2021 External Quality Review

VAYA HEALTH

Submitted: October 29, 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 Vaya Health (Vaya). This report contains a description of the process and the results of the 2021 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the North Carolina Medicaid (NC Medicaid).

Goals of the review are to:

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

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

A. Overall Findings

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

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

Due to COVID-19 pandemic, CCME implemented a focused review. This decision was based on the issuance by the State of the COVID-19 flexibilities PIHP Contract Amendment #9. This PIHP contract amendment stated PIHPs "shall be held harmless for any documentation or other PIHP errors identified through the EQR that are not directly related to member health and safety through the Term of the Amendment." The focused review included comprehensive review of the PIHP's health systems capabilities and provider credentialing and recredentialing documentation and processes. The review includes validation of the PIHP's Performance Improvement Projects (PIPs), Performance Measures (PMs), and Encounter data. Lastly, a thorough review of the PIHP's Utilization Management (UM), Grievances, and Appeals processes were conducted. What was not reviewed were the PIHP's network adequacy, availability of services, subcontractor relationships, and Clinical Practice Guidelines (*42 CFR § 438.206, § 438.207, § 438.230, and § 438.236,* respectively*).*

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

The following provides a global or high-level summary of the status of the Recommendations and Corrective Action items from the 2020 EQR and the findings of the 2021 EQR. Specific Recommendations and Corrective Actions are detailed in each section of this report.

Administration

42 CFR § 438.224 and 42 CFR § 438.242

In the 2020 EQR, Vaya met 100% of the Administrative standards and received three Recommendations. These Recommendations centered around Vaya's ability to submit ICD-10 Diagnosis codes, ICD-10 Procedure codes, and DRG codes to NCTracks. In the 2021 EQR, Vaya was able to demonstrate improvements in submission of DRG codes to NCTracks. However, Vaya was not able to demonstrate improvement in the submission of 25 ICD-10 Diagnosis and Procedure codes in NCTracks. During the 2021 Onsite, Vaya staff reported they are in the process of testing the changes to their system that will allow submission of up to 25 ICD-10 Diagnosis codes and ICD-10 Procedure codes for Institutional encounters. In the 2021 EQR, Vaya again met 100% of the Administrative EQR standards, but received two Recommendations related to the 2020 Recommendations not yet implemented by Vaya.

Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

In Vaya's 2020 EQR of Credentialing/Recredentialing, CCME issued no Corrective Actions and four Recommendations. Vaya implemented three of the 2020 Recommendations. Vaya did not implement the Recommendation to "Revise the *Credentialing Committee*

Charter, Policy 2891 (designated as the *Credentialing Program Description*), and any other documents that detail credentialing processes, to consistently reflect who will chair the Credentialing Committee meetings in the absence of the CMO." Vaya reports having a plan to revise the documents.

In the current EQR, Vaya met 100% of the Provider Services standards. The unaddressed Recommendation from the 2020 EQR remains a Recommendation in this EQR.

Quality Improvement

42 CFR § 438.330

In the 2020 EQR, Vaya met 100% of the Quality standards and received two Recommendations related to the four PIPs validated. Both Recommendations were implemented.

For the 2021 EQR, all standards were met with no Corrective Actions and one Recommendation issued. All PIPs were validated in the High Confidence range. The Recommendation targets rate improvement for the TCLI PN Housing PIP. Vaya was Fully Compliant for (b) Waiver and (c) Waiver Performance Measures. Two (b) Waiver PMs showed a significant rate improvement from the previous measurement year.

Utilization Management

42 CFR § 438.208

In the 2020 EQR, Vaya met 100% of the Care Coordination and Transition to Community Living (TCLI) standards, resulting in two Recommendations to enhance the current monitoring plan by utilizing data from its care management platform and findings from quality reviews to ensure compliance with Vaya's policies. The Recommendation was partially addressed in Care Coordination. A similar Recommendation issued to TCLI was fully addressed.

In the 2021 EQR, Vaya met 96% of the Care Coordination and TCLI standards. CCME has issued one Corrective Action and one Recommendation. The Corrective Action addresses Vaya's inability to provide the complete enrollee record, including documentation verifying termination or discharge from the Innovations Waiver. The Corrective Action also targets concerns regarding a lack of coordination of services and supports, and assessment of the enrollee's health and safety prior to the enrollee's voluntary termination from the Innovations Waiver. For a second year, the one Recommendation targets Vaya's *Complex Care Management Monitoring Plan* regarding timeliness of progress notes.

Grievances and Appeals

42 CFR § 438, Subpart F, 42 CFR 483.430

In the 2020 EQR, Vaya met 100% of the Grievance and Appeal standards, resulting in two Recommendations in each Grievances and Appeals.

- Two 2020 Recommendations were issued primarily targeting monitoring enhancements to ensure all Grievance acknowledgement and resolution letters are completed timely and to enhance Grievance Log monitoring to ensure the Log contains only Grievances. In the 2021 EQR, there was evidence that Vaya addressed all Grievance Recommendations issued in the 2020 EQR.

- Vaya received two 2020 Appeal Recommendations. Both Recommendations were centered around developing an enhanced monitoring process to ensure all Appeal notifications, oral and written, are issued within correct timeframes and to review the full Appeal Log for data entry errors or omissions, including Appeal data related to expedited, extended, invalid, and withdrawn Appeals. Both Appeals Recommendations were implemented.

In this 2021 EQR, Vaya met 100% of the Grievance and Appeal standards, resulting in no Corrective Actions. CCME issued one Recommendation in Grievances and two Recommendations in Appeals. Two Recommendations were centered around continued monitoring of Grievances and Appeals to ensure all acknowledgement notifications and resolution notifications are timely and to identify problems with processes that contribute to compliance issues. The third Recommendation was issued to provide guidance to report a more accurate annual Appeal audit summary by increasing the sample size of the Appeal files reviewed for the *Vaya UM Audit Summary*.

Program Integrity

42 CFR § 455, 42 CFR § 438.455 and *1000* through *1008, 42 CFR § 1002.3(b)(3), 42 CFR 438.608 (a)(vii)*

In the 2020 EQR, Vaya met 100% of the Program Integrity (PI) standards, resulting in no Corrective Actions and four Recommendations. Vaya addressed three of the Recommendations. The fourth Recommendation encouraged Vaya to add language to a Vaya PI policy that detailed the process and timeframes requirement for the monthly submission of NCID holders/FAMS-users to NC Medicaid staff. During the 2021 Onsite, Vaya stated that after discussion with NC Medicaid staff following the 2020 EQR, they respectfully decline to implement this Recommendation.

For the 2021 EQR, Vaya met 100% of the PI standards, resulting in no Corrective Actions and one Recommendation to add language to policy regarding not taking administrative actions once a case is referred to NC Medicaid.

Encounter Data Validation

Based on the analysis of Vaya's encounter data, it has been 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 Other Diagnosis code reporting for both Professional and Institutional claims. Although Other Diagnosis codes do not directly impact pricing of claims, 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 review of encounter data from NCTracks 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.

Corrective Actions and Recommendations from Previous EQR

After the previous EQR, the Corrective Actions issued by CCME were changed to Recommendations, per feedback from the State. Therefore, no standards were scored as "Partially Met" or "Not Met", and no Corrective Action is required from Vaya.

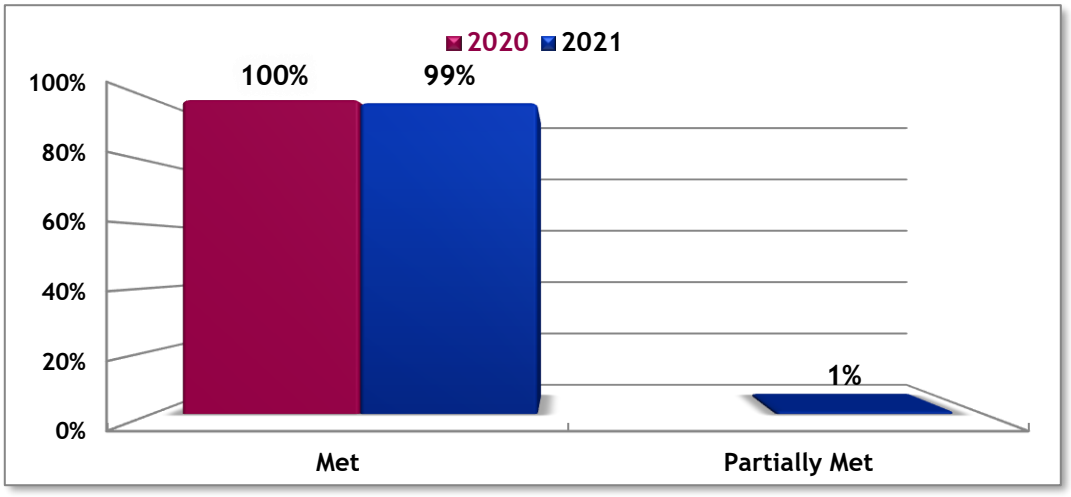
Conclusions

Overall, Vaya has met the requirements set forth in their contract with NC Medicaid. The 2021 Annual EQR shows that Vaya has achieved a "Met" score for 99% of the standards reviewed. As the following chart indicates, 1% of the standards were scored as "Partially Met," and none of the standards scored as "Not Met". *Figure 1, Annual EQR Comparative Results*, provides an overview of the scoring of the current annual review as compared to the findings of the 2020 review. It should be noted that in the 2020 EQR, Vaya initially met 96% of the EQR standards. Vaya disputed all of the Corrective Actions, and NC Medicaid agreed to change those Corrective Actions to Recommendations. This also changed their score to meeting 100% of the 2020 EQR standards.

B. Overall Score

Figure 1: Annual EQR Comparative Results shows Vaya's EQR scores in the 2020 and 2021 focused EQRs.

Figure 1: Annual EQR Comparative Results



The following is a summary of key findings in the 2021 EQR and Recommendations or opportunities for improvement. Specific details of Strengths, Weaknesses, and Recommendations can be found in the sections that follow.

Table 1: Vaya's 2021 Overall Strengths, Weaknesses, and Recommendations

	Strengths	Weaknesses	Corrective Actions/ Recommendations
Quality	Vaya has undertaken a strong internal training process for their PI staff. Two Investigator have attained their Accredited Health Care Fraud Investigator (AHFI) and two Investigator are in process.	Vaya submits only up to 12 Diagnosis codes on Institutional encounters to NCTracks.	***Recommendation: Update Vaya's encounter data submission process and work with providers and the State to submit ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks.***
	Vaya Compliance Plan provides an overview of accomplishments of prior goals and a list of initiative to be undertaken in the current year.	ICD-10 Procedure codes are captured in the AlphaMCS system but are not included on Institutional encounter data submissions	***Recommendation: Update Vaya's encounter data submission process and work with the State to increase the number of ICD-10 Diagnosis codes submitted on Institutional encounter data extracts to NCTracks.***

	Strengths	Weaknesses	Corrective Actions/ Recommendations
	In the 2021 EQR, the Grievance file review demonstrated that Vaya's monitoring process resulted in a decrease from the previous EQR in late Grievance resolution notifications.	PIP rates did not improve for two of the validated PIPs (Community Crisis Management and TCLI Housing)	***Recommendation: TCLI PN Housing PIP: Continue to monitor real-time inventory access, communication, and SOP documentation intervention impacts on members housed.***
	In preparation of the NC Tailored Plan, Vaya has begun integrating pharmacy and nursing into its Complex Care Management team, by holding 'team huddles'.	Vaya's annual Appeal audit, implemented by Vaya's Regulatory Compliance Committee, reviewed less than 10% of the Appeal processed during the year.	***Recommendation: Increase the sample size of the Appeal files reviewed for the Regulatory Compliance Committee and reported in the Vaya UM Audit Summary.***
	(b) Waiver Measures included all necessary documentation, and measures were reported according to specifications.		
	(c) Waiver Measures met or exceeded State benchmark rates		
	All PIPs scored in the High Confidence range during validation		
	Vaya reconciles the monthly per member per month (PMPM) payment with the 820 Capitation file, which helps Vaya determine the specific categories of aid being paid for each month		

	Strengths	Weaknesses	Corrective Actions/ Recommendations
	Vaya can capture of up to 25 ICD-10 Diagnosis codes on Institutional claims and 12 ICD-10 Diagnosis codes on Professional claims		
	Vaya can capture the DRG and ICD-10 Procedure codes on Institutional claims on the provider web portal and via HIPAA files		
	Vaya has the ability to submit DRG on Institutional encounter data extracts to NC Medicaid.		
Timeliness	Vaya provides a toll-free Provider Help Line and a separate toll-free line for business calls	The review of MH/SUD records found 39% of progress notes were submitted outside of the timeframe required by Vaya's Policy 2340, Administrative Health Record Documentation.	***Recommendation: Update the current Complex Care Management Quality Improvement & Monitoring Plan to include a process that identifies progress notes that are submitted beyond the required timeframe. Ensure that progress notes follow the 'late entry' documentation process as listed in Vaya's Policy 2340, Administrative Health Record Documentation when submitted beyond the 24-hour timeframe requirement.***
	Vaya auto adjudicates claims; 79.71% of institutional claims and 96.55% of professional claims.	One of the Grievance files reviewed showed Vaya's Grievance acknowledgement notification was sent in 48 days versus the five business day timeframe required by Vaya's Grievance policy.	***Recommendation: Continue to closely monitor all Grievances to ensure all acknowledgement notifications and resolution notifications are timely and to identify problems with processes that contribute to compliance issues.***

	Strengths	Weaknesses	Corrective Actions/ Recommendations
		One expedited Appeal had a late resolution letter sent in five days instead of within 72 hours, as required by Vaya's Policy 2384, Member and Recipient Appeals of Adverse Decisions. One faxed, standard Appeal was overlooked by Vaya staff and acknowledged in 35 days instead of one business day, as required by Vaya Policy 2384.	***Recommendation: Continue to closely monitor Appeals to ensure all acknowledgement notifications and resolution notifications are timely and to identify problems with processes that contribute to compliance issues.***
		There is no Vaya policy detailing the process and timeframes required by NC Medicaid Contract Section 14.2.14 for submission of the monthly NCID holders/FAMS-users report to the State.	***Recommendation: Add language to a Vaya PI policy detailing the process and timeframes required by NC Medicaid Contract Section 9.8 and 14.2.14 for submission of the monthly NCID holders/FAMS-users report, the Program Integrity Suspected and Confirmed Cases Report and Network Provider Contract Terminations Report to the State.***
		Vaya's PI policies do not include the process for collecting overpayments from a Network Provider who has been referred for NC Medicaid for possible Fraud, Waste, and Abuse as outline in NC Medicaid Contraction Section 14.3.4.	***Recommendation: Update a Vaya PI Policy to include the process for collecting overpayments from a Network Provider who has been referred for NC Medicaid as outlined in NC Medicaid Contract Section 14.3.4.***

	Strengths	Weaknesses	Corrective Actions/ Recommendations
Access to Care	Interdepartmental case coordination was evident in the Grievance and Appeal files reviewed.	The Credentialing Committee is chaired by the CMO, who is responsible for oversight of the clinical aspects of the credentialing program. As was the case at the last EQR, there is conflicting language in the CCC and the Credentialing Program Description regarding who chairs the committee in the absence of the CMO.	***Recommendation: As per the Recommendation at the 2020 EQR, revise the Credentialing Committee Charter, Policy 2891 (designated as the Credentialing Program Description), and any other documents that detail credentialing processes, to consistently reflect who will chair the Credentialing Committee meetings in the absence of the CMO.***
	In the 2021 EQR, overall improvement in compliance and accuracy was noted with all types of Appeal files when compared to the 2020 EQR.	Vaya was unable to produce the full Care Coordination file, including notifications to a member discharging from the Innovations Waiver.	***Corrective Action: Enhance the current Care Coordination documentation quality review to include;*** ○ ***Routine review of notifications within the enrollee's record and ensure those notifications can be generated outside of the enrollee's electronic record.***
	Vaya is working closely with County DSS leadership to start several outreach programs in an effort to reduce the number of children placed in emergency placements.	The review found that Vaya Care Coordination did not provide adequate support and linkages to an Innovations enrollee who elected to discharge from the Innovations Waiver.	***Corrective Action: Enhance the current Care Coordination documentation quality review to include;*** ○ ***Routine review of Care Coordination documentation around any enrollee's terminating from Care Coordination or the Innovations Waiver. The review should ensure proper notifications occurred, alternative services were offered, and the enrollee's health and safety was assessed and addressed throughout the termination.***

	Strengths	Weaknesses	Corrective Actions/ Recommendations
	Vaya staff reported 100 TCLI enrollees have been placed in independent housing, despite challenges posed by the pandemic		
	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 worked with the county Department of Social Services (DSS) offices to identify families in crisis and Vaya assisted the families by addressing some basic needs such as food insecurity and transportation needs. Vaya also has provided basic items such as blankets, feminine products, and ear buds to children in DSS custody.		

METHODOLOGY

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

On August 16, 2021, CCME sent notification to Vaya that the annual EQR was being initiated (see *Attachment 1*). This notification included:

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

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

The review consisted of two segments. The first was a Desk Review of materials and documents received from Vaya on September 7, 2021, and reviewed by CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the QI and Medical Management Programs. Also included in the Desk Review was a review of Credentialing, Grievance, Utilization, Care Coordination, and Appeal files.

The second segment of the EQR is typically a two-day, Onsite review conducted at the PIHP's offices. However, due to COVID-19, this Onsite was conducted through a teleconference platform on September 30, 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 involves 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 (IT) staffing patterns. This system analysis is completed as specified in the Centers for Medicaid and Medicare Services (CMS) protocol. During the Onsite, staff presented a member and claims systems review. Questions regarding the ISCA tool were discussed with Vaya staff.

In the 2020 EQR, Vaya met 100% of the Administrative standards, which included the 2020 ISCA review, and received three Recommendations related to reporting Diagnosis Related Groups (DRGs), ICD-10 Procedure and Diagnosis codes to NCTracks. Vaya successfully implemented one Recommendation related to the DRG code and are in the process of testing the other two Recommendations.

Table 2: 2020 EQR Administrative Findings

2020 EQR Administrative Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The MCO has the capabilities in place to submit the State required data elements to NC Medicaid on the encounter data submission	***Recommendation: Update Vaya's encounter data submission process and work with the State to increase the number of ICD-10 Diagnosis codes submitted on an Institutional encounter to NCTracks.***	**N**
2021 EQR Follow up: Per Vaya, "WellSky reviewed the Procedure that creates the outgoing file to NCTracks. Although up to 25 are collected, initial submission of this change to send all to NCTracks denied the Claims having more than 12. The change had to be rolled back and the process to generate 837 Outgoing Institutional files still only sends 12. WellSky has prioritized this change to switch to send all the ICD-10 Diagnosis codes again to NCTracks. Once the sprint is completed, the change will be tested on a Build. The timing of this change has not been determined."		
The MCO has the capabilities in place to submit the State required data elements to NC MEDICAID on the encounter data submission	***Recommendation: Continue to work with providers and the State to submit ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks.***	**N**
2021 EQR Follow up: Per Vaya, "Review of Outgoing 837I file records show that the ICD 10 Procedure Codes are not being sent to NCTracks. The codes are being captured in the Application. The Outgoing process for 837I generation is currently in development for changes. The timing of this change has not been determined by our vendor WellSky."		
The MCO has the capabilities in place to submit the State required data elements to NC MEDICAID on the encounter data submission	***Recommendation: Update Vaya's encounter data submission process to submit DRG codes on Institutional encounter data extracts to NCTracks.***	**Y**
2021 EQR Follow up: Per Vaya, "Current Outgoing process to generate 837I files to NCTracks does include the submission of DRG." This capability was also observed during the live demonstration of Vaya's encounter and enrollment systems.		

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, 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 that their vendor WellSky uploads the daily and quarterly Global Eligibility Files (GEF) to AlphaMCS. Vaya also loads the GEF files to a local SQL Server database for reporting and troubleshooting purposes. Vaya stated that WellSky had updated the AlphaMCS system to accommodate an extra flag to identify members that transitioned to a Standard plan.

Vaya stores the Medicaid identification number received on the GEF. During the ISCA 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 new Member ID.

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

Vaya enrollment counts for the past three years is presented in Table 3.

Table 3: Enrollment Counts

2018	2019	2020
162,335	144,486	161,127

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 ISCA Onsite, Vaya stated that they receive claims from out-of-network hospitals and Emergency Departments on paper. Table 4 details the percentage of 2020 claims received via the three methods.

Table 4: Percent of claims with 2020 dates of service that were received via Electronic (HIPAA, Provider Web Portal) or Paper forms.

Source	HIPAA File	Paper	Provider Web Portal
Institutional	67%	<1%	32%
Professional	89%	<1%	11%

Vaya adjudicates claims on a nightly basis. Approximately 96.55% of Professional claims and 79.71% of Institutional claims are auto adjudicated. On the AlphaMCS claims system, Vaya captures up to 25 ICD-10 Diagnosis codes via the provider web portal and HIPAA files for Institutional claims. For Professional claims, Vaya has the ability to receive and store up to 12 ICD-10 Diagnosis codes on both the provider web portal and via HIPAA files. Vaya captures ICD-10 Procedure codes and DRGs, if they are submitted on the claim. During the ISCA Onsite, Vaya confirmed that they are able to capture and submit Telehealth modifier codes during the ongoing COVID-19 pandemic.

During the ISCA Onsite, Vaya mentioned that Vaya staffs conduct random audits of 3% of all claims processed on a daily basis. Vaya periodically audits new hire claim examiners for the first nine months. Vaya stated their database is backed up on a nightly basis. Vaya did not have any negative business impact due to the ongoing COVID-19 pandemic. Vaya mentioned that their Disaster Recovery Plan is updated when there are infrastructure changes. The DRP was last updated on July 24, 2021.

The breakdown of encounter data acceptance/denial rates by claim service detail counts was provided for encounters submitted in 2020. Table 5 provides a comparison of 2019 and 2020.

Table 5: Volume of 2019 and 2020 Submitted Encounter Data

2020	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
2019	**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 an approximate 96.6% acceptance rate for both Professional and Institutional encounters with dates of service in 2020. As a follow-up after the ISCA Onsite, Vaya provided the top three denial reason for encounters submitted in 2020:

By Highest Dollar Value:

- 13420 Suspect Duplicate – Overlapping Dates of Service
- 13460 Possible Duplicate Same Provider, Same Procedure Code, Overlapping Dates of Service
- 13470 Less Severe Duplicate-Outpatient

By Highest Claim Count:

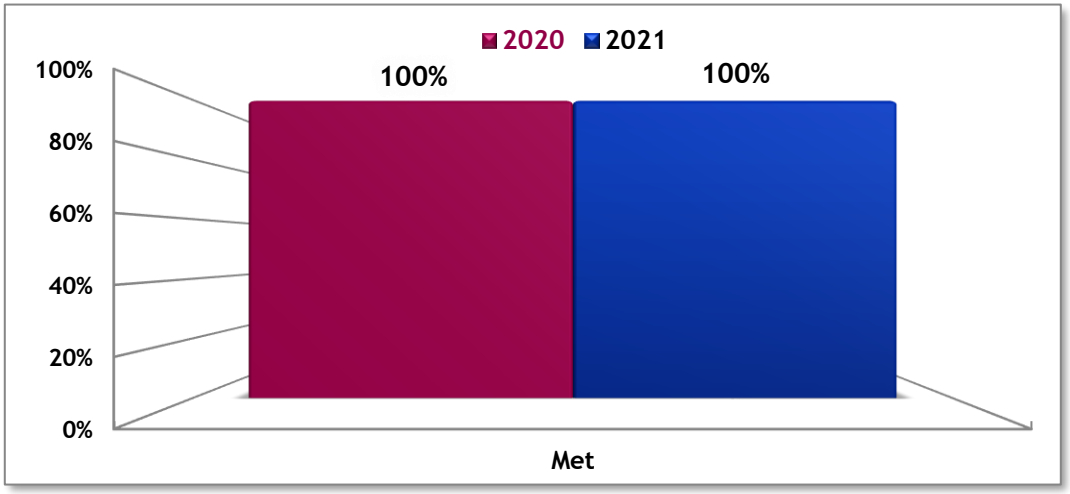
- 13460 Possible Duplicate Same Provider, Same Procedure Code, Overlapping Dates of Service
- 7011 Billing Provider must be Enrolled for Billing Taxonomy Code
- 7001 Taxonomy Code for Attending or Rendering Provider Missing

On average, Vaya submits an encounter within three days from the time of adjudication to NC Medicaid. It takes approximately 36 days to correct and resubmit an encounter to NC Medicaid. Vaya uses the Adam Holtzman's paid and denied reports and the weekly 835 file to identify encounters that were denied. As stated in the ISCA, Vaya has 695 Institutional and 65,510 Professional encounters with dates of service in 2020 still awaiting resubmission as of August 22, 2021. Vaya exceeds the NC Medicaid standards for encounter submissions and has less than 5% denial rate of their encounter data submissions.

Vaya is submitting up to 12 ICD-10 Diagnosis codes for both Institutional and Professional encounters. Vaya received Recommendations on last year's EQR to update their process to submit all 25 ICD-10 Diagnosis codes and ICD-10 Procedure codes on Institutional encounters to NCTracks. Vaya is in the process of testing the changes to their system to submit up to 25 ICD-10 Diagnosis codes and ICD-10 Procedure codes for Institutional encounters. Vaya has implemented one Recommendation from last year's EQR review and can now submit DRG codes on Institutional encounters.

Figure 2 demonstrates that Vaya met all of the Standards in the 2020 and 2021 ISCA EQR.

Figure 2: ISCA Comparative Findings



Strengths

- Vaya reconciles the monthly per member per month (PMPM) payment with the 820 Capitation file, which helps Vaya determine the specific categories of aid being paid for each month.
- Vaya auto adjudicates 79.71% of institutional claims and 96.55% of professional claims.
- Vaya can capture up to 25 ICD-10 Diagnosis codes on Institutional claims and 12 ICD-10 Diagnosis codes on Professional claims.
- Vaya can capture the DRG and ICD-10 Procedure codes on Institutional claims on the provider web portal and via HIPAA files.
- Vaya has the ability to submit DRG on Institutional encounter data extracts to NC Medicaid.

Weaknesses

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

Recommendations

- Update Vaya's encounter data submission process to submit ICD-10 Procedure codes on Institutional encounter data extracts to NCTracks.
- Update Vaya's encounter data submission process to increase the number of ICD-10 Diagnosis codes reported on Institutional encounter data extracts to NCTracks from 12 to 25.

B. Provider Services

42 CFR § 438.214 and 42 CFR § 438.240

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

In the 2020 EQR, Vaya met 100% of the Credentialing/Recredentialing standards, resulting in no Corrective Actions. CCME issued four Recommendations, one of which applied to both credentialing and recredentialing. Vaya implemented three of the 2020 Recommendations, as presented in Table 6.

Table 6: 2020 EQR Provider Services Findings

2020 EQR Provider Services Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	***Recommendation: Revise the Credentialing Committee Charter, Policy 2891 (designated as the Credentialing Program Description), and any other documents that detail credentialing processes, to consistently reflect who will chair the Credentialing Committee meetings in the absence of the CMO.***	N
2021 EQR Follow up: This issue was discussed during the Onsite Review in February 2021 and included as a Recommendation in the report issued in April 2021. In this 2021 EQR, there was no revision in the language in the *Credentialing Committee Charter* (*CCC*) and the *Credentialing Program Description* (*CPD*) regarding who will chair the Credentialing Committee meetings in the absence of the Chief Medical Officer (CMO). On the 2020 EQR Best Practice Recommendations Vaya submitted with the Desk Materials in September 2021, the "Vaya Health Comments" state, "Vaya will revise the Credentialing Committee Charter and Credentialing Program Description to reflect who will chair the Credentialing Committee meetings in the absence of the CMO." During the Onsite, Vaya confirmed the Recommendation has not yet been implemented. This remains a Recommendation for this EQR.		

2020 EQR Provider Services Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Insurance requirements	***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 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.***	**Y**
2021 EQR Follow up: In this 2021 EQR, the submitted files included proof of professional liability (PL) insurance. In some agencies, the Licensed Practitioner (LP) must provide their own PL insurance, and those Certificates of Insurance (COIs) are in the submitted files. For other LPs, the agency insurance covers them, and those files include the agency COI. Vaya verified that, if the applicant is covered by a contracted provider's insurance, the COI is maintained in the agency file. The submitted files for Licensed Independent Practitioners (LIPs) also contained proof of required insurance or an attestation as to why it was not required, such as the LIP does not transport consumers.		
Credentialing: Ownership Disclosure is addressed	***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.***	**Y**

2020 EQR Provider Services Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
2021 EQR Follow up: In this 2021 EQR, Ownership Disclosure information was not provided in the submitted Desk Materials for one initial credentialing file. Vaya submitted the documentation in response to CCME's request on the Missing Desk Materials list.		
Recredentialing: **Ownership Disclosure is addressed**	***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.***	**Y**
2021 EQR Follow up: In this 2021 EQR, Ownership Disclosure information was not provided in the submitted Desk Materials for two recredentialing files. Vaya submitted the documentation in response to CCME's request on the Missing Desk Materials list.		

In the 2021 EQR, Vaya met 100% of the Credentialing/Recredentialing standards. CCME issued no Corrective Actions. The 2020 Recommendation to "Revise the *Credentialing Committee Charter*, Policy 2891 (designated as the *Credentialing Program Description*), and any other documents that detail credentialing processes, to consistently reflect who will chair the Credentialing Committee meetings in the absence of the CMO" continues for the 2021 EQR. There are no additional Recommendations.

As part of the consolidation of Cardinal and Vaya, nine counties will be transitioning to Vaya. During the Onsite, Vaya staff discussed their process for identifying providers that are in Cardinal's network but not currently in Vaya's network. In compliance with *NC Medicaid Contract Amendment #24*, Vaya will not credential those providers. For those providers who are currently in the Vaya network but whose contract with Cardinal included sites, services, or codes that are not currently in their contract with Vaya, Vaya is adding a contract amendment covering those services. The contracts of providers in the Cardinal network who are not currently in the Vaya network are being assigned to Vaya, though the providers can object. Vaya is working to resolve issues with providers who are not in good standing, either with Cardinal or Vaya, before the January 1, 2022 transition date.

Policy 2891 (designated as the *Credentialing Program Description*) and the *CCC* guide the credentialing and recredentialing processes at Vaya. The *Credentialing Program Description* (*CPD*) indicates the Chief Medical Officer (CMO) chairs the Credentialing Committee and is "responsible for oversight of the clinical aspects of the credentialing program." Section XV of the *CPD* defines the "Scope, Responsibilities and Membership of the Credentialing Committee" and states, "In addition to the Chair, the Committee's membership is comprised of no less than five and no more than ten (10) voting members", who are "licensed clinicians and/or Qualified Professionals employed by Vaya and practitioners directly contracted with Vaya or employed/contracted by a Network Provider." Four Vaya staff members and four provider representatives comprise the current voting membership of the committee. Dr. Craig Martin, a board-certified psychiatrist and Vaya's CMO, is "permitted to break a tie." A quorum is defined as "a majority of voting members present." A quorum was present at the Credentialing Committee meetings for which minutes were submitted for this EQR. The Credentialing Committee meeting minutes reflect discussion of, and the committee's decisions regarding, the "flagged" applications.

As was the case at the 2020 EQR, 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 *CPD* 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, the Assistant Medical Director position is currently vacant, and there is no other "contracted/employed psychiatrist" at Vaya. During the Onsite, Vaya staff reported they have identified a Deputy CMO that will meet the Tailored Plan recommendation for the PIHPs to have a medical practitioner in addition to the psychiatrist. Vaya's plan is for this individual to cover if Dr. Martin is unavailable.

CCME's review showed the credentialing and recredentialing files were organized and contained appropriate information with a few exceptions, as outlined in the Tabular Spreadsheet of this report. Vaya submitted the relevant documents in response to CCME's request on the Missing Desk Materials list.

CCME identified an issue with the System for Award Management (SAM) Primary Source Verification (PSV) in the submitted agency initial credentialing file. The file had the print-out of the SAM "Search" pages, instead of the "Results" pages. When CCME requested the SAM "results", Vaya reported "Due to an oversight in the method used to save the SAM verification (print to PDF), the "result" section at the bottom of the PSVs was inadvertently omitted." Vaya submitted a plan to prevent this in the future, noting

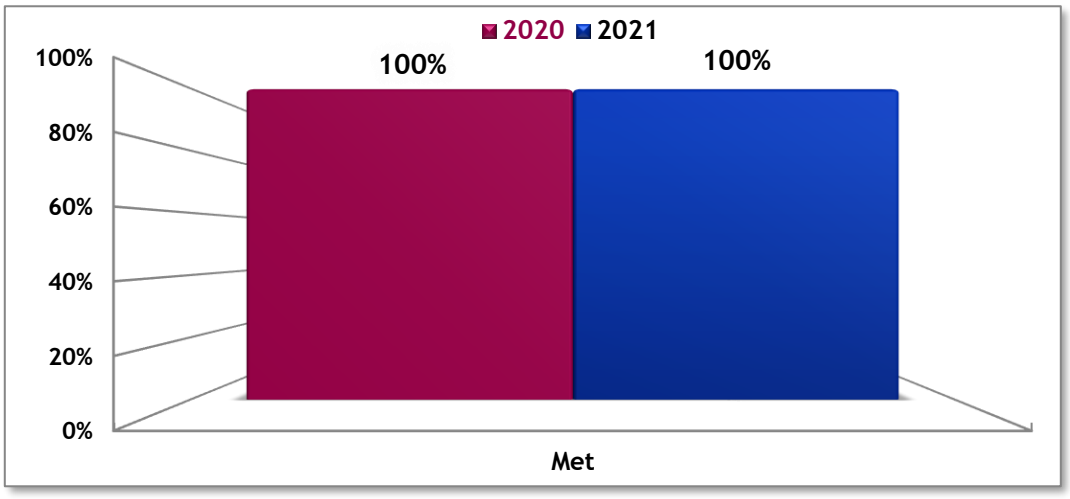
"Moving forward, Vaya's Credentialing Team will re-review every PSV during the quality assurance process to ensure proper saving."

Vaya's Provider Learning Lab includes numerous resources for providers, including the *Provider Operations Manual*, online trainings, provider webinars, information about and sign up for provider events, and the Communications Bulletins Archive. The July 20-21, 2021 Provider and Learning Summit included a presentation on fraud, waste, and abuse, as well as other presentations by Vaya staff and external personnel. The Summit presentations are posted on the Vaya website. With their contracts, new providers receive communications directing them to the materials.

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." During the Onsite, Vaya staff reported they have submitted an updated report to NC Medicaid. Vaya staff discussed actions taken to address gaps and spoke specifically of challenges in service provision due to the pandemic, and Vaya's efforts for continued service provision. For example, no new day treatment programs in school settings have been added due to social distancing requirements, but an "in lieu of" service has been expanded to address needs. Another flexibility Vaya discussed was the transition of one-on-one services in individual's homes, rather than provision of Psychosocial Rehabilitation (PSR) in group settings.

Figure 3, Provider Services Comparative Findings, shows that 100% of the standards in the 2020 and 2021 Credentialing/Recredentialing EQR were scored as "Met".

Figure 3: Provider Services Comparative 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 worked with the county Department of Social Services (DSS) offices to identify families in crisis and assisted the families by addressing some basic needs such as food insecurity and transportation needs. Vaya also has provided basic items such as blankets, feminine products, and ear buds to children in DSS custody.

Weaknesses

- As in the 2020 EQR, 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.

Recommendations

- CCME again recommends that Vaya 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.

C. Quality Improvement

42 CFR § 438.330

The 2021 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 (PMs) and a review of each PIP's *Quality Improvement Project (QIP) report* for validation, using CMS standard validation protocols. An Onsite discussion helped clarify measurement rates for each of the areas.

In the 2020 EQR, Vaya Met 100% of the Quality standards and received two Recommendations related to the four PIPs validated. The 2020 Recommendations and whether they were implemented in this 2021 EQR are presented in Table 7.

Table 7: 2020 PIP Recommendations

Project(s)	Recommendation	Recommendation Implemented in 2021 (Y/N/NA)
Community Crisis Management	***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.***	**Y**
TCLI PN Housing Usage	***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.***	**Y**

Performance Measure Validation

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

Table 8: (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 9: (c) Waiver Measures

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

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

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

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

(b) Waiver Measures Reported Results

In comparing the FY2019 to FY2020 rates, there were no measures with a substantial decline. Two measures showed substantial improvement. The first measure was the 30-Day Readmission Rate for the Psychiatric Residential Treatment Facilities (PRTF) population. The rate improved from 11.0% to 6.8%. During the Onsite review, Vaya staff discussed two primary factors that are contributing to the success of lower readmissions. The first factor is the level of attention with providers maintaining constant contact with the members. The second factor was communication with providers and encouraging them to contact members for follow-up. If the provider is unable to contact the member, Vaya will initiate the contact with the member.

The second measure with substantial improvement was the Initiation and Engagement of Alcohol and Other Drug Dependence (AODD) Treatment. The Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement) went from 28.9% to 40.2%, an 11.30% improvement for those 35 to 64 years old. The current rate in comparison to last year's rate is presented in the *Tables 10* through *19*.

Table 10: A.1. Readmission Rates for Mental Health

30-day Readmission Rates for Mental Health	FY 2019	FY 2020	Change
Inpatient (Community Hospital Only)	11.7%	11.8%	0.10%
Inpatient (State Hospital Only)	4.2%	12.5%	8.30%
Inpatient (Community and State Hospital Combined)	12.1%	12.2%	0.10%
Facility Based Crisis	7.2%	4.4%	-2.80%
Psychiatric Residential Treatment Facility (PRTF)	18.0%	6.8%	-11.20%
Combined (includes cross-overs between services)	13.9%	13.4%	-0.50%

Table 11: A.2. Readmission Rate for Substance Abuse

30-day Readmission Rates for Substance Abuse	FY 2019	FY 2020	Change
Inpatient (Community Hospital Only)	14.9%	10.7%	-4.20%
Inpatient (State Hospital Only)	0.7%	1.2%	0.50%
Inpatient (Community and State Hospital Combined)	12.4%	10.1%	-2.30%
Detox/Facility Based Crisis	7.4%	5.1%	-2.30%
Combined (includes cross-overs between services)	15.4%	13.1%	-2.30%

Table 12: A.3. Follow-Up after Hospitalization for Mental Illness

Follow-up after Hospitalization for Mental Illness	FY 2019	FY 2020	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 7 Days	46.4%	46.5%	0.10%
Percent Received Outpatient Visit Within 30 Days	63.0%	61.1%	-1.90%
Facility Based Crisis			
Percent Received Outpatient Visit Within 7 Days	77.8%	75.0%	-2.80%
Percent Received Outpatient Visit Within 30 Days	85.2%	81.9%	-3.30%
PRTF			
Percent Received Outpatient Visit Within 7 Days	25.7%	25.0%	-0.70%
Percent Received Outpatient Visit Within 30 Days	59.5%	62.5%	3.00%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 7 Days	46.1%	47.5%	1.40%
Percent Received Outpatient Visit Within 30 Days	63.2%	62.3%	-0.90%

Table 13: A.4. Follow-Up After Hospitalization for Substance Abuse

Follow-up after Hospitalization for Substance Abuse	FY 2019	FY 2020	Change
Inpatient (Hospital)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	28.7%	30.8%	2.10%
Percent Received Outpatient Visit Within 30 Days	37.9%	41.2%	3.30%
Detox and Facility Based Crisis			
Percent Received Outpatient Visit Within 3 Days	57.0%	60.7%	3.70%
Percent Received Outpatient Visit Within 7 Days	60.8%	63.9%	3.10%
Percent Received Outpatient Visit Within 30 Days	68.4%	68.9%	0.50%
Combined (includes cross-overs between services)			
Percent Received Outpatient Visit Within 3 Days	NR	NR	NA
Percent Received Outpatient Visit Within 7 Days	34.7%	36.1%	1.40%
Percent Received Outpatient Visit Within 30 Days	43.6%	45.6%	2.00%

**NR = Denominator is equal to zero.*

Table 14: B.1. Initiation and Engagement of Alcohol & Other Drug Dependence Treatment

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	FY 2019	FY 2020	Change
Ages 13–17			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	34.4%	35.0%	0.60%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	25.8%	30.8%	5.00%
Ages 18–20			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	38.0%	38.9%	0.90%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	25.7%	33.6%	7.90%
Ages 21–34			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	50.8%	48.2%	-2.60%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	38.7%	46.2%	7.50%
Ages 35–64			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	43.2%	46.2%	3.00%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	28.9%	40.2%	11.30%
Ages 65+			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	28.3%	26.0%	-2.30%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	19.8%	15.6%	-4.20%
Total (13+)			
Percent With 2nd Service or Visit Within 14 Days (Initiation)	44.3%	45.0%	0.70%
Percent With 2 Or More Services or Visits Within 30 Days After Initiation (Engagement)	31.3%	40.2%	8.90%

Table 15: D.1. Mental Health Utilization-Inpatient Discharges and Average Length of Stay

Age	Sex	Discharges Per 1,000 Member Months			Average LOS		
		FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
3–12	Male	0.4	0.4	0.4	39.7	52.5	12.8
	Female	0.4	0.5	0.4	17.7	29.0	11.3
	Total	0.4	0.4	0.4	30.2	40.5	10.3
13–17	Male	1.7	1.4	1.7	37.9	46.2	8.3
	Female	2.9	3.0	2.9	25.0	20.7	-4.3
	Total	2.3	2.2	2.3	30.0	29.2	-0.8
18–20	Male	1.7	1.6	1.7	8.7	8.4	-0.3
	Female	2.2	2.5	2.2	9.9	12.4	2.5
	Total	1.9	2.1	1.9	9.4	11.0	1.6
21–34	Male	5.9	6.5	5.9	8.6	8.7	0.1
	Female	2.2	2.4	2.2	8.1	7.2	-0.9
	Total	3.2	3.5	3.2	8.4	7.9	-0.5
35–64	Male	4.3	4.3	4.3	9.7	8.3	-1.4
	Female	3.2	3.1	3.2	8.9	8.6	-0.3
	Total	3.7	3.6	3.7	9.3	8.4	-0.9
65+	Male	0.6	0.6	0.6	13.2	13.8	0.6
	Female	0.5	0.5	0.5	12.1	15.8	3.7
	Total	0.5	0.5	0.5	12.5	15.0	2.5
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**	**1.9**	**1.9**	**1.9**	**16.9**	**17.7**	**0.8**
	Female	**1.7**	**1.8**	**1.7**	**13.0**	**13.1**	**0.1**
	Total	**1.8**	**1.8**	**1.8**	**14.8**	**15.2**	**0.4**

Table 16: D.2. Mental Health Utilization -% of Members that Received at Least 1 Mental Health Service in the Category Indicated during the Measurement Period

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
3-12	Male	16.92%	15.59%	-1.33%	0.23%	0.20%	-0.03%	1.14%	0.68%	-0.46%	16.79%	15.49%	-1.30%
	Female	13.45%	12.79%	-0.66%	0.13%	0.20%	0.07%	0.27%	0.24%	-0.03%	13.41%	12.77%	-0.64%
	Total	15.24%	14.23%	-1.01%	0.18%	0.20%	0.02%	0.71%	0.46%	-0.25%	15.15%	14.17%	-0.98%
13-17	Male	18.85%	17.01%	-1.84%	0.71%	0.70%	-0.01%	1.45%	1.02%	-0.43%	18.62%	16.88%	-1.74%
	Female	22.93%	21.81%	-1.12%	0.95%	0.99%	0.04%	0.72%	0.61%	-0.11%	22.83%	21.68%	-1.15%
	Total	20.84%	19.36%	-1.48%	0.83%	0.84%	0.01%	1.10%	0.82%	-0.28%	20.67%	19.22%	-1.45%
18-20	Male	9.76%	9.93%	0.17%	0.14%	0.13%	-0.01%	0.06%	0.00%	-0.06%	9.70%	9.93%	0.23%
	Female	15.02%	15.04%	0.02%	0.22%	0.18%	-0.04%	0.07%	0.12%	0.05%	14.98%	14.98%	0.00%
	Total	12.54%	12.63%	0.09%	0.18%	0.16%	-0.02%	0.07%	0.06%	-0.01%	12.49%	12.60%	0.11%
21-34	Male	28.24%	28.31%	0.07%	0.31%	0.35%	0.04%	0.04%	0.12%	0.08%	28.24%	28.31%	0.07%
	Female	23.73%	22.85%	-0.88%	0.24%	0.26%	0.02%	0.06%	0.09%	0.03%	23.72%	22.85%	-0.87%
	Total	24.90%	24.27%	-0.63%	0.26%	0.28%	0.02%	0.05%	0.10%	0.05%	24.89%	24.27%	-0.62%

Age	Sex	Any Mental Health Service			Inpatient Mental Health Service			Intensive Outpatient/Partial Hospitalization Mental Health Service			Outpatient/ED Mental Health Service		
		FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
35-64	Male	23.49%	22.50%	-0.99%	0.33%	0.25%	-0.08%	0.03%	0.06%	0.03%	23.49%	22.50%	-0.99%
	Female	26.32%	23.99%	-2.33%	0.29%	0.21%	-0.08%	0.10%	0.09%	-0.01%	26.32%	23.98%	-2.34%
	Total	25.18%	23.39%	-1.79%	0.30%	0.22%	-0.08%	0.07%	0.08%	0.01%	25.18%	23.38%	-1.80%
65+	Male	7.90%	7.75%	-0.15%	0.02%	0.00%	-0.02%	0.00%	0.00%	0.00%	7.90%	7.75%	-0.15%
	Female	7.42%	7.57%	0.15%	0.00%	0.00%	0.00%	0.01%	0.00%	-0.01%	7.42%	7.57%	0.15%
	Total	7.57%	7.63%	0.06%	0.01%	0.00%	-0.01%	0.01%	0.00%	-0.01%	7.57%	7.63%	0.06%
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**	**18.08%**	**16.98%**	**-1.10%**	**0.31%**	**0.29%**	**-0.02%**	**0.73%**	**0.48%**	**-0.25%**	**17.98%**	**16.91%**	**-1.07%**
	Female	**18.46%**	**17.45%**	**-1.01%**	**0.28%**	**0.29%**	**0.01%**	**0.21%**	**0.19%**	**-0.02%**	**18.42%**	**17.42%**	**-1.00%**
	Total	**18.29%**	**17.24%**	**-1.05%**	**0.29%**	**0.29%**	**0.00%**	**0.44%**	**0.32%**	**-0.12%**	**18.23%**	**17.20%**	**-1.03%**

Table 17: D.3. Identification of Alcohol and Other Drug Services

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
3–12	Male	0.02%	0.01%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.01%	-0.01%
	Female	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
	Total	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%
13–17	Male	1.20%	0.97%	-0.23%	0.03%	0.04%	0.01%	0.06%	0.05%	-0.01%	1.17%	0.94%	-0.23%
	Female	0.84%	0.66%	-0.18%	0.03%	0.02%	-0.01%	0.05%	0.03%	-0.02%	0.81%	0.63%	-0.18%
	Total	1.02%	0.82%	-0.20%	0.03%	0.03%	0.00%	0.05%	0.04%	-0.01%	1.00%	0.79%	-0.21%
18–20	Male	2.40%	1.72%	-0.68%	0.16%	0.13%	-0.03%	0.12%	0.11%	-0.01%	2.34%	1.70%	-0.64%
	Female	2.62%	1.98%	-0.64%	0.13%	0.20%	0.07%	0.22%	0.22%	0.00%	2.54%	1.94%	-0.60%
	Total	2.51%	1.86%	-0.65%	0.14%	0.17%	0.03%	0.17%	0.17%	0.00%	2.45%	1.83%	-0.62%
21–34	Male	11.15%	9.87%	-1.28%	0.52%	0.58%	0.06%	0.77%	0.54%	-0.23%	10.90%	9.85%	-1.05%
	Female	10.81%	9.54%	-1.27%	0.58%	0.46%	-0.12%	1.07%	1.03%	-0.04%	10.67%	9.39%	-1.28%
	Total	10.90%	9.63%	-1.27%	0.56%	0.49%	-0.07%	1.00%	0.90%	-0.10%	10.73%	9.51%	-1.22%

Age	Sex	Any Substance Abuse Service			Inpatient Substance Abuse Service			Intensive Outpatient/ Partial Hospitalization Substance Abuse Service			Outpatient/ED Substance Abuse Service		
		FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
35–64	Male	9.70%	9.48%	-0.22%	0.45%	0.43%	-0.02%	0.68%	0.57%	-0.11%	9.56%	9.33%	-0.23%
	Female	7.84%	7.06%	-0.78%	0.30%	0.25%	-0.05%	0.46%	0.44%	-0.02%	7.73%	6.97%	-0.76%
	Total	8.59%	8.04%	-0.55%	0.36%	0.33%	-0.03%	0.55%	0.49%	-0.06%	8.47%	7.93%	-0.54%
65+	Male	1.29%	1.63%	0.34%	0.02%	0.04%	0.02%	0.02%	0.04%	0.02%	1.29%	1.63%	0.34%
	Female	0.40%	0.43%	0.03%	0.00%	0.01%	0.01%	0.00%	0.01%	0.01%	0.40%	0.43%	0.03%
	Total	0.69%	0.83%	0.14%	0.01%	0.02%	0.01%	0.01%	0.02%	0.01%	0.69%	0.83%	0.14%
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**	**3.17%**	**2.95%**	**-0.22%**	**0.14%**	**0.14%**	**0.00%**	**0.21%**	**0.17%**	**-0.04%**	**3.12%**	**2.91%**	**-0.21%**
	Female	**3.74%**	**3.27%**	**-0.47%**	**0.17%**	**0.14%**	**-0.03%**	**0.29%**	**0.27%**	**-0.02%**	**3.69%**	**3.23%**	**-0.46%**
	Total	**3.49%**	**3.13%**	**-0.36%**	**0.16%**	**0.14%**	**-0.02%**	**0.25%**	**0.22%**	**-0.03%**	**3.44%**	**3.09%**	**-0.35%**

Table 18: D.4. Substance Abuse Penetration Rate

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
	3-12			13-17			18-20			21-34		
Alexander	0.00%	0.00%	0.00%	0.00%	0.29%	0.29%	0.00%	1.43%	1.43%	7.89%	6.37%	-1.52%
Alleghany	0.13%	0.00%	-0.13%	0.93%	0.93%	0.00%	0.93%	1.63%	0.70%	4.04%	6.29%	2.25%
Ashe	0.00%	0.00%	0.00%	0.29%	1.00%	0.71%	0.29%	0.93%	0.64%	5.21%	6.12%	0.91%
Avery	0.00%	0.00%	0.00%	0.93%	0.46%	-0.47%	0.93%	1.49%	0.56%	6.92%	5.08%	-1.84%
Buncombe	0.01%	0.02%	0.01%	1.03%	1.06%	0.03%	1.03%	2.45%	1.42%	9.25%	8.92%	-0.33%
Caldwell	0.00%	0.02%	0.02%	1.18%	0.62%	-0.56%	1.18%	1.09%	-0.09%	8.34%	6.17%	-2.17%
Cherokee	0.00%	0.00%	0.00%	1.14%	0.91%	-0.23%	1.14%	2.54%	1.40%	7.15%	6.21%	-0.94%
Clay	0.00%	0.00%	0.00%	1.85%	1.86%	0.01%	1.85%	1.43%	-0.42%	5.56%	8.81%	3.25%
Graham	0.00%	0.00%	0.00%	1.23%	0.32%	-0.91%	1.23%	2.27%	1.04%	5.68%	7.19%	1.51%
Haywood	0.00%	0.00%	0.00%	1.50%	0.85%	-0.65%	1.50%	2.15%	0.65%	12.20%	8.93%	-3.27%
Henderson	0.00%	0.00%	0.00%	0.64%	0.54%	-0.10%	0.64%	1.76%	1.12%	6.00%	5.50%	-0.50%
Jackson	0.00%	0.00%	0.00%	1.32%	0.46%	-0.86%	1.32%	2.03%	0.71%	8.79%	7.06%	-1.73%

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County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
	3-12			13-17			18-20			21-34		
Macon	0.00%	0.00%	0.00%	0.93%	1.57%	0.64%	0.93%	1.23%	0.30%	8.24%	9.21%	0.97%
Madison	-	0.00%	0.00%	0.86%	0.35%	-0.51%	0.86%	0.97%	0.11%	10.59%	7.34%	-3.25%
McDowell	0.03%	0.03%	0.00%	0.89%	0.90%	0.01%	0.89%	2.29%	1.40%	8.81%	8.29%	-0.52%
Mitchell	0.00%	0.00%	0.00%	0.00%	0.52%	0.52%	0.00%	2.66%	2.66%	7.28%	7.03%	-0.25%
Polk	0.00%	0.00%	0.00%	0.41%	0.88%	0.47%	0.41%	1.26%	0.85%	2.85%	3.17%	0.32%
Swain	0.06%	0.00%	-0.06%	1.69%	0.49%	-1.20%	1.69%	2.61%	0.92%	5.16%	8.20%	3.04%
Transylvania	0.00%	0.05%	0.05%	1.58%	0.38%	-1.20%	1.58%	2.85%	1.27%	7.82%	6.37%	-1.45%
Watauga	0.07%	0.07%	0.00%	1.28%	0.73%	-0.55%	1.28%	0.83%	-0.45%	6.37%	6.23%	-0.14%
Wilkes	0.02%	0.02%	0.00%	1.25%	1.08%	-0.17%	1.25%	1.80%	0.55%	10.84%	10.30%	-0.54%
Yancey	0.00%	0.00%	0.00%	0.79%	0.58%	-0.21%	0.79%	1.10%	0.31%	8.18%	8.93%	0.75%

County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
	35-64			65+			Unknown			Total		
Alexander	7.88%	9.23%	1.35%	0.35%	0.52%	0.17%	0.00%	0.00%	0.00%	3.16%	2.91%	-0.25%
Alleghany	5.08%	4.13%	-0.95%	0.00%	0.37%	0.37%	0.00%	0.00%	0.00%	1.46%	1.93%	0.47%
Ashe	6.36%	6.79%	0.43%	0.25%	0.78%	0.53%	0.00%	0.00%	0.00%	2.17%	2.64%	0.47%
Avery	6.16%	6.41%	0.25%	0.92%	0.23%	-0.69%	0.00%	0.00%	0.00%	2.28%	1.98%	-0.30%
Buncombe	9.72%	9.53%	-0.19%	1.71%	1.67%	-0.04%	0.00%	0.00%	0.00%	3.87%	3.80%	-0.07%
Caldwell	5.34%	5.60%	0.26%	0.77%	0.88%	0.11%	0.00%	0.00%	0.00%	2.80%	2.36%	-0.44%
Cherokee	8.56%	7.70%	-0.86%	0.53%	0.80%	0.27%	0.00%	0.00%	0.00%	3.19%	2.97%	-0.22%
Clay	9.47%	6.65%	-2.82%	1.63%	1.62%	-0.01%	0.00%	0.00%	0.00%	2.83%	2.96%	0.13%
Graham	7.33%	6.00%	-1.33%	0.00%	0.34%	0.34%	0.00%	0.00%	0.00%	1.70%	2.52%	0.82%
Haywood	12.45%	9.64%	-2.81%	1.41%	1.27%	-0.14%	0.00%	0.00%	0.00%	5.12%	3.80%	-1.32%
Henderson	7.39%	7.71%	0.32%	1.52%	1.48%	-0.04%	0.00%	0.00%	0.00%	2.53%	2.38%	-0.15%
Jackson	9.75%	8.46%	-1.29%	1.21%	0.76%	-0.45%	0.00%	0.00%	0.00%	3.79%	2.99%	-0.80%

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County	Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service			Percent That Received At Least One SA Service		
	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
	35-64			65+			Unknown			Total		
Macon	10.13%	8.08%	-2.05%	0.83%	0.69%	-0.14%	0.00%	0.00%	0.00%	3.44%	3.09%	-0.35%
Madison	8.17%	8.05%	-0.12%	0.63%	1.10%	0.47%	0.00%	0.00%	0.00%	3.14%	3.03%	-0.11%
McDowell	8.89%	8.14%	-0.75%	0.92%	1.04%	0.12%	0.00%	0.00%	0.00%	3.62%	3.31%	-0.31%
Mitchell	7.97%	6.53%	-1.44%	0.48%	0.24%	-0.24%	0.00%	0.00%	0.00%	2.41%	2.65%	0.24%
Polk	5.39%	4.12%	-1.27%	0.59%	0.91%	0.32%	0.00%	0.00%	0.00%	1.55%	1.59%	0.04%
Swain	5.86%	4.92%	-0.94%	0.49%	0.53%	0.04%	0.00%	0.00%	0.00%	2.31%	2.44%	0.13%
Transylvania	10.41%	6.52%	-3.89%	2.00%	2.37%	0.37%	0.00%	0.00%	0.00%	4.03%	2.75%	-1.28%
Watauga	8.89%	6.18%	-2.71%	0.57%	0.98%	0.41%	0.00%	0.00%	0.00%	2.70%	2.31%	-0.39%
Wilkes	9.26%	9.24%	-0.02%	0.47%	0.66%	0.19%	0.00%	0.00%	0.00%	3.86%	3.72%	-0.14%
Yancey	8.02%	9.10%	1.08%	0.79%	0.82%	0.03%	0.00%	0.00%	0.00%	2.45%	3.37%	0.92%

Table 19: D.5. Mental Health Penetration Rate

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
	3-12			13-17			18-20			21-34		
Alexander	9.75%	10.28%	0.53%	17.64%	16.25%	-1.39%	8.35%	12.50%	4.15%	8.70%	9.76%	1.06%
Alleghany	11.01%	12.32%	1.31%	20.68%	20.74%	0.06%	8.24%	7.61%	-0.63%	13.13%	13.25%	0.12%
Ashe	11.15%	10.77%	-0.38%	16.42%	17.05%	0.63%	9.64%	7.74%	-1.90%	10.74%	14.49%	3.75%
Avery	9.21%	8.04%	-1.17%	16.82%	15.01%	-1.81%	12.76%	9.41%	-3.35%	12.89%	14.92%	2.03%
Buncombe	14.56%	14.35%	-0.21%	23.01%	21.95%	-1.06%	15.13%	14.92%	-0.21%	20.26%	19.98%	-0.28%
Caldwell	8.85%	8.29%	-0.56%	15.85%	15.98%	0.13%	8.22%	9.69%	1.47%	11.05%	10.41%	-0.64%
Cherokee	13.33%	10.27%	-3.06%	19.25%	17.33%	-1.92%	12.92%	10.85%	-2.07%	15.76%	14.23%	-1.53%
Clay	15.21%	10.97%	-4.24%	20.37%	21.12%	0.75%	7.44%	9.29%	1.85%	11.90%	15.33%	3.43%
Graham	10.64%	14.71%	4.07%	14.51%	17.83%	3.32%	7.26%	13.64%	6.38%	12.62%	16.78%	4.16%
Haywood	17.24%	13.77%	-3.47%	22.16%	18.76%	-3.40%	15.53%	14.02%	-1.51%	18.88%	17.74%	-1.14%
Henderson	9.97%	10.01%	0.04%	15.99%	14.71%	-1.28%	10.13%	11.78%	1.65%	12.62%	13.17%	0.55%
Jackson	10.71%	10.00%	-0.71%	17.92%	16.42%	-1.50%	14.23%	9.24%	-4.99%	14.30%	12.57%	-1.73%

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County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
	3-12			13-17			18-20			21-34		
Macon	13.63%	11.88%	-1.75%	19.81%	19.54%	-0.27%	11.78%	9.58%	-2.20%	16.13%	16.69%	0.56%
Madison	12.24%	12.19%	-0.05%	19.59%	20.88%	1.29%	11.22%	13.31%	2.09%	17.24%	17.31%	0.07%
McDowell	11.56%	10.33%	-1.23%	19.82%	18.45%	-1.37%	11.88%	12.69%	0.81%	16.18%	15.27%	-0.91%
Mitchell	12.67%	9.59%	-3.08%	19.74%	16.23%	-3.51%	6.84%	9.57%	2.73%	12.14%	12.24%	0.10%
Polk	14.44%	13.69%	-0.75%	23.20%	17.11%	-6.09%	14.94%	15.55%	0.61%	9.50%	7.92%	-1.58%
Swain	7.37%	7.51%	0.14%	19.29%	16.05%	-3.24%	10.20%	10.46%	0.26%	8.76%	10.45%	1.69%
Transylvania	15.97%	11.99%	-3.98%	23.24%	21.88%	-1.36%	17.57%	16.01%	-1.56%	13.62%	13.40%	-0.22%
Watauga	12.70%	11.29%	-1.41%	20.18%	18.50%	-1.68%	12.40%	9.54%	-2.86%	13.86%	14.40%	0.54%
Wilkes	12.86%	12.15%	-0.71%	18.23%	20.09%	1.86%	10.57%	11.44%	0.87%	11.89%	14.38%	2.49%
Yancey	11.01%	8.82%	-2.19%	13.24%	13.87%	0.63%	7.12%	8.42%	1.30%	7.98%	8.74%	0.76%

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
	35-64			65+			Unknown			Total		
Alexander	15.75%	15.02%	-0.73%	5.12%	7.94%	2.82%	0.00%	0.00%	0.00%	11.52%	12.02%	0.50%
Alleghany	22.74%	20.41%	-2.33%	11.67%	7.75%	-3.92%	0.00%	0.00%	0.00%	14.82%	14.26%	-0.56%
Ashe	18.41%	18.13%	-0.28%	8.54%	10.31%	1.77%	0.00%	0.00%	0.00%	12.95%	13.53%	0.58%
Avery	14.59%	16.55%	1.96%	6.22%	8.45%	2.23%	0.00%	0.00%	0.00%	11.63%	11.62%	-0.01%
Buncombe	24.67%	24.79%	0.12%	12.19%	12.80%	0.61%	0.00%	0.00%	0.00%	18.55%	18.37%	-0.18%
Caldwell	15.14%	12.99%	-2.15%	9.32%	6.89%	-2.43%	0.00%	0.00%	0.00%	11.45%	10.69%	-0.76%
Cherokee	19.97%	18.21%	-1.76%	7.49%	6.42%	-1.07%	0.00%	0.00%	0.00%	15.27%	13.19%	-2.08%
Clay	20.37%	15.83%	-4.54%	7.52%	6.49%	-1.03%	0.00%	0.00%	0.00%	15.24%	13.21%	-2.03%
Graham	14.65%	12.89%	-1.76%	9.09%	6.06%	-3.03%	0.00%	0.00%	0.00%	11.90%	13.78%	1.88%
Haywood	23.34%	19.17%	-4.17%	9.66%	10.60%	0.94%	0.00%	0.00%	0.00%	18.56%	15.88%	-2.68%
Henderson	20.24%	19.44%	-0.80%	17.26%	15.10%	-2.16%	0.00%	0.00%	0.00%	13.79%	13.45%	-0.34%
Jackson	18.36%	16.37%	-1.99%	6.33%	7.10%	0.77%	0.00%	0.00%	0.00%	13.65%	12.26%	-1.39%

County	Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service			Percent That Received At Least One MH Service		
	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change	FY 2019	FY 2020	Change
	35-64			65+			Unknown			Total		
Macon	22.03%	19.43%	-2.60%	5.84%	5.25%	-0.59%	0.00%	0.00%	0.00%	15.56%	14.21%	-1.35%
Madison	17.63%	17.13%	-0.50%	6.80%	8.95%	2.15%	0.00%	0.00%	0.00%	14.22%	14.71%	0.49%
McDowell	19.84%	17.62%	-2.22%	10.34%	13.76%	3.42%	0.00%	0.00%	0.00%	15.09%	14.28%	-0.81%
Mitchell	15.22%	13.64%	-1.58%	6.67%	7.88%	1.21%	0.00%	0.00%	0.00%	12.88%	11.45%	-1.43%
Polk	16.16%	12.52%	-3.64%	13.27%	15.15%	1.88%	0.00%	0.00%	0.00%	15.38%	13.44%	-1.94%
Swain	13.32%	11.81%	-1.51%	4.20%	4.22%	0.02%	0.00%	0.00%	0.00%	10.27%	9.91%	-0.36%
Transylvania	21.00%	19.90%	-1.10%	12.77%	12.45%	-0.32%	0.00%	0.00%	0.00%	17.58%	15.63%	-1.95%
Watauga	23.27%	20.64%	-2.63%	11.22%	12.13%	0.91%	0.00%	0.00%	0.00%	15.78%	14.51%	-1.27%
Wilkes	17.72%	19.87%	2.15%	7.60%	6.89%	-0.71%	0.00%	0.00%	0.00%	13.81%	14.63%	0.82%
Yancey	13.74%	12.22%	-1.52%	7.74%	9.26%	1.52%	0.00%	0.00%	0.00%	10.74%	10.24%	-0.50%

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

Table 20: (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 21: (c) Waiver Measures Reported Results 2020 - 2021. Documentation on data sources, data validation, source code, and calculated rate for the five measures was provided. Additionally, all rates exceeded the State Performance Benchmarks.

Table 21: (c) Waiver Measures Reported Results 2020-2021

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%**

** Latest reported rates are shown in Table from Excel files: C Waiver Reported Measures Excel files*

(c) Waiver Validation

All (c) Waiver Measures met the validation requirements and were Fully Compliant as shown in Table 22, (c) Waiver Performance Measure Validation Scores. The validation worksheets offer detailed information on validation and calculation steps for (c) Waiver Measures.

Table 22: (c) Waiver Performance Measures Validation Scores

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

Performance Improvement Project (PIP) Validation

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

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

PIP Validation Results

For the 2020 EQR there were four active PIPs submitted, and all four were validated. The validated PIPs include: TCLI PN Housing Usage, Increase Rate of Routine Access to Care Calls Receiving Service Within 14 Days, Community Crisis Management, and ADATC VIP. All PIPs scored in the High Confidence range.

In the 2021 PIP validation, the same four PIPs were submitted and validated. PIP validation was conducted using the *CMS Protocol 1: Validating Performance Improvement Projects*. The Onsite discussion indicated two PIPs remain active: Access to Care and ADATC VIP. The ADATC VIP will have a shift in focus from the Substance Use Disorder (SUD) population to the Mental Health (MH) population. The TCLI PIP was moved to monitoring status as of May 30, 2021 and a new measure “Retention Rate” is proposed, although the steps for approval are not completed. The Community Crisis Management PIP will be replaced, although the new topic has not been chosen or approved.

Table 23: PIP Summary of Validation Scores

Project Type	Project	2020 Validation Score	2021 Validation Score
Non- Clinical	TCLI PN Housing Usage	73/74 = 99% High Confidence in Reported Results	73/74 = 99% High Confidence in Reported Results
Clinical	Increase Rate of Routine Access to Care Calls Receiving Service Within 14 Days	79/79 = 100% High Confidence in Reported Results	79/79 = 100% High Confidence in Reported Results
	Community Crisis Management	78/79 = 99% High Confidence in Reported Results	72/72 = 100% High Confidence in Reported Results
	ADATC VIP	84/84 = 100% High Confidence in Reported Results	84/84 = 100% High Confidence in Reported Results

Table 24 displays the PIP project title and the interventions reported by Vaya for the current review year aimed at improving PIP outcomes.

Table 24: 2021 Review PIP Interventions

Project(s)	Interventions
TCLI PN Housing Usage- Non Clinical	Real time inventory access, communication between department managers, Standard Operating Procedures (SOP) document
Increase Rate of Routine Access to Care Calls Receiving Service Within 14 Days- Clinical	iPads for real time information on members, contact information of probation officers shared with Vaya managers, workflow/process documentation, text message reminders for appointments, mental health specialized probation officers
Community Crisis Management – Clinical	Provider incentives and penalties, text message reminders, community planning for high-utilizers, interdisciplinary clinical reviews
ADATC VIP- Clinical	Onsite/in-person care management, phone appointments for members, video conferencing with Complex Care Management, monthly check-in calls to enhance communication between CCM and ADATC Departments

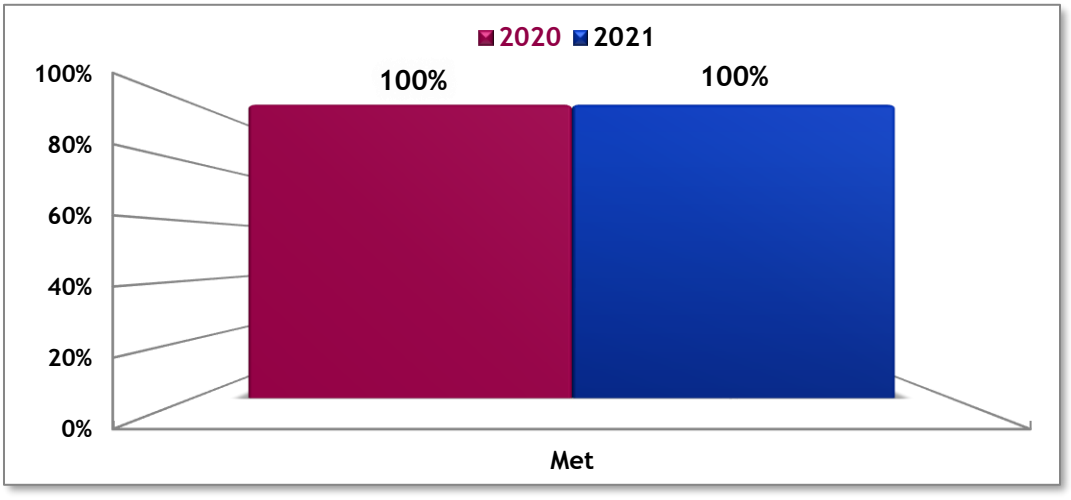
There are no Corrective Actions for the validated PIPS. For one of the PIPs, there is a Recommendation regarding the continued monitoring of the indicators with interventions in place. The project, section, reason, and Recommendation are displayed in Table 25 that follows.

Table 25: Performance Improvement Project Recommendation

Project(s)	Section	Reason	Recommendation
TCLI PN Housing Usage	Was there any documented, quantitative improvement in processes or outcomes of care?	The number housed in April was 6, and May was 6 (Goal is 10). Vacancy alerts declined from 10 to 3; alerts utilized declined from 4 to 1. Goal is 4. The housing rate remained unchanged although alert and utilization of alerts have declined.	Continue to monitor real-time inventory access, communication, and SOP documentation intervention impacts on members housed.

Details of the validation activities for the PMs and PIPs and specific outcomes related to each activity may be found in *Attachment 3, CCME EQR Validation Worksheets*. As demonstrated in Figure 4, Vaya met all the Quality Improvement standards in the 2021 EQR.

Figure 4: Quality Improvement Comparative Findings



Strengths

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

Weaknesses

- PIP rates did not improve for two of the validated PIPs (Community Crisis Management and TCLI Housing).

Recommendations

- TCLI PN Housing PIP: Continue to monitor real-time inventory access, communication, and SOP documentation intervention impacts on members housed.

D. Utilization Management

42 CFR § 438.208

The EQR of Utilization Management (UM) included a review of the Care Coordination and Transition to Community Living (TCLI) programs. CCME reviewed relevant policies, Vaya's Organizational Chart, the *Member and Caregiver Handbook*, 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 2020 EQR, Vaya met 100% of UM standards. CCME issued two Recommendations to encourage Vaya to enhance the current documentation monitoring plan to routinely review the timeliness of MH/SUD, I/DD, and TCLI Care Management activities (e.g., discharge activities, follow up activities, HCBS monitoring, etc.), as well as the quality and completeness of Care Managers' documentation.

Table 26 outlines CCME's review to ensure those Recommendations were implemented by Vaya.

Table 26: 2020 EQR Utilization Management Findings

2020 EQR Utilization Management Findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Care Coordination policies and procedures as formulated.	***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.***	**N**
2021 EQR Follow up: In this 2021 EQR, Vaya partially addressed the Recommendation. Vaya updated the *Complex Care Management Quality Improvement & Monitoring Plan*. However, issues were identified in the timeliness and documenting of MH/SUD Care Management progress notes.		
A review of files demonstrates the PIHP is following appropriate TCLI policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	***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.***	**Y**
2021 EQR Follow up: In this 2021 EQR, Vaya addressed the Recommendation and updated the *Complex Care Management Quality Improvement & Monitoring Plan*.		

For the 2021 EQR, Vaya received one Corrective Action and one Recommendation. The review of I/DD Care Management files included one enrollee who voluntarily terminated from the Innovations Waiver. Findings from the review and information gathered during the Onsite determined that Vaya:

- Was unable to provide the signed and dated *Authorization for Termination* notification to confirm the enrollee's removal from the Innovations Waiver.
- Did not notify the enrollee of final termination according to *NC Clinical Coverage Policy 8P, Attachment B, M: Other North Carolina Innovations Terminations*.

- Did not adequately follow-up with the enrollee who had limited natural supports and no community supports prior to termination.
- Did not ensure the enrollee's health and safety needs were assessed and addressed prior to termination, especially in consideration of the pandemic.

CCME is issuing a Corrective Action for Vaya to develop a process that produces the full Care Management record, including any documentation around termination from the Innovations Waiver. The Corrective Action also targets concerns regarding a lack of coordination of services and supports, and assessment of the enrollee's health and safety prior to the enrollee's voluntary termination from the Innovations Waiver.

The review of MH/SUD Care Management progress notes found issues with the timeliness of documentation. 39% of progress notes were submitted outside of the 24-hour timeframe required by Vaya's Policy 2340, Administrative Health Record Documentation. Furthermore, the review found that none of the late progress notes followed Vaya's process for late entries. Policy 2340 states that, "Notes that cannot be entered within 24 hours shall be noted as 'late entries' with their reason as to the delay (lack of connectivity, etc.)." CCME recommends that Vaya update the current *Complex Care Management Quality Improvement & Monitoring Plan* to include a process that identifies and addresses progress notes that are submitted beyond the required timeframe to ensure compliance with Vaya's policies.

For this EQR, TCLI showed significant improvement in the timeliness of progress notes and other documentation. The review found more proactive engagement with enrollees that addressed barriers to services and other crises. *Figure 5* shows 96% of the Utilization Management standards were scored as "Met" and 4% as "Partially Met," compared to the 2020 EQR UM score.

Figure 5: Utilization Management Comparative Findings

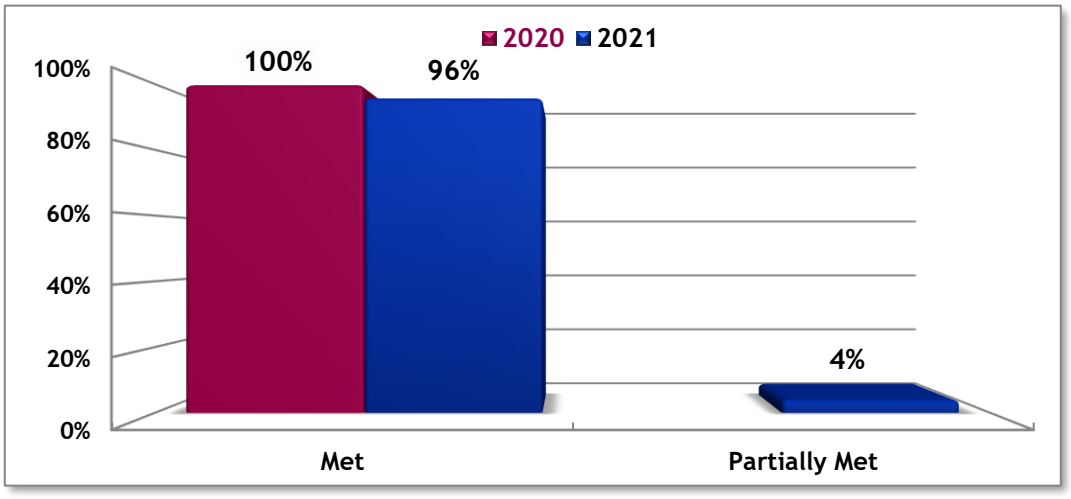


Table 27: Utilization Management

Section	Standard	2021 Review
Care Coordination	Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;	**Partially Met**

Strengths

- In preparation of the NC Tailored Plan, Vaya has begun integrating pharmacy and nursing into its Complex Care Management team by holding "team huddles."
- Vaya is working closely with County Department of Social Services leadership to start several outreach programs in an effort to reduce the number of children placed in emergency placements.
- Vaya staff reported 100 TCLI enrollees have been placed in independent housing, despite challenges posed by the pandemic.

Weaknesses

- The review of MH/SUD files found noncompliance with Vaya's Policy 2340, Administrative Health Record Documentation requirements around progress note submission timeframes and late entry process.
- The reviewed I/DD file of the enrollee who voluntarily terminated from the Innovations Waiver did not include the *Authorization for Termination* notification. The review also found a lack of coordination of services and supports along with poor follow-up and assessment of the enrollee's potential health and safety.

Corrective Action

- Enhance the current Care Coordination documentation quality review to include;
    - Routine review of notifications within the enrollee's record and ensure those notifications can be generated outside of the enrollee's electronic record.
    - Routine review of Care Coordination documentation around any enrollee's terminating from Care Coordination or the Innovations Waiver. The review should ensure proper notifications occurred, alternative services were offered, and the enrollee's health and safety was assessed and addressed throughout the termination.

Recommendation

- Update the current *Complex Care Management Quality Improvement & Monitoring Plan* to include a process that identifies late progress notes and ensures these progress notes are labelled "late entry", as required by Vaya's Policy 2340, Administrative Health Record Documentation.

E. Grievances and Appeals

42 CFR § 438, Subpart F

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

In the 2020 EQR, Vaya met 100% of the Grievance and Appeal standards and received two Recommendations in each of the Grievance and Appeal sections. Follow up to the 2020 EQR Grievance and Appeal Recommendations is detailed in the following sections.

In this 2021 EQR, Vaya met 100% of the Grievance and Appeal standards, resulting in no Corrective Actions. CCME issued one Recommendation in the Grievance and two Recommendations in the Appeal section.

Grievances

In the 2020 EQR, two Recommendations were issued primarily targeting Vaya's quality and compliance monitoring processes around Grievances. These Recommendations were aimed at ensuring all Grievance acknowledgement and resolution letters are issued timely and data within the Grievance Log is accurate. In the 2021 EQR, there was evidence that Vaya addressed all Grievance Recommendations issued in the 2020 EQR.

Table 28 outlines CCME's review to ensure those Recommendations were implemented by Vaya.

Table 28: Follow up to 2020 EQR Grievance Recommendations

2020 EQR Grievance findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP applies the grievance policy and procedure as formulated.	***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.***	**Y**
2021 EQR Follow up: In the 2021 EQR, the file review demonstrated that Vaya's monitoring process resulted in a decrease in late resolution letters from 2 in the 2020 EQR to 0 in the 2021 EQR. There was 1 late Acknowledgment letter in both review years.		

2020 EQR Grievance findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	***Recommendation: Enhance the monitoring of the Grievance Log to ensure the Log contains only Grievances, as defined in Policy 2607, Grievances and Complaints.***	Y
2021 EQR Follow up: In the 2021 EQR, the Grievance Log only contained Grievance files.		

In the 2021 EQR, 10 Grievance files were reviewed. Nine of the 10 files met all timeliness requirements and were acknowledged within five days of receipt required by Policy 2607, Complaints and Grievances. One Grievance file showed the acknowledgment notice was issued in 48 days instead of five days. Onsite discussion with staff explained that there was a delay in entering this Grievance in the system because clarification was needed. In response to this issue, Vaya staff now enter Grievances into the system immediately and get clarification later.

Appeals

In the 2020 EQR of Appeals, Vaya received two Recommendations. Both Recommendations centered around enhancing Vaya's quality and compliance monitoring process of Appeals to include close monitoring of all Appeal notifications (oral and written), not written Appeal resolutions only. Additionally, review of Vaya's Appeal Log, the sole source of Appeal data, contained several errors. CCME recommended that the Appeal Log is also monitored for accuracy. There was evidence in the 2021 EQR of Appeals that both Appeals Recommendations were implemented by Vaya.

Table 29 outlines CCME's review to ensure Vaya implemented the Recommendations.

Table 29: Follow up to 2020 EQR Appeals Recommendations

2020 EQR Appeal findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
The PIHP applies the appeal policies and procedures as formulated.	***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.***	Y

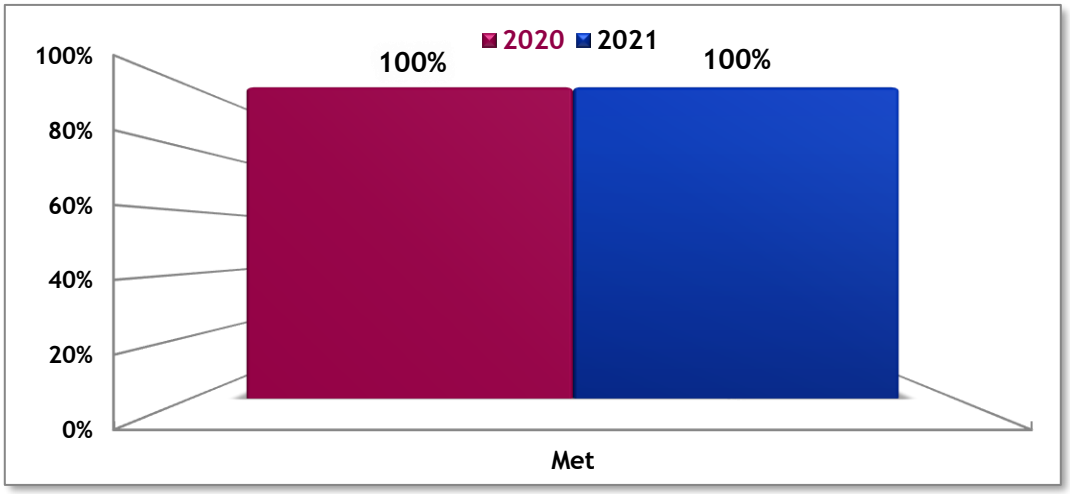
2020 EQR Appeal findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
2021 EQR Follow up: In the 2021 EQR, overall improvement in compliance and accuracy was noted in the Appeal files when compared to the 2020 EQR. The 2021 EQR file review found one expedited Appeal with a late notice of resolution letter. One standard Appeal was not recognized on the fax machine when it originally came in resulting in a late acknowledgement letter and late resolution letter.		
Appeals are tallied, categorized, and analyzed for patterns and potential quality improvement opportunities, and reviewed in committee.	***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.***	**Y**
2021 EQR Follow up: For the 2021 EQR, the data within the Appeal Log matched the data within the Appeal files reviewed.		

In the 2021 EQR, there was overall improvement in compliance and accuracy with all types of Appeal files when compared to the 2020 EQR. Six expedited, three standard, and one extended (by the guardian) Appeals were reviewed. Eight of the Appeals met all timeliness requirements. One expedited Appeal had a late resolution letter sent in five days instead of within 72 hours, as required by Vaya's Policy 2384, Member and Recipient Appeals of Adverse Decisions. One faxed, standard Appeal was overlooked by Vaya staff and acknowledged in 35 days instead of one business day, as required by Vaya Policy 2384. This appeal was also resolved in 37 days as a result of this oversight, and not in the 30-day timeframe required by *NC Medicaid Contract, Attachment M* and *42 CFR § 438* and Vaya's Appeal policy.

During the Onsite, there was discussion around Vaya's *UM Audit Summary June 2, 2021* document. Vaya confirmed this is a yearly report. This review is done outside of the Utilization Management (UM) internal audit which reviews all of the Appeal files monthly. For the Appeal metrics in the *UM Audit Summary June 2, 2021*, the Appeal sample size was eight of 16 Appeal records for the second quarter of 2020-21. For the quarterly review implemented for the Regulatory Compliance Committee, there was concern sample size was too low to adequately identify Appeal compliance issues. For the quarterly review, Vaya followed the NCQA guidelines of randomly selecting 16 files, and if the first half are compliant, no further file review is needed. CCME has issued a Recommendation to increase the sample size of the Appeal files reviewed for the Regulatory Compliance Committee and reported in the Vaya *UM Audit Summary*.

Figure 6 demonstrates that Vaya met 100% of the Grievances and Appeals standards in the 2020 and 2021 EQRs.

Figure 6: Grievances and Appeals Comparative Findings



Strengths

- Interdepartmental case coordination was evident in the Grievance and Appeal files reviewed.
- In the 2021 EQR, the Grievance file review demonstrated that Vaya's monitoring process resulted in a decrease from the previous EQR in late Grievance resolution notifications.
- In the 2021 EQR, overall improvement in compliance and accuracy was noted with all types of Appeal files when compared to the 2020 EQR.

Weaknesses

- One Grievance file was acknowledged in 48 days instead of the required five business days.
- The 2021 EQR Appeal file review found one expedited Appeal was resolved and notification issued in five days instead of the 72 hours required by Vaya's Appeal policy. There was also one standard Appeal acknowledged and the resolution notification provided outside of the standard Appeal timeframe required by Vaya's Appeal policy, *NC Medicaid Contract*, *Attachment M* and *42 CFR § 438.408 (b)(2)*.
- Vaya's quarterly monitoring process implemented by the Regulatory Compliance Committee reviews a small sample of Appeals and may not accurately capture compliance issues within the Appeal files.

Recommendations

- Continue to closely monitor all Grievances to ensure all acknowledgement notifications and resolution notifications are timely and to identify problems with processes that contribute to compliance issues.
- Continue to closely monitor Appeals to ensure all acknowledgement notifications and resolution notifications are timely and to identify problems with processes that contribute to compliance issues.
- Increase the sample size of the Appeal files reviewed for the Regulatory Compliance Committee and reported in the *Vaya UM Audit Summary*.

F. Program Integrity

42 CFR § 455, 42 CFR § 438.455 and *1000* through *1008, 42 CFR § 1002.3(b)(3), 42 CFR 438.608 (a)(vii)*

The 2021 Program Integrity EQR for Vaya encompassed a thorough Desk Review of PIHP Program Integrity (PI) function. Policies related to Special Investigative Unit (SIU) investigations, Provider Overpayments, and related aspects of compliance were reviewed.

The EQR also covers PI staffing, workflows, reports, training materials, committee minutes, and data mining as well as a file review of randomly sampled cases that were active during the review period. Finally, we conducted an interview with the Vaya Regulatory Compliance Officer, General Counsel and Special Investigations Director on September 30, 2021.

All reviews are based on *42 CFR § 438.455*, *42 CFR § 438.608*, and *NC Medicaid Contract, Section 14: Program Integrity*.

In the 2020 EQR Vaya met 100% of the PI standards, resulting in no Corrective Actions and four Recommendations. Vaya addressed three of the four 2020 Recommendations as presented in Table 30.

Table 30: 2020 EQR Program Integrity Findings

2020 EQR Program Integrity findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
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.	***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.***	**Y**
2021 EQR Follow up: Vaya has implemented this Recommendation. NC Medicaid staff indicated that they have been receiving all required minutes since March 2021.		
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.	***Recommendations: Add language to 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.***	**Y**
2021 EQR Follow up: This Recommendation was addressed. Vaya included the required timelines in policies. The 2021 file review found all files implemented within the required timeframe.		
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;	***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.***	**Y**
2021 EQR Follow up: This Recommendation was addressed. The 2021 file review found that Vaya included all information on the NC Medicaid approved template.		

2020 EQR Program Integrity findings		
Standard	**EQR Comments**	**Implemented Y/N/NA**
PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month or the next business day if the 10th day is a non-business day (i.e., weekend or State or PIHP holiday). In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to NC Medicaid Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59 p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to NC Medicaid 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.	***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.***	**N**
2021 EQR Follow up: This Recommendation was not addressed. Vaya has elected not to implement this in policy. During the Onsite, Vaya's expressed that not all contract language needs to be included in their policies.		

For the 2021 EQR, there are no Corrective Actions and one Recommendation. Since the last EQR, Vaya reported only one staff turnover in PI. This change was reported to NC Medicaid staff.

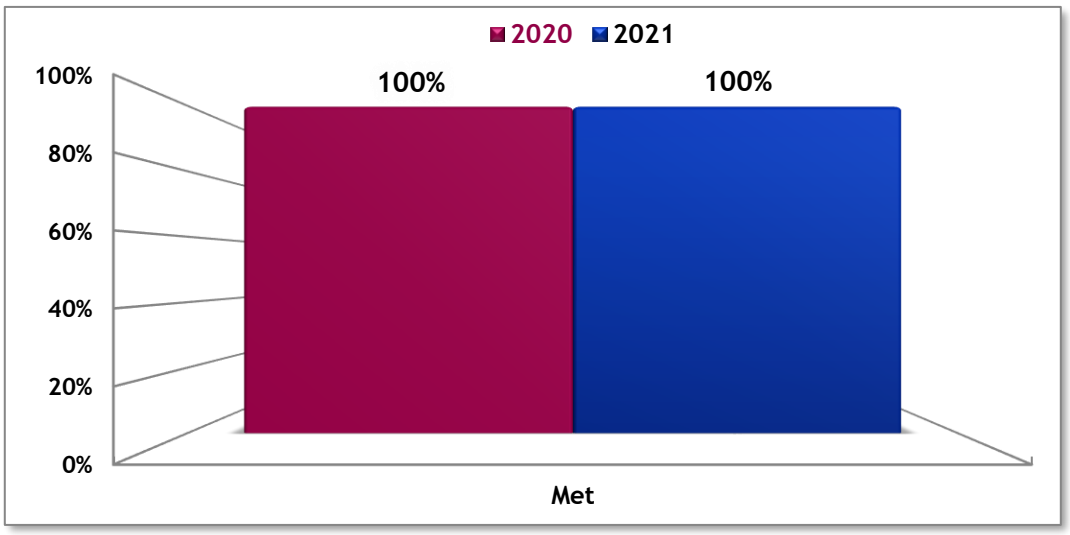
The review of the Provider Payment Suspensions and Overpayments section found that Vaya has Policy 2595, Identification and Recovery of Overpayments and Policy 2577, Provider Sanctions and Administrative Actions place that cover these requirements. However, the policies do not include language regarding not taking administrative actions once a case is referred to NC Medicaid. *NC Medicaid Contract Section 14.3.4* states that, "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." It is recommended that Vaya add this language to a policy to ensure compliance with *NC Medicaid Contract* requirements.

For a third year, the review found that Vaya's policies do not include language regarding the monthly reports and required timeframes submitted to NC Medicaid. *NC Medicaid Contract, Section 9.*8 states that "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 (10) of each month in the format as identified in Attachment Y." Likewise, *NC Medicaid Contract Sectionn14.2.14* requires Vaya to "submit to 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." During the Onsite, Vaya stated that, "They have chosen not to implement this policy wording even though it is a recommended best practice". While not all PIHP contract language is needed, verbatim in policies, critical aspects of the requirements that affect PIHP obligations to the state, members or providers need to be reflected in policies to provide a reference and to guide actions taken by staff. CCME has again issued a Recommendation to ensure this contractual requirement is within a Vaya policy.

The review of Vaya's *Attachment Y Report* found several cases that were more than one year old. Currently, Vaya has 117 opened cases as of March 2021. During the Onsite, Vaya acknowledge the number of old cases and described the process used to address the backlog. Furthermore, Vaya is evaluating current systems to find efficiencies and has implemented a triage system, which includes one Investigator who assesses new cases for initial review, completes the Preliminary Investigation Plans, and if needed, issues warnings or educational letters for those cases that did not rise to the level of investigation.

Figure 7, Program Integrity Findings, shows that 100% of the standards in the 2021 PI EQR were scored as "Met" and provides an overview of 2021 scores compared to 2020 scores.

Figure 7: Program Integrity Findings



Strengths

- Vaya has undertaken a strong internal training process for their PI staff. Two Investigators have attained their Accredited Health Care Fraud Investigator (AHFI) and two Investigators are in the process.
- Vaya's *FY 2021-2022 Compliance Program Plan* provides an overview of accomplishments of prior goals and a list of initiative to be undertaken in the current year.

Weaknesses

- Vaya's policies do not include language detailing the process and required timeframes for submitting Fraud Waste Abuse (FWA) reports to NC Medicaid.

Recommendations

- Add language to a Vaya PI policy detailing the process and timeframes required by *NC Medicaid Contract Section 9.8 and 14.2.14* for submission of the monthly NCID holders/FAMS-users report, the Program Integrity Suspected and Confirmed Cases Report and Network Provider Contract Terminations Report to the State.

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.

Guided by the CMS Encounter Data Validation Protocol, the scope of the review focused on measuring the data quality and completeness of claims paid by Vaya for the period of January 2020 through December 2020. All claims paid by Vaya should be submitted and accepted as a valid encounter to NC Medicaid. The review included:

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

Results and Recommendations

Issue: Other Diagnosis

Principal Diagnosis codes were populated consistently where appropriate. However, Other Diagnosis codes were infrequently populated with only 17.7% of all encounter records containing at least one Other Diagnosis code. The issue is far more pronounced in Professional encounters which saw only 13% of all Professional encounters billed with at least one Other Diagnosis code. This is well below what we expect to see given the comorbidities that are often present in the demographics that PIHPs serve.

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.

Conclusion

Based on the analysis of Vaya's encounter data, it has been 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 Other Diagnosis code reporting for both Professional and Institutional claims. Although Other Diagnosis codes do not directly impact pricing of claims, 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.

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

August 16, 2021
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 2021 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 2021 EQR will be a focused review. The focus of this review will be on the PIHP's Corrective Actions from the previous EQR and PIHP functions that impact enrollee health and safety. Similarly, for the 2021 EQR, the two day Onsite previously performed at Vaya's offices will conducted during a one day, virtual Onsite. The CCME EQR review team plans to conduct the virtual Onsite on **Thursday, September 30, 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 items on the Desk Materials List (items 9, 10, and 19.a) that should be submitted by no later than August 20, 2021,** and the remaining items are due by no later than **September 7, 2021**. 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 **September 7, 2021**.

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 External Review Director
Greg Daniels, NC Medicaid Waiver Contract Manager
Deb Goda, NC Medicaid Behavioral Health Unit Manager
Hope Newsome, NC Medicaid Quality Specialist

Vaya Health

Focused External Quality Review 2021

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 August 20, 2021. The remainder of items must be uploaded by no later than September 7, 2021.**

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 (August 2020 through July 2021). 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 August 20, 2021**, a copy of the complete Appeal log for the months of August 2020 through July 2021. 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 notification.

10. **By August 20, 2021, a copy of the complete Grievances log for the months of August 2020 through July 2021. Please indicate on the log: the nature of the grievance, the date received, and the date of grievance resolution.
11. Copies of all appeal notification templates used for expedited, invalid, extended, and withdrawn appeals.
12. For appeals and grievances, please submit a description of your monitoring process that reviews compliance of oral and written notifications, completeness of documentation within the appeal and grievance records, accuracy of appeal and grievance logs, etc. Provide details regarding frequency of monitoring and any benchmarks, performance metrics, and reporting of monitoring outcomes.
13. Please submit a summary of new provider orientation processes and include a list of materials and training provided to new providers.
14. For MH/SU, I/DD, and TCLI Care Coordination, please submit a description of your monitoring plan that reviews compliance of Care Coordinator documentation. Include in the description the elements reviewed (timeliness of progress notes, timeliness of Innovations monitoring, timeliness of Quality of Life surveys, review of quality, completeness of discharge notes, accuracy of documentation, etc.). Provide details regarding frequency of monitoring, and any benchmarks, performance metrics, and reporting of monitoring outcomes.
15. For Care Coordination enrollees files, please provide:
    a. three MH/SU Care Coordination enrollee files (two active since 2019 and one recently discharged)
    b. three I/DD Care Coordination enrollee files (two active since 2019 and one recently discharged)
    c. four TCLI Care Coordination enrollee files (one active since 2019, one who received In-Reach, one who transitioned to the community and recently discharged).

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

16. Information regarding the following selected Performance Measures:

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

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

Required information includes the following for each measure:

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

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

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

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

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

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

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

    c. Recredentialing files for the four most recently credentialed practitioners (as listed below)
        - One licensed practitioner who is joining an already contracted agency
        - One non-MD, Licensed Independent Practitioner (i.e., clinician who will have their own contract)
        - One physician
        - One practitioner with an associate licensure (e.g., LCSW-A, LMFT-A, etc.)

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

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

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

ii. Insurance:

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

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

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

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

v. Ownership disclosure information/form.

NOTE: Appeals, Grievances, and Program Integrity files will be selected from the logs submitted on August 20, 2021. A request will then be sent to the plan to send electronic copies of the files to CCME. The entire file will be needed.

19. Provide the following for Program Integrity:

a. ****File Review**: By August 20, 2021**, Please produce a listing of all active files during the review period (August 2020 through July 2021). The list should include the following information:

i. Date case opened

ii. Source of referral

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

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

b. Program Integrity Plan and/or Compliance Plan.

c. 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, 2020 – December 31, 2020. 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, 2020 – December 31, 2020. 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
  - TCLI PN Housing Usage
  - Increase Rate of Routine Access to Care Calls Receiving Service Within 14 Days
  - Community Crisis Management
  - ADATC VIP

CCME EQR PM Validation Worksheet

PIHP Name:	**Vaya Health**
Name of PM:	**Readmission Rates for Mental Health**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the 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:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA
SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the 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:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the 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:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	NA
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	NA
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	NA
SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**NA**	NA
S2 Sampling	Sample size and replacement methodologies met specifications.	**NA**	NA
REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the 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:	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the 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:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the 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:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the 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:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the 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:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the 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:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
North Carolina Medicaid Technical Specifications

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

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

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

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

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the 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:	**2020**
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:	**2020**
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:	**2020**
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:	**2020**
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:	**2020**
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:	**INCREASING PN HOUSING USED BY TCLI**
Reporting Year:	**2020**
Review Performed:	**09/2021**

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**	The number housed in April was 6, and May was 6 (Goal is 10). Vacancy alerts declined from 10 to 3; alerts utilized declined from 4 to 1. Goal is 4. The housing rate remained unchanged although alert and utilization of alerts have declined. ***Recommendation: Continue to monitor real-time inventory access, communication, and SOP documentation intervention impacts on members housed.***
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**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. PIP is in monitoring phase as of May 30, 2021.

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.*

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:	2020
Review Performed:	09/2021

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**	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 for prison population improved from 35.5% to 37.8%; rate for other population improved from 71% to 88.4%. Both are above the goal rate of 50%.
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:	2020
Review Performed:	09/2021

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 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.

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 since start of PIP.
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)**	**NA**	MH Rate admissions increased from 1.37 to 1.56 (goal is 1.41; lower is better); SUD Rate declined from .39 to .27 for April and May, which is improvement. ED Admissions rate data were reported for Jan and Feb 2021, and increased to 1.73 (goal is 1.41 and lower rate is better). Note: *Unable to get accurate assessment of outcomes due to unstable data.*
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**	Unable to assess.
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. PIP was closed 8/31 /2021 per PIP report.

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	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	**72**
Project Possible Score	**72**
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:	**ADATC VIP**
Reporting Year:	2020
Review Performed:	09/2021

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 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.

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**	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.
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**	All SUD was sustained at 73% for the most recently reported 2 months; ADATC Follow-up was at 80% for the most recently reported 2 months (February and March 2021); ADATC Opt-In rate was sustained at 90% for the most recently reported 2 months (Feb and March 2021). All rates are above the goal rates of 40%.
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.*

C. Attachment 3: Tabular Spreadsheet

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					During the ISCA Onsite, Vaya stated that they upload the GEF file to a local database and use the database for troubleshooting purposes by comparing the records to the AlphaMCS.
1.3 The MCO's enrollment system member screens store and track enrollment and demographic information.	X					During the ISCA Onsite, 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 on a HIPAA file (67% for Institutional and 89% for Professional) or through the provider web portal (32% for Institutional and 11% for Professional). Very few claims are received via paper (approximately less than 1%). For claims received in 2020, 79.71% of Institutional and 96.55% of Professional claims were auto adjudicated on a nightly basis. Claims in excess of $5,000 and Emergency Department claims are pended for manual review. Pended claims are reviewed daily.
2.2 The 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. Routine audits are performed. Vaya audits a random sample of 3% of all claims processed on a daily basis and also conducts COB and program integrity suspect audits regularly. High dollar claims in excess of $5,000 and paper claims are audited for accuracy and appropriate adjudication. The paper claims are included in the random sample of 3% daily claims audit. Vaya periodically audits new hire claim examiners for the first nine months.
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 ISCA Onsite, Vaya demonstrated the AlphaMCS claims system and capabilities to receive and store all ICD-10 Diagnosis codes. Vaya indicated that ICD-10 Procedure codes, Revenue codes, and DRG codes are captured in the AlphaMCS system electronically and via the provider web portal. The Revenue codes and DRG are also included for encounter data submission reporting. Up to 25 ICD-10 Diagnosis codes are captured for Institutional claims received via the web portal, electronically and displayed on the claim screens. For Professional encounters, up to 12 ICD-10 Diagnosis codes are captured electronically via the web portal and displayed on claim screens.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 The MCO's claim system screens store and track claim information and claim adjudication/payment information.	X					During the ISCA Onsite, Vaya demonstrated their provider web portal, claim system screens, and claim adjudication/payment information. Vaya demonstrated their claim systems ability to capture all the ICD-10 Diagnosis codes, DRGs, Revenue codes, CPT/HCPCS, ICD-10 Procedure codes, and adjudication information.
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 ICD-10 Diagnosis codes and is capable of capturing additional Procedure, DRG and Revenue codes that are submitted on the claims. Vaya stores the DRG and ICD-10 Procedure codes for reporting.
3.2 The MCO has processes in place to back up the enrollment and claims data repositories.	X					ISCA responses indicate Vaya has processes in place that backup the enrollment and claims data in the AlphaMCS system on a nightly basis. A disaster recovery policy was provided along with the ISCA tool. During the ISCA Onsite, Vaya stated that their DRP was last updated on July 24, 2021.
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. ICD-10 Procedure codes are captured in the AlphaMCS system but are not included on Institutional encounter data submissions. During the Onsite, Vaya stated that they are in the process of testing the submission of ICD-10 Procedure codes and up to 25 ICD-10 Diagnosis codes on Institutional encounters to NCTracks. Last year's Recommendation regarding submission of DRG codes on Institutional encounter data submissions has been implemented. Vaya now submits DRG codes to NCTracks.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Update Vaya's encounter data submission process and 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 and work with the State to increase the number of ICD-10 Diagnosis codes submitted 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 data from two sources developed by Adam Holtzman to identify and reconcile encounter data denials: The Encounter Summary by MCO Check Write and Encounter Denial Detail reports. The appropriate departments for investigation and correction work on denied encounters.
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. Encounter denial reports were provided and ISCA documentation shows flow charts and procedures for encounter data submissions to NC Medicaid. Vaya has an encounter acceptance rate of 96.6%.
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's Encounter Team that is within Vaya's Claims Department are responsible for working on the denied encounters and resubmitting them to NC Medicaid. Vaya staff was able to speak to encounter data submissions and reconciliation process.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II. A. Credentialing and Recredentialing						
1. The PIHP formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					Policy 2891, designated as the *Credentialing Program Description (CPD*) and the *Credentialing Committee Charter (CCC)* guide the credentialing and recredentialing processes at Vaya.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the PIHP.	X					The Credentialing Committee is chaired by the Chief Medical Officer (CMO), who is responsible for oversight of the clinical aspects of the credentialing program. As was the case at the last EQR, there is conflicting language in the *CCC* and the *Credentialing Program Description* regarding who chairs the committee in the absence of the CMO. This was discussed during the Onsite review in February 2021 and included as a Recommendation in the report issued in April 2021. There was no change in the documents uploaded in September 2021 for Desk Review. On the 2020 EQR Best Practice Recommendations Vaya submitted with the Desk Materials in September 2021, the "Vaya Health Comments" state, "Vaya will revise the Credentialing Committee Charter and Credentialing Program Description to reflect who will chair the Credentialing Committee meetings in the absence of the CMO." During the Onsite, Vaya confirmed the Recommendation has not yet been implemented. This remains a Recommendation for this EQR. The Credentialing Committee meeting minutes indicate which members are "voting" members, which members are present, which member(s) made specific motions, and the outcome of votes cast. The meeting notes contain evidence of the committee discussion and decision-making.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: As per the Recommendation at the 2020 EQR, revise the Credentialing Committee Charter, Policy 2891 (designated as the Credentialing Program Description), and any other documents that detail credentialing processes, to consistently reflect who will chair the Credentialing Committee meetings in the absence of the CMO.
3. The credentialing process includes all elements required by the contract and by the PIHP's internal policies as applicable to type of Provider.	X					Credentialing files reviewed for the EQR were organized and contained appropriate information. CCME identified the following issues in the file review:
3.1 Verification of information on the applicant, including:						
3.1.1 Insurance requirements;	X					In this 2021 EQR, submitted files included proof of professional liability insurance. The submitted files for Licensed Independent Practitioners (LIPs) also contained proof of required insurance or an attestation as to why it was not required, such as the LIP does not transport consumers. Vaya verified that, if the applicant is covered by a contracted provider's insurance, the Certificate of Insurance is maintained in the agency file.
3.1.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					One of the four submitted practitioner initial credentialing files included the Primary Source Verification (PSV) of the practitioner's clinical license, but the PSV showed the license was to expire on 06/30/21 and credentialing was approved on 07/14/21, after the license was to expire. CCME requested the PSV of the license renewal received prior to approval of recredentialing. In response, Vaya submitted the licensure PSV obtained on 06/24/21, showing the license was renewed prior to approval of credentialing.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.3 Valid DEA certificate; and/or CDS certificate	X					
3.1.4 Professional education and training, or board certificate if claimed by the applicant;	X					
3.1.5 Work History	X					
3.1.6 Malpractice claims history;	X					
3.1.7 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.8 Query of the National Practitioner Data Bank (NPDB) ;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					CCME identified an issue with the System for Award Management (SAM) PSV in the submitted agency initial credentialing file. The file had the print-out of the SAM "Search" pages, instead of the "Results" pages. When CCME requested the SAM "results", Vaya reported "Due to an oversight in the method used to save the SAM verification (print to PDF), the "result" section at the bottom of the PSVs was inadvertently omitted." Vaya submitted a plan to prevent this in the future, noting "Moving forward, Vaya's Credentialing Team will re-review every PSV during the quality assurance process to ensure proper saving."
3.1.11 Query for Medicare and/or Medicaid sanctions Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of the Social Security Administration's Death Master File (SSADMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES)	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.14 Names of hospitals at which the physician has admitting privileges, if any	X					
3.1.15 Ownership Disclosure is addressed.	X					In this 2021 EQR, Ownership Disclosure information was not provided in the submitted Desk Materials for one initial credentialing file. Vaya submitted the documentation in response to CCME's request on the Missing Desk Materials list.
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					In this 2021 EQR, submitted files included proof of professional liability insurance. The submitted files for LIPs also contained proof of required insurance or an attestation as to why it was not required, such as the LIP does not transport consumers. Vaya verified that if the applicant is covered by a contracted agency provider's insurance, the Certificate of Insurance is maintained in the agency file.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.2 Current valid license to practice in each state where the practitioner will treat enrollees;	X					Four practitioner recredentialing files were submitted for this EQR. One of the four practitioners has two clinical licenses (LCAS and LCMHCS). The submitted file contained the PSV of the LCAS license, but no PSV of the LCMHCS license. The PSV of the clinical license for another practitioner was not found in the submitted file. Vaya submitted the relevant PSVs in response to CCME's request on the Missing Desk Materials list.
4.2.3 Valid DEA certificate; and/or CDS certificate	X					
4.2.4 Board certification if claimed by the applicant;	X					
4.2.5 Malpractice claims since the previous credentialing event;	X					
4.2.6 Practitioner attestation statement;	X					
4.2.7 Requery of the National Practitioner Data Bank (NPDB);	X					
4.2.8 Requery for state sanctions and/or license limitations (State Board of Examiners for specific discipline) since the previous credentialing event; and query of the State Exclusion List;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.9 Requery of the SAM.	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (OIG LEIE);	X					
4.2.11 Requery of the Social Security Administration's Death Master File	X					
4.2.12 Requery of the NPPES;	X					
4.2.13 Names of hospitals at which the physician has admitting privileges, if any.	X					
4.2.14 Ownership Disclosure is addressed.	X					In this 2021 EQR, Ownership Disclosure information was not provided in the submitted Desk Materials for two recredentialing files. Vaya submitted the documentation in response to CCME's request on the Missing Desk Materials list.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.3 Site reassessment if the provider has had quality issues.	X					
4.4 Review of provider profiling activities.	X					Submitted Credentialing Committee meeting minutes include performance data reports such as findings of quality management/quality improvement activities, information regarding complaints and grievances, and Utilization Management activities such as Quality of Service Authorizations, the average unduplicated number of members served annually, and the quality of person centered planning documents.
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					All (c) Waiver Measures were above the State benchmark rates. The overall validation scores for all Performance Measures were in the Fully Compliant range, with an average validation score of 100% across the 10 (b) Waiver Measures and the five (c) Waiver Measures.
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 2021 EQR. These four were validated: • TCLI PN Housing Usage- Non Clinical • Increase rate of routine access to care calls receiving service within 14 days- Clinical • Community Crisis Management- Clinical • ADATC VIP- Clinical
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					All four validated PIPs scored in the High Confidence range, although one PIP (TCLI Increase PN Housing- in active monitoring status) had a section with concerns that should be addressed by the Recommendation. See Recommendation in Table 25. ***Recommendation: TCLI PN Housing PIP: Continue to monitor real-time inventory access, communication, and SOP documentation intervention impacts on members housed.***

IV. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV. A. Care Coordination						
1. The PIHP utilizes care coordination techniques to insure comprehensive, coordinated care for Enrollees with complex health needs or high-risk health conditions.	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.4 Guide the develop treatment plans for enrollees that meet all requirements;	X					
2.5 Quality monitoring and continuous quality improvement;	X					
2.6 Determination of which Behavioral Health Services are medically necessary;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.7 Coordinate Behavioral Health, hospital and institutional admissions and discharges, including discharge planning;		X				The review of I/DD Care Management files included one enrollee who voluntarily terminated from the Innovations Waiver. The review found no documentation verifying the withdrawal from the Innovations Waiver, a lack of coordination of services and supports and poor follow-up. According to a progress note dated February 21, 2020, the I/DD Care Manager had the enrollee sign the *Authorization for Termination* from the NC Innovations Waiver. During the Onsite, Vaya was asked to provide the signed *Authorization for Termination*. However, due to technical issues, Vaya stated in an email to CCME that, "In regard to the termination letter, MIS has exhausted all efforts to try and fix the corrupted file. They located the original and it appears to be corrupted as well. They've let me know that we will be unable to provide this." The review also found that Vaya did not provide adequate support through this enrollee's departure from the Innovations Waiver. According to progress notes and the Member's Care Plan, the enrollee has no guardian or Legally Responsible Person (LRP), lives alone, has minimal contact with family and is dyslexic, needing additional supports to read and comprehend written materials. A notification from Utilization Management (UM) dated March 16, 2020, shows that the enrollee was still in the care of Vaya until April 15, 2020. Furthermore, during the Onsite, NC Medicaid staff inquired about additional follow-up due to the enrollee still being assigned to the Innovations Waiver slot several months after the *Authorization for Termination* was signed. There was no evidence within the files that Vaya staff explored alternative services with the enrollee nor was there any evidence the enrollee's health and safety was assessed prior to his termination from the Innovations Waiver. During the Onsite, Vaya acknowledged that no additional follow-up was offered to the enrollee. The letter from UM was sent to Ashe County Department of Social Services and the Provider who rendered services to inform them of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						the enrollee's termination. The notification was not sent to the enrollee. According to *NC Clinical Coverage Policy 8P, Attachment B, M: Other North Carolina Innovations Terminations,* "The PIHP shall give the waiver beneficiary at least 10 days written advance notice of the proposed termination. The reason for termination and the beneficiary's appeal rights must be provided." During the Onsite, Vaya clarified that appeal rights were not required according to *NC Joint Communication Bulletin J127 Innovations Appeals/Grievance Chart,* updated December 11, 2015. CCME is issuing a Corrective Action due to Vaya: • Being unable to produce the signed *Authorization for Termination.* • Not notifying the enrollee of final termination according to *NC Clinical Coverage Policy 8P, Attachment B, M: Other North Carolina Innovations Terminations.* • Not providing follow-up to the enrollee prior to termination. • Not ensuring all health and safety needs are assessed and addressed prior to termination, especially during the COVID-19 pandemic. ***Corrective Action: Enhance the current Care Coordination documentation quality review to include;*** ○ ***Routine review of notifications within the enrollee's record and ensure those notifications can be generated outside of the enrollee's electronic record.*** ○ ***Routine review of Care Coordination documentation around any enrollee's terminating from Care Coordination or the Innovations Waiver. The review should ensure proper notifications occurred, alternative services were offered, and the enrollee's health and safety was assessed and addressed throughout the termination.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.8 Coordinate care with each Enrollee's provider;	X					
2.9 Provide follow-up activities for Enrollees;	X					
2.10 Ensure privacy for each Enrollee is protected.	X					
2.11 NC Innovations Care Coordinators monitor services on a quarterly basis to ensure ongoing compliance with HCBS standards.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The PIHP applies the Care Coordination policies and procedures as formulated.	X					During the 2020 EQR, the file review for I/DD and MH/SUD identified weaknesses in Care Management documentation. The review found late monitoring of I/DD Innovations enrollees and a lack of documented interventions in MH/SUD progress notes as required by Vaya's policies. It was recommended that Vaya enhance the current documentation monitoring plan to routinely review the 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. This Recommendation was partially addressed. This year's EQR found discrepancies in MH/SUD progress notes. The review of MH/SUD records found 39% of progress notes were submitted outside of the required timeframe for submission. Vaya's Policy 2340 Administrative Health Record Documentation states that, "Member notes shall be documented within 24-hours of the intervention to ensure accuracy and continuity of care. Notes that cannot be entered within 24-hours shall be noted as late entries with their reason as to the delay (lack of connectivity, etc.)." Additionally, progress notes that were beyond the 24-hour entry requirement did not follow the late entry process. ***Recommendation: Update the current Complex Care Management Quality Improvement & Monitoring Plan to include a process that identifies late progress notes and ensures these progress notes are labelled "late entry", as required by Vaya's Policy 2340, Administrative Health Record Documentation.***

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.						
2.1 Care Coordination activities occur, as required.	X					
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					All Quality of Life (QOL) surveys reviewed in the TCLI files submitted were implemented timely.
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 TCLI policies, procedures, and processes, as required by NC Medicaid, and developed by the PIHP.	X					In the 2020 EQR, TCLI files again showed activities and tasks (i.e., discharge forms, Person Centered Plan development, and follow up interventions) that were not documented within the enrollee's record. A Recommendation was issued to Vaya to 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. This Recommendation was addressed. The review of TCLI files found that Vaya is compliant with their policies and NC TCLI manuals.

V. GRIEVANCES AND APPEALS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. Grievances						
1. The PIHP formulates reasonable policies and procedures for registering and responding to Enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy 2607, 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, Complaints and Grievances.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.5 Maintenance of a grievance log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Policy 2607, Complaints and Grievances, contains the timeframe for maintenance of Grievance Logs and files. This is required by the *NC Medicaid Contract*.
2. The PIHP applies the grievance policy and procedure as formulated.	X					In the 2020 EQR, CCME issued a Recommendation to 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*, *Attachment M*, and *42 CFR § 438.408 (b)1*. In the 2021 EQR, the file review demonstrated that Vaya's monitoring process resulted in a decrease in late resolution letters from two in the 2020 EQR to zero in the 2021 EQR. There was one late Acknowledgment letter in both review years. In the 2021 EQR, 10 Grievance files were reviewed. All were standard Grievances, and nine of the 10 met all timeliness requirements. Nine of the files were acknowledged within five days and resolved within the 90 days per Policy 2607, Complaints and Grievances. One Grievance file had a late acknowledgement letter (in 48 days instead of five days). Onsite discussion with staff explained that there was a delay entering the Grievance in the system because clarification was needed. This led to the late Acknowledgement Letter. In response to this issue, staff now enter Grievances into the system immediately and get clarification later. ***Recommendation: Continue to closely monitor all Grievances to ensure all acknowledgement notifications and resolution notifications are timely and to identify problems with processes that contribute to compliance issues.***

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					In the 2020 EQR, CCME issued a Recommendation to enhance monitoring of the Grievance Log to ensure the Log contains only Grievances, as defined in Policy 2607, Grievances and Complaints. In the 2021 EQR, the Grievance Log contained only files that were Grievances. Vaya staff explained how they improved this during Onsite discussion. The staff now track Grievances and Complaints separately by entering them into Navex Global, a component of Ethicspoint. Having the Complaint or Grievance data point on each entry allows staff to run a report of all Grievances separately from Complaints.
4. Grievances are managed in accordance with the PIHP confidentiality policies and procedures.	X					
V B. Appeals						
1. The PIHP formulates and acts within policies and procedures for registering and responding to Enrollee and/or Provider appeals of an adverse benefit determination by the PIHP in a manner consistent with contract requirements, including:	X					Policy 2384, Member Appeals of Adverse Decisions, is the primary policy that guides staff throughout the Appeals process.
1.1 The definitions an appeal and who may file an appeal;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 The procedure for filing an appeal;	X					
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The PIHP applies the appeal policies and procedures as formulated.	X					The 2020 EQR file review found there were missing or late Appeal acknowledgment notifications and missing or late Appeal resolution notifications. CCME issued a Recommendation to 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 appeal federal regulations. In the 2021 EQR, overall improvement in compliance and accuracy was noted with all types of Appeal files when compared to the 2020 EQR. Six expedited, three standard, and one extended (by the guardian) Appeals were reviewed. Eight of the Appeals met all timeliness requirements. One expedited Appeal had a late resolution letter sent in five days instead of within 72 hours, as required by Vaya's Policy 2384, Member and Recipient Appeals of Adverse Decisions. One faxed, standard Appeal was overlooked by Vaya staff and acknowledged in 35 days instead of one business day, as required by Vaya Policy 2384. This appeal was also resolved in 37 days as a result of this oversight and not in the 30-day timeframe required by *NC Medicaid Contract, Attachment M,* appeal federal regulations, and Vaya's Appeal policy. ***Recommendation: Continue to closely monitor Appeals to ensure all acknowledgement notifications and resolution notifications are timely and to identify problems with processes that contribute to compliance issues.***

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. CCME issued this 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. For the 2021 EQR, the data within the Appeals Log matched the files reviewed. Quality improvement opportunities were discussed in committees and changes implemented, when needed. During the Onsite, there was discussion around Vaya's *UM Audit Summary June 2, 2021* document. Vaya confirmed this is a yearly report. This review is done outside of the UM internal audit which reviews all of the Appeal files monthly. For the Appeal metrics in the *UM Audit Summary June 2, 2021*, the Appeal sample size was eight of 16 Appeal records for the second quarter of 2020-21. For the quarterly review implemented for the Regulatory Compliance Committee, there was concern sample size was too low to adequately identify Appeal compliance issues. For the quarterly review, Vaya followed the NCQA guidelines of randomly selecting 16 files and if the first half are compliant, no further file review is needed. CCME has issued a Recommendation to increase the sample size of the Appeal files reviewed for the Regulatory Compliance Committee and reported in the *Vaya UM Audit Summary*. ***Recommendation: Increase the sample size of the Appeal files reviewed for the Regulatory Compliance Committee and reported in the Vaya UM Audit Summary.***
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					The general requirements for detection of Fraud Waste and Abuse (FWA) are found in the *FY 2021-2022 Compliance Program Plan*.
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					A description of Compliance Officer and compliance committee designation is found in the *FY 2021-2022 Compliance Program Plan.* Vaya also provided internal staff and Board of Directors training materials, dated February 12, 2021.

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					During the 2020 EQR, it was noted that Vaya had not submitted Regulatory Compliance Committee minutes to NC Medicaid for seven months. It was recommended that Vaya develop a strategy to ensure timely submission of these minutes, as required by *NC Medicaid Contract Section 14.2.5*. This Recommendation was addressed as it was noted and confirmed by the State that that all meeting minutes have been submitted timely in the past year.
8. PIHP's written Compliance Plan shall, at a minimum include:						

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
9. In accordance with *42 CFR § 438.608 (a)(vii),* PIHP shall establish and implement systems and procedures that require utilization of dedicated staff for routine internal monitoring and auditing of compliance risks as required under *NC Medicaid Contract*, prompt response to compliance issues as identified, investigation of potential compliance problems as identified in the course of self-evaluations and audits, and correction of problems identified promptly and thoroughly to include coordination with law enforcement for suspected criminal acts to reduce potential for recurrence, monitoring of ongoing compliance as required under *NC Medicaid Contract*; and making documentation of investigations and compliance available as requested by the State. PIHP shall include in each monthly Attachment Y Report, all overpayments based on fraud or abuse identified by PIHP during the prior month. 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					Vaya provided monthly *Attachment Y* reports for the review period. The *Attachment Y* showed that Vaya had several PI cases that were more than one year old. During the Onsite, Vaya acknowledged the aged cases. Vaya described their current approach that includes closing out referrals with plans of correction, addressing new referrals quicker by assigning one investigator to triage complete the initial review, and encouraging providers to complete more self-audits.

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						
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					Vaya provided a Schedule K which showed no balances on closed PI cases.
10.5 Process for handling self-audits and challenge audits.	X					
10.6 Process for using data mining to determine leads.	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
12. PIHP shall initiate a preliminary investigation within ten (10) business days of receipt of a potential allegation of fraud. If PIHP determines that a complaint or allegation rises to potential fraud, PIHP shall forward the information and any evidence collected to NC Medicaid within five (5) business days of final determination of the findings. All case records shall be stored electronically by PIHP.	X					During the 2020 EQR, it was recommended that Vaya include in its SIU workflow and related policy the timelines requirement of initiating a preliminary investigation as stated in *NC Medicaid Contract Section 14.2.8*. There was evidence in the 2021 EQR this Recommendation was implemented by Vaya.
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:						For this EQR, the review of 15 investigative files found that all cases were initiated with the required timeframe.
13.1 Subject (name, Medicaid provider ID, address, provider type);	X					
13.2 Source/origin of complaint;	X					
13.3 Date reported to PIHP or, if developed by PIHP, the date PIHP initiated the investigation;	X					
13.4 Description of suspected intentional misconduct, with specific details including the category of service, factual explanation of the allegation, specific Medicaid statutes, rules,	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
regulations, or policies violated; and dates of suspected intentional misconduct;						
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					In the 2020 EQR it was recommended that Vaya "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. There was evidence in the 2021 EQR that this Recommendation that Vaya addressed this Recommendation.
13.6 All communications between PIHP and the Provider concerning the conduct at issue, when available.	X					
13.7 Contact information for PIHP staff persons with practical knowledge of the working of the relevant programs; and	X					
13.8 Total Sample Amount of Funds Investigated per Service Type	X					
14. In each case where PIHP refers suspected Enrollee fraud to NC Medicaid, PIHP shall provide NC Medicaid Program Integrity with the following information on the NC Medicaid approved template:						No cases of potential enrollee fraud were provided by Vaya for this 2021 EQR.
14.1 The Enrollee's name, birth date, and Medicaid number;	X					
14.2 The source of the allegation;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
14.11 Information on Biller/Owner;	X					
14.12 Additional Provider Locations that are related to the allegations;	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
17. If PIHP uses FAMS, PIHP shall work with the NC Medicaid designated Administrator to submit appropriate claims data to load into the NC Medicaid Fraud and Abuse Management System for surveillance, utilization review, reporting, and data analytics. If PIHP uses FAMS, PIHP shall notify the NC Medicaid designated Administrator within forty-eight (48) hours of FAMS-user changing roles within the organization or termination of employment.	X					
18. PIHP shall submit to the NC Medicaid Program Integrity a monthly report naming all current NCID holders/FAMS-users in their PIHP. This report shall be submitted in electronic format by 11:59 p.m. on the tenth (10th) day of each month or the next business day if the 10th day is a non-business day (i.e., weekend or State or PIHP holiday). In regard to the requirements of Section 14 – Program Integrity, PIHP shall provide a monthly report to NC Medicaid Program Integrity of all suspected and confirmed cases of Provider and Enrollee fraud and abuse, including but not limited to overpayments and self-audits. The monthly report shall be due by 11:59 p.m. on the tenth (10th) of each month in the format as identified in Attachment Y. PIHP shall also report to NC Medicaid Program Integrity all	X					During the 2020 EQR, it was recommended that Vaya add language to a PI policy detailing the process and timeframes required by *NC Medicaid Contract Section 14.2.14* for submission of the monthly NCID holders/FAMS-users report to the State. This Recommendation was not addressed. During the Onsite, Vaya stated that, "They have chosen not to implement this policy wording even though it is a recommended best practice". While not all PIHP contract language is required to be in policies verbatim, critical aspects of the requirements that affect PIHP obligations to the State, members, or providers should be reflected in policies to guide actions taken by staff. For a second year, CCME is recommending that Vaya include language in a policy regarding the timely submission required monthly reports to NC Medicaid as required in *NC Medicaid Contract Section 9.8, Fraud and Abuse Reports* and *Section 14.2.14 Monthly and Quarterly Reports*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						***Recommendation: Add language to a Vaya PI policy detailing the process and timeframes required by NC Medicaid Contract Section 9.8 and 14.2.14 for submission of the monthly NCID holders/FAMS-users report, the Program Integrity Suspected and Confirmed Cases Report and Network Provider Contract Terminations Report to the State.***
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						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
Medicaid may send a payment suspension notice to the Provider and notify PIHP. If the MFCU/ MID indicates that payment suspension will impact the investigation, NC Medicaid shall temporarily withhold the suspension notice and notify PIHP. Suspension of payment actions under this *Section 14.3* shall be temporary and shall not continue if either of the following occur: PIHP or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider; or Legal proceedings related to the Provider's alleged fraud are completed and the Provider is cleared of any wrongdoing.						
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Upon receipt of a payment suspension notice from NC Medicaid Program Integrity, PIHP shall suspend payment of Medicaid funds to the identified Provider beginning the effective date of NC Medicaid Program Integrity's suspension and lasting until PIHP is notified by NC Medicaid Program Integrity in writing that the suspension has been lifted.	X					
3. PIHP shall provide to NC Medicaid all information and access to personnel needed to defend, at review or reconsideration, any and all investigations and referrals made by PIHP.	X					

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

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

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

D. Attachment 4: Encounter Data Validation Report

Vaya Health

Encounter Data Validation Report

performed on behalf of

North Carolina Medicaid

October 13, 2021

Prepared By:

hms

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

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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 Pre-paid Inpatient Health Plan (PIHP). *North Carolina Senate Bill 371* requires that each PIHP submit encounter data "for payments made to providers for Medicaid and State-funded mental health, intellectual and developmental disabilities, and substance abuse disorder services. NC Medicaid may use encounter data for purposes including, but not limited to, setting PIHP capitation rates, measuring the quality of services managed by PIHPs, assuring compliance with State and federal regulations, and for oversight and audit functions."

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

Overview

The scope of our review, guided by the CMS Encounter Data Validation Protocol, was focused on measuring the data quality and completeness of claims paid by Vaya for the period of January 2020 through December 2020. All claims paid by Vaya should be submitted and accepted as a valid encounter to NC Medicaid. Our approach to the review included:

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

Review of Vaya's ISCA response

The review of Vaya's ISCA response was focused on section V. Encounter Data Submission. NC Medicaid requires each PIHP to submit their encounter data for all paid claims on a weekly basis via 837 Institutional and Professional transactions. The companion guides follow the standard ASC X12 transaction set with a few modifications to some segments. For example, the PIHP must submit their provider number and paid amount to NC Medicaid in the Contract Information CN104 and CN102 segment of Claim Information Loop 2300.

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

Vaya has established a team responsible for investigating, correcting, and resubmitting all denied Encounters. The encounters team coordinates denial research, and requests corrections from other departments or from the encounter billing provider, depending on the denial reason. Vaya relies on NC Medicaid's "The Encounter Summary by MCO Check write" report and an encounter denial detail report listing the header and line edits", as well as numerous other parameters for all encounter records that deny. Vaya has implemented 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 2020, Vaya submitted 1,948,699 unique encounters to the State. To date, 3.4% of all 2020 encounters submitted have not been corrected and accepted by NC Medicaid.

2020	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
Institutional	33,513	31,648	1,170	695	2.07%
Professional	1,915,186	1,747,961	101,715	65,510	3.42%
Total	1,948,699	1,779,609	102,885	66,205	3.40%

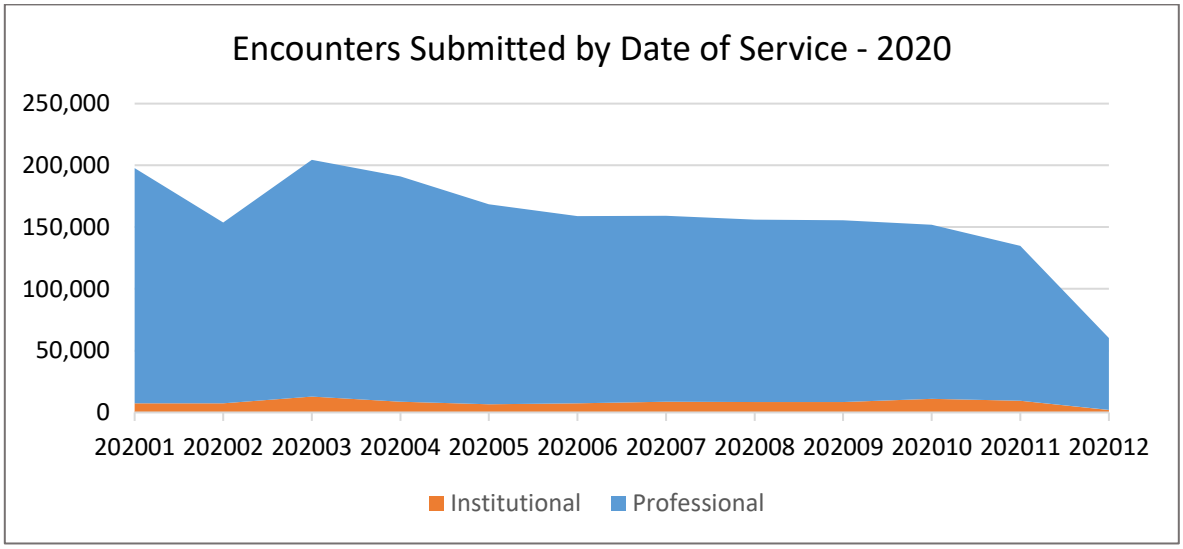
In prior years, Vaya made significant improvements to their encounter submission process, increasing their acceptance rate and quality of encounter data year over year. However, in 2020 we saw a noticeable increase in denials. The table below shows acceptance rates over the past five (5) years.

Year of Service	Submitted	Initially Accepted	Denied, Accepted on Resubmission	Denied, Not Yet Accepted	Percent Denied
2020	1,948,699	1,779,609	102,885	66,205	3.40%
2019	1,850,373	1,810,979	23,841	15,553	0.84%
2018	1,910,482	1,873,781	22,335	14,366	0.75%
2017	1,815,237	1,641,057	79,430	94,750	5.22%
2016	987,620	653,787	63,805	270,028	27.34%

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

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, 2020 and December 31, 2020. Vaya sent 837I and 837P file submitted to NC Medicaid during the requested audit period to HMS via SFTP. The 837P file contained 1,993,352 professional claim headers and line level detail, while the 837I file contained 112,304 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 pre-processed all batch encounter files and loaded them to a consolidated database. After completing data onboarding, 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. Professional and Institutional files included older dates of service that were resubmitted to NC Medicaid during 2020.

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)

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

Adapted and Revised from CMS Encounter Validation Protocol

Data Element	*Expectation*	*Validity Criteria*
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid codes (using International Statistical Classifications of Diseases, Ninth Revision, Clinical Modification [ICD-9-CM] lookup tables) for practitioner providers (not including transportation, lab, and other ancillary providers)
Other Diagnosis	This is not expected to be coded on all claims even with applicable provider types, but should be coded with a fairly high frequency.	90% valid when present
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 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	1,994,324	100.00%	1,994,324	100.00%	1,994,324	100.00%	1,994,324	100.00%
Recipient Name	1,994,352	100.00%	1,994,351	100.00%	1,994,351	100.00%	1,994,351	100.00%
Recipient Date of Birth	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%
MCO/PIHP ID	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%
Provider ID	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%
Attending/Rendering Provider ID	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%
Provider Location	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%
Place of Service	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%
Specialty Code / Taxonomy - Billing	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%
Specialty Code / Taxonomy - Rendering / Attending	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%
Principal Diagnosis	1,994,344	100.00%	1,994,344	100.00%	1,994,344	100.00%	1,994,344	100.00%
Other Diagnosis	352,266	17.66%	352,266	17.66%	352,266	17.66%	352,266	17.66%
Dates of Service	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%	1,994,352	100.00%
Unit of Service (Quantity)	1,994,333	100.00%	1,994,333	100.00%	1,994,333	100.00%	1,994,333	100.00%
Procedure Code	1,948,382	97.69%	1,941,440	97.35%	1,941,439	97.35%	1,941,440	97.35%
Procedure Code Modifier	979,878	49.13%	979,878	49.13%	979,878	49.13%	979,878	49.13%
Patient Discharge Status Code Inpatient	112,304	100.00%	112,264	99.96%	112,304	100.00%	112,264	99.96%
Revenue Code	112,304	100.00%	112,304	100.00%	112,304	100.00%	112,304	100.00%

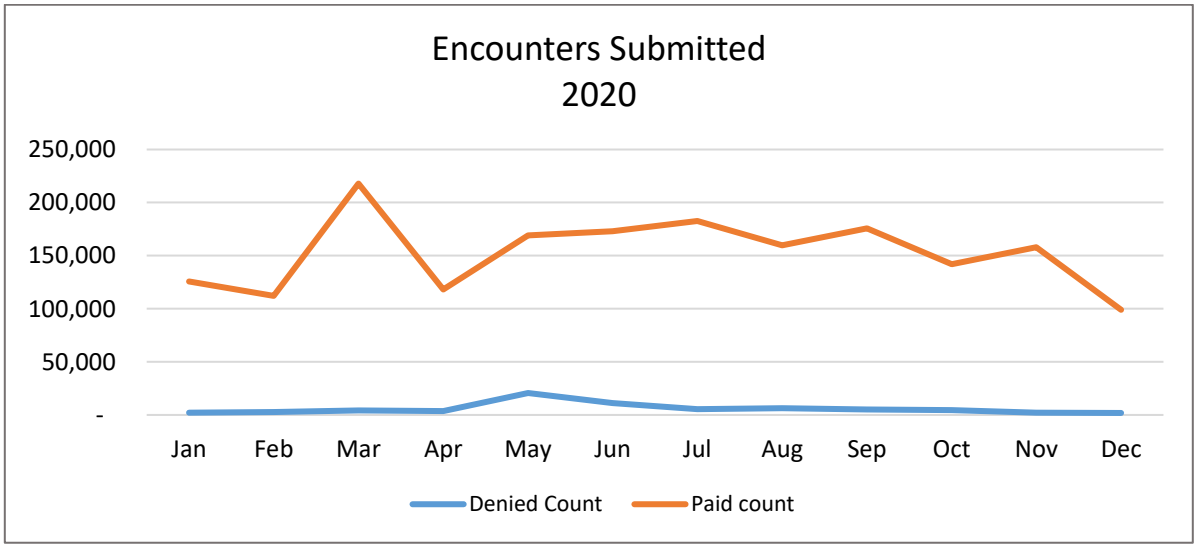
Overall, there were very few inconsistencies in the data other than the denial issues highlighted in Vaya's ISCA response and NC Medicaid's encounter acceptance report. Institutional claims contained complete and valid data in 17 of the 18 key fields (94%) with noted issues to Other Diagnosis codes. Admitting and Principal Diagnosis codes were populated 100% of the time for Institutional claims, whereas Other Diagnosis codes were present on only 66% of the claim lines. The same issue was present in the 2019 claims review. Separately, a minor issue was found with Procedure codes on Institutional claims. 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. The issue does not exceed the error threshold for inpatient stays, so it is not reported as an error in the summary below.

Professional encounter claims submitted contained complete and valid data in 14 of the 15 key Professional fields (93%). The primary issue is the same as Institutional—missing Other Diagnosis codes. The Principal Diagnosis code field was populated 100% of the time, while the Other Diagnosis code field was populated far less frequently at 13%.

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

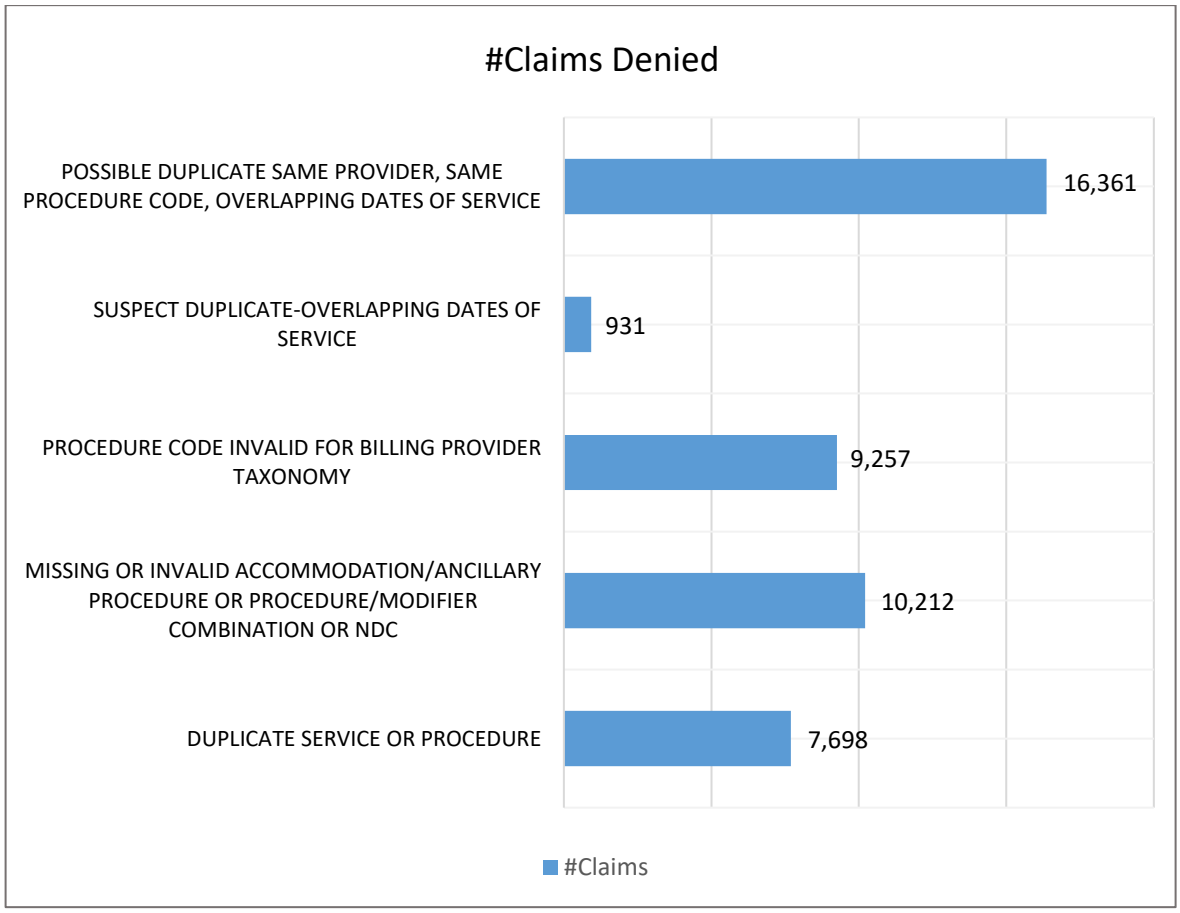
In addition to performing evaluation of the encounter data submitted, HMS reviewed the Encounter Acceptance Report maintained weekly by NC Medicaid. This report reflects all encounters submitted, accepted, and denied for each PIHP. The report is tracked by check write and excludes duplicates or resubmission, 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 2020, Vaya submitted to NC Medicaid a total of 1,994,352 encounters, of which 5.3% were initially denied. This represents an increase compared to 2018 and 2019, which saw initial denial rates of 1.1% and 1.3%, respectively.



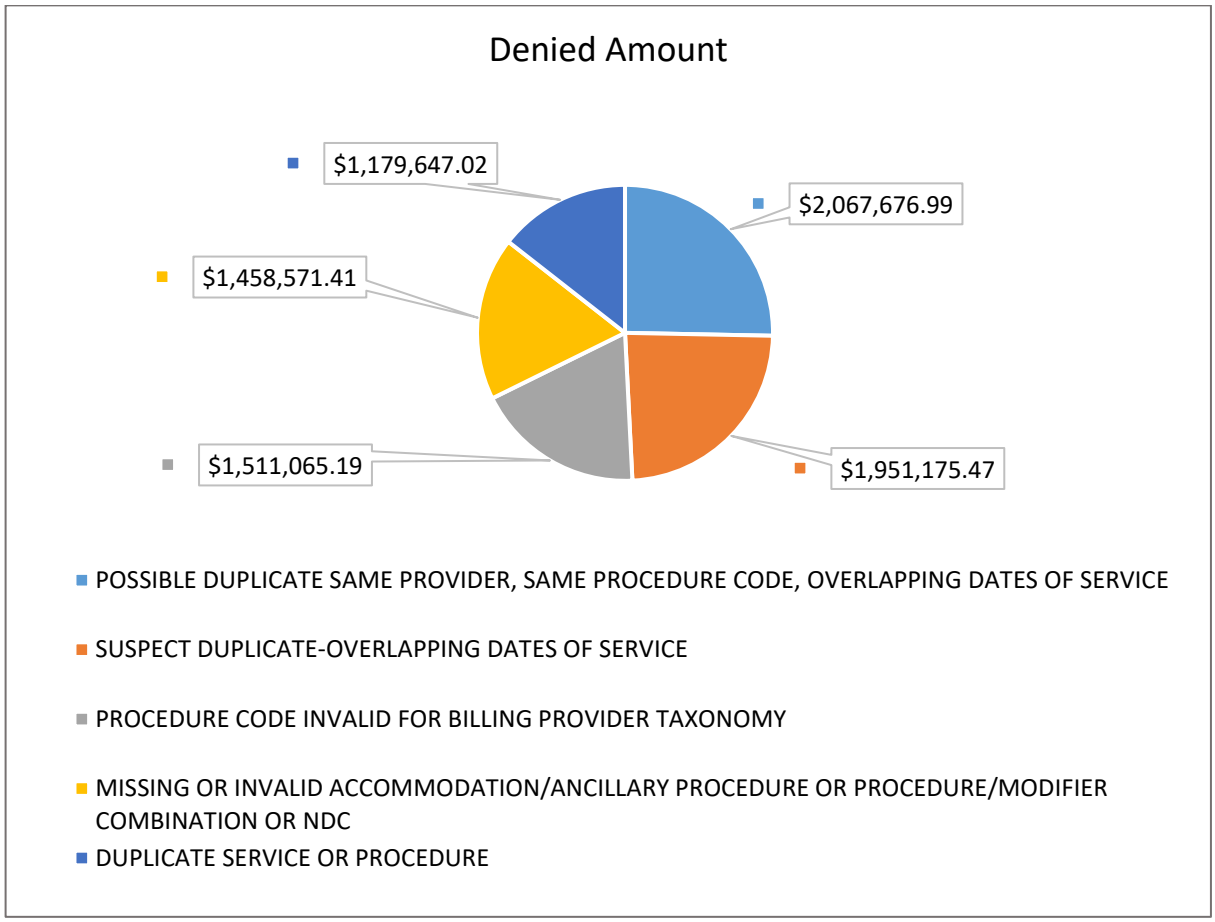
Evaluation of the top denials for Vaya encounters correlates with the data deficiencies identified by the HMS analyst in the Key Field analysis above. Encounters were denied primarily for:

- Possible duplicate same provider, same Procedure code, overlapping dates of service
- Suspected duplicate-overlapping dates of service
- Procedure code invalid for billing provider taxonomy
- Missing or invalid accommodation/ancillary procedure or procedure/modifier combination or NDC
- Duplicate service or procedure

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 at least one Other Diagnosis code. The issue is far more pronounced in Professional encounters, which saw only 13% of all Professional encounters billed with at least one Other Diagnosis code. This is well below what we expect to see given the comorbidities that are often present in the demographics that PIHPs serve.

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.

Conclusion

Based on the analysis of Vaya's encounter data, it has been 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 Other Diagnosis code reporting for both Professional and Institutional claims. Although Other Diagnosis codes do not directly impact pricing of claims, 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. Without 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 NCM 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