencies with the providers.	X					Medical record documentation is monitored via Post Payment Reviews and Investigations. *Policy 2579, Provider Post Payment Reviews,* addresses the post-payment review process, which includes medical record review.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The PIHP has a process for handling abandoned records, as required by the contract.	X					*Policy 2617, Provider Closure*, addresses abandoned records, including the steps of notifying NC Medicaid Program Integrity, notifying the provider of the notification to NC Medicaid Program Integrity, and the PIHP taking "possession of any abandoned Records, if possible." The policy does not address Vaya creating a log of abandoned records. During Onsite discussion, Vaya staff indicated it also has *Policy 2314, Records Retention and Management*; however, CCME reviewed that policy and it does not speak to handling abandoned records. ***Recommendation: Revise Policy 2617, Provider Closure, to include the requirement for the PIHP to complete an inventory log of the records, per NC Medicaid Contract Attachment B, Section 8.2.1.***

III. ENROLLEE SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III A. Enrollee Rights and Responsibilities						
1. The PIHP formulates policies outlining enrollee rights and procedures for informing enrollees of these rights.	X					*Policy 2307 Member Rights and Responsibilities* and *Policy 2557, Marketing Materials, Media Relations and Member Notifications* explain the process.
2. Enrollee rights include, but are not limited to, the right:	X					Member rights are listed in *Policy 2307, Member Rights and Responsibilities*. All enrollee rights are outlined in the *Member and Caregiver Handbook June 2018*. This is the version of the *Member and Caregiver Handbook* effective during the review period.
2.1 To be treated with respect and due consideration of dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;						
2.3 To participate in decisions regarding health care;						
2.4 To refuse treatment;						
2.5 To be free from any form of restraint of seclusion used as a means of coercion, discipline, convenience or retaliation;						
2.6 To request and receive a copy of his or her medical record, except as set forth in 45 C.F.R. §164.524						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
and in N.C.G.S. § 122C-53(d), and to request that the medical record be amended or corrected in accordance with 45 CFR Part 164.						
2.7 Of enrollees who live in Adult Care Homes to report any suspected violation of their enrollee rights, to the appropriate regulatory authority as outlined in NCGS§ 131-D21.						
III B. Enrollee PIHP Program Education						
1. Within 14 business days after an Enrollee makes a request for services, the PIHP shall provide the new Enrollee with written information on the Medicaid waiver managed care program which they are contractually entitled, including:	X					Relevant information is documented in the *Member and Caregiver Handbook June 2018* or on the Vaya website unless otherwise indicated in the sub-standards that follow. The *Member and Caregiver Handbook* is located five layers deep on the Vaya website. From the home screen, hover over the "Get Involved" link at the top, hover over "Member Rights and Responsibilities," then click on "Member Handbook," then scroll to the bottom of this page and click on the link *Vaya Health Member and Caregiver Handbook 2019-2020*. Finally, click the image of the cover page of the handbook to download. ***Recommendation: Relocate the Vaya Health Member and Caregiver Handbook 2019-2020 to a more accessible location on the website.***
1.1 A description of the benefits and services provided by the PIHP and of any limitations or exclusions applicable to covered services. These descriptions must have sufficient detail to ensure the Enrollees understand the benefits						An explanation of "What benefit plans are available through Vaya" are explained on page 21 of the *Member and Caregiver Handbook June 2018.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
to which they are entitled and may include a web link to the PIHP Benefit Plan. This includes a descriptions of all Innovations Waiver services and supports;						
1.2 Benefits include access to a 2nd opinion from a qualified health care professional within the network, or arranges for the enrollees to obtain one outside the network, at no cost to the enrollee;						This is listed as a member right on page 46 of the *Member and Caregiver Handbook June 2018.*
1.3 Updates regarding program changes;						
1.4 A description of the procedures for obtaining benefits, including authorizations and EPSDT criteria;						
1.5 An explanation of the Enrollee's responsibilities and rights and protection as set forth in 42 CFR§438.100;						Page 45 of the *Member and Caregiver Handbook June 2018* has information about member rights and responsibilities.
1.6 An explanation of the Enrollee's rights to select and change Network Providers						*Member and Caregiver Handbook June 2018* advises enrollees of the process when they call the Access to Care Line, including the enrollee choosing a provider and of the right to change providers.
1.7 The restrictions, if any, on the enrollee's right to select and change Network Providers						Page 31 of the *Member and Caregiver Handbook June 2018* explains "Within our provider network, you have the right to change providers for any reason."
1.8 The procedure for selecting and changing Network Providers						This procedure is explained on page 31 of the *Member and Caregiver Handbook*, "If you have an assigned care coordinator, you should let him or her know that you are not happy with your current provider

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						and want to discuss options for changing." Or, call the Access to Care Line if no care coordinator is assigned.
1.9 Where to find a list or directory of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients (a written list of current Network Providers shall be provided by PIHP to any Enrollee upon request);						The online and the downloadable versions of *the Provider Network Directory* contain all required data fields. This was corrected since last EQR and maintained for the current review.
1.10 The non-English languages, if any, spoken by each Network Provider;						Search by language is available when searching on the Vaya website for a provider. The printable complete *Provider Network Directory* has the field "Language" for each provider. This is a Recommendation from last EQR that was implemented and maintained.
1.11 The extent to which, and how, after-hours and emergency coverage are provided, including:						
1.11.1 What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services in accordance with 42 CFR§ 438.114 and EMTALA;						
1.11.2 The fact that prior authorization is not required for emergency services;						Page 29 of the *Member and Caregiver Handbook June 2018* states "You have the right to receive emergency services at any location that provides emergency care without prior authorization from Vaya, even if the provider is not in our network."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.11.3 The process and procedures for obtaining Emergency Services, the use of 911 telephone services or the equivalent;						
1.11.4 The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under the contract;						The Vaya website has a section under the "Get Help" tab called Crisis Help. This section gives several options for Emergency and Post Stabilization care for members and caregivers. Options include walk-in crisis centers, mobile crisis, behavioral health urgent care, and facility-based crisis centers. Locations available for each of these options are included. This website section gives detailed information to help members and caregivers plan for Emergency and Post Stabilization services. This was a Corrective Action Plan (CAP) item from last EQR that was implemented and maintained.
1.11.5 A statement that, subject to the provisions of the NC Medicaid contract, the Enrollee has a right to use any hospital or other setting for Emergency care;						
1.12 The PIHP's policy on referrals for Specialty Care to include cost sharing, if any, and how to access Medicaid benefits that are not covered under the NC Medicaid contract;						
1.13 Any limitations that may apply to services obtained from Out-of Network Providers, including disclosures of the Enrollee's						Information regarding an enrollee receiving services from out-of-network providers is explained on page 31 of the *Member and Caregiver Handbook June 2018*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
responsibility to pay for unauthorized behavioral health care services obtained from Out-of Network Providers, and the procedures for obtaining authorization for such services.						
1.14 How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost-sharing;						
1.15 Procedures for obtaining out-of-area or out-of-state coverage of services, if special procedures exist;						Section 7 "How do I find a provider for my care?" in the *Member and Caregiver Handbook June 2018* explains all the options for finding a provider, including the Provider Search on the website and calling the Access to Care line. Onsite confirms out-of-area and out-of-state services use the same process as out-of-network.
1.16 Information about medically necessary transportation services by the department of Social Services in each country;						Page 14 of the Mem*ber and Caregiver Handbook June 2018* explains medically necessary transportation services availability.
1.17 Identification and explanation of State laws and rules Policies regarding the treatment of minors;						Page 49 of the *Member and Caregiver Handbook June 2018* explains rules about treatment of minors.
1.18 The enrollee's right to recommend changes in the PIHP's policies and services						Page 47 of the *Member and Caregiver Handbook June 2018* explains the right to recommend changes to Vaya policies and services.
1.19 The procedure for recommending changes in the PIHP's policies and services;						Page 47 of the *Member and Caregiver Handbook June 2018* states to recommend changes to Vaya's policies and services, "…please contact

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						our Customer Services Department at 1-800-849-6127 or write us at: Vaya Health, 200 Ridgefield Court, Suite 206, Asheville, NC 28806."
1.20 The Enrollee's right to formulate Advance Directives;						Page 52-54 of the *Member and Caregiver Handbook June 2018* explains advance directives.
1.21 The Enrollee's right to file a grievance concerning non-actions, and the Enrollee's right to file an appeal if PIHP takes an action against an Enrollee;						Section 11 of the *Member and Caregiver Handbook June 2018* explains grievances and appeals.
1.22 The accommodations made for non-English speakers, as specified in 42 CFR §438.10(c)(5);						Page two of the *Member and Caregiver Handbook June 2018* explains that assistance in languages other than English are available in 150 languages via conference call with an interpreter by calling the Access to Care Line.
1.23 Written information shall be made available in the non-English languages prevalent in the PIHP's services area.						The *Member and Caregiver Handbook June 2018* and other member materials are available in Spanish. If not available, they can be requested.
1.24 The availability of oral interpretation service for non-English languages and how to access the service;						
1.25 The availability of interpretation of written information in prevalent languages and how to access those services						The *Member and Caregiver Handbook June 2018* is available in Spanish and large print. Several brochures are available in Spanish (posted on the website). A statement in English and Spanish at the bottom of each page of the website informs readers to "call the toll-free # 24/7 to obtain services and support for mental health, developmental disabilities and substance abuse. Members can request materials in Spanish or English."
1.26 Information on how to report fraud and abuse; and						Section 12 of the *Member and Caregiver Handbook June 2018* explains how to help prevent fraud, waste, or abuse.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.27 Upon an Enrollee's request, the PIHP shall provide information on the structure and operation of the agency and any physician incentive plans.						
1.28 Information on grievance, appeal and fair hearing procedures and information specified in CFR §438.10 (g).						
2. Enrollees are notified annually of their right to request and obtain written materials produced for Enrollee use.	X					Once per year Vaya's mass mailing vendor sends a letter that informs members they can request additional information about the PIHP and member rights and responsibilities. *Policy 2557, Marketing Materials, Media Relations and Member Notifications* explains the annual mailing process.
3. Enrollees are informed promptly in writing of (1) any "significant change" in the information specified in CFR 438.10 (f) (61) and 438.10 (g) at least 30 days before calendar days before the intended effective date of the change; and (2) . termination of their provider within fifteen (15) calendar days after PIHP receives notice that NC Medicaid or Provider has terminated the Provider Agreement or within fifteen (15) calendar days after PIHP provides notice of termination to the Provider.	X					Vaya submitted an attestation signed by the Senior Director of Provider Network Operations that states: "There were no provider closures during the requested time period that required a letter to members. All providers terminations occurred when no Vaya members were receiving services from the terminating providers." CCME asked Vaya to share the written or emailed correspondence between the providers and Vaya for the providers terminated "with cause." CCME also asked for the report used to verify there were no members being seen by the provider 60 days prior to the notice of termination. CCME and Vaya agreed to use one example from the 10 "with cause" terminations. For that example, Vaya used the 60-day lookback period, looking back from the termination date of March 31, 2019. The look back period shown during the Onsite was February 1 - March 31, 2019 The look back date should begin with the date the notice of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						termination was sent to the provider which was February 19, 2019. The correct lookback period should have been December 21, 2018 - February 19, 2019. *Policy 2617, Provider Closure* addresses steps Vaya takes when a provider leaves the network for any reason. It does not address details in *NC Medicaid Contract 6.10* that states "PIHP shall give written notice of the termination to all Enrollees who have been receiving services from the terminated Provider within the sixty (60) calendar day period immediately preceding the date of the notice of termination." Update: Per feedback from the State on May 28, 2021, Vaya's dispute of this score resulted in changing this Corrective Action to a Recommendation. ***Recommendation: Update Policy 2617 Provider Closure to address details in NC Medicaid Contract 6.10 that states "PIHP shall give written notice of the termination to all Enrollees who have been receiving services from the terminated Provider within the sixty (60) calendar day period immediately preceding the date of the notice of termination."***
4. Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation of prevalent non-English languages as required by the contract.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. The PIHP maintains and informs Enrollees of how to access a toll-free vehicle for 24-hours Enrollee access to coverage information from the PIHP, including the availability of free oral translation services for all languages and care management services such as crisis interventions.	X					
III C. Behavioral Health and Chronic Disease Management Education						
1. The PIHP enables each enrollee to choose a Provider upon enrollment and provides assistance as needed.	X					
2. The PIHP informs enrollees about the behavioral health education services that are available to them and encourages them to utilize these benefits.	X					*Policy 2714* explains how Vaya offers education and training opportunities. These events are listed on the Vaya website. One calendar is used for all training, including members and providers. The Provider Central webpage has an "Event Calendar" that goes to the same calendar as the "Get Involved" tab "Calendar of Events" page.
3. The PIHP tracks the participation of enrollees in the behavioral health education services.	X					
III D. Call Center						
1. The PIHP provides customer services that are responsible to the needs of the Enrollees and their families. Services include:	X					Vaya maintains a toll-free 24/7 Access to Care Line that can be used for any need or question from a member or caregiver. The Vaya Customer Services Representatives and Clinicians follow the Customer Services policies and procedures including *Policy 2422, Customer Services Clinical Decision Making and Triage*. This policy ensures the enrollee is directed to the correct level of care.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 Respond appropriately to inquiries by enrollees and their family members (including those with limited English proficiency);	X					
1.2 Connect enrollees, family members and stakeholders to crisis services when clinically appropriate;	X					
1.3 Provide information to enrollees and their family members on where and how to access behavioral health services;	X					
1.4 Train its staff to recognize third-party insurance issues, recipient appeals, and grievances and to route these issues to the appropriate individual;	X					
1.5 Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;	X					
1.6 Process referrals twenty-four (24) hours per day, seven (7) days per week; 365 days per year; and	X					
1.7 Process Call Center linkage and referral requests for services twenty-four (24) hours per day, seven (7) days per week, 365 days per year.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV A. The Quality Improvement (QI) Program						
1. The PIHP formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to enrollees.	X					The *Quality Management Program Description 2019-2020* was reviewed. This document contains the formal structure of Vaya's Quality Management Program including defined goals, structure, and scope of the program.
2. The scope of the QI program includes monitoring of provider compliance with PIHP practice guidelines.			X			As outlined on page 11 of the *Quality Management Program Description 2019-2020*, provider compliance with clinical practice guidelines is a Quality Assurance Activity. Vaya looks at the rate of compliance with guidelines for selected services." From Onsite discussions and Desk Review, no selected services over the review period looked at the rate of compliance with selected Clinical Practice Guidelines. Last EQR Review, Vaya monitored the Clinical Practice Guideline for "Best Practice Treatment of Opioid Dependence" and included the monitoring results in the *Quality Improvement Program Evaluation 2017-2018.* ***Corrective Action: Follow the QM Program Description for provider compliance with clinical practice guidelines. Select practice guidelines and monitor the rate of compliance with the selected guidelines. Include the monitoring results in the Quality Management Program Evaluation at the end of each fiscal year when preparing this document.***
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					*Policy 2385, Detecting Over and Under-Utilization* is in place for detecting over and under-utilization of MH/SU/IDD Services. Several reports were reviewed as evidence of the utilization services presented to the QIC in April 2018. Services presented included engagement for mental health and substance use, inpatient admissions, length of stay, readmissions, and ED admits. Data was

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						presented as quarterly or monthly rates. Committee minutes displayed monitoring and analysis of utilization and recommendations based on analysis. The Onsite included discussion of other interventions for utilization issues such as monthly subgroup of network development, the Assessment Center, Acute Response Team, a hospital discharge planning team, and provider incentives.
4. The PIHP implements significant measures to address quality problems identified through the enrollees' satisfaction survey.	X					No significant measures were implemented to address quality problems identified though the ECHO Surveys. "Key Strengths" and "Opportunities for Improvement" were identified in the Adult ECHO Survey and Child ECHO Survey reports prepared by CCME in December 2018. In Vaya's PowerPoint presentation titled *State Surveys 2018*, the same "Opportunities for Improvement" from the Adult ECHO Survey results were included on a slide. The PowerPoint documented that "the sample is not statistically significant and therefore, further action will not be taken based on survey responses." This response addresses the response rate and not the survey results. Update: Per feedback from the State on May 28, 2021, Vaya's dispute of this score resulted in changing this Corrective Action to a Recommendation. ***Recommendation: Implement significant measures to address problems identified in the Adult and Child ECHO Surveys and show discussion in I-QIC and O-QIC meeting minutes.***
5. The PIHP reports the results of the enrollee satisfaction survey to providers.	X					Adult and Child Echo Survey results are found on the Vaya website. The meeting minutes did not reflect that the survey results were shared with a Vaya provider attended committee/group such as Clinical Advisory Committee or O-QIC during the review period. ***Recommendation: Share Enrollee Satisfaction Survey results with providers at the appropriate in-person provider committees/forums.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. The PIHP reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified.			X			Adult and Child ECHO Survey results were prepared in December 2018, available to Vaya by February 2019, but not reported in the Internal Quality Improvement Committee (I-QIC) or Organizational Quality Improvement Committee (O-QIC) meetings during the review period. The draft September 2019 I-QIC minutes include documentation of a PowerPoint presentation titled *State Surveys 2018* that was presented. The PowerPoint presentation includes highlights of Provider, Perception of Care, and ECHO Survey results. The Child ECHO Survey results were not included in the PowerPoint. There was no discussion from I-QIC on next steps after the PowerPoint was presented. ***Corrective Action: Report both the Adult and Child ECHO Survey results to I-QIC and O-QIC. Facilitate discussion at both committees around measure to be taken to address quality problems that are identified within Adult and Child Survey Results. Committee Minutes of both committees should reflect this discussion.***
7. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, time frame for implementation and completion, and the person(s) responsible for the project(s).	X					An annual plan of QI activities was kept in the document *2018-19 Quality Management Annual Work Plan*. It has fields for performance area, start date, completion date, lead staff, and status. The performance areas are either a Quality Assurance Activity or a Performance Improvement Goal.
IV B. Quality Improvement Committee						
1. The PIHP has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Board of Directors and Vaya's Executive Leadership Team delegated the oversight of Quality Management to the Quality Improvement Committee. Starting in 2018, Vaya initiated an Organizational Quality Improvement Committee (O-QIC) and Internal Quality Improvement Committee (I-QIC). Both committees maintain approved record of minutes.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The composition of the QI Committee reflects the membership required by the contract.	X					I-QIC is comprised of nine voting members in addition to the Chair and Vice Chair. Most voting members have Proxy's assigned and listed in the *QIC Charter*.
3. The QI Committee meets at regular intervals.	X					The *QIC Charter* states "The Committee shall meet no less than 4 times per year. A recurring meeting invite shall be sent to all Committee Members by the Chair, Vice-Chair or Administrative support following approval of the annual Meeting Schedule. Any meeting may be rescheduled as necessary with advance notice given to all Committee Members via electronic mail/ calendar invite." During the Onsite, staff reported the O-QIC meets quarterly and the I-QIC meets monthly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Although minutes are taken at the I-QIC and O-QIC meetings, the minutes do not capture discussion from the meeting topics. ***Recommendation: Include discussion that happens on each agenda item in the I-QIC and O-QIC meeting minutes.***
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					Validation scores for (b) Waiver and (c) Waiver measures are fully compliant with an average validation score of 100%.
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".		X				Four new PIPs were validated for this review: TCLI PN Housing Usage, Access to Care: Routine, ADATC VIP, and Community Crisis Management. Two PIPs scored in the High Confidence range. The following two PIPs scored in the Confidence range, resulting in a "Partially Met" score for this standard: Increase rate of routine access to care calls receiving service within 14 days and Community Crisis Management. ***Corrective Action: Correct the errors in these two PIPs scoring Partially Met: Increase rate of routine access to care calls receiving service within 14 days and Community Crisis Management. Table 21 displays both PIPs and the specific Corrective Action. The specific corrections are also displayed on the PIP Worksheets in Attachment C.***
IV E. Provider Participation in Quality Improvement Activities						
1. The PIHP requires its providers to actively participate in QI activities.	X					Two activities were discussed during the Onsite that involve provider participation in QI Activities: the ADATC PIP and ACTT Learning Network.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					There was a Recommendation last EQR to "Begin providing more feedback for provider's individual QI activities." This Recommendation was not followed, and for this EQR there was no evidence of providers receiving interpretation of their QI performance data and feedback regarding QI activities. The Onsite gave the example of providers participating in Vaya's PIP for ADATC and the ACTT Learning Network. There was no evidence or example of the feedback that was given. Update: Per feedback from the State on May 28, 2021, Vaya's dispute of this score resulted in changing this Corrective Action to a Recommendation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Provide evidence as required per NC Medicaid Contract section 7.1.4 (h) "Provide performance feedback to Providers, including detailed discussions of clinical standards and the expectations of PIHP."
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					The *Quality Management Program Evaluation FY 2019-2020* was included in the Desk Materials for review. The year was mislabeled. Onsite discussion determined it is FY 2018-2019. The Quality Management Program Evaluation did not include information about Enrollee and Provider Survey Results. ***Recommendation: Correct the year on the Quality Management Program Evaluation FY 2019-2020. The year is FY 2018-2019.*** ***Recommendation: Include information about all Survey Results in the Quality Management Program Evaluation annually.***
2. The annual report of the QI program is submitted to the QI Committee and to the PIHP Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. The Utilization Management (UM) Program						
1. The PIHP formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 structure of the program;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;		X				The cost limitation described in In *Policy 2382, EPSDT* does not align with the *NC Medicaid Contract* and *Medicaid Clinical Coverage Policy 8P*. ***Corrective Action: Revise Vaya's Policy 2382, EPSDT to align with the language within the NC Medicaid Contract and Medicaid Clinical Coverage Policy 8P, which does not allow a cost limit for enrollee's accessing services through Innovations and EPSDT.***
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Timeframes are included within policies and the file review indicated UM decisions were timely.
1.5 consideration of new technology;	X					
1.6 the appeal process, including a mechanism for expedited appeal;	X					
1.7 the absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					
1.8 mechanisms to detect underutilization and overutilization of services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The UM Organizational Chart and the UM Policies indicate that the Chief Medical Officer (CMO) has oversight of the UM program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The UM program design is reevaluated annually, including Provider input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The *Utilization Management Plan and Program Description* is reviewed at least annually.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
4. Utilization management standards/criteria are consistently applied to all enrollees across all reviewers.	X					
5. Emergency and post stabilization care is provided in a manner consistent with contract and federal regulations.	X					
6. Utilization management standards/criteria are available for Providers.	X					
7. Utilization management decisions are made by appropriately trained reviewers	X					
8. Initial utilization decisions are made promptly after all necessary information is received	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					
2.5 Quality monitoring and continuous quality improvement;	x					
2.6 Determination of which Behavioral Health Services are medically necessary;	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					
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					
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					Vaya was unable to identify and produce each enrollee's, complete Care Coordination record that was selected for this year's EQR.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Develop a report or process that ensures an enrollee's complete record can be identified, accessed and produced from the AlphaMCS and Incedo platforms. Within the Care Coordination and TCLI files reviewed there was a pattern late progress notes and gaps in engagement by Care Coordinators. These patterns are not compliant with the responsibilities outlined Vaya's *Policy 2335 Complex Care Management Populations, Processes Roles and Responsibilities*. Update: Per feedback from the State on May 28, 2021, Vaya's dispute of this score resulted in changing this Corrective Action to a Recommendation. ***Recommendation: Enhance the current monitoring process to ensure documentation by Care Coordinators is complete, accurate and compliant with documentation requirements set forth by Vaya's policies.***
V. D Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					
2. The PIHP has policies and procedures that address the Transition to Community Living activities and includes all required elements.	X					
2.1 Care Coordination activities occur as required.	X					Vaya continues to use the "Pilot" Transition Tool during the time frame for this EQR review; however, training for the State issued Transition Tool will be provided in November 2019.
2.2 Person Centered Plans are developed as required.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.3 Assertive Community Treatment, Peer Support, Supported Employment, Community Support Team, Psychosocial Rehabilitation, and other services as set forth in the DOJ Settlement are included in the individual's transition, if applicable.	X					
2.4 A mechanism is in place to provide one-time transitional supports, if applicable	X					Vaya includes *Transition Year Fund* information *in Policy 2449, Purchasing,* and the funds are monitored through the Finance Department.
2.5 QOL Surveys are administered timely.	X					
3. Transition, diversion and discharge processes are in place for TCLI members as outlined in the DOJ Settlement and DHHS Contract.	X					
4. Clinical Reporting Requirements- The PIHP will submit the required data elements and analysis to NC Medicaid within the timeframes determined by NC Medicaid.	X					
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					The *Member and Caregiver Handbook* provides information about TCLI and contact information for a TCLI liaison. During the Onsite, Vaya provided a TCLI brochure and a presentation used to educate stakeholders about the Referral, Screening, Verification Process (RSVP).

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				Within the Care Coordination and TCLI files reviewed there was a pattern of late progress notes and gaps in engagement by Care Coordinators. These patterns are not compliant with the responsibilities outlined Vaya's *Policy 2335 Complex Care Management Populations, Processes Roles and Responsibilities.* ***Corrective Action: Enhance the current monitoring process to ensure documentation by Care Coordinators is complete, accurate and compliant with documentation requirements set forth by Vaya's policies.***

VI. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					
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					Vaya states in *Policy 2607, Complaints and Grievances* that it attempts to resolve grievances within 30 calendar days.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					There was no documentation of consultation with subject matter experts, such as the Chief Medical Officer, within the grievance files reviewed, even in grievance files with situations that warranted consultations. ***Recommendations: Ensure consultations with subject matter experts are captured within the grievance file to demonstrate compliance with Policy 2607.***
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 2314, Record Retention Management* states, "records relating to complaints and grievances are maintained as specified in Policy 2607." However, *Policy 2607, Complaints and Grievances* does not provide the timeframe to maintain grievance logs as specified in the *NC Medicaid Contract, Attachment M, Section B.* ***Corrective Action: Include the timeframe to maintain grievance logs within Policy 2607, as specified in Vaya Policy 2314 and NC Medicaid Contract, Attachment M, Section B. Record Keeping, item 2.***
2. The PIHP applies the grievance policy and procedure as formulated.	X					
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					*Policy 2384, Member Appeals of Adverse Decisions* was revised in the past year to accurately correct areas of concern identified through the 2018 EQR Recommendations and Corrective Actions.
1.1 The definitions an appeal and who may file an appeal;	X					
1.2 The procedure for filing an appeal;	X					In the previous year's EQR, it was noted that Vaya was requiring enrollees to submit the *Vaya Reconsideration form* to initiate an appeal. A Corrective Action was issued that required Vaya to clarify in policy, the *Provider Operations Manual*, and the *Member and Caregiver Handbook* that any written document should be accepted as an appeal. *Policy 2384* and the *Provider Operations Manual* were revised in the past year and no longer state there is a required form However, the *Member and Caregiver Handbook* still states, "you must complete and return the Vaya Reconsideration Form." ***Recommendation: Revise the Member and Caregiver Handbook to align with Policy 2384 and state that any written request can initiate the first level appeal process.*** *The Member and Caregiver Handbook (pg. 57)* states, "We will send you a written acknowledgement within one business day when we receive your request." This statement contradicts Vaya's appeals policy that states, "Requests for Expedited Appeal that are accepted do not require written acknowledgement." Correcting this language within the handbook was a Recommendation from last year's EQR and was not addressed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Clarify in the Member and Caregiver Handbook that members may not receive written acknowledgement when an expedited appeal is filed.
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	X					In the previous year's EQR, it was noted that Vaya's *Provider Operations Manual*, *Member and Caregiver Handbook*, and *Policy 2384* had missing or incorrect information regarding expedited appeal notifications. Notification requirements for expedited appeals are contained in *NC Medicaid Contract, Attachment M, 9.b.* As a result of a Corrective Action, the policy and *Provider Operations Manual* were revised to reflect that when Vaya denies an expedited appeal, Vaya must give prompt oral notice and a written notice within two calendar days. However, the *Member and Caregiver Handbook* (pg. 58) does not inform enrollees of the required timeframes of these notifications. ***Recommendation: Add to the Member and Caregiver Handbook that enrollees are given prompt oral notice and a written notice within two calendar days when Vaya denies a request for an expedited appeal.***
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					In response to the Corrective Action item at the last EQR, Vaya's appeals *Policy 2384* and the *Provider Operations Manual* were revised to clarify that when Vaya extends an appeal resolution timeframe, "we will make reasonable efforts to give the member prompt oral notice of the delay and will notify in writing of the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						extension within 2 calendar days. If a member disagrees with the extension, they have the right to file a grievance." These notification requirements are outlined in *the NC Medicaid Contract, Attachment M, G.6*. The *Member and Caregiver Handbook* was included in this Corrective Action from the last EQR, but was not corrected by Vaya. Page 58 of the *Member and Caregiver Handbook* states, "You or your provider can request an expedited reconsideration review if the 60-day timeframe will jeopardize your health and safety". However, the appeals resolution timeframe that can be extended is 30 days. Correcting this typo was a Recommendation from the previous year's EQR. ***Recommendation: Correct to the Member and Caregiver Handbook to explain that reasonable efforts are made to give enrollees prompt oral notice, and a written notice within two calendar days when Vaya extends the expedited or standard appeal resolution timeframe. Ensure members are also informed they have the right to file a grievance against Vaya if they disagree with the decision to delay resolution.*** ***Recommendation: Correct the Member and Caregiver Handbook to state that the "30 day" timeframe for appeal resolution can be expedited. The handbook currently says the timeframe that can be extended is "60" days.***
1.6 Written notice of the appeal resolution as required by the contract;	X					*Policy 2384, Member Appeals of Adverse Decisions* clearly defines the required timeframes for processing appeals and providing written notice of the appeal outcome.
1.7 Other requirements as specified in the contract.	X					
2. The PIHP applies the appeal policies and procedures as formulated.		X				The review of the 25 files submitted for this year's EQR showed timeliness issues in five files. Three files showed acknowledgment letters were sent outside of the "one business day" timeframe

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						required by *Policy 2384, Member Appeals of Adverse Decisions*. Two files showed appeals were processed outside of the 30-day timeframe outlined in this same policy. Review of the *Appeal Log* also showed that of the 166 appeals processed in the past year, three acknowledgments and five appeal resolution notices were sent outside of the required timeframes. While this is a small portion of the appeals processed in the past year, the same issue was noted in last year's appeals EQR despite the Recommendation that Vaya increase their monitoring of appeals to ensure all processed are within all of the required timeframes. ***Corrective Action: Develop and document an enhanced monitoring process to ensure all appeals are acknowledged and processed within the required by Policy 2384, Member Appeals of Adverse Decisions, the NC Medicaid Contract, Attachment M, and 42 CFR § 438.408.*** In one of the 20 first level appeal files reviewed, it was noted that appeal #19 appeared to have been processed outside of the allowable timeframe for standard appeal resolution of 30 days. After the appeals Onsite discussion, Vaya submitted a timeline, labeled "*Additional Information appeal #19 10 9 19.*" This documentation confirmed that this appeal was resolved and notification provided in 74 days. During a subsequent discussion with appeal staff, CCME acknowledged the timing of the oral and written appeal requests placed Vaya in a predicament, and attempted to provide technical assistance regarding other steps that could have been taken by staff. In the end, CCME highlighted that further guidance from the State could help Vaya address any other appeals with a similar timing predicament.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Seek guidance from NC Medicaid on how to accommodate the timeline requirements outlined in Vaya's Policy 2384, Member Appeals of Adverse Decisions and the NC Medicaid Contract, Attachment M, G. 2., G.3.a., and G.4.
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					There was evidence in the Internal Quality Improvement Committee minutes that Vaya analyzes appeal trends by number, type, percentage of service authorization denial decisions that are appealed, funding source, outcome and appeal level.
4. Appeals are managed in accordance with the PIHP confidentiality policies and procedures.	X					Vaya's *Policy 2313, Response to Legal Inquiries and Records 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. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. Delegation						
1. The PIHP has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Vaya has a delegation agreement with Prest for Peer Review/ Utilization Management. During the review period for the current EQR, Vaya had a delegation agreement with Partners Behavioral Health for call roll-over coverage. That delegation agreement ended effective June 30, 2019. Effective July 1, 2019, Vaya has a delegation agreement with Alliance for call roll-over coverage. Vaya conducted an onsite delegation assessment prior to the inception of the delegation agreement with Alliance.
2. The PIHP conducts oversight of all delegated functions sufficient to ensure that	X					Vaya completed the *UM Peer Review Delegation Audit Tool* for Prest on June 28, 2019. During the Onsite, Vaya staff confirmed it reviews

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
such functions are performed using those standards that would apply to the PIHP if the PIHP were directly performing the delegated functions.						"every review completed by Prest,", and receives monthly and quarterly statistics. Karla Mensah, MBA, CCCM, Vaya's Senior Director of Customer Services, met regularly with Partners and completed the *Call Monitoring Checklist* for a sample of calls. Vaya reported Partners met call metrics for the calls Partners answered. *Policy 2303, Delegation and Subcontracting*, includes a reference to "a mechanism for reporting delegation oversight no less than annually to the Quality Improvement Committee (QIC)." The QIC meeting minutes for the timeframe covered by the current EQR do not include reporting of delegation oversight of Prest or of Partners. This was also an issue, with a Recommendation, at the last EQR. Vaya's *EQR CAP 2018 Recommendations-tjh* document submitted for the current EQR states, "Delegation oversight has been built into the QIC schedule for this current fiscal year and moving forward." To ensure Vaya had an additional opportunity to provide any relevant documentation, on the *Onsite Request List*, CCME requested "QIC meeting minutes for meeting(s) in which delegation oversight was reported, during timeframe of July 2018 through June 2019." In response, Vaya submitted: "Delegation oversight had not been built into the QIC schedule when the 2018 EQR Review was finalized. It has been built into the current QIC schedule, which is reflected in the I-QIC 9/10/19 minutes submitted in folder 15 for item #1 of this latest request." Stephen Puckett, PhD, HSP-P, Member Appeals Director, presented the "Annual Prest Delegation Evaluation" to the QIC on September 10, 2019 (which is outside the review period covered by the current EQR). Evidence of annual delegation oversight by the QIC during the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						review period was not submitted for Partners, whose contract ended on June 30, 2019. No *Delegation Assessment* form was submitted for Prest for the current EQR review period. Though the contract with Partners ended on June 30, 2019, Ms. Mensah completed the *Delegation Assessment* on October 7, 2019, after Vaya received the *Onsite Request List* from CCME. The Partners *Delegation Assessment* form does not include the timeframe covered by the delegation assessment, as indicated in the Recommendation at the last EQR. ***Recommendations: Report delegation oversight in a QIC meeting annually as referenced in Vaya Policy 2303, or revise the policy to eliminate the reference to annual reporting in QIC.*** ***Recommendations: For Delegation Assessments, include the timeframe covered by the assessment.***

VIII. PROGRAM INTEGRITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VIII A. General Requirements						
1. PIHP shall be familiar and comply with Section 1902(a)(68) of the Social Security Act, 42 C.F.R. Parts 438,455 and 1000 through 1008, as applicable, including proper payments to Providers and methods for detection of fraud and abuse.	X					This requirement is addressed in the *Compliance Program Plan FY2019-20* on pages 22-23, in the Investigation Oversight policy, in the Identification and Recovery of Overpayments policy, and in the Internal Audits & Investigations policy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. PIHP shall have and implement policies and procedures that guide and require PIHP's, and PIHP's officers', employees', agents' and subcontractors,' compliance with the requirements of this Section 14 of the NC Medicaid contract.	X					This requirement is addressed in the *Compliance Program Plan FY2019-20* on page 22, which addresses routine monitoring by the Contract Performance Unit (CPU) designed to ensure provider compliance with applicable federal and state laws, rules and regulations, NC Medicaid Clinical Coverage Policies, state service definitions and contract requirements
3. PIHP shall include Program Integrity requirements in its written agreements with Providers participating in the PIHP's Closed Provider Network.	X					This requirement is addressed in multiple places in the Network Provider Participation Agreement templates provided by Vaya.
4. PIHP shall investigate all grievances and/or complaints received alleging fraud, waste or program abuse and take appropriate action.	X					This requirement is addressed in the *Compliance Program Plan FY2019-20* on pages 20-21, in the *Grievance and Complaint Workflow 9.4.19* and in the *SIU Business_Process_20190807*.
VIII B. Fraud and Abuse						
1. PIHP shall establish and maintain a written Compliance Plan consistent with 42 C.F.R. 438.608 that is designed to guard against fraud and abuse. The Compliance Plan shall be submitted to the NC Medicaid Contract Administrator on an annual basis.	X					This requirement is addressed in the *Compliance Program Plan FY2019-20* on pages 3-4.
2. PIHP shall designate, however named, a Compliance Officer who meets the requirements of 42 C.F.R. 438.608 and who retains authority to report directly to the CEO and the Board of Directors as needed irrespective of administrative organization. PIHP shall also establish	X					This requirement is addressed in the *NPI Org Chart 2* dated 09/01/2019, which lists Tracy Hayes, JD as "General Counsel & Chief Compliance Officer." Implementation of training was evidenced by the provision of multiple training materials for the Board of Directors, Chief Compliance Officer, Providers, SIU staff, Vaya teams, and all staff.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
a regulatory compliance committee on the PIHP board of directors and at the PIHP senior management level that is charged with overseeing PIHP's compliance program and compliance with requirements under this Contract. PIHP shall establish and implement policies outlining a system for training and education for PIHP's Compliance Officer, senior management, and employees in regard to the Federal and State standards and requirements under NC Medicaid Contract in accordance with 42 CFR 438.608(a)(1)(iv).						New Employee Orientation, detailed in the *Onboarding* policy, refers to Mandatory Compliance and Code of Ethics and Conduct training on page 2.
3. PIHP shall establish and implement a special investigations or program integrity unit, however named, that is responsible for PIHP program integrity activities, including identification, detection, and prevention of fraud, waste and abuse in the PIHP Closed Provider Network. PIHP shall identify an appropriately qualified contact for Program Integrity and Regulatory Compliance issues as mutually agreed upon by PIHP and NC Medicaid. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator. In addition, PIHP shall identify a primary point of contact within the	X					This requirement is addressed in the *Compliance Program Plan FY2019-20* on pages 20-21. The requirement for contact with NC Medicaid is addressed in the Job Descriptions and Organizational Chart.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
Special Investigations Unit to receive and respond to data requests from MFCU/MID. The MFCU/ MID will copy the PIHP Contract Administrator on all such requests.						
4. PIHP shall participate in quarterly Program Integrity meetings with NC Medicaid Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').	X					
5. PIHP shall send staff to participate in monthly meetings with Division Program Integrity staff, either telephonically or in person at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.						
6. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information	X					This requirement is addressed in the attendance of the SIU Director, senior directors of Network Performance & Integrity and Business & Integrity during the meetings, and the NC Medicaid liaison.
7. The Division recognizes that the scope of the PIHP's Regulatory Compliance Committee includes issues beyond those related to Program Integrity. Within seven (7) business days of a	X					During Onsite discussion, it was learned that Vaya does send these minutes to the State for review as requested.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
request by the Division, PIHP shall also make portions of the PIHP's Regulatory Compliance and Program Integrity minutes relating to Program Integrity issues available for review, but the PIHP may, redact other portions of the minutes not relating to Regulatory Compliance or Program Integrity issues.						
8. PIHP's written Compliance Plan shall, at a minimum include:						
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(66) of the Social Security Act;	X					This requirement is addressed in the *Compliance Program Plan FY2019-20* on pages 4, 5, and 13.
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing and development of corrective action initiatives;	X					This requirement is addressed in the *Compliance Program Plan FY2019-20* on pages 4, 5, 8, 15, 19, 21, 24, 25, and 32.
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					This requirement is addressed in the *Compliance Program Plan FY2019-20* on pages 15-18.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including NC Medicaid or MFCU/MID, and including promptly supplying all data in a uniform format provided by DHB and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by Division as provided in Section 13.2 – Monetary Penalties.		X				The requirement is partially addressed in the *Compliance Program Plan FY2019-20* on page 21. However, the *Compliance Program Plan* does not reference the timeliness or format requirements for supplying investigation data to NC Medicaid. ***Corrective Action: Include in the Compliance Program Plan the timeliness and format requirements for submitting investigation data to NC Medicaid as outlined in NC Medicaid Contract, Section 21.d of Amendment 4.***
9. In accordance with 42 CFR 436.606(a)(vii), PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under NC Medicaid Contract, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required	X					This requirement is addressed in the *Compliance Program Plan FY2019-20* on pages 4, 19, 20, and 31 and in monthly *Attachment Y* documents covering the review period. The requirement that the PIHP have written policies and procedures to guard against fraud and abuse is addressed in the *Code of Ethics and Conduct* policy, in the *Identification and Recovery of Overpayments* policy, in the *Internal Audits & Investigations policy*, and in the *Compliance Program Plan FY2019-20*. Implementation of these policies is addressed in the Employee Handbook as well as training materials provided by Vaya.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
under NC Medicaid Contract; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month. PIHP shall be penalized One Hundred Dollars ($100) for each overpayment that is not specified in an Attachment Y Report within the applicable month. In addition, PIHP shall have and implement written policies and procedures to guard against fraud and abuse.						
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					This requirement is addressed in the *Code of Ethics and Conduct* policy, in the Identification and *Recovery of Overpayments* policy, in the Internal *Audits & Investigations* policy, and in the *Compliance Program Plan FY2019-20*. Implementation of these policies is addressed in the *Employee Handbook* as well as training materials.
10.1 At a minimum, such policies and procedures shall include policies and procedures for detecting and investigating fraud and abuse;	X					This requirement is addressed in the *Compliance Program Plan FY2019-20*, in the *Investigation Oversight* policy, in the *Internal Audits & Investigations* policy, and in the *Identification and Recovery of Overpayments* policy.
10.2 Detailed workflow of the PIHP process for taking a complaint from inception through closure. This	X					This requirement is addressed in the *Investigation Oversight* policy on pages 2-3, in the *Grievance and Complaint Workflow 9.4.19*, and in the Vaya *Special Investigations Unit Work Flow Charts*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
process shall include procedures for logging the complaint, determining if the complaint is valid, assigning the complaint, investigating, appeal, recoupment, and closure. The detailed workflow needs to differentiate the steps taken for fraud versus abuse; PIHP shall establish and implement policies for treatment of recoveries of all overpayments from PIHP to Providers and contracted agencies, specifically including retention policies for treatment of recoveries of overpayments due to fraud, waste, or abuse. The retention policies shall include processes, timeframes, and required documentation for payment of recoveries of overpayments to the State in situations where PIHP is not permitted to retain some or all of the recoveries of overpayments. This provision shall not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.						Procedural steps are explained and demonstrated in the Special Investigations Unit Business Process. The retention policy requirement is addressed in the *Identification and Recovery of Overpayments* policy.
10.3 In accordance with Attachment Y – Audits/Self-Audits/Investigations PIHP shall establish and implement a mechanism for each	X					This requirement is addressed in the Identification and *Recovery of Overpayments* policy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						
10.4 Process for tracking overpayments and collections, based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on Attachment Y – Audits/Self-Audits/Investigations;	X					This requirement is addressed in the monthly *Schedule K* reports and in the *Identification and Recovery of Overpayments* policy.
10.5 Process for handling self-audits and challenge audits;	X					This requirement is addressed in *the Internal Audits & Investigations* policy, and in the *Organizational Quality Improvement* policy.
10.6 Process for using data mining to determine leads;	X					This requirement is addressed in the *FAMS Reporting Plan*. Implementation of this policy is demonstrated in the claims adjudication reports and visualization report cards.
10.7 Process for informing PIHP employees, subcontractors and providers regarding the False Claims Act;	X					This requirement is addressed in the *Compliance Program Plan FY2019-20*, in the *New Employee Orientation Compliance* training presentation, in the *Board of Directors Orientation Notebook 2019*, in the FCA annual training materials, in the Code of *Ethics and Conduct* policy, in the *Vaya Health Provider Operations Manual*, and in the provider contract and application templates provided.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.8 If PIHP makes or receives annual payments of at least $5,000,000, PIHP shall establish and maintain written policies for all employees, contractors or agents that detail information about the False Claims Act and other Federal and State laws as described in the Social Security Act 1902(a)(66), including information about rights of employees to be protected as whistleblowers.	X					This requirement is addressed in the *Compliance Program Plan FY2019-20* on page 15 and in the Code of Ethics and Conduct on page 7.
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid - standardized elements or a NC Medicaid -approved template;	X					This requirement is addressed in the *Compliance Program Plan FY2019-20* on page 20, bullet #3, and in the *Internal Audits & Investigations* policy. The latter policy describes how the Regulatory Compliance Team (RCT) develops the annual *Compliance Work Plan* as well as the *Internal Audit Plan*. Standardized audit tools were provided by Vaya as well as an Internal Audit tracker document.
10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available database or other search mechanism.	X					This requirement is addressed in great detail in the *Credentialing Program* policy. The use of the Provider Penalty Tracking Database (DHSR) is described on pages 18 and 24.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
11. PIHP shall identify all overpayments and underpayments to Providers and shall offer Providers an internal dispute resolution process for program integrity, compliance and monitoring actions taken by PIHP that meets accreditation requirements. Nothing in this Contract is intended to address any requirement for PIHP to offer Providers written notice of the process for appealing to the NC Office of Administrative Hearings or any other forum.	X					This requirement is addressed in the Identification and *Recovery of Overpayments* policy and in the *Provider Dispute Resolution* policy.
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					This requirement is addressed in the SIU Business Process dated 08/09/2019 on pages 1 and 7.
13. In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					Two of the fifteen files reviewed did not contain the Medicaid provider ID. Including the Medicaid provider ID in the PI referral form was identified as a deficiency requiring Corrective Action in 2018, which was addressed. It was determined the two deficient files reviewed for the current review period were initiated prior to the implementation of a new referral form, which includes this information, so no corrective action is necessary.
13.2 Source/origin of complaint;	X					This requirement was addressed in fifteen (15) of fifteen (15) files reviewed.
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					This requirement was addressed in fifteen (15) of fifteen (15) files reviewed.
13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules, regulations or policies violated; and dates of suspected intentional misconduct;	X					This requirement was addressed in fifteen (15) of fifteen (15) files reviewed.
13.5 Amount paid to the Provider for the last three (3) years (amount by year) or during the period of the alleged misconduct, whichever is greater;	X					This requirement was not applicable for five (5) of fifteen (15) files reviewed because they were deemed as preliminary rule-out, and was addressed in the remaining ten (10).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13.6 All communications between PIHP and the Provider concerning the conduct at issues, when available.	X					This requirement was addressed in fifteen (15) of fifteen (15) files reviewed.
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and			X			Of the 15 files reviewed, 14 files did not contain any additional contact information for PIHP staff persons with practical knowledge of the working of the relevant programs. *NC Medicaid Contract, 14.2.9 g* requires PIHPs provide NC Medicaid Program Integrity with "Contact information for PIHP staff persons with practical knowledge of the workings of the relevant programs." ***Corrective Action: Add to the PI referral form contact information for PIHP staff persons with practical knowledge of the working of the relevant programs.***
13.8 Total Sample Amount of Funds Investigated per Service Type.	X					This requirement was not applicable for five (5) of fifteen (15) files reviewed because they were deemed as preliminary rule-out, and was addressed in the remaining 10.
14. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						The two cases of suspected enrollee fraud contained all of the required information.
14.1 The Enrollee's name, birth date, and Medicaid number;	X					
14.2 The source of the allegation;	X					
14.3 The nature of the allegation, including the timeframe of the allegation in question;	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.12 Additional Provider Locations that are related to the allegations;						
14.13 Legal and Administrative Status of Case.	X					
15. PIHP and NC Medicaid shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of State and Federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.	X					Vaya provided multiple letters, reports and tools. NC Medicaid indicated during the Onsite that it has approved Vaya's tool and letters and continues to review them on a quarterly basis.
16. PIHP shall use the NC Medicaid Fraud and Abuse Management System (FAMS) or a NC Medicaid approved alternative data mining technology solution to detect and prevent fraud, waste and abuse in managed care.	X					This requirement is addressed in the *FAMS Reporting Plan* and in the monthly Program Integrity Activities FAMS reports, which cover the review period.
17. If PIHP uses FAMS, PIHP shall work with the NC Medicaid designated Administrator to submit appropriate claims data to load into the NC Medicaid Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of FAMS-user	X					This requirement is addressed in monthly FAMS user reports Vaya provides to NC Medicaid and is part of the monthly meeting agenda.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
changing roles within the organization or termination of employment.						
18. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month or the next business day if the 10th day is a non-business day (i.e. weekend or State or PIHP holiday). Section 9.8 Fraud and Abuse Reports. In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to NC Medicaid Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to NC Medicaid Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month	X					This requirement is partially addressed in the monthly Program Integrity Activities FAMS reports, which cover the review period. The monthly *Attachment Y* and *Attachment Z* reports provided by Vaya, which cover the review period, are evidence of the required monthly reports. While there is some evidence of submission by Vaya of the monthly report to NC Medicaid, there is no language in any policy that documents the required format and timeframe. *NC Medicaid Contract, 9.8* requires the monthly report "shall be due by 11:59 p.m. on the tenth day of each month in the format as identified in Attachment Y...", and, further, *Section 25* of *NC Medicaid Contract, Amendment 4* – requires each PIHP submit with the monthly report "or the next business day if the 10th day is a non-business day (i.e. weekend or State or PIHP holiday)." Update: Per feedback from the State on May 28, 2021, Vaya's dispute of this score resulted in changing this Corrective Action to a Recommendation. ***Recommendation: Include in policy the timeliness requirement, as outlined in NC Medicaid Contract 9.8 and 25 of Amendment 4.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.						
VIII C. Provider Payment Suspensions and Overpayments						
1. Within thirty (30) business days of receipt from PIHP of referral of a potential credible allegation of fraud, NC Medicaid Program Integrity shall complete a preliminary investigation to determine whether there is sufficient evidence to warrant a full investigation. If NC Medicaid determines that a full investigation is warranted, NC Medicaid shall make a referral within five (5) business days of such determination to the MFCU/ MID and will suspend payments in accordance with 42 CFR § 455.23. At least monthly, NC Medicaid shall provide written notification to PIHP of the status of each such referral. If MFCU/ MID indicates that suspension will not impact their investigation, NC Medicaid may send a payment suspension notice to the Provider and						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
notify PIHP. If the MFCU/ MID indicates that payment suspension will impact the investigation, NC Medicaid shall temporarily withhold the suspension notice and notify PIHP. Suspension of payment actions under this Section 14.3 shall be temporary and shall not continue if either of the following occur: PIHP or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider; or Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.						
1.1 In the circumstances described in Section 14.3 (c) above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.		X				The timeliness requirement for the lifting of payment suspensions is not addressed in any policy provided by Vaya for review. Vaya provided an email communication stating, "This item was discussed between legal counsel at DHHS and Vaya Health. Vaya agreed to make the changes requested by DHHS to come into compliance with the contract. DHHS legal counsel confirmed that this has been completed to DHHS's satisfaction. NC Medicaid and DHHS legal counsel agree that Vaya Health now meets the contractual requirements for this CAI." However, there was no evidence of documentation revision provided by Vaya for this year's EQR. ***Corrective Action: Include in policy the timeliness requirement in NC Medicaid Contract, 14.3 (c) in policy language.***
2. Upon receipt of a payment suspension notice from NC Medicaid Program	X					This requirement is addressed in the Identification and *Recovery of Overpayments* policy on page 5.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						
3. PIHP shall provide to NC Medicaid all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					This requirement is addressed in the *Compliance Program Plan FY2019-20* on page 21.
4. PIHP shall not take administrative action regarding allegations of suspected fraud on any Providers referred to NC Medicaid Program Integrity due to allegations of suspected fraud without prior written approval from NC Medicaid Program Integrity or the MFCU/MID. If PIHP takes administrative action, including issuing a Notice of Overpayment based on such fraud that precedes the submission date of a Division referral, the State will adjust the PIHP capitated payment in the amount of the original overpayment identified or One Thousand Dollars ($1,000) per case, whichever amount is greater.	X					This requirement is addressed in the *Provider Sanctions and Administrative Actions* policy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. Notwithstanding the foregoing, nothing herein shall be construed as prohibiting PIHP from taking any action against a Network Provider in accordance with the terms and conditions of any written agreement with a Network Provider, including but not limited to prepayment review, identification and collection of overpayments, suspension of referrals, de-credentialing, contract nonrenewal, suspension or termination or other sanction, remedial or preventive efforts necessary to ensure continuous, quality care to Enrollees, regardless of any ongoing investigation being conducted by NC Medicaid, MFCU/MID or other oversight agency, to the extent that such action shall not interfere with Enrollee access to care or with any such ongoing investigation being conducted by NC Medicaid, MFCU/MID or other oversight agency.	X					There is no language in any Vaya policy that outlines the requirement in *NC Medicaid Contract, 14.3.4* regarding Vaya's obligation to ensure there is no interference with Enrollee's access to care during any investigation. Update: Per feedback from the State on May 28, 2021, Vaya's dispute of this score resulted in changing this Corrective Action to a Recommendation. ***Recommendation: Include in a Vaya policy the requirement in NC Medicaid Contract, 14.3.4 regarding Vaya's obligation to ensure there is no interference with Enrollee's access to care during any investigation.***
6. In the event that the Department provides written notice to PIHP that a Provider owes a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. 108C-5, PIHP shall remit to the Department all reimbursement amounts otherwise due to that Provider until the Provider's final overpayment, assessment, or fine to	X					This requirement is addressed in the Identification and recovery of *Overpayments* policy on page 5.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
the Department, including any penalty and interest, has been satisfied. The Department shall also provide the written notice to the individual designated by PIHP. PIHP shall notify the provider that the Department has mandated recovery of the funds from any reimbursement due to the Provider by PIHP and shall include a copy of the written notice from the Department to PIHP mandating such recovery.						
7. Recovery Audit Contactors (RACs) for the Medicaid program may audit Providers in the PIHP Network and may work collaboratively with PIHP on identification of overpayments. NC Medicaid shall require RACs to give PIHP prior written notice of such audits and the results of any audits as permitted by law.						
8. The MFCU/MID reserves the right to prosecute or seek civil damages regardless of payments made by the Provider to PIHP. The Parties shall work collaboratively to develop a plan for the disbursement of the share of monies that are recovered and returned to the state by the MFCU/MID for fraudulent claims paid by PIHP. NC Medicaid will examine options to refund returned funds to PIHP and/or to						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
appropriately account for these recoveries in the rate setting process.						

IX. FINANCIAL SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IX. Financial						
1. The PIHP has policies and systems in-place for submitting and reporting financial data.	X					Vaya's policy review is conducted annually. All reports are submitted on time to NC Medicaid. Update: Per feedback from the State on May 28, 2021, Vaya's dispute of this score resulted in changing this Corrective Action to a Recommendation. ***Recommendation: Add the five-business day transfer requirement after capitation payment of risk reserve payment to Policy 2748, Medicaid Funds Management.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP has and adheres to a cost allocation plan that meets the requirements of *42 CFR § 433.34*.	X					Vaya recalculates their administrative cost allocation by spreadsheet monthly, based on year-to-date service revenues.
3. PIHP maintains detailed records of the administrative costs and expenses incurred as required by the *NC Medicaid Contract*.	X					The administrative costs are captured by the general ledger in Great Plains and allocated to Medicaid via the monthly NC Medicaid report.
4. Maintains an accounting system in accordance with *42 CFR § 433.32 (a).*	X					Vaya uses Great Plains, version 2015 as their accounting system and AlphaMCS for claims processing.
5. The PIHP follows a record retention policy of retaining records for ten years. (*NC Medicaid Contract, Section 8.3.2* and *Amendment 4, Section 31).*	X					Vaya retains records for 10 years, with three fiscal years onsite, and seven fiscal years offsite.
6. The PIHP maintains a restricted risk reserve account with a federally guaranteed financial institution in accordance with *NC Medicaid Contract*.	X					Wells Fargo maintains the restricted risk reserve account, and it is federally guaranteed.
7. The required minimum balance of the Risk Reserve Account meets the requirements of the *NC Medicaid Contract*.	X					The Deputy Director of Finance monitors the monthly contribution. Vaya staff stated that all deposits were made on time and no unauthorized withdrawals were made.
8. All funds received by PIHP are accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as required by the *NC Medicaid Contract*.	X					The segregation of Title XIX (Medicaid) funds is done by funding source. All reports and systems separately identify Title XIX funds, as well as the NC Medicaid reports separating Medicaid funds.
9. The Medical Loss Ratio (MLR) meets the requirements of *42 CFR § 438.8* and the *NC Medicaid Contract*.	X					The MLR is calculated monthly within the NC Medicaid report and is published monthly on the dashboard. The year-to-date MLR percentage is 90.8%, exceeding the 85% requirement.

E. Attachment 5: Encounter Data Validation Report

Vaya Health

Encounter Data Validation Report

performed on behalf of

North Carolina Medicaid

October 30, 2019

Prepared By:

hms

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

Table of Contents

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Background

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

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

Overview

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

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

Review of Vaya's ISCA response

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

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

The 837 files are transmitted securely to CSRA and parsed using an Electronic Data Interchange (EDI) validator to check for errors and produce a 999 response. The 999 response is used to confirm receipt and communicate any compliance o layout errors to the PIHP. The behavioral health encounter claims are then validated by applying a list of edits provided by the State (See Appendix 1) and adjudicated accordingly by Medicaid Management Information System (MMIS). Utilizing existing Medicaid pricing methodology, using the billing or rendering provider accordingly, the

appropriate Medicaid allowed amount is calculated for each encounter claim in order to shadow price what was paid by the PIHP.
The PIHP is required to resubmit encounters for claims that may be rejected due to compliance errors or NC Medicaid edits marked as "DENY" in Appendix 1.

Looking at claims with dates of service in 2018, Vaya submitted 1,910,482 unique encounters to the State. To date, 1% of all 2018 encounters submitted have not been corrected and accepted by NC Medicaid.

2018	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
Institutional	42,787	42,110	287	390	1%
Professional	1,867,695	1,831,671	22,048	13,976	1%
Total	1,910,482	1,873,781	22,335	14,366	1%

Each year Vaya has made significant improvements to their encounter submission process, increasing their acceptance rate and quality of encounter data year over year. The table below reflects the increase in acceptance rate from 73% to 99%, well above NC Medicaid's expectations.

Year of Service	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
2016	987,620	653,787	63,805	270,028	27%
2017	1,815,237	1,641,057	79,430	94,750	5%
2018	1,910,482	1,873,781	22,335	14,366	1%

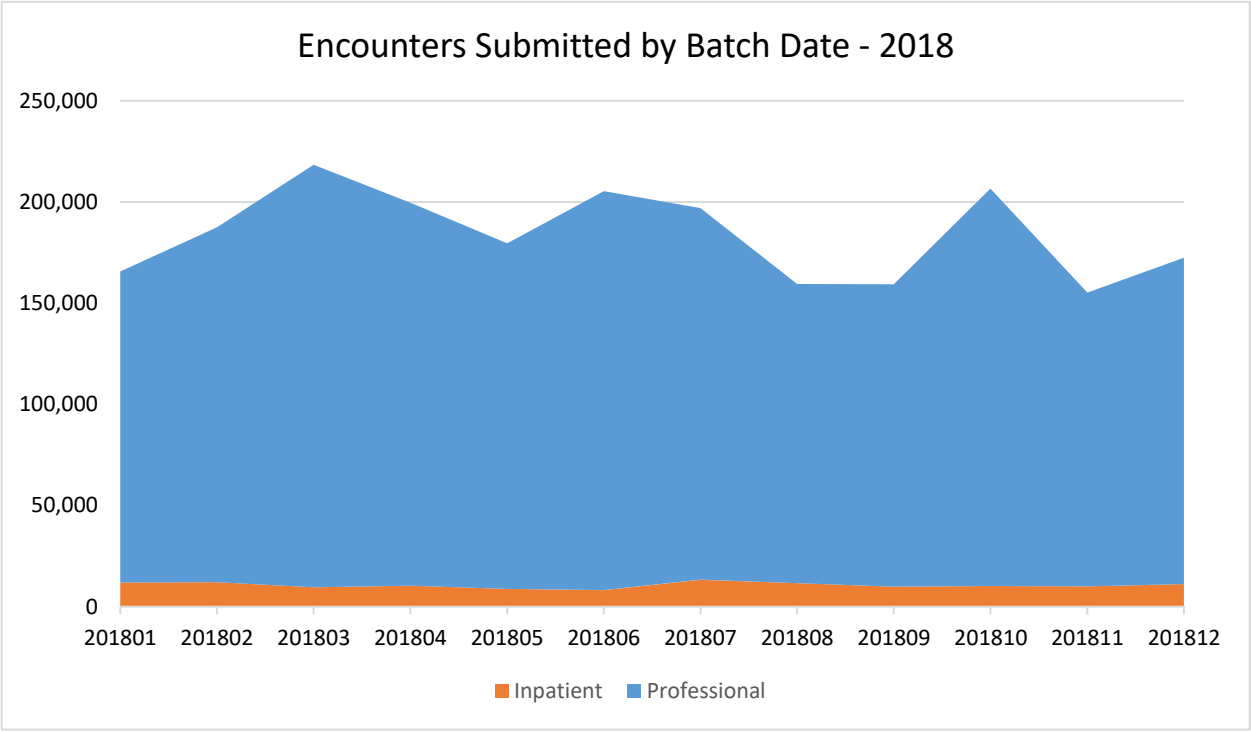
Vaya has established an encounter team responsible for investigating all denied Encounters. The encounters team coordinates denial research, and requests corrections from other departments or from the encounter billing provider, depending on the denial reason. Vaya relies on the Encounter Summary by MCO Check write and an encounter denial detail report listing the header and line edits issued by the State, as well as numerous other parameters for all encounter Transaction Control Numbers (TCNs) that deny. The PIHP has a detailed reconciliation and correction process in place to ensure that 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 to update essential provider taxonomy and address information
- Internal database and reporting tools

- Provider education guidelines
- Rebilling corrected encounter denials

Analysis of Encounters

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



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

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Recipient ID	Should be valid ID as found in the State's eligibility file. Can use State's ID unless State also accepts Social Security Number.	100% valid
Recipient Name	Should be captured in such a way that makes separating pieces of name easy. Expect data to be present and of good quality	85% present. Lengths should vary, but there should be at least some last names of >8 digits and some first names of < 8 digits, validating that fields have not been truncated. Also, a high percentage of names should have at least a middle initial.
Recipient Date of Birth	Should not be missing and should be a valid date.	< 2% missing or invalid
MCO/PIHP ID	Critical Data Element	100% valid
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	95% valid
Attending Provider ID	Should be an enrolled provider listed in the provider enrollment file (will accept the MD license number if it is listed in the provider enrollment file).	> 85% match with provider file using either provider ID or MD license number
Provider Location	Minimal requirement is county code, but zip code is strongly advised.	> 95% with valid county code > 95% with valid zip code (if available)
Place of Service	Should be routinely coded, especially for physicians.	> 95% valid for physicians > 80% valid across all providers
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% nonmissing and valid on physician or other applicable provider type claims (e.g., other practitioners)
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid codes (using International Statistical Classifications of Diseases, Ninth Revision, Clinical Modification [ICD-

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

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

Encounter Accuracy and Completeness

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

Table: Evaluation of Key Fields

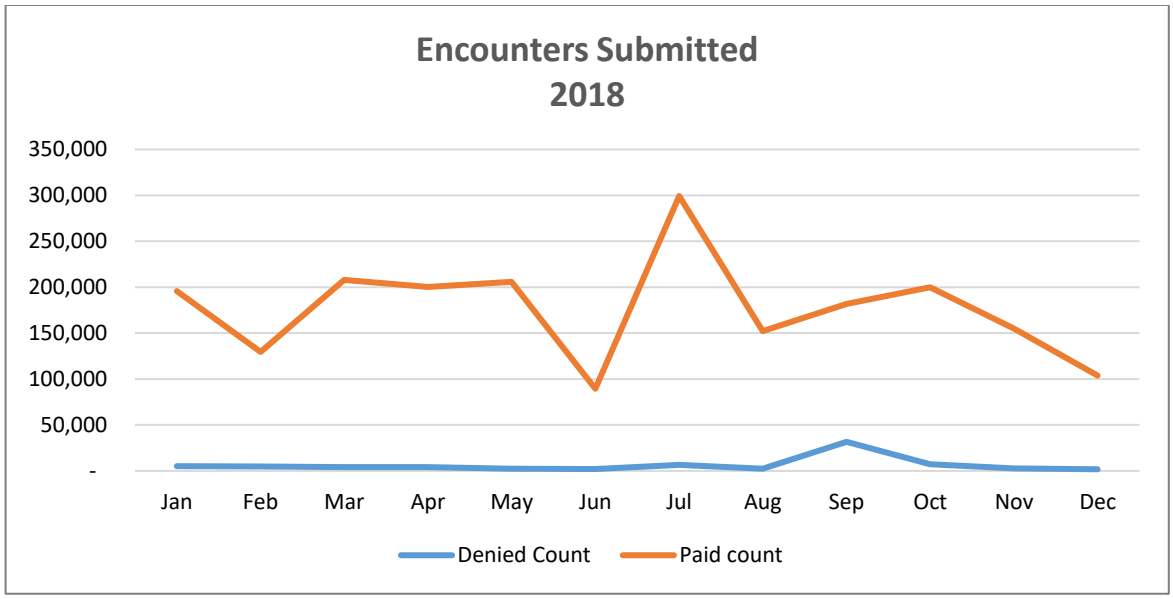
Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%
Recipient Name	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%
Recipient Date of Birth	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%
MCO/PIHP ID	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%
Provider ID	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%
Attending/Rendering Provider ID	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%
Provider Location	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%
Place of Service	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%
Specialty Code / Taxonomy - Billing	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%
Specialty Code / Taxonomy - Rendering / Attending	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%
Principal Diagnosis	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%
Other Diagnosis	243,199	11.02%	243,199	11.02%	243,199	11.02%	243,199	11.02%
Dates of Service	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%
Unit of Service (Quantity)	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%	2,206,011	100.00%
Procedure Code	2,147,543	97.35%	2,147,543	97.35%	2,147,543	97.35%	2,147,543	97.35%
Procedure Code Modifier	806,209	36.55%	806,209	36.55%	806,209	36.55%	806,209	36.55%
Patient Discharge Status Code Inpatient	127,381	100.00%	127,381	100.00%	127,381	100.00%	127,102	99.78%
Revenue Code	127,381	100.00%	127,381	100.00%	127,381	100.00%	127,381	100.00%

Overall, 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 17 of the 18 key fields (94%) with noted issues to Other Diagnosis Codes. Only Admitting and Principal Diagnosis codes were populated for Institutional claims. The same issue was present in our 2017 claims review. A minor issue was noted with procedure code and discharge status. Vaya is allowing and reporting claims without a valid procedure code and using invalid discharge status codes. The issue does not exceed the error threshold, so it is not reported as an error in the summary below.

Professional encounter claims submitted contained complete and valid data in 14 of the 15 key Professional fields (93%). The primary issue is the same as Institutional—missing Other Diagnosis. The principal diagnosis code was populated 100% of the time, however, there was very little consistency in additional diagnosis codes being present. Other Diagnosis codes should be populated more than 11% of the time. One correction from our review in 2018 that was noted is that Vaya is submitting up to 10 diagnosis codes for Professional claims. In the previous reviews, Vaya was only submitting a principal and secondary diagnosis.

Encounter Acceptance Report

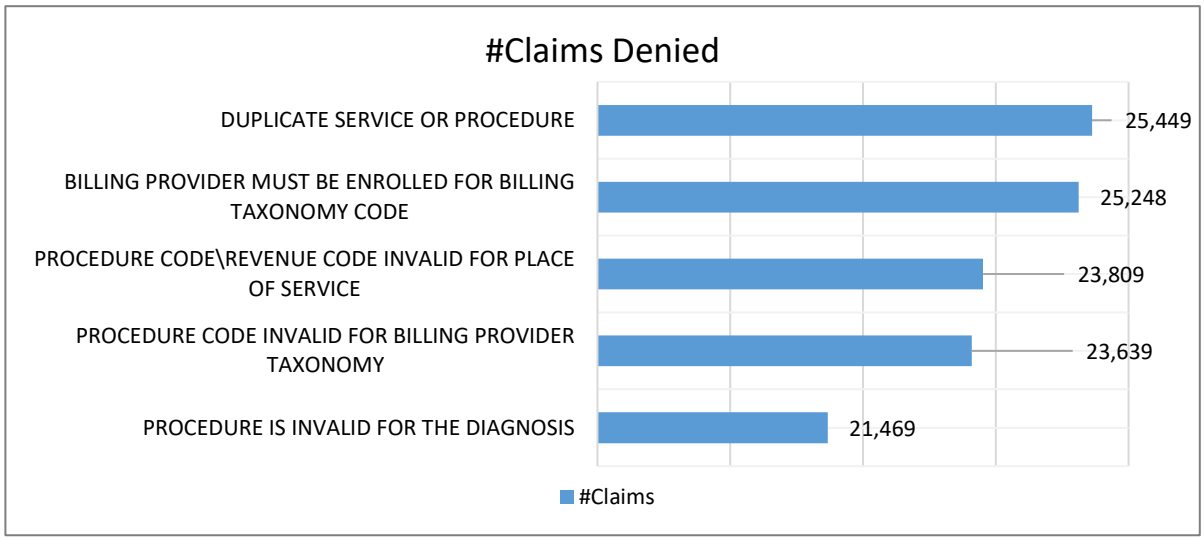
In addition to performing evaluation of the encounter data submitted, the HMS analyst reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write and excludes duplicates or resubmission which made it difficult to tie back to the ISCA response and converted encounter files. Data provided by PIHP's reports for our review includes all submission and resubmissions during 2018 which may include older dates of service. During the 2018 weekly check write schedule, Vaya submitted a total of 2,120,623 encounters to NC Medicaid. On average, 4% of all encounters submitted were initially denied, which is down from 7% for 2017 submissions.



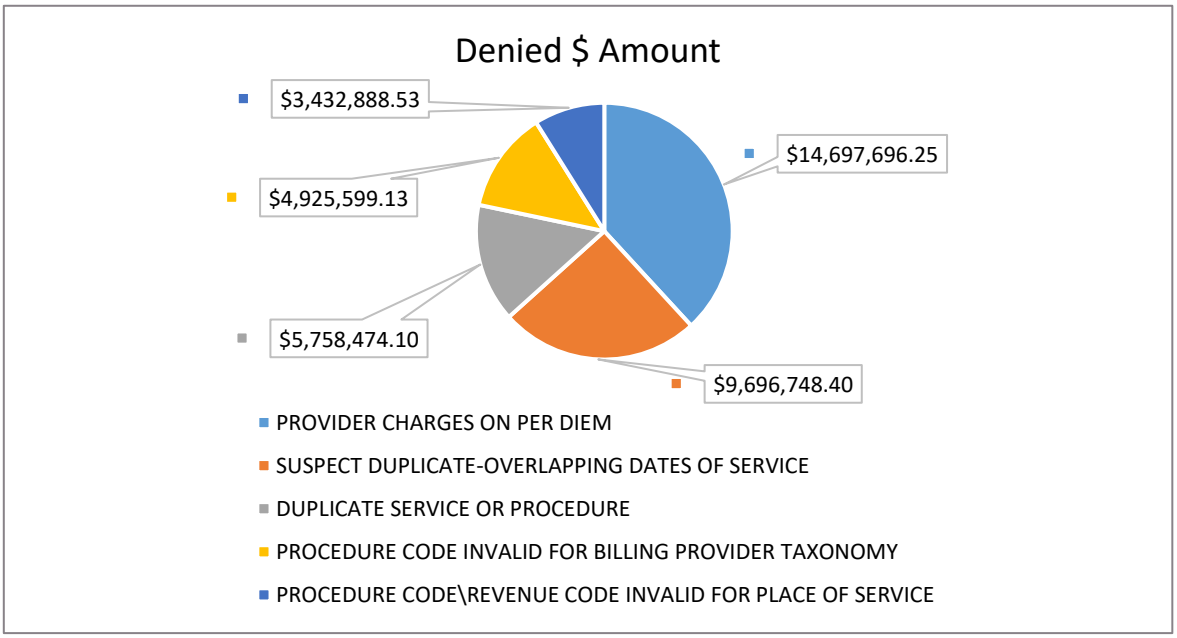
Evaluation of the top denials for Vaya encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis above. Encounters were denied primarily for:

- Duplicate service or procedure
- Billing provider must be enrolled for billing taxonomy code
- Procedure Code/Revenue Code invalid for Place of Service
- Procedure code invalid for billing provider taxonomy
- Procedure is invalid for the diagnosis

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



The pie chart below reflects the top 5 denials by claim dollar amount.



Results and Recommendations

Issue: Other Diagnosis

Principal and admitting diagnosis was populated consistently where appropriate, however, additional diagnosis codes were not populated consistently for Institutional or Professional claims. Institutional claims were not transmitted with any additional diagnosis codes other than principal and admitting. This issue was present in the 2017 review. The Professional claims contained up to ten diagnosis codes which is an improvement from the 2017 review in which only the principal and secondary diagnosis was provided. Vaya noted in their ISCA response that up to twelve diagnosis codes were being provided, which is the maximum number that can be accepted by NCTracks; however, that did not prove true in our review of the encounter data. Vaya should be capturing up to the maximum allowed and submitting to NC Medicaid.

Resolution:

Vaya should expand the number of diagnosis codes being captured in their system. This update will also require Vaya to modify their 837 mapping to ensure all diagnosis codes captured are sent to NC Medicaid moving forward for both Institutional and Professional claims.

Conclusion

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

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

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

Appendix 1

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

00117	ONLY ONE DOS ALLOWED/LINE	PAY AND REPORT
00126	TOOTH SURFACE MISSING/INVALID	IGNORE
00127	QUAD CODE MISSING/INVALID	IGNORE
00128	PROC CDE DOESNT MATCH TOOTH #	IGNORE
00132	HCPCS CODE REQ FOR REV CODE	IGNORE
00133	HCPCS CODE REQ BILLING RC 0636	IGNORE
00135	INVL POS INDEP MENT HLTH PROV	PAY AND REPORT
00136	INVLD POS FOR IDTF PROV	PAY AND REPORT
00140	BILL TYPE/ADMIT DATE/FDOS	DENY
00141	MEDICAID DAYS CONFLICT	IGNORE
00142	UNITS NOT EQUAL TO DOS	PAY AND REPORT
00143	REVIEW FOR MEDICAL NECESSITY	IGNORE
00144	FDOS AND TDOS MUST BE THE SAME	IGNORE
00146	PROC INVLD - BILL PROV TAXON	PAY AND REPORT
00148	PROC\REV CODE INVLD FOR POS	PAY AND REPORT
00149	PROC\REV CD INVLD FOR AGE	IGNORE
00150	PROC CODE INVLD FOR RECIP SEX	IGNORE
00151	PROC CD/RATE INVALID FOR DOS	PAY AND REPORT
00152	M/I ACC/ANC PROC CD	PAY AND REPORT
00153	PROC INVLD FOR DIAG	PAY AND REPORT
00154	REIMB RATE NOT ON FILE	PAY AND REPORT
00157	VIS FLD EXAM REQ MED JUST	IGNORE
00158	CPT LAB CODE REQ FOR REV CD	IGNORE
00164	IMMUNIZATION REVIEW	IGNORE
00166	INVALID VISUAL PROC CODE	IGNORE
00174	VACCINE FOR AGE 00-18	IGNORE

00175	CPT CODE REQUIRED FOR RC 0391	IGNORE
00176	MULT LINES SAME PROC, SAME TCN	IGNORE
00177	HCPCS CODE REQ W/ RC 0250	IGNORE
00179	MULT LINES SAME PROC, SAME TCN	IGNORE
00180	INVALID DIAGNOSIS FOR LAB CODE	IGNORE
00184	REV CODE NOT ALLOW OUTPAT CLM	IGNORE
00190	DIAGNOSIS NOT VALID	DENY
00192	DIAG INVALID RECIP AGE	IGNORE
00194	DIAG INVLD FOR RECIP SEX	IGNORE
00202	HEALTH CHECK SHADOW BILLING	IGNORE
00205	SPECIAL ANESTHESIA SERVICE	IGNORE
00217	ADMISSION TYPE CODE INVALID	PAY AND REPORT
00250	RECIP NOT ON ELIG DATABASE	DENY
00252	RECIPIENT NAME/NUMBER MISMATCH	PAY AND REPORT
00253	RECIP DECEASED BEFORE HDR TDOS	DENY
00254	PART ELIG FOR HEADER DOS	PAY AND REPORT
00259	TPL SUSPECT	PAY AND REPORT
00260	M/I RECIPIENT ID NUMBER	DENY
00261	RECIP DECEASED BEFORE TDOS	DENY
00262	RECIP NOT ELIG ON DOS	DENY
00263	PART ELIG FOR LINE DOS	PAY AND REPORT
00267	DOS PRIOR TO RECIP BIRTH	DENY
00295	ENC PRV NOT ENRL TAX	IGNORE
00296	ENC PRV INV FOR DOS	IGNORE
00297	ENC PRV NOT ON FILE	IGNORE
00298	RECIP NOT ENRL W/ THIS ENC PRV	IGNORE

00299	ENCOUNTER HMO ENROLLMENT CHECK	PAY AND REPORT
00300	BILL PROV INVALID/ NOT ON FILE	DENY
00301	ATTEND PROV M/I	PAY AND REPORT
00308	BILLING PROV INVALID FOR DOS	DENY
00313	M/I TYPE BILL	PAY AND REPORT
00320	VENT CARE NO PAY TO PRV TAXON	IGNORE
00322	REND PROV NUM CHECK	IGNORE
00326	REND PROV NUM CHECK	PAY AND REPORT
00328	PEND PER DHB REQ FOR FIN REV	IGNORE
00334	ENCOUNTER TAXON M/I	PAY AND REPORT
00335	ENCOUNTER PROV NUM MISSING	DENY
00337	ENC PROC CODE NOT ON FILE	PAY AND REPORT
00339	PRCNG REC NOT FND FOR ENC CLM	PAY AND REPORT
00349	SERV DENIED FOR BEHAV HLTH LM	IGNORE
00353	NO FEE ON FILE	PAY AND REPORT
00355	MANUAL PRICING REQUIRED	PAY AND REPORT
00358	FACTOR CD IND PROC NON-CVRD	PAY AND REPORT
00359	PROV CHRGS ON PER DIEM	PAY AND REPORT
00361	NO CHARGES BILLED	DENY
00365	DRG - DIAG CANT BE PRIN DIAG	DENY
00366	DRG - DOES NOT MEET MCE CRIT.	PAY AND REPORT
00370	DRG - ILLOGICAL PRIN DIAG	PAY AND REPORT
00371	DRG - INVLD ICD-9-CM PRIN DIAG	DENY
00374	DRG PAY ON FIRST ACCOM LINE	DENY
00375	DRG CODE NOT ON PRICING FILE	PAY AND REPORT
00378	DRG RCC CODE NOT ON FILE DOS	PAY AND REPORT

00439	PROC\REV CD INVLD FOR AGE	IGNORE
00441	PROC INVLD FOR DIAG	IGNORE
00442	PROC INVLD FOR DIAG	IGNORE
00613	PRIM DIAG MISSING	DENY
00628	BILLING PROV ID REQUIRED	IGNORE
00686	ADJ/VOID REPLC TCN INVALID	DENY
00689	UNDEFINED CLAIM TYPE	IGNORE
00701	MISSING BILL PROV TAXON CODE	DENY
00800	PROC CODE/TAXON REQ PSYCH DX	PAY AND REPORT
00810	PRICING DTE INVALID	IGNORE
00811	PRICING CODE MOD REC M/I	IGNORE
00812	PRICING FACTOR CODE SEG M/I	IGNORE
00813	PRICING MOD PROC CODE DTE M/I	IGNORE
00814	SEC FACT CDE X & % SEG DTE M/I	IGNORE
00815	SEC FCT CDE Y PSTOP SEG DT M/I	IGNORE
01005	ANTHES PROC REQ ANTHES MODS	IGNORE
01060	ADMISSION HOUR INVALID	IGNORE
01061	ONLY ONE DOS PER CLAIM	IGNORE
01102	PRV TAXON CHCK - RAD PROF SRV	IGNORE
01200	INPAT CLM BILL ACCOM REV CDE	DENY
01201	MCE - ADMIT DTE = DISCH DTE	DENY
01202	M/I ADMIT AND DISCH HRS	DENY
01205	MCE: PAT STAT INVLD FOR TOB	DENY
01207	MCE - INVALID AGE	PAY AND REPORT
01208	MCE - INVALID SEX	PAY AND REPORT
01209	MCE - INVALID PATIENT STATUS	DENY

01705	PA REQD FOR CAPCH/DA/CO RECIP	PAY AND REPORT
01792	DME SUPPLIES INCLD IN PR DIEM	DENY
02101	INVALID MODIFIER COMB	IGNORE
02102	INVALID MODIFIERS	PAY AND REPORT
02104	TAXON NOT ALLOWED WITH MOD	PAY AND REPORT
02105	POST-OP DATES M/I WITH MOD 55	IGNORE
02106	LN W/ MOD 55 MST BE SAME DOS	IGNORE
02107	XOVER CLAIM FOR CAP PROVIDER	IGNORE
02111	MODIFIER CC INTERNAL USE ONLY	IGNORE
02143	CIRCUMCISION REQ MED RECS	IGNORE
03001	REV/HCPCS CD M/I COMBO	IGNORE
03010	M/I MOD FOR PROF XOVER	IGNORE
03012	HOME HLTH RECIP NOT ELG MCARE	IGNORE
03100	CARDIO CODE REQ LC LD LM RC RI	IGNORE
03101	MODIFIER Q7, Q8 OR Q9 REQ	IGNORE
03200	MCE - INVALID ICD-9 CM PROC	DENY
03201	MCE INVLD FOR SEX PRIN PROC	PAY AND REPORT
03224	MCE-PROC INCONSISTENT WITH LOS	PAY AND REPORT
03405	HIST CLM CANNOT BE ADJ/VOIDED	DENY
03406	HIST REC NOT FND FOR ADJ/VOID	DENY
03407	ADJ/VOID - PRV NOT ON HIST REC	DENY
04200	MCE - ADMITTING DIAG MISSING	DENY
04201	MCE - PRIN DIAG CODE MISSING	DENY
04202	MCE DIAG CD - ADMIT DIAG	DENY
04203	MCE DIAG CODE INVLD RECIP SEX	PAY AND REPORT
04206	MCE MANIFEST CODE AS PRIN DIAG	DENY

04207	MCE E-CODE AS PRIN DIAG	DENY
04208	MCE - UNACCEPTABLE PRIN DIAG	DENY
04209	MCE - PRIN DIAG REQ SEC DIAG	PAY AND REPORT
04210	MCE - DUPE OF PRIN DIAG	DENY
04506	PROC INVLD FOR DIAG	IGNORE
04507	PROC INVLD FOR DIAG	IGNORE
04508	PROC INVLD FOR DIAG	IGNORE
04509	PROC INVLD FOR DIAG	IGNORE
04510	PROC INVLD FOR DIAG	IGNORE
04511	PROC INVLD FOR DIAG	IGNORE
07001	TAXON FOR ATTND/REND PROV M/I	DENY
07011	INVLD BILLING PROV TAXON CODE	DENY
07012	INVLD REND PROV TAXONOMY CODE	DENY
07013	INVLD ATTEND PROV TAXON CODE	PAY AND REPORT
07100	ANESTH MUST BILL BY APPR PROV	IGNORE
07101	ASC MODIFIER REQUIREMENTS	IGNORE
13320	DUP-SAME PROV/AMT/DOS/PX	DENY
13420	SUSPECT DUPLICATE-OVERLAP DOS	PAY AND REPORT
13460	POSSIBLE DUP-SAME PROV/PX/DOS	PAY AND REPORT
13470	LESS SEV DUPLICATE OUTPATIENT	PAY AND REPORT
13480	POSSIBLE DUP SAME PROV/OVRLAP	PAY AND REPORT
13490	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13500	POSSIBLE DUP-SAME PROVIDER/DOS	PAY AND REPORT
13510	POSSIBLE DUP/SME PRV/OVRLP DOS	PAY AND REPORT
13580	DUPLICATE SAME PROV/AMT/DOS	PAY AND REPORT
13590	DUPLICATE-SAME PROV/AMT/DOS	PAY AND REPORT

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