2020 External Quality Review

VAYA HEALTH

Submitted: March 19, 2021
Revised: July 6, 2021

Prepared on behalf of the
North Carolina Medicaid

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EXECUTIVE SUMMARY

The *Balanced Budget Act of 1997* requires State Medicaid Agencies that contract with Prepaid Inpatient Health Plans (PIHPs) to evaluate their compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358 (42 CFR § 438.358)*. This review determines the level of performance demonstrated by the PIHP. This report contains a description of the process and the results of the 2020 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of North Carolina Medicaid (NC Medicaid).

Goals of the review are to:

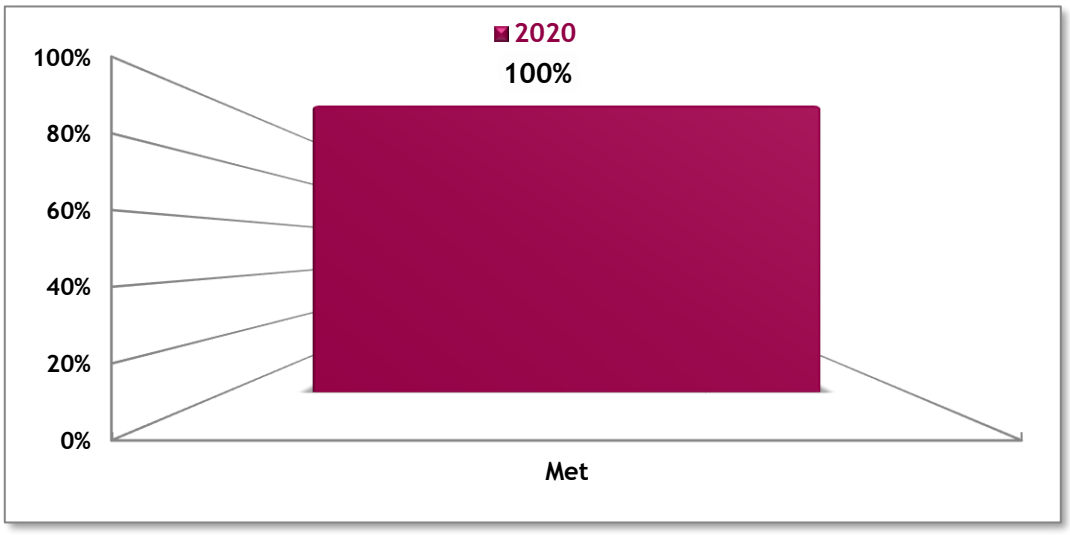
- Determine if Vaya Health (Vaya) complies with service delivery as mandated by their *NC Medicaid Contract*
- Provide feedback for potential areas of further improvement
- Verify the delivery and determine the quality of contracted health care services

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, an Onsite visit, compliance review, validation of performance improvement projects (PIPs), validation of performance measures (PMs), validation of encounter data, an Information System Capabilities Assessment (ISCA) Audit, and Medicaid program integrity review of the PIHP. Due to COVID-19 pandemic, the 2020 EQR was delayed and CCME implemented a focused review.

Overall Score

In the 2020 Annual EQR, Vaya originally met 96% of the standards reviewed and 4% of the standards were scored as “Partially Met”. As a result of these findings, CCME issued seven Corrective Actions across the Administrative, Grievances, Appeals and Program Integrity sections. Vaya disputed these findings and the State on June 18, 2021 informed CCME that all seven of the Corrective Actions issued by CCME should be converted to Recommendations and all scores should be changed to “Met”. This resulted in Vaya’s Overall score changing from 96% to 100%.

Figure 1: Annual EQR Results



Overall Findings

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

Administration

In the 2019 EQR, Vaya met 90% of the Administrative standards, which included the 2019 ISCA review. Vaya received four Corrective Actions related to Vaya's need to better capture and report ICD-10 Procedure and Diagnosis codes. Vaya successfully implemented two of the 2019 Corrective Actions. Vaya has not implemented the Correction Action to report all ICD-10 Diagnosis codes on Institutional encounters to NCTracks, and this remains a Corrective Action for the 2020 EQR. Two Recommendations were also issued for the 2020 EQR. Both Recommendations center around improving Vaya's ability to submit State required data element to NCTracks. As a result, Vaya met 92% of the standards in the 2020 EQR.

Revision: Vaya disputed these findings and the State on June 18, 2021 informed CCME that this 2020 Corrective Action issued by CCME should be converted to a Recommendation and the score in this Administrative section changed from 92% to 100%.

Provider Services

In Vaya's 2019 EQR, there were no items requiring Corrective Action and three Recommendations in the Credentialing/Recredentialing section of Provider Services. Vaya addressed the three Recommendations, though opportunities for improvement persist in

the two standards regarding insurance. Vaya met 100% of the Provider Services standards in the 2020 EQR.

Quality Improvement

In the 2019 EQR there were two PIPs that had Corrective Actions items that were addressed in the 2019 Corrective Action Plan (CAP) process. There were no Recommendations given for the 2019 EQR for the Performance Measures and PIPs. The 2019 EQR validation scores for (b) Waiver and (c) Waiver measures were fully compliant, with an average validation score of 100%. For the 2020 EQR, four PIPs were validated, and all PIPs scored in the High Confidence range. The 2020 EQR has no Corrective Action items, although two PIPs have Recommendations for improvement. The Performance Measure Query was accurate for (b) Waiver Measures and all measures were validated at 100%, fully compliant. The five (c) Waiver Performance Measures were above benchmark rates. All standards were met and all (c) Waiver Measures and were validated at 100%, for this 2020 EQR.

Utilization Management

In the 2019 EQR, Vaya met 93% of UM standards. Four Corrective Actions were issued. One Corrective Action was geared towards incorrect information within Policy 2382, regarding Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) cost limits. The second Corrective Action addressed Vaya's ability to produce an enrollee's complete Care Coordination record. Vaya disputed these two 2019 Corrective Actions. Per feedback from the State on May 28, 2021, Vaya's dispute of this score resulted in changing the second Corrective Action to a Recommendation and changing the score on the related standard from "Partially Met" to "Met". Per feedback from the State on May 28, 2021, the State upheld the finding of requiring correction of the EPSDT policy. Vaya completed this policy edit through the Corrective Action process in June of 2021.

The third Corrective Action required Vaya to enhance their monitoring of Care Coordination progress notes, based on patterns of late notes and gaps in engagement by Care Coordinators. In the 2020 EQR, it was noted Vaya incorporated a two-part monitoring process that uses data derived from Incedo to identify significant areas of risk. This data is used in conjunction with manual record reviews completed by Care Managers and Supervisors. While the monitoring plan was enhanced, weaknesses in Care Coordination documentation were again identified. The review found untimely monitoring of I/DD Innovations enrollees and a lack of documented interventions in MH/SUD progress notes. Similar findings were identified in the TCLI files, in which no documentation was found showing staff participation in the development of the enrollees' Person-Centered Plan.

Grievances and Appeals

In the 2019 EQR, Vaya met 90% of the Grievance and Appeal standards. Two Corrective Actions and seven Recommendations were issued to address concerns noted primarily in the *Member and Caregiver Handbook* and the grievance and appeal files.

In this, the 2020 EQR, Vaya again met 90% of the Grievance and Appeal standards resulting in one Corrective Action in Grievances and one Corrective Action in Appeals. One Recommendation was offered in each section, as well. The Corrective Actions for both grievances and appeals involve enhancing the monitoring to grievances and appeals to ensure improved compliance with required notifications. The Recommendations in both sections encouraged accurate and complete data is captured within the Grievance and Appeal Logs.

Revision: Vaya disputed these findings and the State on June 18, 2021 informed CCME that these two 2020 Corrective Actions issued by CCME should be converted to Recommendations and the score in the Grievance and Appeal section changed from 90% to 100%.

Program Integrity

In the 2019 EQR, Vaya met 92% of the Program Integrity (PI) standards. Five Corrective Actions were issued in the 2019 EQR to address compliance issues found within the PI files reviewed and missing language from Vaya's policies and procedures. It should be noted that Vaya disputed with the State two of these 2019 Corrective Actions. Under the State's direction provided on May 28, 2021, these Corrective Actions were changed to Recommendations and the scores on the related standards changed from "Partially Met" and "Not Met" changed to "Met".

In the 2020 EQR, there was evidence that Vaya addressed four of the five 2019 Corrective Actions. The Corrective Action not addressed was one of the items disputed by Vaya. This Corrective Action required language to be added to a policy and procedure regarding the monthly NCID holder/FAMS-users report. CCME has again issued a Corrective Action to ensure this contractual requirement is within a Vaya procedure. Another Corrective Action issued in this 2020 EQR is related to the timely submission of Regulatory Compliance minutes to the State, when requested. Through corroboration with the State, it was identified that no minutes had been submitted to the State for at least seven months, although minutes are requested by the State each month. The last two Corrective Actions targeted timeliness issues related to initiating preliminary investigations. Six of the files reviewed showed Vaya did not initiate investigations within the ten business days required by their *NC Medicaid Contract*. One of these files showed the investigation did not start until 74 days after receipt of the allegation. Lastly, two of the files reviewed did not contain the "amount paid to the provider for the last three years (amount by year) or during the period of the alleged misconduct, whichever is

greater." This information is required to be provided on the State approved template. As four PI standards were partially met, Vaya met 93% of the PI standards in this year's EQR.

Revision: Vaya disputed these findings and the State on June 18, 2021 informed CCME that these four 2020 Corrective Actions issued by CCME should be converted to Recommendations and the score in this Program Integrity section changed from 93% to 100%.

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 CMS and NC Medicaid standards.

Similar to last year, the biggest issue we noted for Vaya was the low frequency of Diagnosis code reporting for both professional and institutional claims. Although Other Diagnosis codes do not impact claim adjudication, the codes are critical to evaluating member health and factors that will be used in a value based payment model. Vaya should continue to work with its providers to encourage complete and accurate reporting of all known diagnoses.

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. Absent this, we are unable 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 select medical records be requested from providers to validate that the encounter data matches what is documented in the medical records.

METHODOLOGY

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

On November 2, 2020, 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 Vaya 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 on November 22, 2020, and reviewed by CCME (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. The Desk Review included a review of Credentialing, Grievance, Program Integrity, Care Coordination, and Appeal files.

The second segment of the EQR is typically a two-day Onsite review conducted at the PIHP's offices. However, due to COVID-19, this Onsite was conducted through a teleconference platform on February 18, 2021. This Onsite visit focused on areas not covered in the Desk Review and areas needing clarification. For a list of items requested for the Onsite visit, see Attachment 2. CCME's Onsite activities included:

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

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

FINDINGS

The findings of the EQR are summarized in the following pages of this report and are based on the regulations set forth in *42 CFR § 438.358* 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. Information Systems Capabilities Assessment (ISCA)

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

In the 2019 EQR, Vaya met 90% of the Administrative standards, which included the 2019 ISCA review, and received four Corrective Actions related to Vaya's need to better capture and report ICD-10 Procedure and Diagnosis codes. Vaya successfully implemented two of the 2019 Corrective Actions and are in the final phase of testing the third Corrective Action. Vaya has not implemented the Corrective Action to report all ICD-10 Diagnosis codes on Institutional encounters to NCTracks, and this remains a Corrective Action for the 2020 EQR.

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

The ISCA tool and supporting documentation for enrollment systems loading processes clearly define the process for enrollment data updates in the AlphaMCS enrollment system. During the ISCA Onsite, 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 daily into the AlphaMCS by their vendor WellSky.

During the Onsite, Vaya stated they also load the GEF files to a local database that is used to compare the records with AlphaMCS. Vaya confirmed they rarely encounter errors while comparing the local database with AlphaMCS.

Vaya stores the Medicaid identification number received on the GEF. During the Onsite, Vaya indicated that they rarely see members with multiple IDs, but are able to research and merge the information into one Member ID. The historical claims for the member are also merged into one Member ID. Vaya has experienced a small decrease in year-end enrollment numbers over the past three years.

Table 1: Enrollment Counts

2017	2018	2019
168,432	162,160	144,069

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

Vaya's authorizations and claims are processed in the AlphaMCS system. A review of Vaya's processes for collecting, adjudicating, and reporting claims was conducted through a review of its ISCA response and supporting documentation provided. A demonstration of Vaya's Provider web claims entry portal and the AlphaMCS claims processing system was performed during the Onsite.

Vaya receives claims from three methods, 837 electronic file, provider web portal and paper claims. During the Onsite, Vaya stated that they receive claims from out-of-state providers on paper. Table 2 details the percentage of 2019 claims received via the three methods.

Table 2: Percent of claims with 2019 dates of service that were received via Electronic (HIPAA, Provider Web Portal) or Paper forms.

Source	HIPAA File	Paper	Provider Web Portal
Institutional	74.2%	<1%	25.7%
Professional	88.1%	<1%	11.9%

Vaya processes claims within 18 days of receipt, and, if approved, claims are paid within 30 days of receipt. If a required field is missing from a claim, 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 HIPAA 999 response file advising the provider of the claim submission failure. Vaya claims processors do not change any information on the claims.

Vaya conducts audits of claims processed on a daily basis. Vaya staff conduct random audits of 3% of all claims processed. Coordination of Benefits (COB) audits and Program Integrity suspected fraud audits are also conducted on a regular basis. Paper claims are also included in the random sample of 3% daily audit and COB audits. High dollar claims that are higher than $5,000 are audited on a daily basis. Vaya Claims specialist staff and managers review 100% of claims examined by new hire claim examiners.

Vaya has addressed and implemented a Corrective Action from the 2019 EQR resulting in Vaya's ability to capture up to 25 ICD-10 Diagnosis codes on both the provider web portal and via HIPAA files for Institutional claims. For Professional claims, the PIHP has the ability to receive and store up to 12 Diagnosis codes on both the provider web portal and via HIPAA files.

Vaya captures ICD-10 Procedure codes and Diagnosis Related Groups (DRGs), if they are submitted on the claim on both provider web portal and via HIPAA files. This addressed the Corrective Action from the 2019 EQR.

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

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

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

The breakdown of encounter data acceptance/denial rates was provided for 2019. Table 3 provides a comparison of 2018 and 2019.

Table 3: Volume of 2018 and 2019 Submitted Encounter Data

2019	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Total
Institutional	40,592	483	1,162	42,237
Professional	1,770,387	23,358	14,391	1,808,136
2018	**Initially Accepted**	**Denied, Accepted on Resubmission**	**Denied, Not Yet Accepted**	**Total**
Institutional	40,220	327	2,340	42,887
Professional	1,805,662	22,360	42,896	1,870,918

Vaya has 99.2% acceptance rate for both Professional and Institutional encounters with dates of service in 2019. As a follow-up after the Onsite, Vaya provided the five top denial reason codes for encounters in 2019:

- Billing provider must be enrolled for billing Taxonomy code
- Duplicate service or procedure
- Billing/rendering provider terminated
- Taxonomy code for attending or rendering provider missing
- Less severe duplicate-outpatient

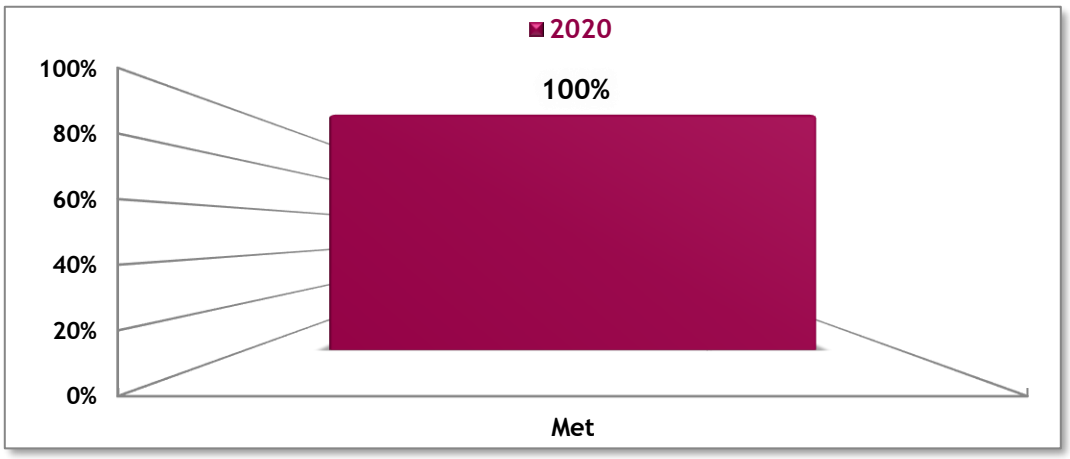
On average, Vaya submits an encounter within five days from the time of adjudication to NCTracks. It takes approximately 54 days to correct and resubmit an encounter to NCTracks. Vaya uses the Adam Holtzman's Encounter Summary by MCO Check write and an encounter denial detail report to identify encounters that were denied. Vaya exceeds the NC Medicaid standards for encounter submissions and has less than 0.8% denial rate of their encounter data submissions.

Vaya advised the number of ICD-10 Diagnosis codes submitted on Institutional and Professional encounters to NC Medicaid. Vaya is submitting up to 12 ICD-10 Diagnosis codes for both Institutional and Professional encounters. Vaya has not addressed the Corrective Action from the 2019 EQR and is submitting only up to 12 ICD-10 Diagnosis codes on Institutional claims to NCTracks. During the Onsite, Vaya stated that they encountered rejects while reporting more than 12 ICD-10 Diagnosis codes on Institutional encounters. It is recommended that Vaya work with NC Medicaid if they encounter rejects while submitting more than 12 ICD-10 Diagnosis codes on Institutional encounters.

Vaya stated that they will start testing the process to report up to 25 ICD-10 Diagnosis codes on Institutional encounters to NCTracks. Vaya does not submit DRG and ICD-10 Procedure codes on Institutional encounters to NCTracks. Vaya is in the process of testing submission of ICD-10 Procedure codes to NCTracks.

Revision: Vaya disputed these findings and the State on June 18, 2021 informed CCME that this 2020 Corrective Action issued by CCME should be converted to a Recommendation and the score in this Administrative section should be changed from 92% to 100%.

Figure 2: ISCA Findings



Strengths

- Vaya can capture of up to 25 Diagnosis codes on Institutional claims and 12 Diagnosis codes on Professional claims.
- Vaya can capture the DRG and ICD-10 Procedure codes on Institutional claims on the Provider Web Portal and via HIPAA files.
- Vaya's current NCTracks encounter data acceptance rate is approximately 99.2%. Vaya has a very high acceptance rate of encounter data submission and has improved their acceptance rate since 2018.

Weaknesses

- Vaya does not have the ability to submit ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks.
- Vaya does not have the ability to submit DRG codes on Institutional encounter data extracts to NCTracks.
- Vaya does not have the ability to submit more than 12 ICD-10 Diagnosis codes on Institutional encounter data extracts to NCTracks.

Recommendations

- Update Vaya's encounter data submission process to increase the number of ICD-10 Diagnosis codes reported on an Institutional encounter to NC Tracks.
- Continue to work with providers and the State to submit ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks.
- Update Vaya's encounter data submission process to submit DRG codes on Institutional encounter data extracts to NCTracks.

B. Provider Services

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

In Vaya's 2019 EQR of Credentialing/Recredentialing, there were no items requiring Corrective Action. There were three Recommendations, which Vaya addressed, though some opportunities for improvement persist.

Policy and Procedure 2891 (designated as the *Credentialing Program Description*) and the *CCC* guide the credentialing and recredentialing processes at Vaya. The credentialing and recredentialing file review showed the files were organized and contained appropriate information with a few exceptions, as outlined in the "Weaknesses" section and the Tabular Spreadsheet of this report.

The Credentialing Committee is chaired by Dr. Craig Martin, the Chief Medical Officer (CMO). There is some conflicting language regarding who will chair the committee in the absence of the CMO. The *CCC* indicates the Vice Chair will chair the committee meetings in the absence of the Chair; however, the Vice Chair position is currently vacant. The *Credentialing Program Description* states "The committee is chaired by Vaya's Chief Medical Officer (CMO). The Chair is a permanent member of the committee. If the CMO is unable to attend the meeting, the Assistant Medical Director or other contracted/ employed psychiatrist attends as the CMO's designee." However, nothing indicates the Assistant Medical Director or "other contracted/employed psychiatrist" is the Vice Chair of the committee, and the Assistant Medical Director position is currently vacant. At the Onsite, Dr. Martin indicated Vaya has been recruiting for the Assistant Medical Director position and has offered it to someone. Once the position is filled, the Assistant Medical Director would cover in Dr. Martin's absence. In the interim, Dr. Wade, the Medical Director for Integrated Care, is available to cover, though Dr. Martin indicated he has not missed a meeting in at least a year-and-a-half.

The *Committee Membership Matrix* and the *Credentialing Committee Charter* indicate current voting membership is four provider representatives and six Vaya staff members, including the Vaya CMO, who is "permitted to break a tie." The Credentialing Committee meeting minutes reflect committee discussion of and decisions about "flagged" applications. Approval of "unflagged" credentialing applications that "meet criteria for participation" is delegated to the CMO or physician designee. The list of unflagged applicants approved by the CMO and the list of flagged applicants (with relevant information that resulted in the 'flag') are provided to the "Credentialing Committee members at least three business days prior to the scheduled Committee meeting", for their review, "in preparation for discussion at the Committee meeting". A quorum was present at the Credentialing Committee meetings for which minutes were submitted for this EQR.

Newly contracted providers receive a letter that provides information about their contract and how to contact Provider Network Operations and Vaya's Contracts Department. The letter contains links to a variety of items on the Vaya website, including the *Provider Operations Manual*, Provider Central, and the Provider Learning Lab.

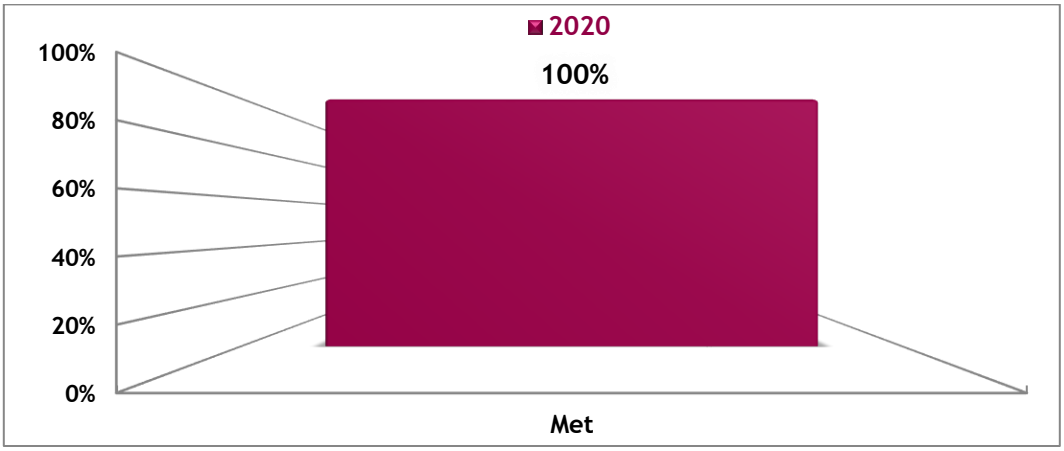
An Events Calendar on the Vaya website includes information about available trainings, which are provided virtually due to the pandemic. The Provider Learning Lab on the Provider Central section of the website provides access to the Provider Webinars and the Communication Bulletins Archive.

Under the COVID-19 flexibilities as outlined in *NC Medicaid Contract, Amendment #9*, the annual *Network Adequacy and Accessibility Analysis* (Gaps Analysis) will be submitted "no later than ninety (90) calendar days after termination of the Amendment." At the last EQR, Vaya reported they filed, and NC Medicaid approved, *Exception Requests* for nine of the ten gaps in choice and access, 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.

During the Onsite review for this EQR, Vaya staff discussed actions taken to address the previously identified gaps and reported Vaya is continuing to show progress in meeting the gaps. Due to adding telehealth services because of the pandemic, Vaya has actually expanded access in rural areas.

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

Figure 3: Provider Services Findings



Strengths

- 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.
- In response to COVID-19, Vaya's Provider Network Operations Department established weekly virtual Question and Answer events, for collaborative discussion of "issues experienced by the network, to share the latest information and resources, and quickly develop solutions to changing needs." Additional steps included increasing rates for some providers, and purchasing/providing "500 cellular smart phones and corresponding data plans, issuing the phone to providers for distribution to members who lack the necessary technology/equipment for telehealth."

Weaknesses

- There is conflicting language in the *Credentialing* Committee *Charter* and the *Credentialing Program Description* regarding who chairs the committee in the absence of the CMO.
- One of the four initial credentialing files submitted for practitioners was missing proof of some of the required types of insurance (or an explanation/attestation of why it would not be required), and evidence that the Licensed Practitioner was covered under the agency insurance. At the last EQR and at several previous EQRs, Vaya has received Recommendations regarding insurance requirements.
- The four initial credentialing files and four recredentialing files submitted for practitioners either did not contain Ownership Disclosure information, or the information was incomplete. In response to CCME's request, Vaya submitted the

Ownership Disclosure (from the contracted agency files) for the Licensed Practitioner (LP) files. During the Onsite discussion, Vaya staff confirmed they do not ask Licensed Independent Practitioners (LIPs) about managing employees, but have now revised their *Credentialing Initiation Form* (*CIF*) to ask about managing employees, going forward.

Recommendations

- Revise the *Credentialing Committee Charter*, Policy 2891 (designated as the *Credentialing Program Description*), and any other documents that detail credentialing processes, to consistently reflect who will chair the Credentialing Committee meetings in the absence of the CMO.

- Prior to approving credentialing or recredentialing, verify all files contain:
  - Proof of all required insurance coverage (or an attestation/waiver for automobile insurance and Worker's Comp/Employer's Liability, if coverage is not required), and a statement that the practitioner is covered under all agency insurance. *See NC Medicaid Contract, Attachment B, Section 7.7.4* and *Attachment N*.
  - Ownership Disclosure, including information regarding managing employees as required by *NC Medicaid Contract Attachment B, Section 1.13* and *NC Medicaid Contract Attachment O, #6.*

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.

C. Quality Improvement

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

In the 2019 EQR, there were two PIPs that had Corrective Actions items that were addressed in the 2019 Corrective Action Plan (CAP) process. There were no Recommendations given for the 2019 EQR for the PMs and PIPs. The 2019 EQR validation scores for (b) Waiver and (c) Waiver Performance Measures were fully compliant with an average validation score of 100%.

For the 2020 EQR, four PIPs were validated, and all PIPS scored in the High Confidence range. The 2020 EQR has no Corrective Action items, although two PIPs have recommendations for improvement. The Performance Measure Query was accurate for (b)

Waiver Measures and all measures were validated at 100%, fully compliant. At the Onsite, discussion included measures with rate increases and measures with rate decreases when compared to the 2019 EQR. The five (c) Waiver Performance Measures were above benchmark rates and did not require further Onsite discussion. All (c) Waiver Measures were validated at 100%, fully compliant, for this 2020 EQR.

Performance Measure Validation

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

Table 4: (b) Waiver Measures

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

Table 5: (c) Waiver Measures

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

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

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

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

(b) Waiver Measures Reported Results

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

There was a substantial increase in the *7-day* and *30-day Follow-up After Hospitalization for Mental Illness* for the Facility Based Crisis (FBC) population. The 7-day rate improved by 21% and the 30-day rate improved by almost 16%. There was also improvement in *Follow-up After Hospitalization for Substance Abuse* for Detox/FBC population, with a 16% improvement in 3-day, 14% improvement in 7-day, and nearly 15% improvement in 30-day follow up rates. Substantial declines of >10% occurred for the *30-day Follow-up After Hospitalization for Substance Abuse* for Detox/FBC subpopulation; *Alcohol and Other Drug Dependance (AODD) Engagement* for age 13–17 (11% decline), age 18-20 (11% decline), age 21-34 (11.5% decline), and age 35-64 (13% decline); and total (12% decline).

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

30-day Readmission Rates for Mental Health	2018	2019	Change
Inpatient (Community Hospital Only)	11.0%	11.7%	0.7%
Inpatient (State Hospital Only)	0.0%	4.2%	4.2%
Inpatient (Community and State Hospital Combined)	10.9%	12.1%	1.2%
Facility Based Crisis	4.1%	7.2%	3.1%
Psychiatric Residential Treatment Facility (PRTF)	18.3%	18.0%	-0.3%
Combined (includes cross-overs between services)	12.9%	13.9%	1.0%

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

30-day Readmission Rates for Substance Abuse	2018	2019	Change
Inpatient (Community Hospital Only)	13.1%	14.9%	1.8%
Inpatient (State Hospital Only)	0.0%	0.7%	0.7%
Inpatient (Community and State Hospital Combined)	12.7%	12.4%	-0.3%
Detox/Facility Based Crisis	6.0%	7.4%	1.4%
Combined (includes cross-overs between services)	11.7%	15.4%	3.7%

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

Follow-up after Hospitalization for Mental Illness	2018	2019	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	52.2%	46.4%	**-5.8%**
Percent Received Outpatient Visit Within 30 Days	68.7%	63.0%	**-5.7%**
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	56.5%	77.8%	**21.3%**
Percent Received Outpatient Visit Within 30 Days	69.6%	85.2%	**15.6%**
PRTF			
Percent Received Outpatient Visit Within 7 Days	30.4%	25.7%	-4.7%
Percent Received Outpatient Visit Within 30 Days	62.0%	59.5%	-2.5%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	51.4%	46.1%	-5.3%
Percent Received Outpatient Visit Within 30 Days	68.4%	63.2%	-5.2%

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

Follow-up after Hospitalization for Substance Abuse	2018	2019	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	30.0%	28.7%	**-1.3%**
Percent Received Outpatient Visit Within 30 Days	38.0%	37.9%	**-0.1%**
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	40.9%	57.0%	16.1%
Percent Received Outpatient Visit Within 7 Days	46.4%	60.8%	14.4%
Percent Received Outpatient Visit Within 30 Days	53.6%	68.4%	14.8%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NR
Percent Received Outpatient Visit Within 7 Days	35.2%	34.7%	-0.6%
Percent Received Outpatient Visit Within 30 Days	42.9%	43.6%	0.7%

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2018	2019	Change
Ages 13-17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	36.6%	34.4%	-2.2%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	36.6%	25.8%	-10.8%
Ages 18-20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	40.7%	38.0%	-2.7%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	36.7%	25.7%	-11.0%
Ages 21-34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	50.6%	50.8%	0.2%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	50.2%	38.7%	-11.5%
Ages 35-64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	46.7%	43.2%	-3.5%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	41.6%	28.9%	-12.7%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	33.7%	28.3%	-5.4%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	25.8%	19.8%	-6.0%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	46.5%	44.3%	-2.2%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	43.3%	31.3%	-12.0%

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

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		2018	2019	Change	2018	2019	Change
3-12	Male	0.4	0.4	0.0	39.2	39.7	0.5
	Female	0.4	0.4	0.0	29.1	17.7	-11.4
	Total	0.4	0.4	0.0	34.7	30.2	-4.5
13-17	Male	1.7	1.7	0.0	34.6	37.9	3.3
	Female	2.9	2.9	0.0	26.0	25.0	-1.0
	Total	2.3	2.3	0.0	29.3	30.0	0.7
18-20	Male	1.9	1.7	-0.2	10.2	8.7	-1.5
	Female	2.2	2.2	0.0	13.4	9.9	-3.5
	Total	2.1	1.9	0.0	12.0	9.4	-2.6
21-34	Male	5.1	5.9	0.0	9.9	8.6	-1.3
	Female	2.1	2.2	0.1	7.1	8.1	1.0
	Total	2.9	3.2	0.3	8.3	8.4	0.1
35-64	Male	3.6	4.3	0.7	10.1	9.7	-0.4
	Female	2.8	3.2	0.4	8.9	8.9	0.0
	Total	3.1	3.7	0.6	9.5	9.3	0.0
65+	Male	0.6	0.6	0.0	8.9	13.2	0.0
	Female	0.4	0.5	0.0	14.5	12.1	-2.4
	Total	0.5	0.5	0.0	12.3	12.5	0.2
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**	**1.7**	**1.9**	**0.2**	**17.2**	**16.9**	**-0.3**
	Female	**1.7**	**1.7**	**0**	**14.2**	**13.0**	**-1.2**
	Total	**1.7**	**1.8**	**0.1**	**15.5**	**14.8**	**-0.7**

Table 12: D.2. Mental Health Utilization -% of Members that Received at Least 1 Mental Health Service in the Category Indicated during the Measurement Period

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
3-12	Male	17.17%	16.92%	-0.25%	0.39%	0.23%	-0.16%	1.22%	1.14%	-0.08%	17.05%	16.79%	-0.26%
	Female	13.15%	13.45%	0.30%	0.30%	0.13%	-0.17%	0.33%	0.27%	-0.06%	13.12%	13.41%	0.29%
	Total	15.22%	15.24%	0.02%	0.35%	0.18%	-0.17%	0.79%	0.71%	-0.08%	15.14%	15.15%	0.01%
13-17	Male	18.90%	18.85%	-0.05%	1.56%	0.71%	-0.85%	1.51%	1.45%	-0.06%	18.58%	18.62%	0.04%
	Female	23.15%	22.93%	-0.22%	2.72%	0.95%	-1.77%	0.87%	0.72%	-0.15%	22.86%	22.83%	-0.03%
	Total	20.97%	20.84%	-0.13%	2.13%	0.83%	-1.30%	1.20%	1.10%	-0.10%	20.67%	20.67%	0.00%
18-20	Male	11.02%	9.76%	-1.26%	1.48%	0.14%	-1.34%	0.06%	0.06%	0.00%	10.90%	9.70%	-1.20%
	Female	14.07%	15.02%	0.95%	1.71%	0.22%	-1.49%	0.05%	0.07%	0.02%	13.84%	14.98%	1.14%
	Total	12.62%	12.54%	-0.08%	1.60%	0.18%	-1.42%	0.06%	0.07%	0.01%	12.44%	12.49%	0.05%
21-34	Male	28.65%	28.24%	-0.41%	3.55%	0.31%	-3.24%	0.00%	0.04%	0.04%	28.47%	28.24%	-0.23%
	Female	22.59%	23.73%	1.14%	1.62%	0.24%	-1.38%	0.02%	0.06%	0.04%	22.40%	23.72%	1.32%
	Total	24.15%	24.90%	0.75%	2.11%	0.26%	-1.85%	0.02%	0.05%	0.03%	23.97%	24.89%	0.92%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
35-64	Male	23.13%	23.49%	0.36%	2.37%	0.33%	-2.04%	0.01%	0.03%	0.02%	22.84%	23.49%	0.65%
	Female	26.40%	26.32%	-0.08%	2.02%	0.29%	-1.73%	0.01%	0.10%	0.09%	26.22%	26.32%	0.10%
	Total	25.08%	25.18%	0.10%	2.16%	0.30%	-1.86%	0.01%	0.07%	0.06%	24.86%	25.18%	0.32%
65+	Male	6.42%	7.90%	1.48%	0.19%	0.02%	-0.17%	0.00%	0.00%	0.00%	6.32%	7.90%	1.58%
	Female	7.34%	7.42%	0.08%	0.16%	0.00%	-0.16%	0.01%	0.01%	0.00%	7.25%	7.42%	0.17%
	Total	7.05%	7.57%	0.52%	0.17%	0.01%	-0.16%	0.01%	0.01%	0.00%	6.96%	7.57%	0.61%
Unknown	Male	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Female	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Total	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**Male**	**18.18%**	**18.08%**	**-0.10%**	**1.28%**	**0.31%**	**-0.97%**	**0.76%**	**0.73%**	**-0.03%**	**17.99%**	**17.98%**	**-0.01%**
	Female	**18.23%**	**18.46%**	**0.23%**	**1.28%**	**0.28%**	**-1.00%**	**0.22%**	**0.21%**	**-0.01%**	**18.09%**	**18.42%**	**0.33%**
	Total	**18.21%**	**18.29%**	**0.08%**	**1.28%**	**0.29%**	**-0.99%**	**0.46%**	**0.44%**	**-0.02%**	**18.05%**	**18.23%**	**0.18%**

Table 13: D.3. Identification of Alcohol and Other Drug Services

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
3-12	Male	0.02%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.02%	0.00%
	Female	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
	Total	0.01%	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	1.31%	1.20%	-0.11%	0.06%	0.03%	-0.03%	0.13%	0.06%	-0.07%	1.23%	1.17%	-0.06%
	Female	1.11%	0.84%	-0.27%	0.07%	0.03%	-0.04%	0.10%	0.05%	-0.05%	1.03%	0.81%	-0.22%
	Total	1.21%	1.02%	-0.19%	0.06%	0.03%	-0.03%	0.12%	0.05%	-0.07%	1.13%	1.00%	-0.13%
18-20	Male	2.52%	2.40%	-0.12%	0.45%	0.16%	-0.29%	0.35%	0.12%	-0.23%	2.36%	2.34%	-0.02%
	Female	2.40%	2.62%	0.22%	0.39%	0.13%	-0.26%	0.25%	0.22%	-0.03%	2.28%	2.54%	0.26%
	Total	2.45%	2.51%	0.06%	0.42%	0.14%	-0.28%	0.30%	0.17%	-0.13%	2.32%	2.45%	0.13%
21-34	Male	11.76%	11.15%	-0.61%	1.07%	0.52%	-0.55%	0.74%	0.77%	0.03%	11.53%	10.90%	-0.63%
	Female	10.83%	10.81%	-0.02%	0.84%	0.58%	-0.26%	1.10%	1.07%	-0.03%	10.56%	10.67%	0.11%
	Total	11.07%	10.90%	-0.17%	0.90%	0.56%	-0.34%	1.00%	1.00%	0.00%	10.81%	10.73%	-0.08%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
35-64	Male	9.42%	9.70%	0.28%	1.32%	0.45%	-0.87%	0.63%	0.68%	0.05%	9.00%	9.56%	0.56%
	Female	7.48%	7.84%	0.36%	0.69%	0.30%	-0.39%	0.60%	0.46%	-0.14%	7.22%	7.73%	0.51%
	Total	8.26%	8.59%	0.33%	0.94%	0.36%	-0.58%	0.61%	0.55%	-0.06%	7.94%	8.47%	0.53%
65+	Male	0.95%	1.29%	0.34%	0.07%	0.02%	-0.05%	0.03%	0.02%	-0.01%	0.95%	1.29%	0.34%
	Female	0.31%	0.40%	0.09%	0.02%	0.00%	-0.02%	0.00%	0.00%	0.00%	0.30%	0.40%	0.10%
	Total	0.52%	0.69%	0.17%	0.03%	0.01%	-0.02%	0.01%	0.01%	0.00%	0.51%	0.69%	0.18%
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%**	**3.17%**	**-0.04%**	**0.39%**	**0.14%**	**-0.25%**	**0.23%**	**0.21%**	**-0.02%**	**3.08%**	**3.12%**	**0.04%**
	Female	**3.75%**	**3.74%**	**-0.01%**	**0.33%**	**0.17%**	**-0.16%**	**0.34%**	**0.29%**	**-0.05%**	**3.63%**	**3.69%**	**0.06%**
	Total	**3.51%**	**3.49%**	**-0.02%**	**0.35%**	**0.16%**	**-0.19%**	**0.29%**	**0.25%**	**-0.04%**	**3.39%**	**3.44%**	**0.05%**

Table 14: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	3-12			13-17			18-20			21-34		
Alexander	0.00%	0.00%	0.00%	0.29%	0.00%	-0.29%	1.63%	0.00%	-1.63%	9.64%	7.89%	-1.75%
Alleghany	0.00%	0.13%	0.13%	0.58%	0.93%	0.35%	1.19%	0.93%	-0.26%	4.44%	4.04%	-0.40%
Ashe	0.00%	0.00%	0.00%	0.29%	0.29%	0.00%	0.58%	0.29%	-0.29%	5.90%	5.21%	-0.69%
Avery	0.00%	0.00%	0.00%	0.69%	0.93%	0.24%	2.39%	0.93%	-1.46%	5.29%	6.92%	1.63%
Buncombe	0.01%	0.01%	0.00%	1.00%	1.03%	0.03%	3.09%	1.03%	-2.06%	9.39%	9.25%	-0.14%
Caldwell	0.00%	0.00%	0.00%	1.38%	1.18%	-0.20%	1.30%	1.18%	-0.12%	8.30%	8.34%	0.04%
Cherokee	0.05%	0.00%	-0.05%	1.59%	1.14%	-0.45%	1.41%	1.14%	-0.27%	6.64%	7.15%	0.51%
Clay	0.00%	0.00%	0.00%	1.65%	1.85%	0.20%	1.49%	1.85%	0.36%	5.45%	5.56%	0.11%
Graham	0.00%	0.00%	0.00%	0.30%	1.23%	0.93%	1.64%	1.23%	-0.41%	2.92%	5.68%	2.76%
Haywood	0.08%	0.00%	-0.08%	1.76%	1.50%	-0.26%	2.58%	1.50%	-1.08%	11.93%	12.20%	0.27%
Henderson	0.00%	0.00%	0.00%	0.90%	0.64%	-0.26%	1.46%	0.64%	-0.82%	7.06%	6.00%	-1.06%
Jackson	0.00%	0.00%	0.00%	1.15%	1.32%	0.17%	4.44%	1.32%	-3.12%	8.10%	8.79%	0.69%
Macon	0.00%	0.00%	0.00%	1.36%	0.93%	-0.43%	2.96%	0.93%	-2.03%	7.43%	8.24%	0.81%

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
Madison	0.00%	0.00%	0.00%	0.99%	0.86%	-0.13%	3.15%	0.86%	-2.29%	8.58%	10.59%	2.01%
McDowell	0.00%	0.03%	0.03%	1.53%	0.89%	-0.64%	2.49%	0.89%	-1.60%	8.46%	8.81%	0.35%
Mitchell	0.00%	0.00%	0.00%	0.27%	0.00%	-0.27%	2.31%	0.00%	-2.31%	5.84%	7.28%	1.44%
Polk	0.00%	0.00%	0.00%	0.00%	0.41%	0.41%	1.65%	0.41%	-1.24%	4.30%	2.85%	-1.45%
Rutherford	0.02%	0.02%	0.00%	0.76%	0.51%	-0.25%	2.22%	0.51%	-1.71%	6.37%	5.69%	-0.68%
Swain	0.00%	0.06%	0.06%	1.63%	1.69%	0.06%	3.13%	1.69%	-1.44%	6.14%	5.16%	-0.98%
Transylvania	0.00%	0.00%	0.00%	2.06%	1.58%	-0.48%	3.06%	1.58%	-1.48%	9.58%	7.82%	-1.76%
Watauga	0.00%	0.07%	0.07%	1.60%	1.28%	-0.32%	1.21%	1.28%	0.07%	5.70%	6.37%	0.67%
Wilkes	0.02%	0.02%	0.00%	0.98%	1.25%	0.27%	1.19%	1.25%	0.06%	11.52%	10.84%	-0.68%
Yancey	0.00%	0.00%	0.00%	0.55%	0.79%	0.24%	1.00%	0.79%	-0.21%	7.24%	8.18%	0.94%
	35-64			65+			Unknown			Total		
Alexander	7.90%	7.88%	-0.02%	0.00%	0.35%	0.35%	0.00%	0.00%	0.00%	3.16%	2.54%	-0.62%
Alleghany	3.06%	5.08%	2.02%	0.81%	0.00%	-0.81%	0.00%	0.00%	0.00%	1.46%	1.72%	0.26%
Ashe	5.53%	6.36%	0.83%	0.52%	0.25%	-0.27%	0.00%	0.00%	0.00%	2.17%	2.09%	-0.08%
Avery	6.16%	6.16%	0.00%	0.91%	0.92%	0.01%	0.00%	0.00%	0.00%	2.28%	2.26%	-0.02%

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
Buncombe	9.34%	9.72%	0.38%	1.12%	1.71%	0.59%	0.00%	0.00%	0.00%	3.87%	3.63%	-0.24%
Caldwell	5.48%	5.34%	-0.14%	0.70%	0.77%	0.07%	0.00%	0.00%	0.00%	2.80%	2.61%	-0.19%
Cherokee	8.50%	8.56%	0.06%	0.41%	0.53%	0.12%	0.00%	0.00%	0.00%	3.19%	3.09%	-0.10%
Clay	8.25%	9.47%	1.22%	0.00%	1.63%	1.63%	0.00%	0.00%	0.00%	2.83%	3.19%	0.36%
Graham	5.08%	7.33%	2.25%	0.34%	0.00%	-0.34%	0.00%	0.00%	0.00%	1.70%	2.61%	0.91%
Haywood	12.13%	12.45%	0.32%	1.19%	1.41%	0.22%	0.00%	0.00%	0.00%	5.12%	4.81%	-0.31%
Henderson	7.32%	7.39%	0.07%	1.11%	1.52%	0.41%	0.00%	0.00%	0.00%	2.53%	2.20%	-0.33%
Jackson	10.06%	9.75%	-0.31%	0.90%	1.21%	0.31%	0.00%	0.00%	0.00%	3.79%	3.51%	-0.28%
Macon	9.94%	10.13%	0.19%	0.28%	0.83%	0.55%	0.00%	0.00%	0.00%	3.44%	3.19%	-0.25%
Madison	6.34%	8.17%	1.83%	0.61%	0.63%	0.02%	0.00%	0.00%	0.00%	3.14%	3.30%	0.16%
McDowell	8.77%	8.89%	0.12%	0.51%	0.92%	0.41%	0.00%	0.00%	0.00%	3.62%	3.31%	-0.31%
Mitchell	6.09%	7.97%	1.88%	0.23%	0.48%	0.25%	0.00%	0.00%	0.00%	2.41%	2.71%	0.30%
Polk	3.90%	5.39%	1.49%	0.84%	0.59%	-0.25%	0.00%	0.00%	0.00%	1.55%	1.49%	-0.06%
Rutherford	5.18%	5.17%	-0.01%	0.43%	0.50%	0.07%	0.00%	0.00%	0.00%	2.48%	2.07%	-0.41%

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
Swain	4.58%	5.86%	1.28%	0.25%	0.49%	0.24%	0.00%	0.00%	0.00%	2.31%	2.29%	-0.02%
Transylvania	9.18%	10.41%	1.23%	1.65%	2.00%	0.35%	0.00%	0.00%	0.00%	4.03%	3.65%	-0.38%
Watauga	7.81%	8.89%	1.08%	0.96%	0.57%	-0.39%	0.00%	0.00%	0.00%	2.70%	2.85%	0.15%
Wilkes	9.41%	9.26%	-0.15%	0.46%	0.47%	0.01%	0.00%	0.00%	0.00%	3.86%	3.57%	-0.29%
Yancey	6.00%	8.02%	2.02%	0.39%	0.79%	0.40%	0.00%	0.00%	0.00%	2.45%	2.90%	0.45%

Table 15: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	3-12			13-17			18-20			21-34		
Alexander	9.54%	9.75%	0.21%	16.10%	17.64%	1.54%	8.33%	8.35%	0.02%	9.44%	8.70%	-0.74%
Alleghany	9.24%	11.01%	1.77%	15.56%	20.68%	5.12%	6.55%	8.24%	1.69%	13.97%	13.13%	-0.84%
Ashe	10.87%	11.15%	0.28%	16.98%	16.42%	-0.56%	8.67%	9.64%	0.97%	10.77%	10.74%	-0.03%
Avery	8.85%	9.21%	0.36%	21.10%	16.82%	-4.28%	11.48%	12.76%	1.28%	11.14%	12.89%	1.75%
Buncombe	14.59%	14.56%	-0.03%	22.60%	23.01%	0.41%	15.87%	15.13%	-0.74%	18.44%	20.26%	1.82%
Caldwell	9.16%	8.85%	-0.31%	15.34%	15.85%	0.51%	8.97%	8.22%	-0.75%	9.96%	11.05%	1.09%

2020 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		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	3-12			13-17			18-20			21-34		
Cherokee	12.37%	13.33%	0.96%	20.34%	19.25%	-1.09%	13.35%	12.92%	-0.43%	14.13%	15.76%	1.63%
Clay	14.26%	15.21%	0.95%	15.51%	20.37%	4.86%	11.94%	7.44%	-4.50%	11.67%	11.90%	0.23%
Graham	8.98%	10.64%	1.66%	14.55%	14.51%	-0.04%	7.10%	7.26%	0.16%	11.68%	12.62%	0.94%
Haywood	17.02%	17.24%	0.22%	23.38%	22.16%	-1.22%	13.26%	15.53%	2.27%	18.88%	18.88%	0.00%
Henderson	10.52%	9.97%	-0.55%	15.66%	15.99%	0.33%	9.86%	10.13%	0.27%	13.09%	12.62%	-0.47%
Jackson	12.06%	10.71%	-1.35%	22.36%	17.92%	-4.44%	13.71%	14.23%	0.52%	12.35%	14.30%	1.95%
Macon	14.65%	13.63%	-1.02%	21.69%	19.81%	-1.88%	13.83%	11.78%	-2.05%	15.39%	16.13%	0.74%
Madison	11.38%	12.24%	0.86%	20.03%	19.59%	-0.44%	11.99%	11.22%	-0.77%	16.72%	17.24%	0.52%
McDowell	13.63%	11.56%	-2.07%	19.69%	19.82%	0.13%	12.84%	11.88%	-0.96%	14.72%	16.18%	1.46%
Mitchell	11.48%	12.67%	1.19%	19.78%	19.74%	-0.04%	14.35%	6.84%	-7.51%	11.46%	12.14%	0.68%
Polk	15.47%	14.44%	-1.03%	25.10%	23.20%	-1.90%	12.35%	14.94%	2.59%	11.46%	9.50%	-1.96%
Rutherford	10.22%	10.15%	-0.07%	18.51%	19.52%	1.01%	10.06%	11.66%	1.60%	14.82%	14.74%	-0.08%
Swain	7.80%	7.37%	-0.43%	17.97%	19.29%	1.32%	9.40%	10.20%	0.80%	8.91%	8.76%	-0.15%
Transylvania	15.88%	15.97%	0.09%	25.00%	23.24%	-1.76%	13.27%	17.57%	4.30%	14.67%	13.62%	-1.05%

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	3-12			13-17			18-20			21-34		
Watauga	11.35%	12.70%	1.35%	19.40%	20.18%	0.78%	10.48%	12.40%	1.92%	11.22%	13.86%	2.64%
Wilkes	12.36%	12.86%	0.50%	16.35%	18.23%	1.88%	8.88%	10.57%	1.69%	10.63%	11.89%	1.26%
Yancey	9.90%	11.01%	1.11%	14.55%	13.24%	-1.31%	9.70%	7.12%	-2.58%	8.38%	7.98%	-0.40%
	35-64			65+			Unknown			Total		
Alexander	15.87%	15.75%	-0.12%	7.59%	5.12%	-2.47%	0.00%	0.00%	0.00%	11.52%	11.52%	0.00%
Alleghany	22.32%	22.74%	0.42%	14.63%	11.67%	-2.96%	0.00%	0.00%	0.00%	13.75%	14.82%	1.07%
Ashe	18.36%	18.41%	0.05%	8.78%	8.54%	-0.24%	0.00%	0.00%	0.00%	12.93%	12.95%	0.02%
Avery	16.43%	14.59%	-1.84%	6.14%	6.22%	0.08%	0.00%	0.00%	0.00%	12.21%	11.63%	-0.58%
Buncombe	24.65%	24.67%	0.02%	10.02%	12.19%	2.17%	0.00%	0.00%	0.00%	18.13%	18.55%	0.42%
Caldwell	14.61%	15.14%	0.53%	7.48%	9.32%	1.84%	0.00%	0.00%	0.00%	11.14%	11.45%	0.31%
Cherokee	20.19%	19.97%	-0.22%	6.15%	7.49%	1.34%	0.00%	0.00%	0.00%	14.83%	15.27%	0.44%
Clay	19.32%	20.37%	1.05%	5.79%	7.52%	1.73%	0.00%	0.00%	0.00%	13.93%	15.24%	1.31%
Graham	15.85%	14.65%	-1.20%	4.10%	9.09%	4.99%	0.00%	0.00%	0.00%	10.86%	11.90%	1.04%
Haywood	22.14%	23.34%	1.20%	8.52%	9.66%	1.14%	0.00%	0.00%	0.00%	18.12%	18.56%	0.44%

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	2018	2019	Change	2018	2019	Change	2018	2019	Change	2018	2019	Change
	3-12			13-17			18-20			21-34		
Henderson	20.70%	20.24%	-0.46%	17.29%	17.26%	-0.03%	0.00%	0.00%	0.00%	14.01%	13.79%	-0.22%
Jackson	17.83%	18.36%	0.53%	4.78%	6.33%	1.55%	0.00%	0.00%	0.00%	14.12%	13.65%	-0.47%
Macon	21.79%	22.03%	0.24%	7.48%	5.84%	-1.64%	0.00%	0.00%	0.00%	16.38%	15.56%	-0.82%
Madison	17.36%	17.63%	0.27%	4.15%	6.80%	2.65%	0.00%	0.00%	0.00%	13.70%	14.22%	0.52%
McDowell	19.13%	19.84%	0.71%	7.16%	10.34%	3.18%	0.00%	0.00%	0.00%	15.16%	15.09%	-0.07%
Mitchell	16.43%	15.22%	-1.21%	7.03%	6.67%	-0.36%	0.00%	0.00%	0.00%	13.16%	12.88%	-0.28%
Polk	14.45%	16.16%	1.71%	8.12%	13.27%	5.15%	0.00%	0.00%	0.00%	15.15%	15.38%	0.23%
Rutherford	21.87%	22.28%	0.41%	6.02%	10.87%	4.85%	0.00%	0.00%	0.00%	14.37%	15.04%	0.67%
Swain	11.62%	13.32%	1.70%	3.55%	4.20%	0.65%	0.00%	0.00%	0.00%	9.76%	10.27%	0.51%
Transylvania	21.12%	21.00%	-0.12%	11.52%	12.77%	1.25%	0.00%	0.00%	0.00%	17.51%	17.58%	0.07%
Watauga	22.60%	23.27%	0.67%	14.18%	11.22%	-2.96%	0.00%	0.00%	0.00%	14.86%	15.78%	0.92%
Wilkes	17.39%	17.72%	0.33%	6.98%	7.60%	0.62%	0.00%	0.00%	0.00%	12.96%	13.81%	0.85%
Yancey	13.21%	13.74%	0.53%	6.31%	7.74%	1.43%	0.00%	0.00%	0.00%	10.57%	10.74%	0.17%

(b) Waiver Validation Results

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

Table 16: (b) Waiver Performance Measure Validation Scores

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

(c) Waiver Measures Reported Results

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

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

Performance Measure	Data Collection	Latest Reported Rate	State Benchmark
Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available. IW D9 CC	Annually	1421/1421 = 100%	85%
Proportion of beneficiaries reporting they have a choice between providers. IW D10	Annually	1421/1421 = 100%	85%
Percentage of level 2 and 3 incidents reported within required timeframes. IW G2	Quarterly	52/56 = 92.86%	85%
Percentage of beneficiaries who received appropriate medication. IW G5	Quarterly	1525/1527 = 99.87%	85%
Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required. IW G8	Quarterly	18/18 = 100%	85%

Note: Rates reported using C waiver Excel files. Latest reported rates are shown in Table.

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

(c) Waiver Validation

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

Table 18: C Waiver Performance Measures Validation Scores

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

Performance Improvement Project (PIP) Validation

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

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

PIP Validation Results

Vaya submitted four projects for this 2020 EQR. All four were validated: TCLI PN Housing Usage (non-clinical), Access to Care: Routine (clinical), ADATC VIP (clinical), and Community Crisis Management (clinical). *Table 19: PIP Summary of Validation Scores* provides an overview of the previous year's validation scores with the current scores.

Table 19: PIP Summary of Validation Scores

Project Type	Project	2019 Validation Score	2020 Validation Score
Clinical	Access to Care: Routine	74/85 = 87% Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
	Community Crisis Management	57/67 = 85% Confidence in Reported Results	78/79 = 99% High Confidence in Reported Results
	ADATC VIP	90/90 = 100% High Confidence in Reported Results	84/84 = 100% High Confidence in Reported Results
Non-Clinical	TCLI PN Housing Usage	95/95 = 100% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results

All validated PIPs received a validation score within the High Confidence range and met the validation requirements. All four of the PIPs validated for the 2020 EQR were also validated in the 2019 EQR. In the 2019 EQR, two PIPs, Access to Care and Community Crisis Management had corrective actions regarding documentation. Those Corrective Actions were addressed in the 2019 Corrective Action Plan (CAP) process.

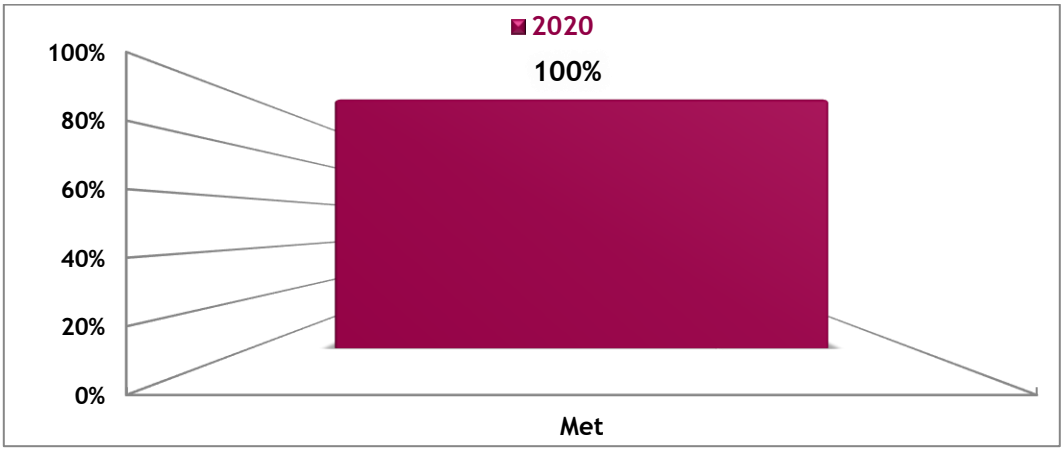
There were no Corrective Actions for the 2020 PIPs. Recommendations for the Community Crisis Management and TCLI PN Housing Usage projects centered around documented, quantitative improvement in processes or outcomes of care. These Recommendations are displayed in *Table 20: Performance Improvement Project Recommendations*.

Table 20: Performance Improvement Project Recommendations

Project	Section	Reason	Recommendations
Community Crisis Management	Was there any documented, quantitative improvement in processes or outcomes of care?	MH Community Hospital Rate decreased, which is improvement; SUD Community Hospital Rate increased, which is not improvement; Non-Medicaid Rate decreased for MH and increased for SUD; ED visits increased, but is still below the goal rate, which is good, as lower ED visits rate is improvement.	Continue interventions that focus on the hospital population for SUD Medicaid and Non-Medicaid admissions, as those are not improving. Focus on interventions that are unique to that population. MH rates are declining, which is improvement.
TCLI PN Housing Usage	Was there any documented, quantitative improvement in processes or outcomes of care?	Number housed increased most recently but is still below the goal of 10 per month. Housing Alerts utilized declined to 0 in the most recent measurement.	Continue with documented interventions to get clarity on the process for managing housing, including real time updates.

Details of the validation activities for the PMs and PIPs and specific outcomes related to each activity may be found in *Attachment 3, CCME EQR Validation Worksheets*. As demonstrated in Figure 4, Vaya met all of the Quality Improvement standards in the 2020 EQR.

Figure 4: Quality Improvement Findings



Strengths

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

Weaknesses

- The Community Crisis Management PIP did not show improvement. MH Community Hospital Rate decreased, and SUD Community Hospital Rate increased. Non-Medicaid Rate decreased for MH and increased for SUD.
- The TCLI PN Housing Usage PIP is still below the goal of 10 per month. Housing Alerts declined to 0 in the most recent measurement.

Recommendations

- Continue interventions that focus on the hospital population for SUD Medicaid and Non-Medicaid admissions for the Community Crisis Management PIP, as those are not improving.
- Continue with documented interventions to get clarity on the process for managing TCLI housing, including real time updates for the TCLI PN Housing Usage PIP.

D. Utilization Management

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

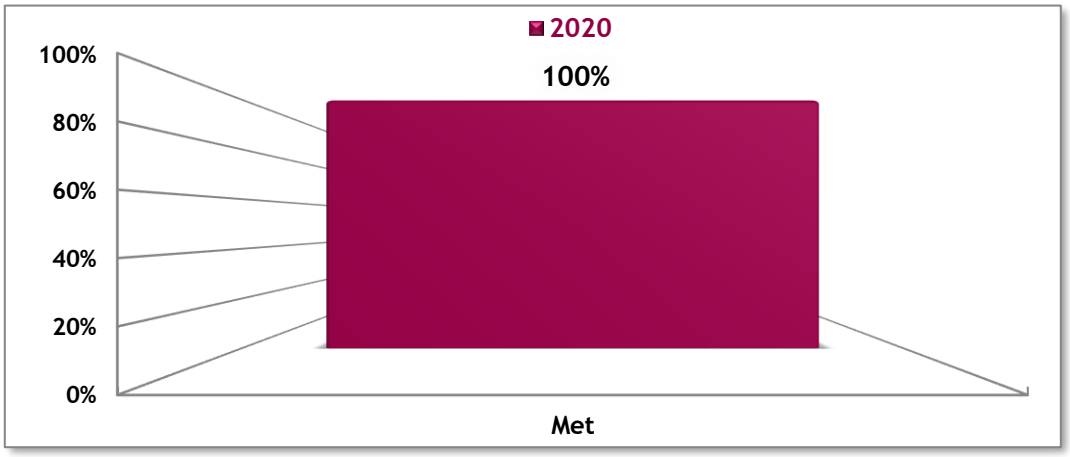
In the 2019 EQR, Vaya met 93% of UM standards. Four Corrective Actions were issued. One Corrective Action was geared towards incorrect information within Policy 2382, regarding Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) cost limits. The second Corrective Action addressed Vaya's ability to produce an enrollee's complete Care Coordination record. Vaya disputed these two 2019 Corrective Actions. Per feedback from the State on May 28, 2021, Vaya's dispute of this score resulted in changing the second Corrective Action to a Recommendation and changing the score on the related standard from "Partially Met" to "Met". Per feedback from the State on May 28, 2021, the State upheld the finding of requiring correction of the EPSDT policy. Vaya completed this policy edit through the Corrective Action process in June of 2021.

The third Corrective Action in the 2019 EQR required Vaya to enhance their monitoring of Care Coordination progress notes, based on patterns of late notes and gaps in engagement by Care Coordinators. In the 2020 EQR, it was noted Vaya incorporated a two-part monitoring process that uses data derived from Incedo to identify significant areas of risk. This data is used in conjunction with manual record reviews completed by Care Managers and Supervisors. While the monitoring plan was enhanced, weaknesses in Care Coordination documentation were again identified. The review found untimely monitoring of I/DD Innovations enrollees and a lack of documented interventions in MH/SUD progress notes. Similar findings were identified in the TCLI files, in which no documentation was found showing staff participation in the development of the enrollees' Person-Centered Plan.

During the Onsite, Vaya staff acknowledged Care Coordination documentation continued to have compliance issues. Staff reported they have implemented workgroups aimed at improving documentation and compliance with required Care Coordination activities. CCME recommends that Vaya develop a process that merges data from Incedo with the results of manual record reviews to ensure compliance with Vaya policies. The monitoring process will also need to incorporate a quality review of MH/SUD, I/DD, and TCLI Care Management documentation and progress notes.

As Figure 5 indicates, 100% of the standards in the UM review were scored as "Met".

Figure 5: Utilization Management Comparative Findings



Strengths

- Vaya was able to produce a complete Care Management record for the files reviewed for this year's EQR.

- Vaya made significant improvements to the monitoring plan of I/DD/MH/SUD/TCLI documentation.

- TCLI continued to place enrollees in housing throughout the Covid-19 pandemic.

Weaknesses

- In the 2020 EQR, I/DD enrollee files reviewed showed monitoring did not occur as required by *NC Medicaid Contract 6.3* and *NC Clinical Coverage Policy 8P,* which states that monitoring must occur face to face on a monthly basis for the first six months for members new to the Innovations Waiver.

- Within the MH/SUD and TCLI files, it was evident required activities and tasks (i.e., discharge forms, Person Centered Plan development, and follow up interventions) were not documented within the enrollee's Care Management record.

Recommendations

- Enhance the current documentation monitoring plan to routinely review timeliness of MH/SUD and I/DD Care Management activities (e.g., discharge activities, follow up activities, participation in PCP development, HCBS monitoring, etc.), as well as the quality and completeness of Care Managers' documentation.

- Enhance the current documentation monitoring plan to routine review of timeliness of TCLI Care Management activities (e.g., discharge activities, follow up activities, participation in PCP development, etc.), as well as the quality and completeness of Care Managers' documentation.

E. Grievances and Appeals

The Grievances and Appeals EQR included a Desk Review of policies and procedures, ten grievance and ten appeal files, the Grievance and Appeal Logs, the *Provider Operations Manual*, the *Member and Caregiver Handbook,* the *Utilization Management Plan Program Description,* and information about grievances and appeals available on the Vaya website. An Onsite discussion with Grievance and Appeal staff occurred to further clarify Vaya's documentation and processes.

In the 2019 EQR, Vaya met 90% of the Grievance and Appeal standards. Two Corrective Actions and seven Recommendations were issued to address concerns noted primarily in the *Member and Caregiver Handbook and* the grievance and appeal files. In this, the 2020 EQR, Vaya again met 90% of the Grievance and Appeal standards, resulting in one Corrective Action in Grievances and one Corrective Action in Appeals. One Recommendation was offered in each section as well.

Grievances

In the 2019 EQR, Vaya received one Corrective Action and one Recommendation. The Corrective Action targeted language missing from the policies and procedures regarding the timeframe for maintaining grievance files. The Recommendation was to ensure Vaya captured in the grievance files any consultation regarding the grievance with Vaya subject matter experts (e.g., Vaya's Chief Medical Officer, Legal Department, Human Resources, etc.). There was evidence in the 2020 EQR that Vaya addressed and implemented both the 2019 EQR Corrective Action and Recommendation.

The 2020 EQR of grievances included review of ten grievance files. Within those reviewed files, it was noted that the grievance resolution notification provided detailed steps taken by Vaya to resolve the grievance. However, two of the reviewed files showed the grievances were resolved and written resolution notifications sent outside of the 90 day timeframe required by Vaya's Policy and Procedure 2607, the *NC Medicaid Contract*, *Attachment M, Section C*, and *42 CFR § 438.408 (b)1*. These files showed resolution notifications were sent within 97 and 125 days and did not indicate Vaya had taken steps to extend the grievance resolution timeframe. Further, one of the files showed the grievance acknowledgement was sent in 29 days after receipt of the grievance, exceeding the "within five (5) working days" of receipt. In this file, the grievance acknowledgment was sent 29 days after receipt of the grievance. During the Onsite, Vaya staff acknowledged multiple transitions and challenges in the past year within the Grievance Department impacted the compliance of grievance files.

Within the files selected from the Grievance Log and reviewed in this EQR, there was also concern that the log contained both grievances and complaints. Vaya's Policy and Procedure 2607, defines a grievance as, "an expression of dissatisfaction either orally or written by or on behalf of a Medicaid enrollee or Legally Responsible Person (LRP)" and indicates a complaint pertains to "non-Medicaid member or Legally Responsible Person (LRP)". However, three of the ten files reviewed contained complaint acknowledgements or complaint resolution notifications, and two files contained both complaint acknowledgements and complaint resolution notifications. CCME recommends Vaya enhance their monitoring of the Grievance Log to ensure that the Grievance Log contains only grievances, as defined in Policy and Procedure 2607, Grievances and Complaints. Enhanced monitoring will ensure data is accurate when trending and tracking grievances, and that only grievances are submitted for Medicaid audits.

Appeals

In the 2019 EQR of appeals, CCME issued six Recommendations and one Corrective Action. The Recommendations targeted incorrect or incomplete information in the *Member and Caregiver Handbook*. In the 2020 EQR, it was evident Vaya implemented those Recommendations through revision of the handbook.

The Corrective Action issued in the 2019 EQR was aimed at addressing compliance issues noted in the reviewed appeal files. This Corrective Action required Vaya to enhance their appeal monitoring process to ensure all appeal acknowledgement and resolution notifications occur within the timelines required by Vaya's policies and procedures, *Attachment M* of the *NC Medicaid Contract*, and federal regulations. Similar compliance issues within the appeal files were noted in the 2018 EQR, as well.

In the 2020 EQR, overall improvement in compliance and accuracy was noted with standard appeal files when compared to the 2019 EQR. However, compliance issues were still evident despite Vaya having implemented a comprehensive monitoring process. There were again missing or late appeal acknowledgment notifications and missing or late appeal resolution notifications across standard, expedited, invalid, and withdrawn appeals. During the Onsite, these issues were discussed and a sample of files reviewed with Vaya staff. Staff confirmed areas noted to be of out of compliance.

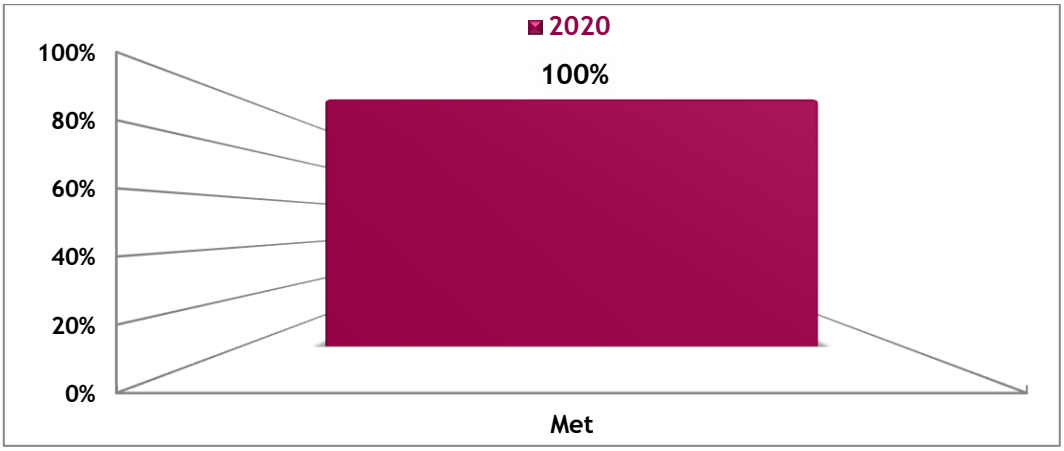
Vaya's appeal monitoring process and monitoring outcomes were also discussed with staff during the Onsite. CCME highlighted that the monitoring process, tools, and reports are not adequately identifying compliance issues within the appeal files. Further, CCME noted a high rate of errors within the Appeal Log. Data within the log was missing or incorrect, especially data related to expedited appeals (e.g., time of oral appeal receipt, time of oral appeal acknowledgement, date of appeal resolution notification, etc.) Similar data errors were noted in the 2019 EQR. During the Onsite, CCME highlighted the issues noted within the log regarding the expedited appeals data. Staff agreed it was evident within the log that data was missing and/or incorrect for expedited appeals.

As the Appeal Log is the sole source of appeals data and used by staff for daily appeal activities, appeals reporting, and compliance monitoring, CCME recommends Vaya routinely monitor the Appeal Log for completeness and accuracy. All appeal data within the log should be reviewed for accuracy and completeness, in addition to the date of resolution. Data on the log related to all appeal types (i.e., expedited, extended, invalid, and withdrawn appeals) should also be reviewed, in addition to standard appeal data.

CCME has again issued a Corrective Action to ensure Vaya fully implements a comprehensive monitoring process that includes routine review of all appeals, including expedited, extended, invalid, and withdrawn appeals. This review should encompass a check that all steps in processing appeals are compliant with the requirements in Vaya's appeal policy and procedure, *Attachment M* of the *NC Medicaid Contract*, and federal regulations governing Medicaid appeals.

Revision: Vaya disputed these findings and the State on June 18, 2021 informed CCME that these two 2020 Corrective Actions issued by CCME should be converted to Recommendations and the score in this Grievance and Appeals section changed from 90% to 100%.

Figure 6: Grievances and Appeals Findings



Strengths

- Interdepartmental coordination was evident in the grievance and appeal files reviewed.
- Vaya fully implemented the best practice Recommendations given in the 2019 EQR.

Weaknesses

- The Grievance Log and grievance files reviewed showed grievance acknowledgement and resolution notifications were sent outside of the timeframes required by Policy and Procedure 2607, Grievances and Complaints, *NC Medicaid Contact and Attachment M*, and *42 CFR § 438.408*.
- There was concern noted that the Grievance Log submitted for this EQR contained both grievances and complaints. Per Vaya's Policy and Procedure 2607, Grievances and Complaints, complaints are filed on behalf of "non-Medicaid members."
- Vaya's current monitoring process, tools, and reports are not adequately identifying compliance issues within the appeal files.
- CCME noted a high rate of errors within the Appeal Log. Data within the log was missing or incorrect, especially data related to expedited, withdrawn, and invalid appeals.

Recommendations

- Develop, document, and implement an enhanced monitoring process to ensure all grievance acknowledgement and resolution letters are completed within the timeframes required by Policy 2607, Grievances and Complaints, *NC Medicaid Contact* and *Attachment M*, and *42 CFR § 438.408*.

- Develop, document, and implement an enhanced monitoring process to ensure all appeals notifications, oral and written, are issued within the timeframes required by Policy 2384, Member Appeals of Adverse Decisions, *NC Medicaid Contract*, *Attachment M*, and *42 CFR § 438*.

- Enhance the monitoring of the Grievance Log to ensure the Log contains only grievances, as defined in Policy 2607, Grievances and Complaints.

- As a part of the enhanced appeals monitoring process, routinely review the full Appeal Log for data entry errors or omissions, including appeal data related to expedited, extended, invalid, and withdrawn appeals.

F. Program Integrity

The Program Integrity (PI) EQR involves an assessment of Vaya's compliance with federal and state regulations regarding PI functions. A Desk Review of Vaya's documentation was conducted, and included review of Vaya's policies, procedures, 15 PI files, training materials, organizational charts, job descriptions, committee meeting minutes and reports, provider agreements, enrollment application, PI workflows, *Provider Operations Manual*, employee handbook, newsletters, conflict of interest forms and the *Compliance Plan*. The Onsite interviews were conducted to discuss the findings within the Desk Materials and PI files.

In the 2019 EQR, Vaya met 92% of the PI standards. Five Corrective Actions were issued in the 2019 EQR to address compliance issues found within the PI files reviewed and missing language from Vaya's policies and procedures. It should be noted that Vaya disputed with the State two of these 2019 Corrective Actions. Under the State's direction provided on May 28, 2021, these Corrective Actions were changed to Recommendations and the scores on the related standards changed from "Partially Met" and "Not Met" changed to "Met".

In the 2020 EQR, there was evidence that Vaya addressed four of the five Corrective Actions. The Corrective Action not addressed was one of the items disputed by Vaya. This Corrective Action required language to be added to a policy regarding the monthly NCID holder/FAMS-users report. *NC Medicaid Contract, Section 14.2.14* requires Vaya to "submit to DMA Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month." While Vaya was able to demonstrate, through email chains, these reports were submitted timely, there still is no policy that states these requirements. CCME has again issued a Corrective Action to ensure this contractual requirement is within a Vaya policy.

Another issue identified in the 2020 EQR is related to the timely submission of Regulatory Compliance minutes to the State, when requested. Through corroboration with the State,

it was identified that no minutes had been submitted to the State for at least seven months, although minutes were requested by the State each month. *NC Medicaid Contract, Section 14.2.4* requires Vaya to submit these minutes "within seven (7) days of a request by the Division." To prevent this backlog in the future, CCME is requiring Vaya to develop a strategy that ensures Regulatory Compliance minutes are submitted to the State within the required timeframe.

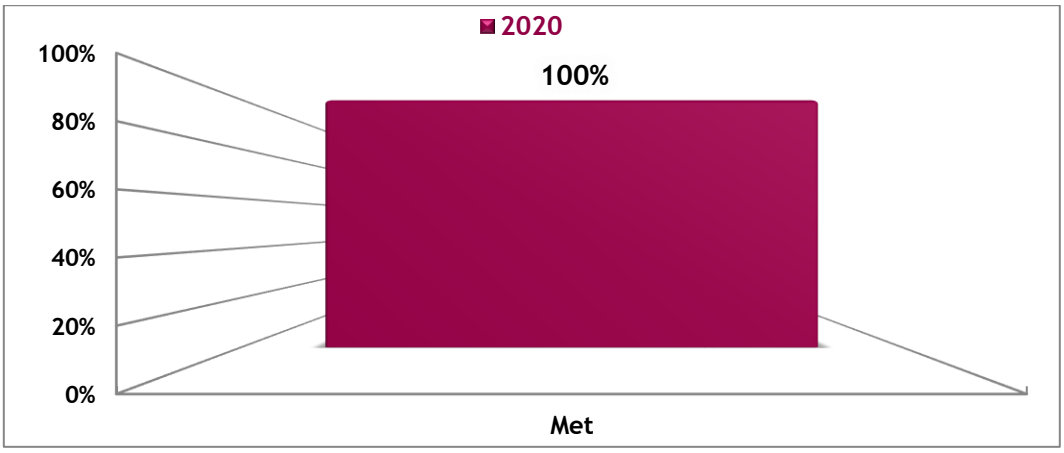
Within the PI files reviewed for the 2020 EQR, other areas of noncompliance were identified. Six of the fifteen files reviewed showed investigations were not initiated within ten days of receipt of the potential allegation of fraud, as listed in referral documentation. One of these files showed the preliminary investigation was not initiated until 74 days after receipt of the potential allegation. These six cases were indicated to have been assigned to an investigator within the ten day timeframe, but the Preliminary Investigation Plan was not completed within the ten day period required by *NC Medicaid Contract, Section 14.2.8*. Based on this finding, CCME has issued a Corrective Action to add this requirement to a Vaya policy and Vaya's Special Investigation Unit workflow charts.

Another issue identified in the review of Vaya's PI files was missing information about the amount paid to the providers being investigated. *NC Medicaid Contract, Section 14.2.9* requires Vaya to identify on the NC Medicaid approved template the "amount paid to the provider for the last three years (amount by year) or during the period of the alleged misconduct, whichever is greater." However, this information was missing in two of the fifteen files reviewed. Based on this finding, CCME has issued a Corrective Action for Vaya to develop, document, and implement a monitoring plan that routinely reviews PI files to ensure information on the NC Medicaid approved template is complete and accurate and contains the information required by *NC Medicaid Contract, Section 14.2.9*.

In addition to adding language to Vaya's policies to increase compliance with contractual requirements, CCME is also issuing a Corrective Action to enhance Vaya's monitoring of PI files to ensure investigations are initiated timely and the PI files contain all required information.

Revision: Vaya disputed these findings and the State on June 18, 2021 informed CCME that these four 2020 Corrective Actions issued by CCME should be converted to Recommendations and the score in this Program Integrity section changed from 93% to 100%.

Figure 7: Program Integrity Findings



Strengths

- Vaya has implemented an initiative working on predictive modeling to help deter Fraud, Waste, and Abuse on the front end in addition to its efforts in identifying cases on the back end with the integration of the Coordination of Benefits review.
- Vaya's Preliminary Investigation Plan is a succinct tool used in summarizing the steps that are to be taken during an investigation.

Weaknesses

- No Regulatory Compliance minutes had been submitted to the State for at least seven months.
- Six of the fifteen PI files reviewed showed the preliminary investigation was not initiated within ten business days. One of these files showed the preliminary investigation was not initiated until 74 days after receipt of the potential allegation.
- Two of the 15 PI files reviewed did not indicate the amount paid to the Provider for the last three years or during the period of alleged misconduct.
- There is no Vaya policy that contains the requirements around submission of the NCID holder/FAMS-users report to the State.

Recommendations

- Develop, document, and implement a strategy that ensures Regulatory Compliance minutes are submitted to NC Medicaid within seven days of the State's request.

- Add language to a Vaya PI policy that details the contractual requirement of initiating preliminary investigations within ten business days of receipt of a potential allegation of fraud.
- Develop, document, and implement a monitoring plan that routinely reviews the PI files for timely initiation of preliminary investigations.
- Develop, document, and implement a monitoring plan that routinely reviews PI files to ensure information on the NC Medicaid approved template is complete and accurate, including the amount paid to the Provider for the last three years or during the period of alleged misconduct.
- Add language to a Vaya PI policy that details the process and timeframes required by *NC Medicaid Contract* for submission of the monthly NCID holders/FAMS-users report to the State.

G. Encounter Data Validation

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 Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid by Vaya for the period of January 2019 through December 2019. All claims paid by Vaya should be submitted and accepted as a valid encounter to NC Medicaid. Our approach to the review included:

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

Results and Recommendations

Issue: Other Diagnosis

Principal Diagnosis codes were populated consistently where appropriate. However, Other Diagnosis codes were infrequently populated with only 17.7% of all encounter records containing Other Diagnosis codes. One notable improvement was seen in institutional encounters. Vaya completed a corrective action in 2019 and began submitting Other Diagnosis codes on institutional claims.

Resolution:

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

Issue: Invalid Procedure Code

During our review of 2019 encounter data, we found that an outpatient institutional claim had paid despite the Procedure code being invalid. More specifically, the encounter was an Emergency Department visit and there were two (2) evaluations and management (E&M) codes billed, both of which were paid by Vaya. The first E&M code was valid but there was a second E&M code "998325," which also paid. This error points to two separate issues. First, an invalid Procedure code should never be accepted by Vaya's system. This claim should have been rejected back to the provider. Second, this errant code is the second E&M code on the claim. It is unusual for two (2) separate E&M codes to be billed on the same Emergency Department encounter. It is possible that a second E&M code should never have been billed.

Resolution:

It is recommended that Vaya investigate this claim to determine how this claim was accepted and paid. Once the cause is identified, Vaya should update its claiming edits – both "front-end" and "back-end" and ensure that invalid Procedure codes are rejected regardless of how they were submitted. Vaya should also request more information from the provider to verify that a second E&M procedure that was indeed performed and documented.

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 CMS and NC Medicaid standards.

Similar to last year, the biggest issue we noted for Vaya was the low frequency of Diagnosis code reporting for both professional and institutional claims. Although Other Diagnosis codes do not impact claim adjudication, the codes are critical to evaluating member health and factors that will be used in a value based payment model. Vaya should continue to work with its providers to encourage complete and accurate reporting of all known diagnoses.

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. Absent this, we are unable 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 select medical records be requested from providers to validate that the encounter data matches what is documented in the medical records.

ATTACHMENTS

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

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

November 2, 2020

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 2020 External Quality Review (EQR) of Vaya Health is being initiated. The review will be conducted by us, The Carolinas Center for Medical Excellence (CCME), and is a contractual requirement. The review will include both a Desk Review (at CCME) and a one-day, virtual Onsite that will address contractually required services.

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

The CMS EQR protocols can be found at:
https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

Due to COVID-19 and the issuance of the contractual flexibilities issued by the State outlined in Contract Amendment #9, the 2020 EQR will be a focused review. The focus of this review will be on the Corrective Actions from the previous EQR and Vaya Health functions that impact enrollee health and safety. Similarly, for the 2020 EQR, the two day Onsite previously performed at PIHP offices will conducted during a one day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **February 18, 2021**. For your convenience, a tentative agenda for this one-day, virtual review is enclosed.

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

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

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

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

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

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

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

Thank you and we look forward to working with you!

Sincerely,

Katherine Niblock, MS, LMFT

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

Enclosure(s) – 5

Cc: Andrea Hartman, Vaya Health Contract Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager
Hope Newsome, NC Medicaid Quality Management Specialist

Vaya Health

Focused External Quality Review 2020

MATERIALS REQUESTED FOR DESK REVIEW

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

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

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

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

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

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

a.

Required information includes the following for each measure:

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

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

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

data, barriers to improvement and interventions planned or implemented to address each barrier, calculated result, results, etc.)

18. Provide copies of the following Credentialing/Recredentialing files:
    a. Credentialing files for the five most recently credentialed practitioners/agency (as listed below)
        i. One licensed practitioner who is joining an already contracted agency
        ii. One non-MD, Licensed Independent Practitioner (i.e., clinician who will have their own contract)
        iii. One physician
        iv. One practitioner with an associate licensure (e.g., LCSW-A, LMFT-A, etc.)
        v. One file for a network provider agency

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

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

        B. Other:
            1. All PSVs conducted during the current process, including current supervision contracts for all LPAs and all provisionally-licensed practitioners (*i.e.*, LCAS-A, LCSW-A).
            2. Ownership disclosure information/form (For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file).

    b. Recredentialing files for the five most recently recredentialed practitioners/agency (as listed below)
        i. One licensed practitioner who is joining an already contracted agency
        ii. One non-MD, Licensed Independent Practitioner (i.e., clinician who will have their own contract)
        iii. One physician
        iv. One practitioner with an associate licensure (e.g., LCSW-A, LMFT-A, etc.)
        v. One file for a network provider agency

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

A. Insurance:

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

B. Other:

1. Proof of original credentialing date and all recredentialing dates, including the current recredentialing (this is usually a letter to the provider, indicating the effective date).
2. All PSVs conducted during the current process, including current supervision contracts for all LPAs and all provisionally-licensed practitioners (*i.e.*, LCAS-A, LCSW-A).
3. Site visit/assessment reports if the provider has had a quality issue or a change of address.
4. Ownership disclosure information/form (For practitioners joining an already-contracted agency, this may be in the agency file, but should be included in the submitted practitioner file).

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

    b. Program Integrity Plan and/or Compliance Plan.
    c. Organizational Chart including job descriptions of staff members in the Program Integrity Unit.
    d. Workflow of process of taking complaint from inception through closure.
    e. All 'Attachment Y' reports collected during the review period.
    f. All 'Attachment Z' reports collected during the review period.
    g. Provider Manual and Provider Application.
    h. Enrollee Handbook
    i. Subcontractor Agreement/Contract Template.
    j. Training and educational materials for the PIHP's employees, subcontractors, and providers as it pertains to fraud, waste, and abuse and the False Claims Act.

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

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

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

n. Code of Ethics and Business Conduct.

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

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

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

    i. NC Medicaid approved reporting templates.

r. Sample Data Mining Reports.

s. NC Medicaid Monthly Meeting Minutes for entire review period, including agendas and attendance lists.

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

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

v. Corrective Action Plans including any relevant follow-up documentation.

w. Policies/Procedures for:

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

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

a. A completed ISCA.

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

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

c. A copy of the IT Disaster Recovery Plan.

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

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

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

a. Include all adjudicated claims (paid and denied) from January 1, 2019 – December 31, 2019. Follow the format used to submit encounter data to NC Medicaid (i.e., 837I and 837P). If you archive your outbound files to NC Medicaid, you can forward those to HMS for the specified time period. In addition, please convert each 837I and 837P to a pipe delimited text file or excel sheet using an EDI translator. If your EDI translator does not support this functionality, please reach out immediately to HMS.

b. Provide a report of all paid claims by service type from January 1, 2019 – December 31, 2019. Report should be broken out by month and include service type, month and year of payment, count, and sum of paid amount.

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

B. Attachment 2: EQR Validation Worksheets

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

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

- Performance Improvement Project Validation Worksheet
  - Access to Care: Routine
  - Community Crisis Management
  - ADACT VIP
  - TCLI PN Housing Usage

CCME EQR PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Vaya Health**
Name of PM:	**Readmission Rates for Substance Abuse**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Technical Specifications

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Vaya Health**
Name of PM:	**Follow-up After Hospitalization for Mental Illness**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Vaya Health**
Name of PM:	**Follow-up After Hospitalization for Substance Abuse**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Technical Specifications

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Vaya Health**
Name of PM:	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Vaya Health**
Name of PM:	**Mental Health Utilization**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Vaya Health**
Name of PM:	**Identification of Alcohol and Other Drug Services**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Vaya Health**
Name of PM:	**Substance Abuse Penetration Rate**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

PIHP Name:	**Vaya Health**
Name of PM:	**Mental Health Penetration Rate**
Reporting Year:	**2019**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NC Medicaid Technical Specifications

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Innovations PM 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. IW D9 CC
Reporting Year:	**2019**
Review Performed:	**2021**

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

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

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

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

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

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	State specifications were followed and found compliant.
Overall assessment			Rates reported using NC Medicaid template with numerator, denominator, and rate.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

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

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

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

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

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Vaya Health**
Name of PIP:	**INCREASE RATE OF ROUTINE ACCESS TO CARE CALLS RECEIVING SERVICE WITHIN 14 DAYS**
Reporting Year:	2019-2020
Review Performed:	02/2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator is related to processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data are collected system generated reports.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data source is administrative records.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Automatically generated reports
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument is documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed and reported quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Member services staff collect reports.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Quarterly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using line graphs for quarterly rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several quarters.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate most recently improved from 34% to 48.9%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be a result of interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; not required for non-sampling metrics.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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:	2019-2020
Review Performed:	02/2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to processes of care and functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data are collected using programming logic.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data source is claims and encounter data.
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**	Programming logic is used to pull data.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument is documented.

Component / Standard (Total Points)	Score	Comments
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed and reported monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualified staff collect reports.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Monthly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using line graphs for monthly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several months.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**PARTIALLY MET**	MH Community Hospital Rate decreased, which is improvement; SUD Community Hospital Rate increased, which is not improvement; Non-Medicaid Rate decreased for MH and increased for SUD; ED visits increased, but is still below goal rate, which is good, as lower ED visits rate is improvement. ***Recommendation: Continue interventions that focus on the hospital population for SUD Medicaid and Non-Medicaid admissions, as those are not improving. Focus on interventions that are unique to that population. MH rates are declining, which is improvement.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be a result of interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	78
Project Possible Score	79
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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:	**ADATC VIP**
Reporting Year:	2019-2020
Review Performed:	02/2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to processes of care and functional status.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data are collected using programming logic.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data source is administrative records and medical records.
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**	Programming logic is used to pull data.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument is documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed and reported monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualified staff collect reports.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Monthly rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using line graphs for monthly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent rates are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation over several months.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	SUD rates decreased, ADATC follow up slightly increased; ADATC opt in was last measured at 100%. No rate for July or August 2020 for ADATC Opt In. All rates are above the goal.
9.2 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be a result of interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**MET**	Rates have been above 40% goal rate for several months.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	84
Project Possible Score	84
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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:	**INCREASING PN HOUSING USED BY TCLI**
Reporting Year:	2019-2020
Review Performed:	02/2021

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
4.2 Did the PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data are collected in a database.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data source is TCLI database.
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**	Report from database.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument is documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is collected and reviewed and reported monthly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualified staff collect reports.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Monthly numbers are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using line graphs for monthly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and subsequent numbers are presented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included numbers evaluation over several months.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**PARTIALLY MET**	Number housed increased most recently but is still below the goal of 10 per month. Housing Alerts Utilized declined to 0 in the most recent measurement. ***Recommendation: Continue with documented interventions to get clarity on the process for managing housing, including real time updates.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to evaluate.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the 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.*

C. Attachment 3: Tabular Spreadsheet

CCME PIHP Data Collection Tool

PIHP Name:	Vaya Health
Collection Date:	2020

I. Information Systems Capabilities Assessment (ISCA)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I A. Management Information Systems						
1. Enrollment Systems						
1.1 The MCO capabilities of processing the State enrollment files are sufficient and allow for the capturing of changes in a member's Medicaid identification number, changes to the member's demographic data, and changes to benefits and enrollment start and end dates.	X					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 reconcile the payment received every month to determine the categories of aid for which payments were received. Demographic data is captured in the AlphaMCS system and patients' IDs are unique to members. Historical enrollment information is captured and maintained for all members.
1.2 The MCO is able to identify and review any errors identified during, or as a result, of the State enrollment file load process.	X					Vaya produces an enrollment completeness report to verify the completeness of data following the quarterly GEF load. During the Onsite discussion, Vaya stated that they upload the GEF file to a local database and use the database to compare the records to the AlphaMCS.
1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.	X					During the Onsite discussion, Vaya demonstrated the AlphaMCS enrollment screens and their capability to store the demographic information. All historical data for members is stored and merged under one member ID.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Claims System						
2.1 The MCO processes provider claims in an accurate and timely fashion.	X					The majority of claims received are electronic or through the provider web portal. Very few claims from Out-of-State providers are received via paper. Approximately 86.63% of Institutional and 97.14% of Professional claims are auto-adjudicated. Claims in excess of $5,000 and all Emergency Department claims are pended for manual review. Pended claims are manually reviewed and completed on a daily basis.
2.2 The MCO 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 on a daily basis. Vaya also conducts Coordination of Benefits (COB) and program integrity suspect audits regularly. High dollar claims in excess of $5,000 and paper claims are audited for accuracy. The paper claims are also included in the random sample of 3% claims audit.
2.3 The MCO has processes in place to capture all the data elements submitted on a claim (electronic or paper) or submitted via a provider portal including all ICD-10 Diagnosis codes received on an 837 Institutional and 837 Professional file, capabilities of receiving and storing ICD-10 Procedure codes on an 837 Institutional file.	X					During the Onsite system demonstration of the AlphaMCS claims system, it was evident that ICD-10 Procedure codes, Revenue codes and DRG codes are captured in the AlphaMCS system. The Revenue codes and DRG are also included for encounter data submission reporting. Up to 25 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.
2.4 The MCO's claim system screens store and track claim information and claim adjudication/payment information.	X					Onsite review of the claim system screens identified the capture of adjudication/payment information for the claims.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Reporting						
3.1 The MCO's data repository captures all enrollment and claims information for internal and regulatory reporting.	X					Vaya captures all required Diagnosis codes and is capable of capturing additional Procedure, DRG and Revenue codes that are submitted on the claims. Vaya stores and uses the ICD-10 Procedure codes for reporting. Historical data is stored in the AlphaMCS system from the inception of the PIHP.
3.2 The MCO has processes in place to back up the enrollment and claims data repositories.	X					Vaya has processes in place that backup the enrollment and claims data in the AlphaMCS system on a nightly basis. A Disaster Recovery Plan policy was provided along with the ISCA tool. However, Vaya has not provided their Disaster Recovery Plan as a part of their Desk Materials for the past two EQRs. In this year's EQR, Vaya cited the sensitive nature of the document and stated they "don't typically send this document outside of our organization." Reviewers analyzed the Disaster Recovery Plan submitted in 2018 and explored changes to the plan during the Onsite discussion.
4. Encounter Data Submission						
4.1 The MCO has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission.	X					Vaya submits all secondary Diagnosis codes for Professional encounters. Vaya submits only up to 12 Diagnosis codes on Institutional encounters to NCTracks. *Revision: Vaya disputed these findings and the State on June 18, 2021 informed CCME that this 2020 Corrective Action issued by CCME should be converted to the below Recommendation and the score in this Administrative section changed from 92% to 100%.* ***Recommendation: Update Vaya's encounter data submission process and work with the State to increase the number of ICD-10 Diagnosis codes submitted Institutional on an encounters to NCTracks.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						ICD-10 Procedure codes are captured in the AlphaMCS system but are not included for Institutional encounter data submissions. During the Onsite, Vaya stated they are in the process of testing the submission of ICD-10 Procedure codes to NCTracks. ***Recommendation: Continue to work with providers and the State to submit ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks.*** DRG codes are captured in the AlphaMCS system but are not included for Institutional encounter data submissions. ***Recommendation: Update Vaya's encounter data submission process to submit DRG codes on Institutional encounter data extracts to NCTracks.***
4.2 The MCO has the capability to identify, reconcile and track the encounter data submitted to NC Medicaid.	X					Vaya uses the Adam Holtzman's Encounter Summary by MCO Check write and an encounter denial detail report to identify and reconcile encounter data denials. Denied encounters are worked on by the appropriate department for investigation and correction.
4.3 MCO has policies and procedures in place to reconcile and resubmit encounter data denied by NC Medicaid.	X					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.
4.4 The MCO has an encounter data team/unit involved and knowledgeable in the submission and reconciliation of encounter data to NC Medicaid.	X					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. Vaya has a very high acceptance rate of encounter data submission and has improved their acceptance rate over the years.

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 (the *Credentialing Program Description*) and the *Credentialing Committee Charter* guide the credentialing and recredentialing processes at Vaya. Vaya archived Policy 2909, Credentialing Committee Policy, as it was merged into Policy 2891.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	X					The Credentialing Committee is chaired by the CMO, who is responsible for oversight of the clinical aspects of the credentialing program. There is conflicting language in the *Credentialing Committee Charter* and the *Credentialing Program Description* regarding who chairs the committee in the absence of the CMO. Vaya submitted the minutes of three meetings (August 2020, September 2020, and October 2020) for this EQR. The Credentialing Committee Minutes indicate which members are "voting" members, which members are present, which member(s) made specific motions, and the outcome of votes cast. The meeting minutes contain evidence of the committee discussion and decision-making. ***Recommendation: Revise the Credentialing Committee Charter, Policy 2891 (designated as the Credentialing Program Description), and any other documents that detail credentialing processes, to consistently reflect who will chair the Credentialing Committee meetings in the absence of the CMO.***
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Credentialing files reviewed for the EQR were organized and contained appropriate information. CCME identified the following issues in the file review:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					The file of a LP who was joining a contracted agency included the Certificate of Insurance (COI) in the LP's own name for professional liability insurance coverage, and a COI in the name of the agency for General Liability, Auto Liability, and Umbrella Liability insurance. The file did not contain proof of Workers' Compensation/Employer's Liability (WC/EL) insurance, nor a statement indicating the LP is covered under the agency insurance coverage. In response to CCME's request for those items, Vaya submitted the COI for WC/EL in the name of the agency, and this statement, "We don't require the agency to show that the practitioner is covered by (the agency's) General Liability, Auto Liability or Workers' Compensation policies." In each Annual EQR since 2016, some of Vaya's 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, such as the practitioner does not transport enrollees, so does not need to be covered under auto insurance), or the verification that the individual practitioner is covered under the agency insurance. Vaya received Recommendations regarding insurance information verification in each of those EQRs. ***Recommendation: Verify credentialing files contain proof of all of the required insurance coverages or the relevant statement about why it is not required (for example, a written statement from Licensed Practitioners that they do not transport clients, so are not required to obtain automobile liability insurance).*** ***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***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						insurance. If the practitioner is not named on the Certificate of Insurance, a letter from the provider agency 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/	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;						
3.1.8 Query of the National Practitioner Data Bank (NPDB) ;	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); and query of the *State Exclusion List*;	X					
3.1.10 Query for the System for Awards Management (SAM);	X					
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	X					
3.1.14 Names of hospitals at which the physician has admitting privileges, if any	X					
3.1.15 Ownership Disclosure is addressed.	X					Though page 2 and page 5 of the *CIF* include questions regarding ownership, the submitted/reviewed credentialing files for both LIPs and for LPs joining contracted agencies do not include questions regarding managing employees. When asked for that information, Vaya submitted the agency application, including the *Ownership Disclosure*, for the three LPs (joining contracted agencies). Regarding the LIP, Vaya responded, in part, that their "LIP application does not request information regarding managing employees." Vaya also stated "our interpretation of the 'managing employee' at *42 CFR § 455.101* led us to believe this question was not applicable to LIPs", and "if EQR can demonstrate that the 'managing employee' definition applies to LIPs," Vaya will request the information, going forward. During the Onsite discussion, Vaya staff indicated they have now revised the *CIF* to ask LIPs about managing employees. ***Recommendation: Verify whether there are managing employees for all applicants. Include documentation in the credentialing files to verify Ownership Disclosure is addressed, including by the agency for the employee. If Vaya does not keep a copy of the relevant ownership disclosure information in the individual credentialing file, retrieve copies from the relevant file and upload as part of the credentialing files for the Desk Review. See NC Medicaid Contract Attachment B, Section 1.13 & Attachment O, #5 and #6.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 for the EQR were organized and contained appropriate information. CCME identified the following issues in the file review:
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Insurance Requirements	X					
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					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					
4.2.14 Ownership Disclosure is addressed.	X					Though page 2 and page 5 of the *CIF* include questions regarding ownership, the submitted/reviewed credentialing files for both LIPs and for LPs joining contracted agencies do not include questions regarding managing employees. When asked for that information, Vaya submitted the agency application, including the *Ownership Disclosure*, for the three LPs (joining contracted agencies). Regarding the LIP, Vaya responded, in part, that their "LIP application does not request information regarding managing employees." Vaya also stated "our interpretation of the 'managing employee' at *42 CFR § 455.101* led us to believe this question was not applicable to LIPs", and "if EQR can demonstrate that the 'managing employee' definition applies to LIPs," Vaya will request the information, going forward. During the Onsite discussion, Vaya staff indicated they have now revised the *CIF* to ask LIPs about managing employees. ***Recommendation: Verify whether there are managing employees for all applicants. Include documentation in the credentialing files to verify Ownership Disclosure is addressed, including by the agency for the employee. If Vaya does not keep a copy of the relevant ownership disclosure information in the individual recredentialing file, retrieve copies from the relevant file and upload as part of the recredentialing files for the Desk Review. See NC Medicaid Contract Attachment B, Section 1.13 & Attachment O, #5 and #6.***
4.3 Site reassessment if the provider has had quality issues.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.4 Review of provider profiling activities.	X					Credentialing Committee meeting minutes include discussion of provider profile information such as "flags" related to legal charges or PIHP audits or other items. Section V of the *Credentialing Program Description* describes the process of the Credentialing Team "coordinating with other Vaya Departments to collect, analyze and present the results of internal continuous monitoring for all providers and LIPs (but not LPs) scheduled for re-credentialing presentation to the Credentialing Committee." The process includes a review of external data bases, and notifying "internal Vaya stakeholders, which may include Claims, Complex Care Management, Member Services, NPI and UM Departments, that a provider or practitioner is seeking to be re-credentialed. The notification will include a form requesting information about the Applicant's documented and substantiated performance and quality of care within the previous credentialing period only." The submitted recredentialing file for an LIP included documentation from several Vaya departments, including Program Integrity, Utilization Management, and the Grievance Resolution & Incidents Team.
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					

III. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III. Quality Improvement						
III. A Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					Performance Measure query was accurate for (b) Waiver measures. One (b) Waiver measure had a substantial rate decline in several age categories. Two (b) Waiver measures had rate increases. All (c) Waiver measures were above the State benchmark rates.
III. B Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or required by contract.	X					Vaya submitted four projects for this 2020 EQR. All four were validated: TCLI PN Housing Usage, Access to Care: Routine, ADATC VIP, and Community Crisis Management.

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 validated PIPs scored in the High Confidence range, although two PIPs had errors and CCME provided Recommendations for improvement that included: The Community Crisis Management PIP did not show improvement. MH Community Hospital Rate decreased, and SUD Community Hospital Rate increased. Non-Medicaid Rate decreased for MH and increased for SUD. ***Recommendation: Continue interventions that focus on the hospital population for SUD Medicaid and Non-Medicaid admissions for the Community Crisis Management PIP, as those are not improving.*** The TCLI PN Housing Usage PIP is still below the goal of 10 per month. Housing Alerts declined to 0 in the most recent measurement. ***Recommendation: Continue with documented interventions to get clarity on the process for managing TCLI housing, including real time updates for the TCLI PN Housing Usage PIP.***

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. A Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					
2. The case coordination program includes:						
2.1 Staff available 24 hours per day, seven days per week to perform telephone assessments and crisis interventions;	X					
2.2 Referral process for Enrollees to a Network Provider for a face-to-face pretreatment assessment;	X					
2.3 Assess each Medicaid enrollee identified as having special health care needs;	X					
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.5 Quality monitoring and continuous quality improvement;	X					
2.6 Determination of which Behavioral Health Services are medically necessary;	X					
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	X					
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					
2.10 Ensure privacy for each Enrollee is protected.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.11 NC Innovations Care Coordinators The PIHP applies the monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					
3. Care Coordination policies and procedures as formulated.	X					In the 2019 EQR, Vaya met 93% of UM standards. Three Corrective Actions were issued. One Corrective Action was geared towards incorrect information within Policy 2382, regarding Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) cost limits. The second Corrective Action addressed Vaya's ability to produce an enrollee's complete Care Coordination record. Vaya disputed these two Corrective Actions. Vaya did not revise Policy 2382 as the dispute has not been resolved as of the date of this report. However, Vaya was able to produce complete Care Coordination files for the 2020 EQR. The third Corrective Action required Vaya to enhance their monitoring of Care Coordination progress notes, based on patterns of late notes and gaps in engagement by Care Coordinators. In the 2020 EQR, it was noted Vaya incorporated a two-part monitoring process that uses data derived from Incedo to identify significant areas of risk. This data is used in conjunction with manual record reviews completed by Care Managers and Supervisors. While the monitoring plan was enhanced, weaknesses in Care Coordination documentation were again identified. The review found untimely monitoring of I/DD Innovations enrollees and a lack of documented interventions in MH/SUD progress notes required by Vaya's policies. ***Recommendation Enhance the current documentation monitoring plan to routine review of timeliness of MH/SUD and I/DD Care Management activities (e.g., discharge activities, follow up activities, HCBS monitoring, etc.), as well as the quality and completeness of Care Managers' documentation.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. B Transition to Community Living Initiative						
1. Transition to Community Living Initiative (TCLI) functions are performed by appropriately licensed, or certified, and trained staff.	X					
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					During the 2019 EQR, Vaya staff reported that they are continuing to use the "Pilot" In-Reach/Transition Tool until training is provided by the State, scheduled to occur in November 2019. TCLI files reviewed for this EQR included the current version of the In-Reach/Transition Tool.
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					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. The PIHP will develop a TCLI communication plan for external and internal stakeholders providing information on the TCLI initiative, resources, and system navigation tools, etc. This plan should include materials and training about the PIHP's crisis hotline and services for enrollees with limited English proficiency.	X					
6. A review of files demonstrates the PIHP is following appropriate TCL policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	X					During the 2019 EQR, CCME identified a pattern of late progress notes and gaps in engagement within TCLI files. CCME issued a Corrective Action to enhance the current monitoring process to ensure documentation by Care Managers is complete, accurate, and in compliance with documentation requirements set forth in Vaya's policies. In the 2020 EQR, while some improvement was noted, TCLI files again showed activities and tasks (i.e., discharge forms, Person Centered Plan development, and follow up interventions) were not documented within the enrollee's record. ***Recommendation: Enhance the current documentation monitoring plan to routine review of timeliness of TCLI Care Management activities (e.g., discharge activities, follow up activities, participation in PCP development, etc.), as well as the quality and completeness of Care Managers' documentation.***

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					Policy 2607, Complaints and Grievances, is the primary policy guiding staff through the grievance process.
1.1 Definition of a grievance and who may file a grievance;	X					
1.2 The procedure for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					Documentation of consultations with subject matter experts is captured within the grievance files, and demonstrates compliance with Policy 2607. This was a Recommendation issued in the 2019 EQR that Vaya implemented.
1.5 Maintenance of a grievance log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Policy 2607 contains the timeframe for maintenance of Grievance Logs and files. This is required by the *NC Medicaid Contract* and was implemented as a result of a 2019 Corrective Action.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP applies the grievance policies and procedures as formulated.	X					The review of the 10 Grievance files noted three files that exceeded the timeframes for providing notifications outlined in Policy 2607, *NC Medicaid Contract Attachment M*, and *42 CFR § 438.408 (b)1*. In one file, the Acknowledgement and Resolution notification was sent on the 29th day. In addition, two files exceeded the 90-day time frame to resolve a grievance and provide notice. During the Onsite, Vaya staff acknowledged several transitions within the department resulted in compliance issues for a period of time. However, compliance issues were still noted outside of the transition period described by staff. Vaya needs to enhance the monitoring process to ensure all grievance Acknowledgement and Resolution notifications are issued within the timeframes required by Policy 2607, Grievances and Complaints, the *NC Medicaid Contract* and *Attachment M*, and *42 CFR § 438.408 (b)1*. *Revision: Vaya disputed this finding and the State on June 18, 2021 informed CCME that this 2020 Corrective Action issued by CCME regarding Grievances should be converted to the below Recommendation.* ***Recommendation: Enhance Vaya's monitoring process to ensure all grievance acknowledgement and resolution letters are completed within the timeframes required by Policy 2607, Grievances and Complaints, NC Medicaid Contact and Attachment M, and 42 CFR § 438.408 (b)1.***
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Within the files selected from the Grievance Log and reviewed in this EQR, there was also concern the log contained both grievances and complaints. Vaya's Policy 2607 defines a grievances as, "an expression of dissatisfaction either orally or written by or on behalf of a Medicaid enrollee or Legally Responsible Person (LRP)" and indicates a complaint pertains to "non-Medicaid member or Legally Responsible Person (LRP)". However, three of the ten reviewed files contained complaint acknowledgements or complaint resolution notifications, and two files contained both complaint acknowledgements and complaint resolution notifications. CCME

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						recommends Vaya enhance their monitoring of the Grievance Log to ensure that the Grievance Log contains only grievances, as defined in Policy 2607, Grievances and Complaints. Enhanced monitoring will ensure data is accurate when trending and tracking grievances, and ensure only grievances are submitted for Medicaid audits. ***Recommendation: Enhance the monitoring of the Grievance Log to ensure the Log contains only grievances, as defined in Policy 2607, Grievances and Complaints.***
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					
VI. B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					Policy 2384, Member Appeals of Adverse Decisions, is the primary policy that guides staff throughout the appeals process.
1.1 The definitions an appeal and who may file an appeal;	X					
1.2 The procedure for filing an appeal;	X					In the 2019 EQR, two Recommendations were issued to correct information within the *Member and Caregiver Handbook*. The issues noted related to a clear description of how enrollees can initiate an appeal and whether Vaya acknowledges expedited appeals. Both issues were corrected in the past year.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	X					In the 2019 EQR, it was noted that Vaya's *Member and Caregiver Handbook* was missing information regarding expedited appeal notifications. The handbook was revised in the past year and now clarifies the timeframes for expedited notifications to enrollees are correct.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					In the previous year's EQR, it was noted that Vaya's *Member and Caregiver Handbook* was missing information regarding extensions issued by Vaya to the appeal resolution timeframe. The handbook was revised in the past year and now clarifies the timeframes for expedited notifications to enrollees are correct.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP applies the appeal policies and procedures as formulated.	X					The Corrective Action issued in the 2019 EQR was aimed at addressing compliance issues noted in the reviewed appeal files. This Corrective Action required Vaya to enhance their appeal monitoring process to ensure all appeal acknowledgement and resolution notifications occur within the timelines required by Vaya's policies, *Attachment M* of the *NC Medicaid Contract*, and federal regulations. Similar compliance issues within the appeal files were also noted in the 2018 EQR. In the 2020 EQR, overall improvement in compliance and accuracy was noted with standard appeal files when compared to the 2019 EQR. However, compliance issues were still evident despite Vaya having implemented a comprehensive monitoring process. There were again missing or late appeal acknowledgment notifications and missing or late appeal resolution notifications. These compliance issues were noted across standard, expedited, invalid, and withdrawn appeals and are required by Policy 2384, Member Appeals of Adverse Decisions, *NC Medicaid Contract*, *Attachment M*, and *42 CFR § 438*. During the Onsite, these issues were discussed and a sample of files reviewed with Vaya staff. Staff confirmed areas noted to be of out of compliance. Vaya's appeal monitoring process and monitoring outcomes were discussed with staff during the Onsite. CCME highlighted that the monitoring process, tools, and reports are not adequately identifying compliance issues within the appeal files. *Revision: Vaya disputed this finding and the State on June 18, 2021 informed CCME that this 2020 Corrective Action issued by CCME regarding Appeals should be converted to the below Recommendation.* ***Recommendation: Develop, document, and implement an enhanced monitoring process to ensure all appeals notifications, oral and written, are issued within the timeframes required by Policy 2384, Member Appeals of Adverse Decisions, NC Medicaid Contract, Attachment M, and 42 CFR § 438.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	X					In the 2020 EQR, CCME noted a high rate of errors within the Appeal Log. Data within the log was missing or incorrect, especially data related to expedited appeals (e.g., time of oral appeal receipt, time of oral appeal acknowledgement, date of appeal resolution notification, etc.). Similar errors were noted in the 2019 EQR. During the Onsite, CCME highlighted the issues noted within the log regarding the expedited appeals data. Staff agreed it was evident within the log that data was missing and/or incorrect for expedited appeals. As the Appeal Log is the sole source of appeals data and used by staff for daily appeal activities, appeals reporting, and compliance monitoring, CCME recommends Vaya routinely monitor the Appeal Log for completeness and accuracy. All appeal data within the log should be reviewed for accuracy and completeness, and not just date of resolution. Data on the log related to all appeal types (i.e., expedited, extended, invalid, and withdrawn appeals) should also be reviewed, and not just standard appeal data. ***Recommendation: As a part of the enhanced appeals monitoring process, routinely review the full Appeal Log for data entry errors or omissions, including appeal data related to expedited, extended, invalid, and withdrawn appeals.***
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. Program Integrity

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

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. PIHP shall establish and implement a special investigations or program integrity unit, however named, that is responsible for PIHP program integrity activities, including identification, detection, and prevention of fraud, waste, and abuse in the PIHP Closed Provider Network. PIHP shall identify an appropriately qualified contact for Program Integrity and Regulatory Compliance issues as mutually agreed upon by PIHP and NC Medicaid. This person may or may not be the PIHP Compliance Officer or the PIHP Contract Administrator. In addition, PIHP shall identify a primary point of contact within the Special Investigations Unit to receive and respond to data requests from MFCU/MID. The MFCU/ MID will copy the PIHP Contract Administrator on all such requests.	X					
4. PIHP shall participate in quarterly Program Integrity meetings with NC Medicaid Program Integrity, the State of North Carolina Medicaid Fraud Control Unit (MFCU) and the Medicaid Investigations Division (MID) of the N.C. Department of Justice ("MFCU/ MID').	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. PIHP shall send staff to participate in monthly meetings with NC Medicaid Program Integrity staff either telephonically or in person, at PIHP's discretion, to review and discuss relevant Program Integrity and/or Regulatory Compliance issues.	X					
6. PIHP shall designate appropriately qualified staff to attend the monthly meetings, and the parties shall work collaboratively to minimize duplicative or unproductive meetings and information	X					
7. Within seven (7) business days of a request by the Division, PIHP shall also make portions of the PIHP's Regulatory Compliance and Program Integrity minutes relating to Program Integrity issues available for review, but the PIHP may, redact other portions of the minutes not relating to Regulatory Compliance or Program Integrity issues.	X					*NC Medicaid Contract, Section 14.2.4* requires Vaya to submit these minutes "within seven (7) days of a request by the Division." Through corroboration with the State, it was identified that no minutes had been submitted to the State for at least seven months, although minutes are requested by the State each month. *Revision: Vaya disputed this finding and the State on June 18, 2021 informed CCME that this 2020 Corrective Action issued by CCME regarding Program Integrity should be converted to the below Recommendation.* ***Recommendation: Develop, document, and implement a strategy that ensures Regulatory Compliance minutes are submitted to NC Medicaid within seven days of the State's request.***
8. PIHP's written Compliance Plan shall, at a minimum include:						
8.1 A plan for training, communicating with and providing detailed information to, PIHP's Compliance Officer and PIHP's employees, contractors, and Providers regarding fraud and abuse policies	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
and procedures and the False Claims Act as identified in *Section 1902(a)(66)* of the *Social Security Act;*						
8.2 Provision for prompt response to offenses identified through internal and external monitoring, auditing, and development of corrective action initiatives;	X					
8.3 Enforcement of standards through well-publicized disciplinary guidelines;	X					
8.4 Provision for full cooperation by PIHP and PIHP's employees, contractors, and Providers with any investigation conducted by Federal or State authorities, including NC Medicaid or MFCU/MID, and including supplying all data in a uniform format provided by NC Medicaid and information requested for their respective investigations within seven (7) business days or within an extended timeframe determined by the Division as provided in *NC Medicaid Contract Section 13.2-Monetary Penalties.*	X					In the 2019 EQR, Vaya received a Corrective Action to include in the *Compliance 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*. Vaya provided a draft of the *Compliance Plan* through the Corrective Action process with the required edits. In the 2020 EQR, the revisions made in the 2019 Corrective Action process were evident in the finalized *Compliance Plan*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9. In accordance with *42 CFR § 436.606 (a)(vii),* PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under *NC Medicaid Contract*, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under *NC Medicaid Contract*; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month. PIHP shall be penalized One Hundred Dollars ($100) for each overpayment that is not specified in an Attachment Y Report within the applicable month. In addition, PIHP shall have and implement written policies and procedures to guard against fraud and abuse.	X					
10. PIHP shall have and implement written policies and procedures to guard against fraud and abuse	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10.3 In accordance with Attachment Y - Audits/Self-Audits/investigations PIHP shall establish and implement a mechanism for each Network Provider to report to PIHP when it has received an overpayment, returned the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and provide written notification to PIHP of the reason for the overpayment.	X					
10.4 Process for tracking overpayments and collections based on fraud or abuse, including Program Integrity and Provider Monitoring activities initiated by PIHP and reporting on Attachment Y – Audits/Self-Audits/investigations.	X					
10.5 Process for handling self-audits and challenge audits.	X					This requirement is addressed in the Internal Audits & Investigations policy.
10.6 Process for using data mining to determine leads.	X					
10.7 Process for informing PIHP employees, subcontractors, and providers regarding the *False Claims Act.*	X					

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					
10.9 Verification that services billed by Providers were actually provided to Enrollees using an audit tool that contains NC Medicaid-standardized elements or a NC Medicaid-approved template;	X					
10.10 Process for obtaining financial information on Providers enrolled or seeking to be enrolled in PIHP Network regarding outstanding overpayments, assessments, penalties, or fees due to any State or Federal agency deemed applicable by PIHP, subject to the accessibility of such financial information in a readily available database or other search mechanism.	X					

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					
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					Six of the fifteen files reviewed showed investigations were not initiated within ten days of receipt of the potential allegation of fraud, as listed in referral documentation. One of these files showed the preliminary investigation was not initiated until 74 days after receipt of the potential allegation. These six cases were indicated to have been assigned to an investigator within the ten day timeframe, but the Preliminary Investigation Plan was not completed within the ten day period required by *NC Medicaid Contract, Section 14.2.8.* *Revision: Vaya disputed this finding and the State on June 18, 2021 informed CCME that these two 2020 Corrective Action issued by CCME regarding Program Integrity should be converted to the below Recommendations.* ***Recommendations: Add language to a Vaya PI policies detailing the contractual requirement of initiating preliminary investigations within ten business days of receipt of a potential allegation of fraud.*** ***Develop, document, and implement a monitoring plan that routinely reviews the PI files for timely initiation of preliminary investigations as required by NC Medicaid Contract, Section 14.2.8.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
13. In each case where PIHP refers to NC Medicaid an allegation of fraud involving a Provider, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					All of the PI files reviewed contained this required information.
13.2 Source/origin of complaint;	X					All of the PI files reviewed contained this required information.
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					All of the PI files reviewed contained this required information.
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					All of the PI files reviewed contained this required information.
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					*NC Medicaid Contract, Section 14.2.9*, requires Vaya to identify on the NC Medicaid approved template the "amount paid to the provider for the last three years (amount by year) or during the period of the alleged misconduct, whichever is greater." However, this information was missing in two of the fifteen files reviewed. Revision: Vaya disputed this finding and the State on June 18, 2021 informed CCME that this 2020 Corrective Action issued by CCME regarding Program Integrity should be converted to the below Recommendation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Develop, document, and implement a monitoring plan that routinely reviews PI files to ensure information on the NC Medicaid approved template is complete and accurate and contains the information required by NC Medicaid Contract, Section 14.2.9.
13.6 All communications between PIHP and the Provider concerning the conduct at issue, when available.	X					This requirement was satisfied in all of the applicable files reviewed.
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					There was a Corrective Action issued in the 2019 EQR regarding missing contact information within the files reviewed. Vaya revised their PI referral form to include a space for contact information and, as a result, all PI files in the 2020 EQR contained this information.
13.8 Total Sample Amount of Funds Investigated per Service Type	X					This requirement was satisfied in all of the applicable files reviewed.
14. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						No enrollee files were submitted for the 2020 EQR.
14.1 The Enrollee's name, birth date, and Medicaid number;	X					
14.2 The source of the allegation;	X					
14.3 The nature of the allegation, including the timeframe of the allegation in question;	X					
14.4 Copies of all communications between the PIHP and the Provider concerning the conduct at issue;	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.13 Legal and Administrative Status of Case.	X					
15. PIHP and NC Medicaid shall mutually agree on program integrity and monitoring forms, tools, and letters that meet the requirements of State and Federal law, rules, and regulations, and are consistent with the forms, tools and letters utilized by other PIHPs.	X					
16. PIHP shall use the NC Medicaid Fraud and Abuse Management System (FAMS) or a NC Medicaid approved alternative data mining technology solution to detect and prevent fraud, waste and abuse in managed care.	X					
17. If PIHP uses FAMS, PIHP shall work with the NC Medicaid designated Administrator to submit appropriate claims data to load into the NC Medicaid Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
18. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month or the next business day if the 10th day is a non-business day (i.e., weekend or State or PIHP holiday). In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to NC Medicaid Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59 p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to NC Medicaid Program Integrity all Network Provider contract terminations and non-renewals initiated by PIHP, including the reason for the termination or non-renewal and the effective date. The only report shall be due by 11:59p.m. on the tenth (10th) day of each month in the format as identified in attachment Z – Terminations, Provider Enrollment Denials, Other Actions. Compliance with the reporting requirements of Attachments X, Y and Z and any mutually approved template shall be considered compliance with the reporting requirements of this Section.	X					*NC Medicaid Contract, Section 14.2.14* requires Vaya to "submit to DMA Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month." While Vaya was able to demonstrate through email chains these reports were submitted timely, there still is no policy that contains these reporting requirements. It should be noted that Vaya disputed with the State this 2019 Corrective Action. Under the State's direction provided on May 28, 2021, this 2019 Corrective Action was changed to a Recommendation and the score on this standard changed from "Partially Met" to "Met". *Revision: Vaya disputed this 2020 finding and the State on June 18, 2021 informed CCME that this 2020 Corrective Action issued by CCME regarding Program Integrity should be converted to the below Recommendation and the score changed to "Met".* ***Recommendation: Add language to a Vaya PI policy detailing the process and timeframes required by NC Medicaid Contract for submission of the monthly NCID holders/FAMS-users report to the State.***

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
and the Provider is cleared of any wrongdoing.						
1.1 In the circumstances described in *Section 14.3 (c)* above, PIHP shall be notified and must lift the payment suspension within three (3) business days of notification and process all clean claims suspended in accordance with the prompt pay guidelines starting from the date of payment suspension.	X					In the 2019 EQR, Vaya received a Corrective Action to include in policy this timeliness requirement in *NC Medicaid Contract, Section 14.3 (c)*. In the 2020 EQR it was evident Vaya revised Policy 2595, Identification and Recovery of Overpayments to include this information.
2. Upon receipt of a payment suspension notice from NC Medicaid Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of NC Medicaid Program Integrity's suspension and lasting until PIHP is notified by NC Medicaid Program Integrity in writing that the suspension has been lifted.	X					
3. PIHP shall provide to NC Medicaid all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. Notwithstanding the foregoing, nothing herein shall be construed as prohibiting PIHP from taking any action against a Network Provider in accordance with the terms and conditions of any written agreement with a Network Provider, including but not limited to prepayment review, identification and collection of overpayments, suspension of referrals, de-credentialing, contract nonrenewal, suspension or termination or other sanction, remedial or preventive efforts necessary to ensure continuous, quality care to Enrollees, regardless of any ongoing investigation being conducted by NC Medicaid, MFCU/MID or other oversight agency, to the extent that such action shall not interfere with Enrollee access to care or with any such ongoing investigation being conducted by NC Medicaid, MFCU/MID or other oversight agency.	X					There was a Corrective Action issued in the 2019 EQR requiring Vaya to add language to policy regarding Vaya's obligation to ensure there is no interference with Enrollee's access to care during any investigation. It should be noted that Vaya disputed with the State this 2019 Corrective Action. Under the State's direction provided on May 28, 2021, this 2019 Corrective Action was changed to a Recommendation and the score on this standard changed from "Not Met" to "Met". In the 2020 EQR, there was evidence that Vaya did revise Policy 2577, Provider Sanctions and Administrative Actions.

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

D. Attachment 4: Encounter Data Validation Report

Vaya Health

Encounter Data Validation Report

performed on behalf of

North Carolina Medicaid

March 3, 2021

Prepared By:

hms

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

Table of Contents

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Background

Health Management Systems (HMS) has completed a review of the encounter data submitted by Vaya Health (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 use the encounter data as intended and provide proper oversight, NC Medicaid must be able to confirm the data is complete and accurate.

Overview

The scope of our review, guided by the CMS Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid by Vaya for the period of January 2019 through December 2019. 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 ASC X12 transaction set with a few modifications to some segments. For example, the PIHP must submit their provider number and paid amount to NC Medicaid in the Contract Information CN104 and CN102 segment of Claim Information Loop 2300.

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

Vaya has established a team responsible for investigating, correcting, and resubmitting all denied Encounters. The encounters team coordinates denial research, and requests corrections from other departments or from the encounter billing provider, depending on the denial reason. Vaya relies on NC Medicaid's "The Encounter Summary by MCO Check write" report and an encounter denial detail report listing the header and line edits", as well as numerous other parameters for all encounter records that deny. Vaya has implemented has a detailed reconciliation and correction processes 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 (PUFs) to update essential provider taxonomy and address information
- Internal database and reporting tools
- Provider education guidelines
- Rebilling corrected encounter denials

Looking at claims with dates of service in 2019, Vaya submitted 2,040,244 unique encounters to the State. To date, 1% of all 2019 encounters submitted have not been corrected and accepted by NC Medicaid.

2019	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
Institutional	42,237	40,592	483	1,162	2.75%
Professional	1,808,136	1,770,387	23,358	14,391	0.80%
Total	1,850,373	1,810,979	23,841	15,553	0.84%

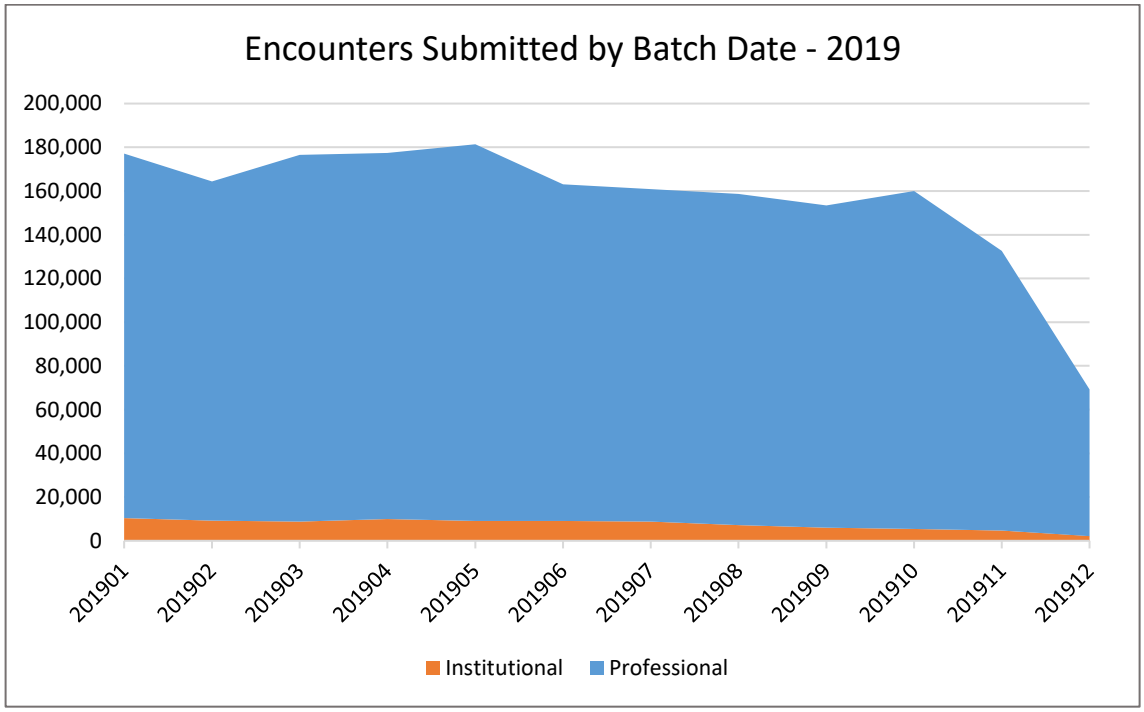
In recent years, Vaya has made significant improvements to their encounter submission process, increasing their acceptance rate and quality of encounter data year over year. The table below reflects the increase in acceptance rate from 73% to over 99%.

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	27.34%
2017	1,815,237	1,641,057	79,430	94,750	5.22%
2018	1,910,482	1,873,781	22,335	14,366	0.75%
2019	1,850,373	1,810,979	23,841	15,553	0.84%

However, 2019 saw a slight uptick in denials compared to the prior year. Most of this increase was concentrated among institutional encounter submissions, which saw a 2.75% denial rate. Overall, 30.3% of all denials were Taxonomy code related, while 8.6% were due to suspected duplicates. Despite this, the overall denial rate in 2019 held relatively steady.

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, 2019 and December 31, 2019. Vaya sent 837I and 837P file submitted to NC Medicaid during the requested audit period to HMS via SFTP. The 837P file contained 1,924,771 professional claim headers and line level detail while the 837I file contained 115,473 institutional claim headers and line level detail. Additionally, some of these records were resubmissions of previous denials or adjustments to previously accepted encounters. Therefore, these numbers do not match the metrics reported in Vaya's ISCA response.



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 Alpha (Healthcare Common Procedure Coding System [HCPCS]).
Patient Discharge Status Code (Hospital)	Should be valid codes for inpatient claims, with the most common code being “Discharged to Home.” For outpatient claims, the code can be “not applicable.”	For inpatient claims, expect >90% “Discharged to Home.” Expect 1%–5% for all other values (except “not applicable” or “unknown”).
Revenue Code	If the facility uses a UB04 claim form, this should always be present	100% valid

Encounter Accuracy and Completeness

The table below outlines the key fields that were reviewed to determine if information was present, whether the information was the correct type and size, and whether or not the data populated was valid. Although we looked at the complete data set and validated all data values, the fields below are key to NC Medicaid's properly "shadow pricing" 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	2,040,244	100.00%	2,040,202	100.00%	2,040,202	100.00%	2,040,202	100.00%
Recipient Name	2,040,244	100.00%	2,040,225	100.00%	2,040,244	100.00%	2,040,225	100.00%
Recipient Date of Birth	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%
MCO/PIHP ID	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%
Provider ID	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%
Attending/Rendering Provider ID	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%
Provider Location	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%
Place of Service	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%
Specialty Code / Taxonomy - Billing	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%
Specialty Code / Taxonomy - Rendering / Attending	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%
Principal Diagnosis	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%
Other Diagnosis	360,934	17.69%	360,934	17.69%	360,934	17.69%	360,934	17.69%
Dates of Service	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%
Unit of Service (Quantity)	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%	2,040,244	100.00%
Procedure Code	1,987,384	97.41%	1,987,383	97.41%	1,987,383	97.41%	1,987,383	97.41%
Procedure Code Modifier	794,025	38.92%	794,025	38.92%	794,025	38.92%	794,025	38.92%
Patient Discharge Status Code Inpatient	115,473	100.00%	115,473	100.00%	115,473	100.00%	115,473	100.00%
Revenue Code	115,473	100.00%	115,473	100.00%	115,473	100.00%	115,473	100.00%

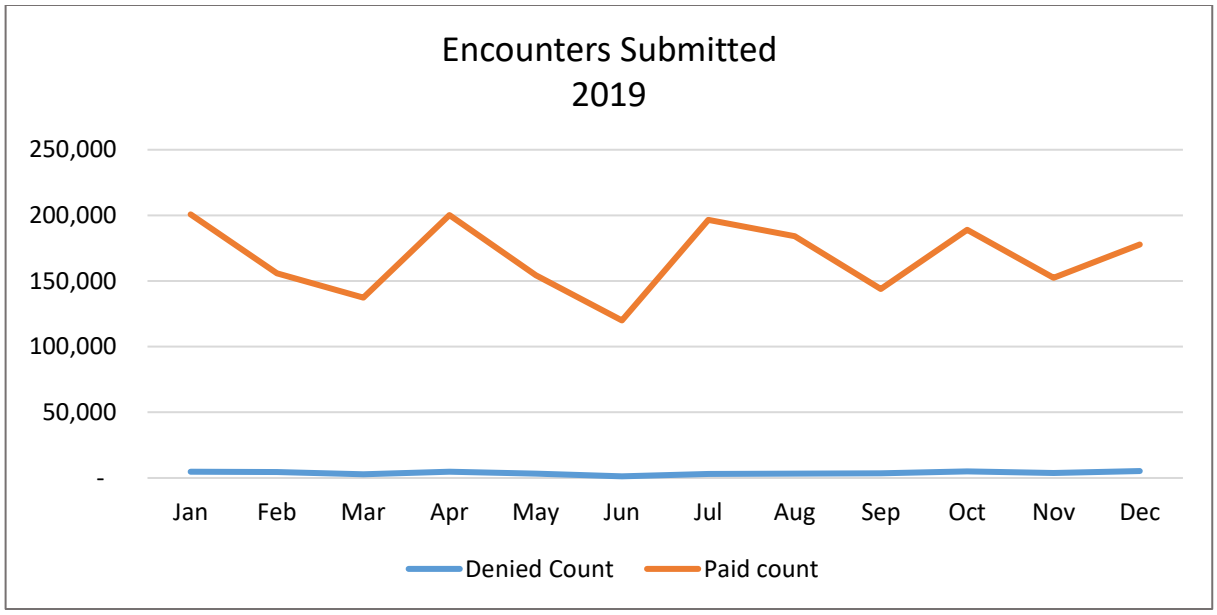
Overall, there were very few inconsistencies in the data other than the denial issues highlighted in Vaya's ISCA response and NC Medicaid's encounter acceptance report. Institutional claims contained complete and valid data in 17 of the 18 key fields (94%) with noted issues to Other Diagnosis codes. Admitting and Principal Diagnosis codes were populated 100% of the time for institutional claims. However, additional Diagnosis codes were present on only 35% of the claim lines. The same issue was present in our 2018 claims review. A minor issue was found with Procedure codes on institutional claims, especially inpatient claims that pays per diem. In a small number of cases, Revenue codes were populated where Procedure codes were missing. While the claim may still have paid appropriately under the per diem payment methodology, the missing Procedure codes make it impossible to assess which procedures or other ancillary services were provided during those inpatient stays. The issue does not exceed the error threshold, so it is not reported as an error in the summary below. However, we did note one instance where an outpatient institutional encounter was billed with an invalid Procedure code but was still paid by Vaya. We noted this issue in further detail 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 codes. The Principal Diagnosis code field was populated 100% of the time while the Other Diagnosis code field was populated far less frequently at 14.9%. However, this figure does represent a slight improvement compared to 2018 when Other Diagnosis code was present on only 11% of the records.

Beginning in 2018, Vaya began submitting up to 10 Diagnosis codes on professional encounters and they are continuing to do so when the data is present. Additionally, we found that in 2019 Vaya implemented changes to begin submitting Other Diagnosis codes on the institutional encounters.

Encounter Acceptance Report

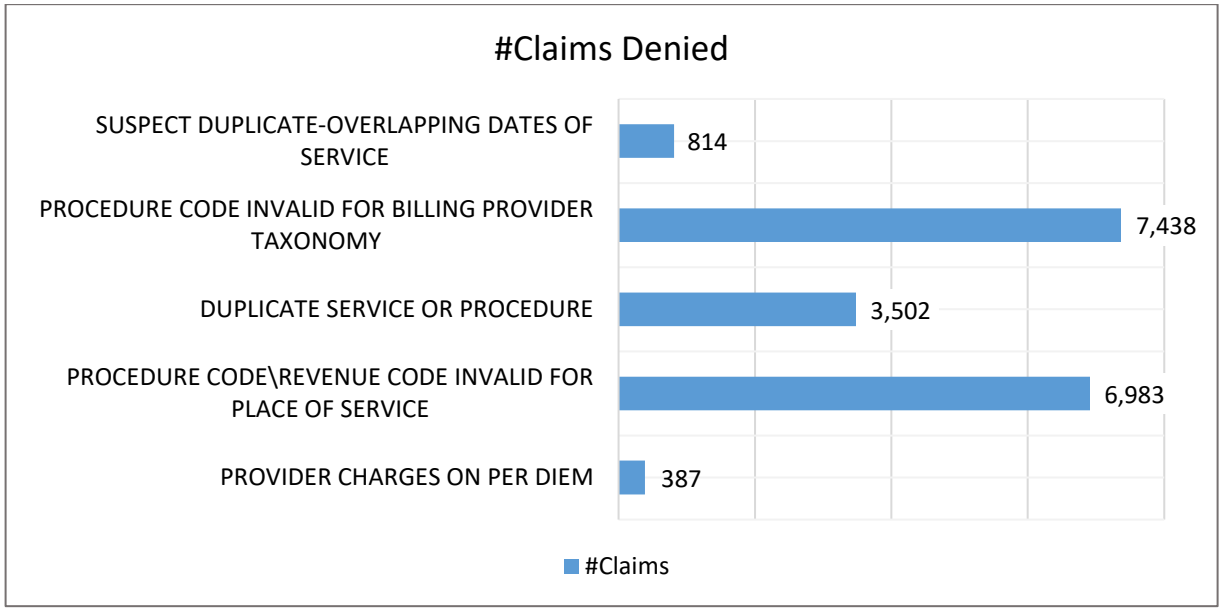
In addition to performing evaluation of the encounter data submitted, HMS reviewed the "Encounter Acceptance Report" maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write and excludes duplicates or resubmission which made it difficult to tie back to PIHP's ISCA response and the encounter data submitted to HMS. Data provided by PIHP's for our review includes all submissions and resubmissions during 2019 which includes older dates of service. During 2019, Vaya submitted to NC Medicaid a total of 2,012,958 encounters, of which 2% were initially denied. This represents a noticeable improvement over 2018 and 2017, which saw initial denial rates of 4% and 7%, respectively.



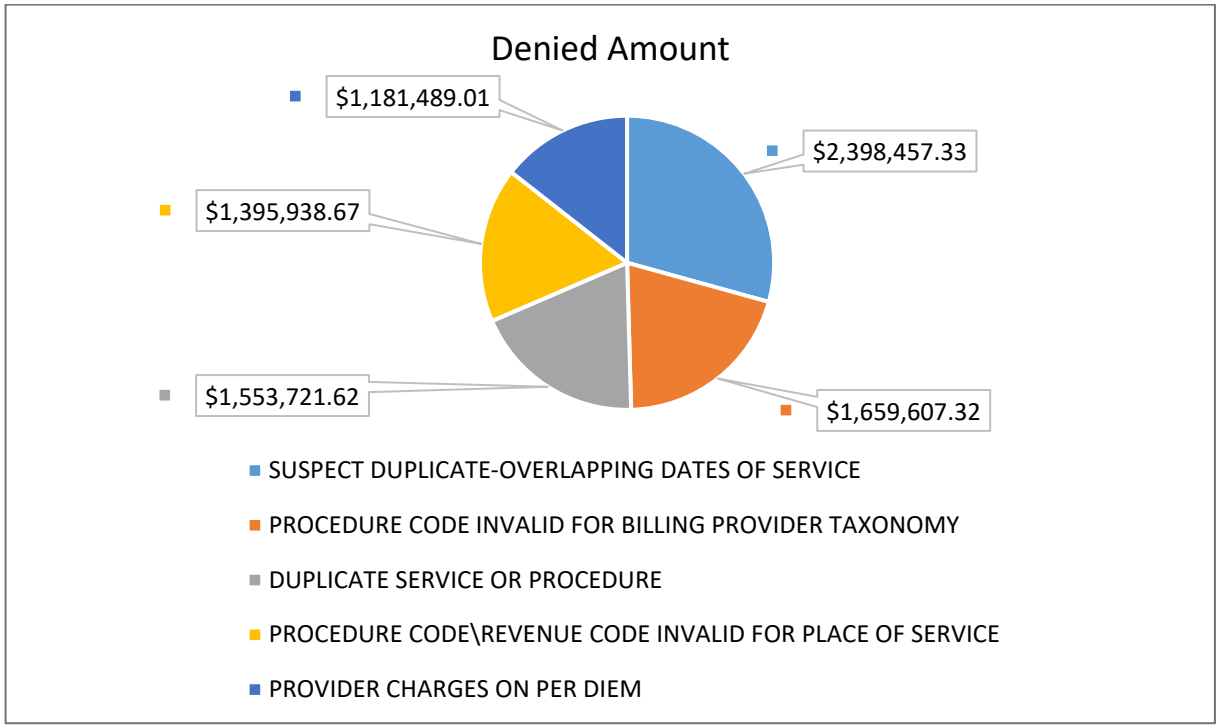
Evaluation of the top denials for Vaya encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis above. Encounters were denied primarily for:

- Suspect duplicate-overlapping dates of service
- Procedure code invalid for billing provider taxonomy
- Duplicate service or procedure
- Procedure code/Revenue code invalid for place of service
- Provider charges on per diem

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



The pie chart below reflects the top five (5) denials by claim dollar amount:



Results and Recommendations

Issue: Other Diagnosis

Principal Diagnosis codes were populated consistently where appropriate. However, Other Diagnosis codes were infrequently populated with only 17.7% of all encounter records containing Other Diagnosis codes. One notable improvement was seen in institutional encounters. Vaya completed a corrective action in 2019 and began submitting Other Diagnosis codes on institutional claims.

Resolution:

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

Issue: Invalid Procedure Code

During our review of 2019 encounter data, we found that an outpatient institutional claim had paid despite the Procedure code being invalid. More specifically, the encounter was an Emergency Department visit and there were two (2) evaluations and management (E&M) codes billed, both of which were paid by Vaya. The first E&M code was valid but there was a second E&M code "998325," which also paid. This error points to two separate issues. First, an invalid Procedure code should never be accepted by Vaya's system. This claim should have been rejected back to the

provider. Second, this errant code is the second E&M code on the claim. It is unusual for two (2) separate E&M codes to be billed on the same Emergency Department encounter. It is possible that a second E&M code should never have been billed.

Resolution:

We recommend that Vaya investigate this claim to determine how this claim was accepted and paid. Once the cause is identified, Vaya should update its claiming edits – both "front-end" and "back-end" – and ensure to that invalid Procedure codes are rejected regardless of how it was submitted. Vaya should also request more information from the provider to verify that a second E&M procedure that was indeed performed and documented.

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 CMS and NC Medicaid standards.

Similar to last year, the biggest issue we noted for Vaya was the low frequency of Diagnosis code reporting for both professional and institutional claims. Although Other Diagnosis codes do not impact claim adjudication, the codes are critical to evaluating member health and factors that will be used in a value based payment model. Vaya should continue to work with its providers to encourage complete and accurate reporting of all known diagnoses.

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. Absent this, we are unable 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 select medical records be requested from providers to validate that the encounter data matches what is documented in the medical records.

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