Quality Assessment and Performance Improvement Program

VAYAHEALTH

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3212 Quality Assessment and Performance Improvement Program

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I. Introduction

Vaya Health (Vaya) is committed to the design and implementation of a robust Quality Assessment and Performance Improvement program (QAPI) to advance the aims, goals, and objectives of the North Carolina Department of Health and Human Services (NCDHHS or Department) NC Medicaid Managed Care Quality Strategy and ensure State-funded services are readily accessible. Vaya structured our culture, systems, and processes to further our mission to improve the health of Medicaid members and State-funded services recipients (collectively "members"). The QAPI utilizes a systematic approach to quality, using reliable and valid methods of monitoring, analysis, improvement, and evaluation in the care provided to all members. This systematic approach provides a continuous cycle for assessing the quality of care and services managed by Vaya in areas such as preventive health; acute and chronic care; behavioral health; population health management; over- and underutilization of services; continuity and coordination of care; administrative, member, and network services; and patient safety.

Vaya understands our legal and ethical obligations to provide members with a level of care that meets recognized professional standards and is delivered in safe and appropriate settings. Vaya ensures the delivery of quality care with the primary goal of improving the health status of members. The QAPI includes identification of members at risk of developing conditions, implementation of appropriate interventions, and designation of adequate resources to support the interventions. Whenever possible, Vaya supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of members.

This document is the annual workplan and will be evaluated annually by the Quality Director of NC Medicaid Managed Care Program (Key Personnel Quality Director) to assess the overall effectiveness of the program and progress in meeting quality program goals and will be reviewed and approved at least annually by the Vaya Quality Improvement Committee (QIC) and Board of Directors Regulatory Compliance and Quality Committee (RCQC) [QI 1(B)(5)]. The QAPI complies with the quality management and quality improvement requirements contained in North Carolina's Section 1115 Demonstration Waiver, Section 1915(c) Home and Community Based Services (HCBS) Waiver, and Vaya's contracts with NCDHHS to manage certain health benefit plans, including the NC Medicaid Prepaid Inpatient Health Plan (PIHP) and the Behavioral Health (BH) and Intellectual/ Developmental Disabilities Tailored Plan. We will also work collaboratively with the Cherokee Indian Hospital Authority (CIHA) Quality Team to execute the Tribal Quality Plan as detailed in Vaya's Tribal Engagement Strategy.

II. Design and Scope

The scope of Vaya's QAPI Program is comprehensive and addresses both the quality and safety of care and services provided to members in all care settings, including physical and behavioral health. The QAPI incorporates all demographic groups and service categories in its quality improvement activities, including preventive care, emergency and crisis care, primary care, specialty care, and ancillary services. Vaya is committed to providing a

comprehensive array of clinically appropriate, integrated physical health, behavioral health, and pharmacy services for individuals with more severe behavioral health disorders, intellectual/developmental disabilities (I/DD), and/or traumatic brain injury (TBI) that meet or exceed objective quality standards, regardless of the setting. Vaya seeks input from and collaborates with members, providers, community resources, and agencies to actively improve the quality of care provided to members.

III. Governance and Leadership

The governance and leadership structure for Vaya's QAPI program is outlined in the Quality Management and Improvement Program (QMIP).

IV. Goals and Objectives

Vaya bases its goals and objectives for quality upon the Department's health priorities as outlined in the QMIP. In addition, Vaya develops goals, objectives, and strategies considering the following:

- Applicable laws, rules, regulations, and accreditation standards.
- Evidence-based guidelines, public health goals identified by the Department (e.g., opioid and tobacco use) or other public health stakeholders, and national medical criteria.
- Institute of Healthcare Improvement's Quintuple Aim focused on improving population health, enhancing the care experience, reducing costs, advancing health equity, and improving care team well-being.
- Performance measures such as Health Care Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), member and provider surveys, and available results from the External Quality Review Organization (EQRO).

We apply evidence-based quality improvement concepts and techniques to continuously improve the quality and appropriateness of care, services, and supports for members. Our QMIP description and QAPI serve as the foundation for Vaya's quality improvement efforts, with program goals and priorities embedded throughout organizational operations. Vaya will also share the QMIP description, QAPI workplan, and appropriate performance results with subcontractors and network providers, including Advanced Medical Home (AMH) and AMH Plus (AMH+) agencies and Care Management Agencies (CMAs) delivering Tailored Care Management (TCM) individually or through Clinically Integrated Networks (CINs). Vaya tracks, trends, and reports quality metrics to the Quality Improvement Committee (QIC), Executive Leadership Team (ELT), and Board of Directors (BOD). We also share quality metrics with our Consumer and Family Advisory Committee (CFAC), Provider Advisory Council (PAC) and other collaboratives and advisory groups as appropriate. At least annually, the QIC reviews and assesses the effectiveness of Vaya's QM program.

Vaya maintains additional program objectives that include, but are not limited to, the following:

- Establish and maintain a system that promotes continuous quality improvement.
- Adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in practice.
- Select areas of study based on demonstration of need and relevance to the population served.

- Develop standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time.
- Utilize information systems in data collection, integration, tracking, analysis, and reporting of data that reflects performance on standardized measures of health outcomes.
- Allocate personnel and resources necessary to support the quality improvement program, including data analysis and reporting, and to meet the educational needs of members, providers, and staff relevant to quality improvement efforts.
- Seek input and work with members, providers, and community resources to improve quality of care provided to members.
- Develop partnerships with new stakeholders and providers to establish services and relationships to support home and community-based services and options.
- Establish a system to provide frequent, periodic quality improvement information to participating providers to support them in their efforts to provide high-quality health care; and
- Recommend and institute “focused” quality studies in clinical and non-clinical areas, where appropriate.

V. Feedback, Data Systems, and Monitoring

Vaya collects, analyzes, tracks, monitors, and trends data, measures, and indicators from a wide variety of sources to identify gaps and opportunities, establish goals, benchmarks, and thresholds, plan performance, drive decision-making, identify and prioritize performance issues, and develop interventions for resolution. Vaya’s data sources include, but are not limited to, performance data, member and provider satisfaction data, complaints and grievances, incident reports, access and availability reports, provider and vendor quality improvement reports, quality measure rates, and utilization patterns.

Vaya’s PRT oversees and supports processes related to the development, implementation, and monitoring of performance measures, required reports, and adherence to service level agreements and performance standards with associated liquidated damages. The PRT coordinates with key stakeholders, including the Information Services Division (ISD), to refine all quality and data integrity standards, to produce accurate clinical and non-clinical metrics, and to report to the Department. This provides a basis for stratification, regional reporting, and reporting of quality measures for all provider types and patient populations. Throughout this process, the PRT maintains appropriate communication with the Department, Vaya's QM Department, QIC, ELT, and the BOD.

Vaya’s Enterprise Analytics Team develops and maintains capabilities to support analytic workflows and data stratification. Vaya currently utilizes Microsoft SQL Server capabilities to extract data and run reports. It also uses Power Business Intelligence (BI) to create dashboards. Vaya also uses Microsoft SQL Server Integration Services to orchestrate automation and timing for updating data. These capabilities allow Vaya to stratify data, filter as appropriate, sort/rank, aggregate, and create visualizations. The Enterprise Analytics Team then makes these reports and dashboards available to key stakeholders throughout Vaya, including the PRT. Our data models support multiple levels of stratification at a regional, provider type, patient population, and individual level.

VI. Systematic Analysis and Action:

Two-Tiered Strategy

Vaya incorporates an ongoing cycle that applies a systematic process of quality assessment, barrier/root cause analysis, identification of improvement opportunities, implementation of interventions as indicated, and evaluation of the effects of the interventions. To accomplish this, Vaya utilizes a two-tiered methodology that enables us to maintain focus on clearly defined indicators of success, proactively detect measurable gaps or deficiencies in quality and safety and respond to gaps in a timely manner with customized improvement efforts. These two interdependent phases include:

- **Quality Assessment/Assurance:** This is a structured program for monitoring, evaluating, and assessing potential and existing problems to ensure quality standards are met. The process begins with the review and analysis of member-outcome and safety measures that reflect system performance or other sources of performance information. Measure owners and the QIC evaluate performance against established standards, goals, or benchmarks and make decisions regarding potential improvement activities intended to address identified gaps. In addition, the Performance Data Workgroup reviews data monthly.
- **Quality Improvement:** This provides a methodology to systematically address issues that adversely impact quality. Quality improvement is guided by a well-defined, cross-functional process to define problems in quantifiable terms and to design Performance Improvement Projects (PIPs) and quality improvement activities that address root causes. Vaya evaluates quality improvement activities continuously over time and makes incremental improvements to further enhance performance and enhance internal and external customer satisfaction.

Throughout both phases, Vaya utilizes the National Committee for Quality Assurance (NCQA) “Measure, Analyze, Improve, Repeat” methodology to improve processes and facilitate change. This cycle is a series of steps that guides quality efforts and provides a robust framework for the continuous improvement of a product or process. Vaya also uses other established tools to help identify root causes of performance and quality issues and to promote systems thinking. These tools include failure mode and effects analysis, flowcharting, fishbone diagramming, and the Five Whys.

VII. Program Elements

Vaya maintains multiple programs targeting improved outcomes and focuses on numerous interventions throughout the year to positively impact member health, medical costs, and member/provider care experiences. Vaya designs its areas of focus in the upcoming year to support and further the aims and goals of the NC Medicaid Managed Care Quality Strategy and the NCQA. Vaya utilizes best practices for performance and quality improvement and includes information from providers, members, caregivers, and families in the development and implementation of quality management and performance improvement activities. Vaya also utilizes previously identified information obtained through periodic ongoing monitoring to guide program development. Currently, Vaya has identified no issues that must be incorporated into this year’s program [QI 1(B)(4)].

Performance Improvement Projects (PIPs) and Quality Improvement Activities (QIAs)

Vaya departments, committees, and cross-functional teams work with QM and the QIC to develop PIPs and QIAs designed to achieve meaningful, sustained improvement in health outcomes and member satisfaction over time. Vaya reports PIPs to the Department and the QIC and reports QIAs internally to QIC. PIPs and QIAs measure performance against objective indicators, implement interventions to improve access to and quality of care, evaluate effectiveness of interventions, and plan for sustained improvement. After identifying areas requiring improvement, Vaya will establish a PIP or QIA Team comprised of a QM representative, a data analyst, and subject matter experts tasked with executing the PIP or QIA and submitting all required documentation to the QIC and the Department, as appropriate, in a timely manner. The Team will complete analysis, select interventions, and modify programs, as appropriate, to achieve the desired outcome. At a minimum, the Team will meet monthly and include a representative from the QM department trained in process improvement principles, key internal stakeholder(s)/subject matter expert(s), a data analyst, and a project coordinator. As appropriate, Vaya will incorporate member voice through CFAC involvement at QIC, utilization of survey data, focus groups, and/or key informant interviews.

Each year, Vaya will conduct at least three Department-approved PIPs. Of the required PIPs, two will relate to clinical performance in select areas outlined in the QMIP, and one will relate to non-clinical performance improvement. PIPs will align with the goals of the NC Medicaid Managed Care Quality Strategy and with the requirements contained in North Carolina's federal Medicaid waivers (e.g., Section 1115, Section 1915(c)), and other benefit plans (NC Medicaid Direct). Vaya focuses PIPs and/or QIAs on addressing quality of clinical care, safety of clinical care, quality of service, and/or member experience.

For 2024, Vaya plans the following PIPs/QIAs [QI 1(B)(1-3)]:

Category	PIP or QIA	Title	Objective	Responsible Staff	Baseline Period
Quality of Clinical Care	PIP	Medicaid Mental Health Follow Up after Discharge – Seven Day	Forty percent of members receive follow up within seven days	Key Personnel Quality Director	CY 2024
Safety of Clinical Care	PIP	Transitions to Community Living Separation Rate	Five percent decrease in quarterly average separation rate over prior year performance	Vice President of Transition and Housing	CY 2024
Safety of Clinical Care	PIP	Follow-up after Emergency Department visit for Mental Illness – Seven Day	Five percent improvement over prior year performance	Key Personnel Quality Director	CY 2024

Category	PIP or QIA	Title	Objective	Responsible Staff	Baseline Period
Quality of Service	QIA	Service Authorization Request Decision Timeliness	Average annual turnaround time for ABA denied or partially denied - 10 days or less	Vice President of Clinical Strategies	CY 2024
Member Experience	QIA	EOR Improvement Project	Improve satisfaction rate by 5% over prior year performance	Co-chairs of Individual and Family Directed Services (IFDS) Workgroup	CY 2024

Quality and Appropriateness of Care to Members with Special Health Care Needs

Given the eligibility criteria for Tailored Plan and the expansive array of priority subpopulations within Tailored Plan, many of our members have special health care needs. Mechanisms for monitoring the quality and appropriateness of care by subpopulation include the below.

Members with Complex Medical and Behavioral Health Needs

This includes members identified through our custom TCM assignment algorithm ("Vaya Assignment Protocol") experiencing complex conditions such as heart failure, use of a ventricular assist device, end-stage renal disease and dialysis, organ transplants, active cancer treatment, chronic obstructive pulmonary disease (COPD), asthma, diabetes (all types) with complications and Type 1 without complications, chronic blood disorders (sickle cell, hemophilia A), cystic fibrosis, Hepatitis C, infective endocarditis, amyotrophic lateral sclerosis (ALS) and Huntington's disease, early-onset major neurocognitive disorder with one or more significant comorbidities (e.g., prion disease and Parkinson's) , and/or members under age 18 with a behavioral health residential facility claim (Level IV, Level III, Level II, Level I, Therapeutic Foster Care, Residential In Lieu of Services [ILOS]).

This subpopulation will also include select member groups identified through other population health data mining and population health assessments. For example, our annual Population Assessment includes the most common and prevalent conditions and diagnoses. Finally, there are several special groups we will support through various population health programs, as described in greater detail below. We will monitor the quality and appropriateness of care through various means, which may include:

- Tracking member engagement in various population health programs, including associated referral and utilization metrics, etc.
- Monitoring member level and frequency of engagement with clinical providers (e.g., service utilization patterns).
- Utilizing subpopulation identification to trigger inclusion of certain care plan goals and referrals for these members.
- Monitoring these members to determine if any special health care needs or conditions resolved.
- Stratifying other measures and reports to monitor the experience of these subpopulations.

Members with Multiple Hospitalizations (Behavioral Health and Physical Health)

This subpopulation includes members identified through the Vaya Assignment Protocol who are experiencing any of the following: rapid readmits associated with severe and persistent mental illness (SPMI) and/or a diagnosis of schizophrenia, bipolar disorder with psychosis, or schizoaffective disorder; four or more inpatient admissions in a six-month period and who fall within the top 10% of high-cost members; and/or inpatient length of stay greater than 10 days. We will monitor the quality and appropriateness of care through various means that may include the following:

- Using subpopulation identification to trigger inclusion of certain care plan goals and referrals for these members; and
- Including or linking these criteria to well-established reporting and monitoring of service utilization patterns and break-out results to identify specific patterns and experiences for these groups.

Members Receiving Specialized, High-Intensity Services

This subpopulation includes members engaged in Assertive Community Treatment (ACT), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and High-Fidelity Wraparound Services, all of which include embedded care management, which makes members ineligible for TCM. These services have prerequisites based on established complex and/or severe diagnoses. We will monitor the quality and appropriateness of care through various means, which may include:

- **ACT:** Our ACT/CST Learning and Quality Collaborative actively monitors level and intensity of services provided, including an assessment of the degree to which contact frequency and engagement matches established best practice standards.
- **ICF/IID:** Vaya monitors ICF/IID service use through various UM reports and processes, including SARs and consultative support from cross-departmental workgroups and includes some aspects of ICF/IID service use reports required by the Department.
- **High-Fidelity Wraparound:** We are in the process of developing a data-driven pathway to identify these members, operationalize metrics for clinical appropriateness and sufficiency of services, and further stratify members to identify those who may not be experiencing appropriate care or care that matches the High-Fidelity Wraparound model.

Special Populations

Children with Complex Needs: Vaya will continue to actively monitor identification of children with complex needs and efforts to meet their needs through established reporting and monitoring processes.

Children ages Zero to Three Receiving Early Intervention Services: Vaya will develop data-driven processes to identify these children and monitor their needs and use of services. We will leverage related and associated data as needed and closely communicate and coordinate with providers and other partners (e.g., Children's Developmental Service Agencies [CDSA]).

For children receiving TCM, Vaya and our provider based TCM entities will coordinate directly with the CDSA Service Coordinator to help to ensure that the child's Individual Support Plan (ISP) is integrated into the care plan and appropriately updated to reflect any changes. Coordination will include linkage to services that remain within the NC Medicaid Direct program. The CDSA Service Coordinator will participate as a member of the care planning process and may take part in any case conferences with consent from the parent or legal guardian. The assigned

care manager will be responsible for coordinating care and working closely with the CDSA Service Coordinator to ensure the child's and family's needs are met. Vaya will develop job aids for TCM entities to help them work with our CDSAs to support this population.

Women with High-Risk Pregnancies: Vaya will monitor care through oversight of the Care Management for High-Risk Pregnancies program and other means. We will align oversight with established reporting parameters and data exchange with Community Care of North Carolina (CCNC).

The long-term services and supports (LTSS) needs for members on the Innovations Waiver Registry of Unmet Needs (referred to herein as the "waitlist"), TBI Waiver waitlist, and other members are described in greater detail below.

Vaya is redesigning internal processes to track and monitor several types of waitlists to expedite access to needed care and communicate appropriately and accurately with members, their families, providers, and care teams. This includes communication and follow-up with individuals making referrals. These activities build on current processes to regularly monitor service utilization among members on the RUN. This development work will also incorporate new and/or updated reporting requirements.

Vaya recognizes our responsibility to help ensure Medicaid members on the Innovations waitlist and TBI waitlist have appropriate education and choice of where they will receive TCM to promote informed decision-making. Vaya will provide this information to members who apply for the RUN at the time of application if they do not already have an established relationship with a care manager. In their comprehensive assessment, care managers identify LTSS needs and link members to services such as Long-Term Community Supports, a wraparound Medicaid service for members with I/DD, as well as ensure these members have access to primary and specialty care and resources to address unmet health-related resource needs. Many members may require assistance completing psychological evaluations or gathering records that support their eligibility for the Innovations or TBI waivers. Care managers also provide support and access to gather this information.

Quality and Appropriateness of Care to Members Needing LTSS

LTSS are medical and non-medical programs and services provided in a variety of settings, including nursing facilities, group or private living settings, and the community. People of all ages may receive these services for a short or extended time to support regaining or maintaining maximum health and independence when living with a chronic illness or disability. Vaya is committed to meeting the needs of members receiving LTSS and utilizes multiple mechanisms to address quality and appropriateness of care. A summary of key programmatic activities is provided below.

LTSS Member Advisory Committee

Vaya maintains an LTSS Member Advisory Committee (LTSS MAC) to gather stakeholder feedback regarding LTSS, including care provided in the home, community-based settings, and facilities such as nursing homes. Membership reflects the LTSS populations covered by Vaya, and the committee reviews reports and provides feedback on member experience and quality of care. The committee also helps resolve quality-of-care concerns related to LTSS as appropriate. Vaya's Member Engagement Team coordinates, monitors, and supports the work of the LTSS MAC and reports its activities to the Vaya BOD at least annually.

Utilization Management

Vaya's UM team uses assessment tools to determine if members meet the level of care required by the Innovations and TBI waivers. UM reviews information in the initial and subsequent assessments to identify the clinical assessments or other services a member might require. Care Managers and Complex Care Coordinators also use this information to develop individualized treatment plans and coordinate connecting the member to LTSS. The individualized treatment plans include integration and coordination of clinical and non-clinical services. Vaya also evaluates the services and supports received compared to those planned in the treatment/service plan.

Performance Monitoring

Vaya continually monitors LTSS performance and will develop, track, and analyze measures of effectiveness with a robust quality improvement cycle. In addition, care managers monitor services and supports for members receiving LTSS in their homes, community, and facilities. Each service has established monitoring requirements through the care management program. Vaya conducts monitoring monthly via face-to-face contact, telephonic/telephone contact, contact with the provider, review of documentation, service provision monitoring, and/or contact with the member or guardian at defined intervals based on the Department's acuity tiering. In addition, Vaya conducts focused performance monitoring on the completeness, quality, and timeliness of the care plan and any encountered barriers toward member progress.

Innovations Waitlist

Vaya maintains a waitlist for individuals who meet preliminary eligibility for the Innovations Waiver but for whom a slot is not available at the time of their eligibility determination. Vaya's UM team oversees regular communication (e.g., a minimum of every six months) with individuals on the Innovations Waitlist. In addition, UM presents information on the utilization of the Innovations Waitlist and Innovations Waiver services to QIC quarterly. A significant percentage of individuals on Vaya's Innovations Waitlist continue to receive at least one service from Vaya. This helps Vaya maintain contact with these members to more easily facilitate their move to waiver services as slots become available.

1915(i) Workgroup

Vaya will continue to offer a comprehensive array of critical home and community-based services (HCBS) for members with significant behavioral health needs, I/DD, and/or TBI. The 1915(i) Workgroup will oversee provision of these services to improve the service array offered and ensure members do not experience disruption in covered services. To accomplish this, the workgroup will coordinate with key stakeholders to better understand the needs of individuals receiving and providing HCBS. The workgroup will identify individuals who need HCBS services, crosswalk the available services, work to connect members to services, and will provide ongoing training and support to internal and provider-based TCM regarding the process to connect members to i-waiver services. In addition, the 1915(i) Workgroup will develop quality processes to monitor appropriate service provision and utilization.

TCL Barriers Committee

Vaya maintains a TCL Barriers Committee that addresses the needs of marginalized individuals with behavioral health needs and I/DD, especially for individuals in institutional settings such as adult care homes and community intermediate care facilities. Membership includes a Vaya employee, local ombudsman, adult care home directors, and a representative from the NCDHHS Office of the Secretary. The committee provides oversight, direction, and leadership of Vaya's work to address diversion, in-reach, and transition barriers impacting Vaya's region. It works

collaboratively with the State and key stakeholders to reduce or eliminate barriers impacting TCL member outcomes post-discharge. The Vaya TCL Barriers Committee reports key findings and trends to QIC at regular intervals.

Tailored Care Management Care Transitions

Transition between service delivery systems, including between health plans, poses unique challenges to ensuring service continuity and effective coordination between responsible entities. Well-managed transitions of care are vital to Vaya's LTSS efforts. Care managers work to ensure members, families, and caregivers understand Medicaid managed care; help them navigate the health care system; conduct outreach; provide ongoing education; and ensure each member has a comprehensive assessment and solid plan of care in place as the individual transfers between services, providers, and plans. Monitoring includes tracking transition status, identifying members with an unplanned transition, and analyzing rates of unplanned admissions to facilities and emergency department (ED) visits. Vaya will use this information to identify and act in areas where improvement may be warranted.

Efforts to Improve Quality Disparities Based on Age, Race, Ethnicity, Sex, Primary Language, and Key Population Groups

In an ongoing effort to improve the quality of care delivered to members, Vaya analyzes population demographics, including disease prevalence and health disparities, to identify opportunities for improvement, trends that indicate potential barriers to care, and potentially effective interventions. This is a new area of data stratification that has not been present in Vaya's program historically. Vaya's goal is to develop robust methods for stratification, establish baseline data, and incorporate these elements into predictive analytics to better target population health and member-specific programs. In addition, Vaya's Health Equity Council and Diversity, Equity, and Inclusion (DEI) Committee will identify and evaluate Vaya's progress toward education, awareness, and advocacy. The Health Equity Council, which includes provider and member/family representation, will monitor and recommend a wide range of health equity activities. The DEI Committee focuses on diversity and inclusion within Vaya (e.g., hiring, staffing, training, organizational health, etc.) and may coordinate efforts with the larger Health Equity Council as appropriate.

Population Health Programs Targeted to Improve Outcome Measures

Vaya's population health programs targeted to improve outcome measures are intended to improve adherence to recommended preventive health guidelines for examinations, screenings, and immunizations to promote the prevention and early diagnosis of disease. These programs utilize various member and provider interventions to improve access to preventive services.

Promoting Wellness and Prevention

Vaya has created workflows and assessments within the CM platform for referrals to our Wellness and Prevention Programs. This enables us to track eligible members, attempts to refer eligible members, and member engagement in these programs. Vaya has created a Wellness Programs Referral Form that enables us to track referrals from members and stakeholders. Additionally, we have contracted with Healthwise, Inc. to provide comprehensive member health education on a wide range of topics and track members' review of Healthwise

materials. We have also developed our Human Immunodeficiency Virus and Hepatitis C Screening Plan to guide provider efforts in these areas (see Appendix A).

To promote child health and wellness, Vaya is designing a section of our website to provide education to members and their parents/guardians about early childhood interventions. Vaya identifies members potentially eligible for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); makes referrals; and provides comprehensive application assistance to help members access the WIC program as needed. To identify a baseline percentage of Vaya's Medicaid membership who have delayed vaccinations, we will access the North Carolina Immunization Registry (NCIR) information. This will aid us in tracking at the member, provider, and population levels.

Using available administrative and clinical data, we will track and monitor the following NCQA measures as they pertain to women's health: Cervical Cancer Screening, Chlamydia Screening in Women, and Prenatal and Postpartum Care.

Improving Chronic Condition Management

Vaya routinely develops unique solutions and strategies for complying with Department standards for quality and performance measures. Our Vice President of Physical Health Network Operations and Value-Based Care works with Vaya's QM department to develop quality improvement and assurance activities for these measures. Other measures Vaya will track include use of multiple antipsychotics in adolescents and children, metabolic testing for children and adolescents on antipsychotics, and antidepressant medication management.

Within Vaya's CM Platform, Vaya has created workflows and assessments for Diabetes Management, Hypertension Management, Asthma Management, and Tobacco Cessation programs. Vaya's care managers and/or Nursing team will monitor program participants and coordinate their care. Vaya also is working to develop disease management member stratification through the CM Platform. Vaya also plans other approaches to member identification, including the use of a referral form and/or use of the Health Risk Assessment (HRA) data for manual program enrollment. The HRA contains screening questions for all disease management conditions to allow for member identification. The developed workflows will enable us to track members identified as eligible, attempts to engage or refer eligible members, and whether members engaged in the programs.

Collaborating with Communities to Improve Population Health

Vaya has created an Opioid Misuse and Prevention Program workgroup and a Tobacco Cessation workgroup to design, develop, and implement the interventions outlined in the respective plans. The work includes collaboration with community stakeholders to improve the health of our communities. Using the CM Platform, Vaya has created workflows and assessments for referrals to the tobacco cessation program "Quit for Life." This will enable us to track eligible members, attempts to refer eligible members to this program, and whether members engaged in the program.

To reduce stigma and health care disparities, Vaya continues to provide community trainings that are publicized for providers, stakeholders, and other audiences on our website events calendar. Vaya also offers brief trainings for internal staff on health equity. In April 2020, the Vaya Pharmacy team began prioritizing chart reviews for members whose race/ethnicity places them at elevated risk for experiencing health care disparities due to longstanding systematic inequality in U.S. economic, housing, and health care systems.

As additional information became available regarding increased COVID-19-related risks in these populations, Vaya's pharmacist worked with Vaya's Care Management department and our Nursing and Medical teams to further refine this process to identify and prioritize high-risk ethnic/racial minority groups for review. As of July 7, 2022, our pharmacist identified further interventions in 90% of these prioritized chart reviews.

Collection and Submission of Required Quality and Performance Measurement Data

The Vaya PRT within the QM department is responsible for the collection, submission, analysis, and reporting of quality performance measurement data and for responding to requests for specific data needs from both internal and external stakeholders. The team is responsible for submitting monthly, quarterly, semi-annual, and annual performance measures as required by Vaya's contracts with NCDHHS.

Prior to each submission, the PRT reviews performance metrics and key performance indicators, completing an in-depth analysis that establishes trends, identifies anomalies, and compares data against standards and benchmarks. The Regulatory Reporting Director, with support from team members, presents the analysis monthly to the Performance Data Workgroup, an inter-departmental, cross-functional subcommittee of the QIC that provides feedback and context to the data, poses questions, and identifies opportunities for further analysis. The Regulatory Reporting Director is responsible for reviewing any data-related issues that need further evaluation with the QIC and seeking guidance on possible next steps, to include informal quality assurance activities and/or initiation of formal PIPs. QIC then ensures this presentation is shared with ELT, RCQC, and the BOD.

Underutilization and Overutilization of Services

Vaya's UM team reviews utilization patterns for all members, including provider utilization. To ensure appropriate care and service to members, Vaya analyses utilization data to identify potential over- and underutilization issues or practices. We conduct data analysis using various sources, such as medical service encounter data, pharmacy, and encounter reporting, to identify patterns of potential or actual inappropriate service utilization. The QM department works closely with the UM team to identify problem areas, conduct analysis, identify opportunities for improvement, and provide recommendations. QM and UM will identify areas of potential concern and communicate those concerns to Vaya's Network Services Management Committee for review and determination of any needed interventions or recommendations. This information regarding interventions or recommendations is communicated to the QIC for oversight and monitoring. In addition, the State-funded Budget Workgroup assists with utilization analysis for State-funded services. The UM team will report to the QIC on utilization of services on a quarterly basis. Our under- and overutilization monitoring includes the following:

- Use of congregate care settings, including county-by-county and member demographic-based monitoring where available.
- ED use, including length of stay, for crisis visits.
- Out-of-home placements greater than thirty miles/thirty minutes (urban) or sixty miles/sixty minutes (rural) from a member's/family's home, including out-of-state placements.
- Time to service initiation from request of service or determination of service need by a provider, as well as lengths of stay in inappropriate settings while awaiting access to appropriate services.
- Use of community/home-based services for youth residing in foster care settings who have behavioral health diagnoses.

- 30/60/180-day readmissions to congregate care settings and ED settings following discharge from any congregate care setting.

Prevention, Detection, and Remediation of Critical Incidents, including HCBS Waiver Programs

The Provider Quality Operations Unit within the QM department collaborates with both internal and external stakeholders to build and enhance operational processes and develops polices for improved provider quality and member safety. This function is conducted through the Network Quality and Performance Team and the GRIT.

The GRIT tracks and trends incident and grievance data to assess performance trends and patterns. If trends are identified, the team refers providers to the Network Quality and Performance Team and brings the trends to Critical Incident Review Committee for recommendation or referral to the Network Quality and Performance Team. In addition, the GRIT has established defined thresholds to trigger additional monitoring. If defined threshold trends are found at the provider level, the GRIT refers providers to the Provider Quality Operations Unit for in-depth review, potential on-site assessment, and/or action plan development. Threshold trend reviews apply to all provider types, including physical health and home and community-based waiver programs.

To prevent, detect, and remediate critical incidents, the GRIT prepares quarterly trend data from collected incident and grievance data. The GRIT summarizes trends and patterns of incidents and grievances and presents a summary to the Quality Director and quarterly to the QIC.

Assess and Address Health Disparities at a Statewide and Regional Level

Vaya is committed to centering equity in our policies, procedures, member engagement, and partnerships at local, regional, and state levels. Identifying disparities based on health outcomes and service utilization is a necessary but insufficient step toward this aim. We forecast that inequities may vary based on geographic location. Location itself may be correlated with inequitable outcomes and access to care (e.g., rurality). Vaya has long employed geo-mapping and GIS tools to assess network access, proximity, and “hot spots” for key trends. We will leverage this technology to provide equitable care and quality improvement for members. Specifically, Vaya will identify disparities for key groups (e.g., race, ethnicity, age, sex, language, disability, LTSS) and examine where and how those inequities are experienced. Experiences are common to a community or region will inform and guide various activities, including the following:

- Provider capacity building and support (e.g., support for health equity and historically underutilized providers).
- Member engagement (e.g., the required member engagement and marketing plan for historically marginalized populations).
- Investments in health-related resources and initiatives that advance public health and health equity.
- Partnerships with regional partners, Area Health Education Centers, other Tailored Plans, and Standard Plans to achieve shared equity goals.

As the Department and the EQRO identify cross-cutting inequities for North Carolina and/or key regions, we will align efforts and support those larger initiatives and priorities. Throughout, our Health Equity Council will

coordinate and lead the identification of disparities, ensure stakeholder engagement and representation, and develop initiatives to address inequities.

Provider Support Plan

Vaya recognizes the critical importance of our provider partners in advancing the aims, goals, and objectives of the Department's NC Medicaid Managed Care Quality Strategy and ensuring that State-funded Services are readily accessible. Vaya is committed to proactively, collaboratively addressing network provider needs. The Provider Support Plan (PSP), Appendix B, outlines strategies to provide education and technical assistance and to foster open communication. In addition, Vaya's PSP provides an overview of methods we will use to evaluate provider engagement over time and identify opportunities for quality improvement.

While Vaya seeks to minimize burden on network providers, we value their insight into root causes of performance issues and innovative ways to improve. As provider capacity and availability matures, we plan to engage providers in quality improvement through various means, such as coaching as part of the PSP; feedback on performance metrics, benchmarks, and goals; and Vaya's plan for value-based contracting. Other communication and provider support activities may include communication of correlations, associated trends, and root causes; results of data mining that may illuminate trends; engagement through advisory groups and learning collaboratives; and collaboration with other partners and workgroups.

Contributions to Health-related Resources with Improvement in Particular Health Outcomes

Vaya is actively working to reduce potential barriers to member health due to unmet resource needs (e.g., transportation, food insecurity, housing). We engage and collaborate with the Department and local counties and communities to understand the needs within our state and the communities we serve. For example, Vaya will partner with the Department to achieve Healthy NC 2030 goals and to better understand state performance on the Behavioral Risk Factor Surveillance System survey. Vaya will customize the approaches developed to unique county and community needs and include identifying, utilizing, and helping members navigate available social supports and resources at the local level. Vaya accomplishes this through the following:

NCCARE360

Vaya has designed assessments to identify unmet social needs and created workflows that will trigger activities for care managers and other staff to help members obtain resources. Vaya utilizes NCCARE360, a closed-loop platform, to make and track social determinants of health (SDOH) referrals, and accesses analytics to help us assess the robustness of our network. We also have developed an NCCARE360 Workgroup, which aims to ensure all Vaya departments have a voice in addressing barriers, analyzing referral information, and developing job aids. The leader of this workgroup also has regular communication with UniteUs to support the growth and enhancement of NCCARE360.

Healthy Opportunities

Vaya actively participates in the Department's Healthy Opportunities Pilot (HOP) Program, which will launch on May 15, 2024 in sixteen of the thirty-two counties in our region. Through the HOP, eligible members can receive SDOH resources in four priority domains (housing, food, transportation, and interpersonal violence/toxic stress). In conjunction with the Department, Vaya will systematically assess how evidence-based interventions in each of

the four priority domains can be delivered effectively to Medicaid members and study the effects on health outcomes and cost of care. Our goal is to learn which evidence-based interventions and processes are most effective to improve health, lower health care costs for specific populations, and to inform health care delivery statewide.

NCServes

Vaya provides funding, oversight, and support to Veteran Services of the Carolinas, Veterans Bridge Home, and Governors Institute (all of which create NCServes) to ensure Veterans and Military Families have access to unmet health related resources. Vaya and NCServes work with a third-party vendor that specializes in Veterans issues to complete thorough measurement and evaluation of the NCServes coordination efforts happening across the state. Measurement and evaluation results will guide next steps in improving access to SDOH resources for Veterans and their families.

Vaya Total Care Perks (Value-added Services)

Vaya provides supportive (value-added) services to assist members with health-related needs that are not typically addressed within the health care system. For example, our value-added services include meal delivery, help achieving the general education development (GED) certificate, breast pumps, and weight loss support. Vaya is currently developing member analytics, member feedback channels, and usage analytics to refine our value-added service array based on community needs and priority development. Future efforts in other aspects of SDOH (e.g., Care Needs Screening data) also will guide future value-added services selections.

NC Integrated Care for Kids (NC InCK)

Vaya works closely with NC Integrated Care for Kids (NC InCK), a pediatric whole-person collaboration for children enrolled in Medicaid who live in Alamance, Durham, Granville, Orange, and Vance counties. NC InCK collaborates with public and private community partners to help meet health and unmet health-related resource needs for youth and families. Vaya provides an integration consultant to serve on the care management team. This role supports care managers who navigate cross-sector disciplines such as schools, early childhood, food, housing, child welfare, juvenile justice, Title V, and legal aid to ensure pediatric integrated care.

Housing

Vaya believes that having a safe and stable place to live is an integral part of wellbeing and recovery. To that end, we have a dedicated Housing Supports Team to help prevent and address member housing insecurity. The team collaborates with providers, members, and community partners to provide educational outreach, resources, and training about housing and residential options. Team activities may include coordinating education events, negotiating with property owners and managers, implementing landlord recruitment and retention plans, and helping partners with housing searches, eligibility evaluation, and application-approval processes. The team also operates the Transitions to Community Living Voucher as part of the Transitions to Community Living (TCL) program, the Permanent Supportive Housing program, Non-Medicaid Residential Services, the Housing Supports Grant, the Independence Project, and the Integrated Supportive Housing Program.

North Carolina Collaborative for Ongoing Recovery through Employment (NC CORE)

Vaya has partnered with the Division of Employment and Independence for People with Disabilities (EIPD) to develop and utilize a milestone-based payment model for Individual Placement and Support (IPS) services for members (age 16 and up). The program, known as NC CORE, focuses on helping individuals with disabilities find

and maintain competitive integrated employment. This model combines either Medicaid or State funds with funding from NC EIPD to help people with disabilities achieve their goals for employment and independence. Vaya utilizes EIPD partnerships for additional assistance with training, clothing, job placement, etc. and will focus future program efforts on expanding our provider base to ensure underserved areas have IPS services. This will, in turn, allow us to increase the number of members receiving IPS services.

Community Engagement

As detailed in our Local Community Collaborative Engagement Plan, Vaya leverages its Community Relations department (CR) to continuously establish and nurture relationships with communities, county leaders, and community stakeholders in support of health-related resource needs identification and fulfillment. CR Regional Directors routinely convene and facilitate stakeholder meetings to address and develop solutions, innovative programs, and initiatives. CR Regional Directors also participate in community-led activities addressing health related resource needs, including but not limited to:

- Community events and sponsorships.
- Health Trust funding-related activities, education and training sessions, and listening sessions.
- Association of Regional Councils of Government capacity building in the areas of economic and workforce development and affordable housing.
- Linkages to NCWorks and the Area Agency on Aging Departments of Social Services (DSS).
- Disaster response roles and responsibilities assumed by CR team members that address member resource needs that emerge in disaster scenarios (e.g., housing, continuity of care).

Permanent Supportive Housing

Vaya's Permanent Supportive Housing (PSH) grants serve members who are chronically homeless and have a disabling condition certified by a licensed professional. Disabling conditions include physical, mental, and emotional disabilities; I/DD; substance dependence; and/or visual disabilities.

Vaya maintains two grant areas that operate a total of 103 rent-assisted units. Shelters and unsheltered outreach providers identify people and families experiencing homelessness, conduct case-conferences involving stakeholders in each region, and refer individuals to Vaya's PSH program when units are available. We currently serve seventy people (fifty-six adults and fourteen children; two veterans) in our western region and 121 people (seventy-one adults, fifty children; zero veterans) in our central region. Vaya tracks performance measures annually with a focus on helping members improve their quality of life through employment assistance, addressing of SDOH, advocacy, educational support, assistance in obtaining available disability benefits, and linkage to services. In addition, we focus on parenting skills, reunification with family members, and relationships with natural supports.

Mechanisms to Assess and Address Health Equity including Culturally and Linguistically Appropriate Services and Diverse Provider Pool

We continually monitor our network using member demographic information, types of providers needed, historic and projected enrollment, travel distances, regional infrastructure, and special member needs. Monitoring allows us to identify specific gaps in linguistic, cultural, or disease/disability-related expertise to meet member needs and recruit accordingly. Vaya approaches health equity through multiple systemic mechanisms:

EBCI Tribal Support

Vaya maintains a strong relationship with Eastern Band of Cherokee Indians (EBCI) and a Tribal Support Plan to guide our efforts. Additionally, we have added a Tribal Provider Network Contract Manager to serve as Vaya's liaison to the EBCI. Vaya also offers training to all network providers on Vaya's Tribal Support Plan, cultural and linguistic aspects of the EBCI, and resources for working with Tribal members, their families, and support systems.

Network Monitoring

Vaya currently utilizes generalized population data, data from the Department, pharmacy data, Vaya claims data, care management reporting, and provider-reported demographic data to identify special populations within our region. This data informs decisions about the development and addition of services in our region. We are developing a cross-departmental workgroup within Vaya to develop additional means to identify and support special populations. This workgroup will utilize feedback from the Provider Advisory Council and appropriate committees. These activities will guide the development and contracting of specialized services where needed within the individual population areas of Vaya's overall region, specialized provider training and support, and outreach to populations needing special support.

Network Providers

Vaya contractually requires network providers to assess and address the needs of special populations within our region. Vaya provides training, resources, and technical support to network providers through our Provider Network Operations department, including individualized additional support as needed. In addition, Vaya is committed to working with and creating opportunities for Historically Underutilized Businesses (HUBs) that serve children, youth, and adults through a range of services including administrative support agencies, treatment providers, and organizations that address unmet-health related resource needs. Vaya is committed to working with and creating opportunities for Historically Underutilized Businesses (HUBs) in current business lines that serve children, youth, and adults through a range of services including administrative support agencies, treatment providers, and organizations that address unmet-health related resource needs. We will leverage our experience in identifying and creating tailored services and supports when partnering with HUBs that are representative of the members and communities we serve. Vaya's Provider Network Operations senior leadership participates in regular meetings with Resource Connections Provider Association, an association for minority-owned providers in North Carolina. We actively recruit and work with numerous HUB providers to expand services to our historically underserved communities across North Carolina. Vaya will continue to make every effort to seek out and pursue opportunities to utilize HUBs within the CFSP scope of services.

Meeting Language Needs

Vaya analyzes key demographic characteristics, including race, ethnicity, gender, regional and rural/urban distribution, and language preferences to ensure our provider network meets member needs. Linguistic needs are assessed through data supplied in member enrollment files, CAHPS survey results on race and ethnicity, U.S. Census Bureau data on resident language preference and race distribution for Vaya's region, data on linguistic needs based on Vaya Member and Recipient Services (MRS) translation requests or needs expressed by members and their families through direct interaction with Vaya staff in community settings or through complaints and grievances. Members and families can find information on provider language capabilities in our online Provider Directory. Additionally, Vaya MRS contracts with an interpretation service that can currently assist callers in eighty plus languages.

Consumer and Family Advisory Committee (CFAC) Activity

As an independent and self-governed committee, the CFAC consists of four regional groups that cover Vaya's region. Regional CFACs meet at least six times per year. The CFAC steering committee, which consists of representatives from the regional bodies, meets at least four times per year. All regional groups hold a joint meeting at least twice per year. The CFAC and Vaya have a multi-step and recurring process to: (a) collect and assess feedback, (b) determine a response and act, and (c) evaluate the sufficiency of actions and Vaya's responsiveness to recommendations. Specific mechanisms for collecting and assessing feedback include representation on the statewide CFAC, Vaya's BOD, the QIC, Vaya's Human Rights Committee, and our Clinical Advisory Committee. These committee charters specify the need for member and family input and CFAC representation. The CFAC makes a formal report to Vaya's BOD during each regular board meeting.

Vaya and the CFAC work together to maintain and monitor a list of the committee's recommendations and document responses and actions taken for each recommendation. Vaya monitors the status of each recommendation reported to the CFAC for their review. Below is an example of a CFAC tracking mechanism (Table 1).

Table 1. CFAC Recommendations by Type and Current Status

Type of Recommendation	Total	New Since Last Quarterly Update	Number Satisfactorily Addressed and Resolved ("Closed")	Number In Process ("Open")
Implementation of contract deliverables between Vaya and NCDHHS				
Service Gaps and Underserved Populations				
Service Array and Development of Additional Services				
Budget Package (Area Authority Budget)				
Service Delivery and System Change Issues				
Performance and Quality Improvement				
Other and Miscellaneous (e.g., other ways to improve the delivery of mental health, I/DD, SUD, and TBI services, including statewide issues)				

Within its membership, the CFAC aims to maintain diverse representation from across Vaya's region that aligns with the populations served. Recruiting efforts include a CFAC webpage with an online membership application, an annually reviewed brochure, information tables at community events, and member announcements during meetings. Vaya provides staff liaisons to support the CFAC with its efforts, including application assistance for prospective representatives. Vaya's CFAC Liaisons work to fill committee vacancies by notifying the regional chairperson and adding vacancy discussions to regional meeting agendas. CFAC representatives can nominate themselves or other representatives to serve on committees. Liaisons assist with communicating meeting frequency, providing information about how to join meetings, and working with CFAC representatives to

effectively share their input during meetings.

As part of the quarterly QAPI update, the CFAC will include any updates and modifications to the CFAC roster. We recognize the statutory requirements for representatives and the need to achieve representative composition by demographics and disability designation. Vaya will continue to encourage and advise committees to recruit and engage representative members. As a self-governed organization, the CFAC has not elected to formally track the race, ethnicity, and demographic makeup of its participants. Vaya will encourage CFAC members to voluntarily self-identify information related to these key constituencies and consider how and if current CFAC composition matches regional member populations, including potential representation from the EBCI.

Vaya works with additional stakeholder groups to ensure our activities are informed by member, family, and community input. These groups include Innovations Stakeholders, Provider Advisory Council (PAC), and our LTSS MAC (described in greater detail above).

Overview of Metrics to Ensure Provider Engagement Over Time

To validate provider engagement with Vaya's support efforts, we will gather feedback through the delivery of surveys, including but not limited to brief surveys made available after website, call center, and in-person interactions; periodic surveys that assess overall satisfaction with functions including provider education and trainings, provider communication, and resolution to provider complaints/disputes; and the annual Provider Survey, as conducted by the EQRO.

Vaya reviews all responses and feedback and initiates quality assurance and/or performance improvement activities based on identified negative or neutral trends. In addition, Vaya will utilize all available opportunities to gain input and insight from and offer support to our provider network, including through our Provider Advisory Council, biweekly Provider Touchpoint webinars, regular provider contract meetings, and all other direct interactions.

Metrics tracked to assess provider engagement with Vaya's support offerings may include:

- Attendance rates and organizational demographics for in-person, virtual and pre-recorded educational and technical support offerings.
- Overall satisfaction rates with Vaya staff.
- Engagement rates with Vaya's Provider Central website, including online tools and resources.
- Provider ratings of Vaya's ability communicate timely and effectively and to keep them informed of changes that affect the network.

Tribal Quality

As outlined in Vaya's Tribal Engagement Strategy, we will partner with the EBCI and the Cherokee Indian Hospital Authority (CHIA) to collaboratively address Tribal member needs through disparities-segmented analytics, Tribal feedback/collaboration, and innovative quality initiatives. Our approach to quality improvement begins with using our Quality Performance Metric business tools to segment health outcome metrics across key indicators such as race, ethnicity, geographic location, and gender to identify specific health disparities and trends in health outcomes. Where possible, we will stratify all Vaya HEDIS measures to identify disparities. We will continually analyze segmented data to identify statistically significant disparities in health outcomes, perform root-cause

analysis to determine factors affecting disparities, and design interventions designed to meet specific needs of disparate populations.

When Vaya identifies a Tribal disparity, we will offer to collaborate with the CIHA Quality Team to develop community-designed, culturally appropriate interventions. Our shared Quality Management Strategy and Disparities Analysis allows for early identification of disparities and insight into previously overlooked measures. Our comprehensive disparities analysis prioritizes metrics such as Follow-Up for Hospitalization After Mental Illness, Initiation and Engagement of Alcohol and other Dependence Treatment, Prenatal and Postpartum Care, Medical Assistance with Smoking and Tobacco Use Cessation, Low Birth Weight, Comprehensive Diabetes Care, and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.

VIII. Conclusion

Vaya looks forward to aligning with the Department to transform and drive quality improvement for the benefit of our members and communities. Our focus is the delivery of high-value care that impacts both population health and the medical and non-medical drivers of health. Our QAPI Program provides the framework for successful collaboration throughout Vaya and our associated organizations. We will continue to focus on creating and maintaining a well-integrated quality program that is data-driven and focused on continually improving the quality of care and services provided.

Related Documents: (All Hyperlinked) **Forms:** **Referenced Policies:** **Other:**

Accreditation Standards: **NCQA:** PHM 3(A), QI 1(B) **URAC:** Subcategories of URAC not selected.
Supersedes: v.1 Quality Assessment and Performance Improvement Program

Appendix A: Human Immunodeficiency Virus and Hepatitis C Screening Plan

To ensure that appropriate Human Immunodeficiency Virus (HIV) and Hepatitis C (HCV) screenings are conducted, Vaya has set requirements with our behavioral health providers for general screenings and increased screenings for higher risk populations. Vaya is also establishing methods for monitoring these screenings.

HIV

Vaya's Provider Operations Manual requires our primary care providers to:

- Conduct routine HIV screenings at least once for all their patients.
- Conduct more frequent screenings for patients at greater risk for HIV.
- Link all patients who test positive for HIV to medical treatment, care, and prevention services.
- Be familiar with the Centers for Disease Control and Prevention's (CDC) Guidelines for HIV Screening, Testing, and Diagnosis and incorporate them into practice.

HCV

Vaya has budgeted for an internal HCV Bridge Counselor position to train providers and address barriers to screening and treatment. Our Provider Operations Manual requires network providers to screen for Hepatitis C or confirm the recommended screening has been completed. This includes harm reduction and treatment. Primary care providers are also required to be familiar with the CDC's Hepatitis C-Related Guidelines and incorporate them into practice. Vaya will coordinate with local Ryan White HIV case management programs and providers.

Appendix B:
Provider Support Plan

Introduction

Vaya Health (Vaya) recognizes the critical importance of provider partners in advancing the aims, goals, and objectives of the North Carolina Department of Health and Human Services' (the Department's) NC Medicaid Managed Care Quality Strategy and ensuring State-funded Services are readily accessible to recipients. Vaya is committed to proactively, collaboratively addressing the needs of providers in our network. This Provider Support Plan (PSP) describes high-level strategies to foster open communication with network providers, plans for provider education and technical assistance, and methods to both evaluate provider engagement over time and identify opportunities for quality improvement.

Tools and Strategies

To support NC Medicaid's focus on improved delivery of care, Vaya has developed tools and strategies to maintain provider engagement and ensure our network can best meet the needs of members (Aim 1, Goal 1, Objective 1.2). Strategies include offering training opportunities, providing technical support, engaging in regular communication, and sharing data with the provider on a regular frequency with the goal of assisting in delivery of care. Vaya will offer provider orientation and education on the following topics:

- NC Medicaid Managed Care Program requirements and policies
- Annual Early Periodic Screening, Diagnostic, and Treatment (EPSDT) training (including the Into the Mouths of Babes Oral Prevention Program)
- Guideline concordant, best practice prescribing of psychotropics, including but not limited to clozapine usage, considerations, and utilization requirements
- Comprehensive crisis services system
- Critical incident reporting
- Equity, bias, diversity and inclusion, and culturally and linguistically competent care (including information's specific to North Carolina's tribal populations) [PHM 3(A)(6)]
- Electroconvulsive therapy usage and utilization requirements
- Federal Block Grant regulations and requirements
- First Episode Psychosis (FEP) programs
- Fraud, waste, and abuse
- Identification of and action to address unmet health-related resource needs
- Infection control and prevention practices, including frequent handwashing, proper use of personal protective equipment (PPE), and proper practices for individuals receiving care in home or community-based settings, or as individuals transition across care settings
- Incident reporting
- Integrated and whole-person care
- Medicaid beneficiary resources, including the NC Medicaid Ombudsman
- NC-TOPPS outcomes and timelines
- Prevention and population health management programs
- Provider monitoring activities

- State-funded Services requirements, policies, and procedures
- Tailored Care Management
- Tailored Plan, Standard Plan, NC Medicaid Direct, NC Innovations Waiver, and NC TBI Waiver eligibility criteria, including differences between NC Medicaid Direct and the Department's Medicaid Managed Care Programs
- Tobacco cessation
- Training to enable providers to staff disaster shelters

Vaya offers all orientation and training resources through the Vaya Learn Portal in an on-demand, self-paced format to allow all providers to access the resources at any time. We will make **evidence-based shared decision-making aids (SDM)** available to our provider network to facilitate conversations with members about treatment options and outcomes. Vaya has chosen to utilize SDMs from two recognized organizations, the Washington State Healthcare Authority and the Substance Abuse and Mental Health Services Administration (SAMHSA). Vaya's chief medical officer (CMO) or designee evaluates SDMs, with support from Vaya's Clinical Strategies Committee, and selects those that are representative of the populations we serve. Initially, we are utilizing SDMs that address mental health, substance use disorder, and physical health decisions. SDMs are available on-demand and located on our Provider Central website. We notify providers of the availability of SDMs through our provider communication bulletin and interactions with Vaya team members. The CMO, or designee, and the Clinical Strategies Committee will review SMDs bi-annually to ensure the SMDs are up-to-date and appropriate to the populations we serve [PHM 3(A)(2)].

- Practice Transformation through Learning Collaboratives [PHM 3(A)(3)]
    - Assertive Community Treatment (ACT) and Community Support Team (CST) Learning Community, which invites all ACT and CST team leads to review reports about trends in service frequency, inpatient hospitalization, rapid readmissions, and emergency department (ED) utilization rates by each provider and share ideas for overcoming obstacles and barriers to quality outcomes for members.
    - Advanced Medical Home Plus (AMH+)/Care Management Agency (CMA) Learning Community, which provides a forum for TCM providers to coordinate efforts and to ensure their understanding of TCM requirements, review trends in member data, and share ideas for overcoming obstacles and barriers to quality outcomes for members.
    - Opioid Roundtable, which provides a forum for providers to share information, review trends in member data, share ideas for overcoming obstacles and barriers to quality outcomes for members, and learn about resources and opportunities to assist members living with opioid addiction.
    - Child Residential Roundtable, which aims to build connections and strong working relationships between Vaya and providers through discussion about topics that impact children living in residential settings and providers who support them.
    - Pathways to Permanency Project, a collaborative effort with Benchmarks which aims to build the continuum of services and supports for children in foster care.

As we launch Tailored Plan, we will continue our efforts to identify additional learning needs and collaboration opportunities for both physical and behavioral health providers. These collaborative groups will use data generated from currently available sources (e.g., demographic, authorization, service usage, claims, social determinants of health, Healthy Opportunities Pilot [HOP], NC Health Connect, etc.) to assist Vaya in advocating

for and implementing policies, procedures, and services that are person-centered and beneficial to members.

- Enhanced practice support for physical health practices at Tailored Plan launch through communication, education, and participation
    - Support to help network providers move to integrated or advanced practices and value-based care delivery.
    - Medical practice office manager support meetings.
    - Practice site visits by Vaya's Provider Network Operations team and subject matter experts (SMEs) to support practices in working with Vaya.
    - Expanded weekly Provider Communication Bulletins (PCBs) to address issues, policies, and procedures for doing business with Vaya that are specifically relevant to physical health providers.
    - One-hour, bi-weekly Provider Touchpoint webinars with Vaya SMEs from multiple departments to provide information and answer provider questions about doing business with Vaya.
    - Annual one-day Provider Summits – offering education and opportunities for collaboration among all types of network providers and Vaya staff on a variety of topics.
    - Presentations at North Carolina health and provider conferences.
    - Regular participation in hospital joint operations committees.
    - Ongoing collaboration with North Carolina AHEC practice support programs.
    - Ongoing regular communication and collaboration with Clinically Integrated Networks (CIN)
- Continued efforts to promote collaboration in engaging and supporting network providers through our Provider Advisory Council (PAC). We will work with the PAC to:
    - Increase organizational participation in the PAC through participating provider and Vaya outreach efforts.
    - Establish relationships with provider specialty boards identified by the PAC as being beneficial to Vaya's goals of increased collaboration and the PAC's goals of building a more robust, multi-disciplinary council.
    - Advise Vaya on the issues/concerns of all network providers and provide recommendations for mitigation/resolution including:
        - Input regarding systemic barriers to care and services;
        - Minimizing provider abrasion by developing processes that reduce the administrative burden on provider organizations.
- Ongoing regular communication between Vaya and providers:
    - Weekly Provider Communication Bulletins (PCB) – multi-topic emails providing the most recent and important information and guidelines for working with Vaya.
    - Weekly Provider Touchpoint webinars – multi-topic webinars addressing the information included in the PCBs as well as presentations on topics of interest to providers, and question & answer sessions (Webinars will alternate weekly between physical health and behavioral health topics).
    - Monthly provider podcast – single topic episodes featuring providers and subject matter experts.
    - Topic-specific memos - as needed and appropriate for sharing information regarding specific populations or services.
    - Monthly provider contract meetings.
    - Expansion of social media platforms to disseminate information to providers in easily digestible formats.
    - Vaya's comprehensive Provider Central website
- Provider Central website (providers.vayahealth.com), which offers providers easy, on-demand access to:

  - Provider Learning Lab: Provider Touchpoint Q&A webinars, Provider Communication Bulletin archive, online training resources, forms, evidence-based decision-making aids; Zixmail, and the Provider Operations Manual;
  - Authorization and billing: Eligibility and enrollment, coverage information, authorizations, appeals, claims, provider grievances, and prior authorization submission;
  - Information about Vaya's quality management program and efforts to address health equity/health disparity, and learning opportunities related to diversity, equity and inclusion, cultural humility, etc.;
  - Network participation: Provider enrollment, Relative as Direct Support Employee (RaDSE), after-hours coverage, Vaya's crisis services continuum, hospital information, and Vaya's Opioid Misuse Prevention and Treatment Program;
  - Program integrity: Fraud, waste, and abuse, as well as monitoring and post-payment review, incident reporting, performance and quality, utilization management program and in-lieu of services policies, and emergency and disaster information;
  - Population health: Integrated care and Transitions to Community Living; and
  - How to submit grievances and file appeals
- Resources, tools, and support for network providers through a committed Provider Network Operations (PNO) department, a dedicated provider information email and Provider Support Service Line, and a provider portal for administrative and information-sharing functions.
- Technical assistance and education from Vaya subject matter experts on topics including but not limited to:
  - Timely and accurate submission of claims.
  - Procedures for filing appeals and grievances.
  - Provider monitoring, including processes and plans of correction.
  - Clinical practice guidelines.
  - NC-TOPPS tools and guidelines.
  - Service authorization requirements, evidence-based practices, and other components of quality service provision.
  - Value-based care delivery.
- Support through Shared Decision-Making Guides.

To validate provider engagement with Vaya's support efforts, we will gather feedback through surveys, including but not limited to:

- Brief surveys made available after website, call center, and in-person interactions.
- Periodic surveys that assess overall satisfaction with Vaya functions such as provider education and trainings, provider communication, and provider complaint/dispute resolution.
- Our annual Provider Satisfaction Survey designed to allow providers to give feedback on items specific to Vaya. The design of the survey allows the Quality Management department at Vaya to evaluate provider responses based on the size of the provider organization, the populations and age groups that the organization serves, and the areas the organization serves within the greater Vaya region. In this way, we can target our improvement strategies to better suit the needs of our network providers. All responses and feedback to surveys will be internally reviewed, with quality assurance or performance improvement activities initiated based on identified negative or neutral trends. In addition, Vaya will use all available opportunities to gain input and insight from and offer support to our provider network, including through our Provider Advisory Council, Provider Touchpoint webinars, regular provider contract meetings, and other direct interactions.

Metrics used to assess provider engagement with Vaya's support opportunities may include:

- Attendance rates and organizational demographics for in-person, virtual, and pre-recorded educational and technical support offerings.
- Overall satisfaction rates with Vaya's provider-facing staff.
- Engagement rates with Provider Central website pages, tools, and resources.
- Provider ratings of Vaya's ability to timely and effectively communicate and inform providers about changes that affect the provider network.

Vaya's focus on person-centered, whole-person care includes encouraging members to engage with their health care (A1, G2). To support increased engagement, we will link members to appropriate care management and care coordination services (O2.2). As providers move through the Advanced Medical Home Plus (AMH+) or Care Management Agency (CMA) certification processes, we will continue to facilitate a TCM Learning Community. This effort provides a venue for conducting care management specific provider training, developing standardized performance measures, creating protocols for transitions of care, improving data-sharing across organizations, and strengthening overall relationships and communication regarding TCM. We will provide agencies with both initial and ongoing one-on-one support. In addition, we will ensure AMH+s and CMAs promote wellness and prevention by educating members about and referring them to Vaya's prevention and population health management programs and/or other programs that address exercise, nutrition, stress management, substance use reduction/cessation, harm reduction, relapse prevention, suicide prevention, tobacco cessation, self-help recovery, and other wellness services based on individual needs and preferences.

Our focus on integrated care will extend into our efforts to address behavioral and physical health comorbidities (A1, G2, O2.3). We will support providers as they work to increase their coordination of behavioral health and physical health care. Our experience completing assessments and designing plans of care/Individual Support Plans (ISPs) to address physical health and de-institutionalization goals serves a foundation for our training team to support providers in developing plans of care that reflect integrated care needs.

To address NC Medicaid's aim to improve the health of North Carolinians through prevention, better treatment of chronic conditions, and better behavioral health care, Vaya is committed to collaborating with community partners to create and manage initiatives and programs that promote wellness and prevention, especially for women and children, and for members receiving long-term services and supports (LTSS) (A2, G3, O3.1-3.3). Our programs will provide members with information and resources and give network providers additional opportunities to improve care delivery. For each, we will provide education on program goals and procedures, as well as ongoing support to enlist providers in involving members. To promote child health, development, and wellness (A2, G3, O3.1), Vaya has planned initiatives including activities to support at-risk children, address infant mortality, and low birth weight. We will cover office visits for prevention services, such as well-child visits, for Medicaid members. Visits will include routine physical examinations as recommended and updated by the American Academy of Pediatrics, "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents." To promote women's health (O3.2), we will establish and maintain a pregnancy management program. In addition, Vaya will continue to develop plans to maximize quality of life for members receiving LTSS (O3.3).

With the move to whole-person care, improving the health of North Carolinians requires that Vaya expand our

focus on improving chronic condition management (A2, G4). Tailored Plan members often experience both complex behavioral health needs and physical health comorbidities that significantly impact overall health and wellness. To improve diabetes management, Vaya will participate in the CDC 6|18 Initiative and establish diabetes prevention and management programs (O4.2). We will also maintain programs related to asthma and hypertension disease management (O4.3).

Vaya will enlist the help of network providers in working with communities to improve population health (A2, G5). We will utilize resources identified through the Healthy Opportunities program and, in partnership with our providers, address unmet health-related resource needs (O5.1). We will require provider-based TCM organizations to be onboarded with NCCARE360 and support training care managers on using the platform to track closed-loop referrals. Vaya's Opioid Roundtable for providers and stakeholders and our Opioid Misuse Prevention and Treatment Program, which includes helping providers understand the program and recommending it to members, will aim to reduce the impact of opioids in our communities (O5.2). We will address tobacco use through our Tobacco Cessation Plan and by promoting QuitlineNC to members and network providers. We will ensure that AMH+s, CMAs, and both plan- and provider-based care managers promote wellness and prevention through member education and referral to Vaya's prevention and population health management initiatives, programs, and wellness services based on individual needs and preferences. Vaya programs will focus on exercise, nutrition, stress management, substance use reduction or cessation, harm reduction, relapse prevention, suicide prevention, tobacco cessation, and self-help recovery.

Vaya partners with network providers to help reduce health disparities and ensures improvements in quality performance are equitably distributed (O5.4). We will gather data from available sources, including network providers, and evaluate by select strata (including age, race, ethnicity, sex, primary language, and disability status, as well as by key population groups and geography) as feasible. Vaya will initiate internal and external activities to address identified disparities. Vaya's internal Diversity, Equity, and Inclusion Committee continues to improve cultural humility and awareness throughout both the organization and our provider network through collaboration and by ensuring internal and external policies and procedures reflect our commitment to diversity, equity, and inclusion.

Vaya's commitment to smarter spending (A3) is guided by paying for value rather than volume, incentivizing innovation, and ensuring high-value, appropriate care by maintaining a value-based contracting program. We continue to develop alternative payment models (APMs) in lieu of the rate floor. Our robust Value-Based Contracting (VBC) program for behavioral health providers aligns with Category 2c of the Health Care Payment Learning and Action Network (HCP-LAN) APM framework. Under the Tailored Plan, Vaya will expand the VBC program to include APMs that correspond to higher levels of the HCP-LAN model, including pay-for-performance and quality, episode-based payments, and condition-specific population-based payment models.

Conclusion

The wide array of services and supports in this plan reflect Vaya's strong commitment to collaborating with and supporting all types of network providers. We will continue to adapt and expand information, supportive tools, forums, and resources that enable network providers to best meet the needs of Vaya members.