PROVIDER OPERATIONS MANUAL

2020-2021

Revised February 17, 2021

VAYAHEALTH

Vaya Health
200 Ridgefield Court
Asheville, NC 28806

Business calls: 1-800-893-6246
24-Hour Access to Care: 1-800-849-6127
www.vayahealth.com

IMPORTANT CONTACTS

Vaya Health Provider Help Line General questions Technical assistance Requests to add a site or service	**1-866-990-9712** provider.info@vayahealth.com
24/7 Compliance Hotline Report fraud, waste or abuse Report suspicious billing	**1-866-916-4255** LegalandCompliance@vayahealth.com
Claims and Reimbursement Billing and reimbursement RAs, credit memos and service codes	**1-800-893-6246, ext. 2455** Claims@vayahealth.com
Eligibility and Enrollment Health plan eligibility and enrollment Client updates	**1-800-893-6246, ext. 2355** EandE@vayahealth.com
Credentialing Hotline Credentialing and re-credentialing Update or change information Add new practitioners to agency roster	**1-855-432-9139** CredentialingTeam@vayahealth.com
Utilization Management Service definitions Prior and retrospective authorizations	**1-800-893-6246, ext. 1513** UM@vayahealth.com
Member Appeals Peer-to-peer discussions Reconsideration of authorization decisions	**1-800-893-6246, ext. 1400** Member.Appeals@vayahealth.com
MIS Service Desk Vaya software platform issues Electronic billing (837/835)	**1-800-893-6246, ext. 1500** ServiceDesk@vayahealth.com
24/7 Access to Care Line Help for appointments and referrals Link to Mobile Crisis Management	**1-800-849-6127** Customer.Services@vayahealth.com
Complaints and Grievances Report a compliment, complaint or concern	**1-800-893-6246, ext. 1600** ResolutionTeam@vayahealth.com

WELCOME TO VAYA

On behalf of all of us at Vaya Health, I am pleased to present to you this latest edition of our Provider Operations Manual. This manual contains vital information for Vaya Network Providers and Practitioners serving individuals with mental health needs, substance use disorders and intellectual and/or developmental disabilities.

We recognize the outstanding efforts you have made to continue serving the people of western North Carolina during a year that brought us COVID-19, stay-at-home orders, civil unrest and a marked increase in the percentage of Americans reporting behavioral health concerns. The pandemic has disrupted our professional and personal lives, as well as the lives of Vaya members, their families and our communities.

Throughout these challenges, we've been inspired by your perseverance, dedication and flexibility. Our Provider Network has responded in creative ways to social distancing requirements and leapt forward with advancements in telehealth services. At the same time, you've continued preparing for a new way of healthcare management as North Carolina moves forward with Medicaid Transformation and a commitment to whole-person health.

The work you do is critical for our communities, but it is not easy. Working together with you, alongside our Provider Advisory Council, we will continue to develop and expand a strong network of community-based services and supports. Together, we are making a positive impact on western North Carolina today and for generations to come.

As always, we remain grateful for your support. Thank you.

Brian Ingraham
CEO, Vaya Health

MISSION, VISION AND VALUES

MISSION

Who We Are

Vaya Health is a public manager of care for individuals facing challenges with mental illness, substance use and/or intellectual/developmental disabilities. Our goal is to successfully evolve in the healthcare system by embracing innovation, adapting to a changing environment and maximizing resources for the long-term benefit of the people and communities we serve.

VISION

What We're Building

Communities where people get the help they need to live the life they choose

VALUES

What We Believe In

Person-Centeredness
Interacting with compassion, cultural sensitivity, honesty and empathy

Integration
Caring for the whole person within the home and community of an individual's choice

Commitment
Partnering with members, families, providers and others to foster genuine, trusting, respectful relationships essential to creating the synergy and connections that make lives better

Integrity
Ensuring quality care and accountable financial stewardship through ethical, responsive, transparent and consistent leadership and business operations

WHAT'S INSIDE

SECTION 1
About Vaya Health

Congratulations on joining the Vaya Health Provider Network! Vaya developed this Provider Operations Manual to provide detailed information and technical assistance to Vaya Network Providers on all requirements of network participation. A Network Provider is an appropriately credentialed provider of mental health, intellectual and/or developmental disabilities or substance use disorder (MH/IDD/SUD) services who has a contract in effect for participation in the Vaya Closed Provider Network as set forth at 42 CFR § 438.2.

Network participation means that you are listed in the Vaya Network Directory and are eligible for referrals from Vaya. This does not include providers who are serving a member under an Out-of-Network (OON) Agreement. Participation is based on selection and retention criteria outlined in Section 2 of this Manual.

Throughout this manual, the term "provider" refers to an institution or organization that provides services for enrollees pursuant to a contract with Vaya, and the term "practitioner" refers to a licensed or certified professional who provides medical or behavioral healthcare services to enrollees.

This Manual and all requirements outlined within it are a binding part of your contract with Vaya and are incorporated by reference therein. Please read it carefully and make sure that your employees and contractors are familiar with the requirements. Note that information or procedures which pertain only to a particular funding source (e.g. Medicaid, federal Block Grants or state funds) are identified as such.

If unspecified, the information applies to all Vaya Network Providers regardless of funding source. Some information also applies to providers who signed an OON Agreement. All references to timeframes in this Manual refer to calendar days unless otherwise stated. A "business" or "working" day means Monday through Friday, 8:30 a.m. through 5 p.m., with the exception of any day recognized by Vaya as an official holiday, as well as any day Vaya is not open for administrative functions due to a weather-related event or other natural cause.

To provide suggestions or feedback about the information in this Manual, please call Vaya's Provider Network Department at 1-866-990-9712 or email us at Manuals@vayahealth.com. We look forward to hearing from you.

What is Vaya Health?

Vaya is a local political subdivision of the state of North Carolina and a Local Management Entity/ Managed Care Organization (LME/MCO) as that term is defined at N.C.G.S. § 122C-3(20c). We operated under the name Smoky Mountain Center for Mental Health, Developmental Disabilities and Substance Abuse Services since 1972 and changed our name to Vaya Health in September 2016.

We operate a Medicaid Prepaid Inpatient Health Plan (PIHP) on a capitated per-member per-month (PMPM) basis pursuant to a contract with the N.C. Department of Health and Human Services (DHHS), Division of Health Benefits

(DHB), and in accordance with the N.C. 1915(b)/(c) combined Medicaid Waiver (the "Waiver"). North Carolina's combined Medicaid Waiver includes a 1915(b) Service Delivery Waiver, known as the "MH/DD/SA Health Plan," and a 1915(c) Home and Community Based Services Waiver for persons with intellectual and/or developmental disabilities (IDD) who meet institutional level-of-care criteria, referred to as the "Innovations Waiver."

Vaya also receives state and federal Block Grant funding pursuant to a contract with the DHHS Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). Under our contracts with DHB and DMH/DD/SAS, we are responsible for the planning, development, implementation, management and monitoring/ oversight of all publicly-funded MH/IDD/SUD services in a 22-county catchment area composed of Alleghany, Alexander, Ashe, Avery, Buncombe, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Swain, Transylvania, Watauga, Wilkes and Yancey counties. This includes payment and reimbursement for services within available funding.

Currently, Vaya operates three different health benefit plans: (1) the MH/DD/SA Health Plan for Medicaid beneficiaries whose eligibility is based in Vaya's catchment area and need MH/IDD/SUD services, (2) the Innovations Waiver Health Plan for Innovations Waiver participants whose eligibility is based in Vaya's catchment area and (3) a Non-Medicaid Benefit Plan for persons who need MH/IDD/SUD services and meet financial and other eligibility criteria. The Non-

Medicaid Benefit Plan includes federal Block Grant funding, state MH/DD/SUD funding and funding from counties in our catchment area. Each benefit plan contains its own distinct set of services and eligibility criteria.

The State of North Carolina is in the process of implementing Medicaid Transformation, which will transition the current fee-for-service Medicaid and NC Health Choice programs to managed care plans known as "Standard Plans" (including commercial Prepaid Health Plans and Provider-Led Entities). Standard Plans are expected to go live starting in July 2021, at which time they will be responsible for managing the care for Medicaid enrollees with mild-to-moderate behavioral health conditions. Vaya will then transition to operate a "BH and I/DD Tailored Plan", which is designed for people with significant behavioral health and IDD needs as well as other special populations, including Traumatic Brain Injury (TBI) waiver enrollees. As a Tailored Plan, Vaya will ultimately be responsible for the entire continuum of care for this population — physical health, long-term services and supports, pharmacy, behavioral health, I/DD, traumatic brain injury, and healthy opportunities interventions, including both Medicaid and state-funded services.

For more information about Medicaid Transformation and Tailored Plans, refer to the DHHS website.

Vaya is accredited by URAC in the areas of Health Call Center, Health Network and Health Utilization Management. We are responsible for operating a 24/7/365 Call Center (the Vaya Access to Care Line) that provides screening, triage and referral services, as well as crisis intervention. We protect public funding through utilization management and utilization review, which ensure requested services are medically necessary, as well as claims adjudication and data mining, which guard against fraud, waste and abuse.

We ensure accessibility, availability and quality of MH/IDD/SUD services through our network development, credentialing, quality management and monitoring and investigation efforts. We also offer care coordination/ complex care management services to eligible members. This Manual describes your roles and responsibilities related to each of these functions.

The 1915(b)/(c) Medicaid Waiver Model

The N.C. Medicaid 1915(b)/(c) Waiver was approved by the federal Centers for Medicare & Medicaid Services (CMS) and is designed to:

- Better coordinate the system of care for individuals, families and providers
- Manage resources so that service dollars can be directed to those most in need
- Develop a more complete range of services and supports in the community so that more people can receive services in the home and community of their choice, with as little disruption to their lives as possible
- Create new services and programs by using the money generated from savings achieved by managing care and resources more effectively

The 1915(b) MH/DD/SA Health Plan Waiver

The N.C. MH/DD/SA Health Plan is a pre-paid inpatient health plan funded by Medicaid and authorized under Section 1915(b) of the Social Security Act. It allows North Carolina to manage MH/IDD/SUD services using alternatives to the traditional service delivery system. It is called a "waiver" because some requirements of the Social Security Act are waived. This waiver:

- Waives state-wideness: Allows North Carolina to implement behavioral health managed care plans in specific areas of the state, such as Vaya's catchment area

- Waives comparability of services: Lets North Carolina provide different benefits to people enrolled in the managed care system
- Waives freedom of choice: Allows Vaya to operate a Closed Network of providers and require members to choose from providers within that network, with some limited exceptions

The N.C. Innovations 1915(c) Waiver

The Innovations 1915(c) Waiver is a home and community-based services (HCBS) waiver for people with an IDD, regardless of age, who meet institutional level of care criteria. This waiver allows long-term care services to be provided in home and community-based settings instead of an institutional setting, such as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). The Innovations Waiver includes some non-medical services, such as home modification, which are not available under traditional Medicaid. HCBS waivers are designed to help keep people out of institutions and to promote independence, choice, community integration and the ability to realize life goals. To accomplish this, the Innovations Waiver incorporates self-direction, person-centered planning, individual budgets, participant protections (including monthly health and safety visits) and quality assurance to support the development of a strong continuum of services.

The number of people who participate in the Innovations Waiver is limited by CMS and by the availability of slots funded by the state of North Carolina. People who are potentially eligible for the Innovations Waiver may need to wait for funding to become available and are placed on the Registry of Unmet Needs. The Registry is a first-come, first-serve list, so Network Providers must work with families of children who are diagnosed with an IDD to place them on the Registry as soon as possible. For more information about the N.C. Innovations Waiver, please refer to Section 13 of this Manual.

Where is Vaya Located?

Vaya's administrative headquarters are centrally located in Buncombe County, with additional regional office locations accessible to providers, community stakeholders and members throughout our catchment area, including co-locations with county Health Departments, Departments of Social Services and Network Providers. We also support a large number of home-based employees to ensure a local presence in our communities. Addresses and phone numbers for our regional offices are listed below.

Please note that you do not need to dial the local number – all Vaya offices and staff can be reached toll-free by calling 1-800-893-6246.

BUNCOMBE COUNTY (ADMINISTRATIVE OFFICES)

200 Ridgefield Court, Suite 206, Asheville, NC 28806
Telephone: 828-225-2785
Facsimile: 828-412-4098

CALDWELL COUNTY

825 Wilkesboro Blvd. NE, Lenoir, NC 28645
Telephone: 828-225-2785
Facsimile: 828-412-4098

JACKSON COUNTY

128 Sylva Plaza, Sylva, NC 28779
Telephone: 828-225-2785
Facsimile: 828-412-4098

Governance and Administration

Vaya is governed by a Board of Directors appointed in accordance with N.C.G.S. Chapter 122C. Our Board includes six individuals with specific expertise consistent with the nature of managed care operations, a county commissioner representative, a member appointed by the DHHS Secretary, a hospital administrator, three members of our Consumer and Family Advisory Committee (CFAC), nine at-large members and the president of the Vaya Provider Advisory Council, who serves in a non-voting ex officio capacity. The Board provides broad oversight and policy direction for the organization and ensures that Vaya is accountable to community needs and local government. The Board actively and regularly reviews reports on finances, regulatory compliance, performance, quality, service utilization, member services, unmet local service needs, access to services and provider capacity.

Vaya's administrative structure includes the Chief Executive Officer (CEO), Executive Leadership Team (ELT), numerous committees and cross-functional teams (CFTs) and internal departments responsible for broad functional areas, including: Executive Administration, Business Integrity, Clinical Strategy (which includes Utilization Management), Claims and Reimbursement, Community Relations, Complex Care Management (previously known as Care Coordination), Finance, Human Resources, Legal, Management Information Services, Member Services, Network Performance & Integrity, Office of Communications and Provider Network Operations. Vaya's ELT includes the CEO, General Counsel and Chief Compliance Officer (CCO), Chief Medical Officer (CMO), Executive Vice President and Chief Information Officer (CIO), Executive Vice President and Chief Population Health Officer (CPHO) and the Executive Vice President and Chief Financial Officer (CFO), all of whom report directly to the CEO.

Information about Vaya Departments

BUSINESS INTEGRITY

The Business Integrity (BI) Department is responsible for DHHS relationship management, regulatory compliance, internal audits and investigations, organizational policy management, administration of state-mandated and internal surveys of members and providers, submission and analysis of Vaya performance data, provider reconsiderations, and oversight and management of accreditation compliance, organization-wide Quality Improvement Activities (QIA), and external reviews.

CLAIMS AND REIMBURSEMENT

The Claims and Reimbursement Department is responsible for claims adjudication, assisting providers with claims and billing questions, troubleshooting claims that pass out of the Vaya managed care information system ("MCIS") into NCTracks, and ensuring correct provider setup in both platforms to maintain adjudication percentages and meet state-mandated standards. This Department also enters and maintains member information in the MCIS utilizing provider updates, Global Eligibility File (GEF) downloads, interdepartmental coordination and comparisons between the MCIS and NCTracks.

CLINICAL STRATEGY

The Clinical Strategy Department is responsible for planning and executing population health management, integrated whole-person care strategies and the Vaya Total Care (VTC) complex care planning model. VTC is Vaya's model of Complex Care Management to support the overall health of qualifying members. VTC offers a team-based approach to integrated healthcare, using a customized software system supported by evidence-based or-informed workflows and clinical pathways to produce a unified care plan tailored to address members' full range of individualized needs effectively and efficiently, moving Vaya closer to achieving the Quadruple Aim of Healthcare. The Clinical Strategy Department also includes the Utilization Management team, which is responsible for URAC-accredited Health Utilization

Management functions, including prospective, concurrent and retrospective utilization review. UM evaluates the medical necessity, appropriateness and efficacy of requests for services against State Plan and Waiver requirements, benefit plan limitations and criteria, DHB Clinical Coverage Policies, DMH/DD/SAS Service Definitions and established Clinical Practice Guidelines. Member Appeals staff within the team provide written notification of UM decisions and oversees the member reconsideration review process, which includes an impartial review by a clinical peer who was not involved in the original decision. UM also conducts service utilization and trend analysis to guide organizational decision-making. For more information about the authorization process, see Section 6 of this Manual.

COMMUNITY RELATIONS

The Community Relations Department focuses on identifying, establishing and nurturing relationships with people and communities in the counties that Vaya serves, including local government representatives, county boards of commissioners, county managers and other county leaders. This Department also supports the operations of the County Commissioner Advisory Board (CCAB).

COMPLEX CARE MANAGEMENT

Complex Care Management (CCM) enhances traditional models of care coordination and equips members and their care teams with the resources they need to achieve better, more sustainable health outcomes. CCM is a set of activities delivered by Care Managers designed to more effectively assist eligible members and their caregivers in managing health conditions and co-occurring psychosocial factors. Eligible members include those identified through Vaya's contracts with DHB and DMH/DD/SAS and those identified internally as the Complex Care Population. The CCM Department is comprised of teams based in the communities they serve, and some are co-located in county departments of social services, health departments or provider agencies, with clinical support from Vaya's medical and pharmacy professionals. CCM is further described in section 9 of this manual.

FINANCE

The Finance Department is responsible for all finance and accounting functions, including but not limited to provider and vendor reimbursement, development of the annual budget and development of the annual service management plan, which allocates the federal Block Grant, state and county funds received by Vaya.

HUMAN RESOURCES

Human Resources (HR) is responsible for recruitment and retention, employee relations, compensation and benefits, workplace safety, facilities, wellness and organizational development. This includes credentialing all Vaya licensed staff and performing criminal background, driver history and exclusion checks for all new hires.

LEGAL

Under the direction of the General Counsel & Chief Compliance Officer, Vaya's team of legal professionals is responsible for contracting and procurement, dispute resolution, litigation and records management, and regularly provides advice and counsel to Vaya leadership and staff on a wide array of legal, compliance and risk issues confronting the organization. **However, they do not represent, and cannot provide legal advice to, Vaya Network Providers.**

MANAGEMENT INFORMATION SERVICES (MIS)

Under the direction of the CIO, the MIS Department is responsible for all aspects of research, development, operations and support for Vaya's network infrastructure, telecommunications and computer systems, including the electronic

authorization and claims processing system, which supports secure transmission of data via standard Electronic Data Interchange (EDI) formats. MIS also develops Vaya's contingency plan for back-up, disaster recovery and emergency operations and securely protects all sensitive electronic information, including Protected Health Information (PHI) maintained by Vaya. For questions related to the MCIS, please call 828-225-2785, ext. 1500, or email us at ServiceDesk@vayahealth.com.

MEMBER SERVICES

The Member Services Department is responsible for URAC-accredited Health Call Center functions and operates a 24/7/365 toll-free Access to Care Line (Call Center) for individuals who are in crisis or seeking access to services. The department also operates a Member Services Line, available from 8 a.m. to 5 p.m. Monday through Friday, for general inquiries and assistance. Member Service Clinicians perform screening and triage using uniform clinical decision support tools that measure acuity and make referrals to Network Providers in accordance with urgent, emergent and routine access and appointment standards established by DHHS, including referrals to mobile crisis management providers to appropriately divert from the ED. Member Services Representatives (MSRs) perform initial screening, make warm transfer calls to licensed clinicians when needed, answer general questions, provide information about MH/IDD/SUD resources and services and the Vaya Health Plan(s), document complaints and grievances and follow up on appointments and provider availability. For more information about Vaya's Access to Care Line, see Section 4 of this Manual. This department also includes the Member Engagement and Outreach Team, which engages members, caregivers, advocates, community partners and service providers and supports the operations of Vaya's Consumer and Family Advisory Committee (CFAC) and Innovations Stakeholders group.

NETWORK PERFORMANCE & INTEGRITY

Network Performance & Integrity (NPI) is responsible for ensuring the quality and integrity of Vaya's network providers through complaint investigations; health and safety investigations; focused monitoring; post-payment reviews; referral of suspected fraud to DHB and the Medicaid Investigations Division of the N.C. Department of Justice for potential civil and/or criminal investigation; resolution of complaints and grievances filed by members, providers and stakeholders; resolution of claims disputes; tracking, gathering follow-up information and coordinating the review of incidents filed by providers in the state's Incident Response Improvement System (IRIS); and site reviews. NPI also collaborates with providers by providing technical assistance and solutions for correcting out-of-compliance findings. For more information about audits, monitoring and investigations, see Section 16 of this Manual.

OFFICE OF COMMUNICATIONS

This department is responsible for public relations and internal and external communications, including Provider Communication Bulletins, as well as annual materials review, compliance with Medicaid marketing guidelines, coordination with broadcast, print, web-based and social media, development and content management of the Vaya website and other digital platforms, health literacy and educational outreach/ advertising initiatives, and public event planning.

PROVIDER NETWORK OPERATIONS

Provider Network Operations (PNO) is responsible for URAC-accredited Health Network functions, including network development, credentialing and network management. PNO recruits, selects and credentials/ re-credentials all participating providers to ensure high-quality services, fiscal sustainability, geographic accessibility and member choice, where required. PNO also designs innovative programs to create and enhance access to care and improve service availability and efficiency, including capitated and outcome-based payment models, ensures that the Vaya Provider Search Tool and Provider Directory are accurate and up-to-date, assists other departments in identifying available

providers to meet member needs and is chiefly responsible for the development and submission of Vaya's annual required Community Mental Health, Substance Use, and Developmental Disability Services, Network Adequacy and Accessibility Analysis report. Provider Relations staff offer technical assistance to participating providers through a dedicated, toll-free number and email account. For more information about credentialing, see Section 3 of this Manual.

Advisory Boards

Vaya has several advisory boards and subcommittees that provide input and recommendations to the governing board and executive leadership, including a Provider Advisory Council (PAC), as discussed below.

COUNTY COMMISSIONER ADVISORY BOARD

The County Commissioner Advisory Board (CCAB) serves as the chief advisory board to Vaya and the CEO on matters pertaining to the delivery of MH/IDD/SUD services within the catchment area and provides input on appointments to the Vaya Board of Directors. In accordance with N.C.G.S. § 122C-118.2, the CCAB consists of one county commissioner from each county in Vaya's catchment area. Members are designated by the boards of commissioners of each county. The individual who serves as the county commissioner member of the Vaya Board of Directors, in accordance with N.C.G.S. § 122C-118.1(b)(1), serves as chair of the CCAB. The CCAB serves in an advisory capacity only, and its duties do not include authority over Vaya budgeting, personnel matters, governance or policymaking.

CONSUMER AND FAMILY ADVISORY COMMITTEE

The Consumer and Family Advisory Committee (CFAC) consists of individuals and family members of individuals who receive MH/IDD/SUD services funded by Vaya. CFAC is a self-governing committee that helps ensure that people receiving services are involved in Vaya's oversight, planning and operational committees. Under state law, CFAC is responsible for the following functions:

- Review, comment on and monitor implementation of the local business plan
- Identify service gaps and underserved populations
- Make recommendations about the service array
- Review and comment on the Vaya annual budget
- Participate in Vaya's review of performance indicators and quality improvement measures
- Submit findings and recommendations to the state CFAC about ways to improve service delivery

The CFAC meets at least six times per year and fulfills the composition requirements of N.C.G.S. § 122C-170, with members representing all counties in Vaya's service area, as well as all three disability groups. The CFAC also has regional sub-groups that facilitate local planning for members and families, as well as cross-regional planning and implementation.

The Vaya Board of Directors and the CFAC work cooperatively in accordance with a mutually established relational agreement that addresses each group's roles and responsibilities and a method for conflict resolution. Vaya CFAC liaisons provide staff support and coordination of information between Vaya, CFAC and the board. CFAC members serve on several Vaya committees, and three CFAC members also serve as voting members of the Vaya Board of Directors.

For more information about the Vaya CFAC, email CFAC@vayahealth.com or refer to the CFAC page on our website at www.vayahealth.com.

HUMAN RIGHTS COMMITTEE

The Human Rights Committee (HRC) is a subcommittee of the full governing Vaya Board of Directors and is responsible for monitoring Vaya's compliance with federal and state laws, rules and regulations regarding client rights and confidentiality; ensuring implementation of the Cultural Competency Plan and related issues; and reviewing and monitoring trends related to restrictive interventions, abuse, neglect and exploitation, as well as member deaths and medication errors. The HRC complies with N.C.G.S. § 122C-64 and 10A NCAC 27G.0504 and consists of a majority of people who receive services and their family members, along with expert advisors, community members and stakeholders, who meet at least quarterly.

The HRC reports to the Board of Directors, which is ultimately responsible for the assurance of member rights.

Provider Advisory Council

As a Network Provider, you can participate in Vaya's Provider Advisory Council (PAC), which serves as an advisory body to Vaya on issues affecting Network Providers. The PAC operates pursuant to a set of bylaws and is a self-governing committee. Voting members of the PAC are nominated and put up for vote in a manner that ensures representation from a broad cross-section of provider types serving all three service areas. While there are a set number of voting member seats on the PAC, all Network Providers are encouraged to attend the monthly PAC meetings.

Members of the PAC serve as fair and impartial representatives of all Network Providers for the purpose of advocacy, support and communication. The PAC is designed to facilitate an open exchange of ideas, shared values, goals and visions and to bring forward concerns and solutions while promoting collaboration, ethical operations, mutual accountability and quality services.

The objectives for the PAC include, but are not limited to:

1. Fostering partnerships with Vaya to address issues affecting the MH/IDD/SUD public service system
2. Recommending and supporting the provision of best practices to empower members within Vaya's catchment area to achieve their personal goals
3. Fostering communication and collaboration between Network Providers to improve member care
4. Providing input and recommendations to Vaya about clinical and provider payment policies, selection and retention criteria, dispute resolution mechanisms, the Provider Operations Manual and other guidelines and requirements that directly impact Network Providers
5. Assisting in the dissemination of statewide Provider Satisfaction and Member Perception of Care surveys, providing input in the development of Vaya surveys and making recommendations to improve survey participation and the perception of care in the community
6. Reviewing the results of surveys and the annual Network Adequacy and Accessibility Analysis, advising Vaya in continued network development, and developing and making recommendations for service delivery models and gaps in services
7. Addressing strategies regarding funding and financial issues and providing feedback about network development initiatives, funding priorities and opportunities, as well as Requests for Proposal (RFPs), Requests for Information (RFIs) and other procurement initiatives
8. Assisting in the development of global and individual provider performance outcomes, making recommendations for network quality management practices and advising Vaya regarding service trends, quality improvement plans, utilization and performance measures and provider quality and outcome indicators
9. Providing feedback to Vaya about provider and community education, technical assistance and training needs

10. Identifying members to participate in designated Vaya committees and PAC subcommittees that address initiatives such as quality improvement, credentialing, clinical practices, finance/claims, integrated care, training, bylaws, ethics, cultural competency, network development, claims processing, and this Manual.

Code of Ethics

Vaya requires all employees and contractors to practice honesty, directness and integrity in dealings with one another, business partners, the public, the business community, internal and external stakeholders, members, suppliers, elected officials and government authorities.

To further this requirement, the PAC developed a Code of Ethics that is incorporated into this Manual as Appendix A. All Network Providers are required to comply with the Code as a condition of network participation. Any alleged violation of the Code should first be discussed with the Network Provider. If the issue cannot be resolved informally, allegations of ethics violations may be presented to the PAC and considered in a closed session. The PAC may refer Network Providers alleged to be in violation of the Code of Ethics to Vaya for investigation and potential adverse action.

Stakeholder and Community Involvement

Vaya hosts a variety of committees, open meetings and forums to ensure engagement of members, families, advocates, Network Providers and community stakeholders. Network Providers participate as members of Vaya's Quality Improvement, Credentialing and Clinical Advisory committees and provide important feedback to Vaya concerning performance and clinical practices. Please remember to regularly check Vaya's Calendar of Events on our website for upcoming forums, meetings, trainings and other events.

Vaya also maintains collaborative working relationships with a variety of community stakeholder and human service agencies within the catchment area to assess what services are working or needed and to ensure integration of care to support members who are involved with multiple agencies. These organizations include, but are not limited to, county departments of Social Services, local health departments, Federally Qualified Health Centers (FQHCs), community hospitals and regional health systems, public schools, law enforcement, courts, Juvenile Court counselors, the National Alliance on Mental Illness (NAMI), Community Care of North Carolina (CCNC), Area Health Education Centers (including the Mountain Area Health Education Center, known as MAHEC, the Northwest Area Health Education Center, known as NW AHEC) and primary care providers.

For more information about participating in a Vaya committee or providing feedback about Vaya's performance or policies, please contact the PNO Department at 1-866-990-9712 or at provider.info@vayahealth.com.

Provider Communications, Training and Technical Assistance

Vaya is committed to ongoing communication with Network Providers through a variety of mechanisms to provide updates about network activities, training opportunities, request(s) for proposal and other procurement mechanisms, opportunities for collaboration, changes in the NC Medicaid fee schedule and/or Vaya reimbursement rates, provider dispute resolution mechanisms, information about Vaya benefit plans and changes to contracting provisions or this Manual, as well as any changes to federal or state laws, rules, regulations, policies or guidelines affecting service delivery.

Vaya requires all Network Providers to remain up to date on relevant information and changes communicated by the DHB and DMH/DD/SAS through the following links on the DHHS website:

- Joint DHB and DMH/DD/SAS Communication Bulletins: https://www.ncdhhs.gov/divisions/mhddsas/joint-communication-bulletins. These bulletins supersede the previous joint DHB and DMH/DD/SAS Implementation Updates and the previous DMH/DD/SAS Communication Bulletins.
- NC Medicaid Bulletins available at https://dma.ncdhhs.gov/providers/medicaid-bulletins
- DHB Clinical Coverage Policies available at https://dma.ncdhhs.gov/providers/clinical-coverage-policies

Network Providers must keep abreast of changes in laws, rules, regulations or policies affecting the delivery of publicly funded MH/IDD/SUD services, attend workshops and trainings to maintain clinical skills and/or licensure, be knowledgeable on evidence-based or emerging best practices and be current on coding and reimbursement standards. Vaya provides resources to assist you in meeting this requirement.

We will communicate information regarding workshops in a variety of ways and will offer trainings or technical assistance as needed. You should regularly check our online Calendar of Events for upcoming trainings at www.vayahealth.com.

Vaya can also provide technical assistance related to requirements of the Vaya provider agreement, this Manual, and of DHHS and other oversight authorities. This may include topics such as authorization processes, claims, billing and reimbursement, the development of appropriate clinical services, and quality improvement initiatives, but not on issues that are generally considered standard operational activities in the healthcare industry. We can also link you to national or state resources for technical assistance. However, we are not required to provide repeated technical assistance to Network Providers that have demonstrated they are unable to assimilate previous help from Vaya.

Vaya maintains a section on our website that includes helpful information specifically targeted to Network Providers. Additionally, Vaya disseminates critical and/or time-sensitive information, including changes in policy or requirements that impact Network Providers, through official Vaya Communication Bulletins delivered free of charge to your designated email through Constant Contact. All Network Providers are required to subscribe to Vaya Provider Communication Bulletins and must adhere to any changes communicated in these bulletins as of the effective dates indicated. Please make sure to visit the Vaya website to join the Provider Communication Bulletin email list at https://providers.vayahealth.com/.

We will strive to keep our communications meaningful, targeted and on point to avoid “information overload.” However, failing to read Vaya Provider Communication Bulletins is not a valid excuse for non-compliance with requirements. Network Providers are required to be aware of changes that affect delivery of publicly funded MH/IDD/SUD services. There are several ways to do that:

- Read all written communications sent to you by Vaya.
- Keep apprised of current information regarding service provision through communication bulletins offered by Vaya, other LME/MCOs (if applicable), DHHS, DHB and DMH/DD/SAS.
- Review the Vaya, DHHS, DHB and DMH/DD/SAS websites for updates on a regular basis.
- Ensure that your employees and contractors are informed of new and/or changing information as it relates to their functions.
- Join national and state provider advocacy organizations to learn more about best practices.
- Attend Vaya’s governing Board of Directors, CCAB, HRC, CFAC or Innovations Stakeholders meetings.
- Attend and participate in PAC meetings and other provider forums hosted by Vaya to learn from and about other Network Providers and share suggestions and guidance on how to improve the MH/IDD/SUD system of care.
- Participate in provider trainings offered by Vaya, DHHS and other organizations.

- Invite Vaya staff to meet with you, your staff or your governing board as needed to clarify issues or provide technical assistance.
- For more information, call the PNO Department at 1-866-990-9712 or contact us via email at provider.info@vayahealth.com. Our goal is to respond to all inquiries within one business day.

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SECTION 2
Network Participation

Policy Statement

Vaya's policy is to develop and maintain a sufficient network of high-quality service providers that meets member and community needs within available resources. However, participation in the Vaya Closed Provider Network is a privilege, not a right. Vaya established and implements a fair, impartial, objective and consistent process for the enrollment and re-enrollment of service providers in the Vaya Closed Network that complies with applicable federal and state laws, rules and regulations and the requirements of our DHB Waiver Contract.

Background

When Vaya began 1915(b)/(c) Medicaid Waiver operations in July 2012, providers of MH/IDD/SUD services who submitted a timely application, met Vaya credentialing criteria, were in good standing with DHHS and had billed for services delivered to Vaya members in the 60 days prior to their application were offered a contract for participation in the Vaya Closed Provider Network. On October 1, 2013, the Vaya and Western Highlands Network (WHN) catchment areas were consolidated, and providers enrolled and in good standing with WHN were offered contracts with Vaya. Both are referred to as "open enrollment" periods. Subsequent provider contract extensions or renewals and new applications for participation in the Vaya Closed Network are subject to Vaya's selection and retention criteria and credentialing and re-credentialing requirements.

Federal regulations require Vaya to maintain a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Medicaid enrollees served by Vaya. When the Waiver was approved, CMS exempted North Carolina from complying with the provider "freedom of choice" requirements under the Social Security Act. This waiver is balanced by Vaya's responsibility to ensure accessibility of services. DHHS monitors the adequacy of our network through the annual Network Adequacy and Accessibility Analysis.

Most services will be available within 30-45 miles or 30-45 minutes driving time. There is a walk-in center location in every county. However, because of insufficient demand and economy of scale factors, some specialty providers may be located outside this radius, or there may only be one provider available to deliver the needed service. The annual Network Adequacy and Accessibility Analysis report evaluates the ability of Network Providers to meet the needs of our members and measures geographic access to service locations. We are not required to contract with providers beyond the number necessary to meet the overall service needs of our members.

There is no right under federal or state law for any provider to participate in our Closed Provider Network. The only exceptions are for emergency services or when there is no Network Provider available to provide medically necessary covered services to a particular individual. In fact, the DHB Waiver Contract explicitly states that Vaya "shall have the authority to operate a Closed Network and shall not be required to review the qualifications and credentials of Providers that wish to become Network Members if the Network has sufficient numbers of Providers with the same or similar qualifications and credentials to provide adequate access to all services covered under this Contract in accordance with

42 CFR 438.206." The contract also states that we "have the sole discretion to determine provider participation in the PIHP Closed Network, including determinations regarding contract renewal and procurement, subject to the requirements of this Contract and Federal regulations."

This means that we are authorized to develop and implement our own provider network model. Vaya developed a Comprehensive Care Center model that is designed to promote quality services, maximize public resources, reduce fragmentation and ensure the clinical and financial viability of providers in the Closed Network. This model is embedded in our Network Development Plan. Ultimately, Vaya's goal is to achieve integrated, collaborative care across our network, develop provider expertise in evidence-based and best practices and establish data-driven outcome and performance measures to ensure that the system is meeting the needs of the individuals we serve.

Vaya department representatives meet at least annually to develop recommendations about renewals of existing contracts from a cross-functional perspective. Decisions about contract renewals are made in accordance with the written selection and retention criteria as required by 42 CFR § 438.214. Please read them carefully.

Vaya's Closed Network includes providers who use evidence-based and best practices, practice a commitment to high-quality care and treatment that improves member outcomes, adhere to ethical and responsible practices, robustly protect member rights and meet Vaya's business, operational and network development needs. Vaya is committed to the achievement of positive outcomes for members, as well as member satisfaction. We depend on our Network Providers to offer high-quality services and demonstrate accountability for the wellbeing of Vaya Health Plan members.

Network Access Plan

The annual Network Adequacy and Accessibility Analysis report includes objective measures, such as geo-mapping to help us analyze service access and availability throughout the catchment area, as well as input from member, family, provider and stakeholder surveys. As part of the Network Adequacy and Accessibility Analysis, Vaya maintains an ongoing Network Access Plan, which outlines Vaya's strategies for addressing service and program development needs and will always reflect our commitment to flexible, accessible, person-centered services that honor the dignity, respect the rights and maximize the potential of the individual.

Non-Discrimination Statement

Title VI of the Civil Rights Act of 1964 mandates that no person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of or be subjected to discrimination under any program or activity receiving federal financial assistance. This includes the Medicaid program and programs funded with federal Block Grant dollars.

Vaya does not discriminate on the basis of any protected classification or characteristic, including, but not limited to, race, color, creed, religion, ancestry, sex, gender identity, sexual orientation, ethnic or national origin, age, disability, handicap, genetic information, health status/need for health services, or veterans', marital, parental or other protected status, in compliance with laws that prohibit discrimination, including, but not limited to, Title VI of the Civil Rights Act 42 U.S.C. 2000d and regulations issued pursuant thereto; the Americans with Disabilities Act, 42 U.S.C. 12101 et seq., and regulations issued pursuant thereto; Title IX of the Education Amendments of 1972 and regulations issued pursuant thereto; The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et. seq., and regulations issued pursuant thereto; and the Rehabilitation Act of 1974, as amended, 29 U.S.C. 794 and regulations issued pursuant thereto. Vaya also does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment or based on practitioner or facility license or certification type. This applies to all aspects of network

participation, including, but not limited to, selection and retention, credentialing and re-credentialing, contracting, audits, monitoring and investigations, adverse actions and dispute resolution.

Furthermore, Vaya does not permit Network Providers to discriminate on the basis of any protected classification or characteristic, including, but not limited to, race, color, creed, religion, ancestry, sex, gender identity, sexual orientation, ethnic or national origin, age, disability, handicap, genetic information, health status/need for health services, or veterans', marital, parental or other protected status. It is a violation of your contract to engage in unlawful discrimination or harassment of any kind related to hiring or employment practices or the provision of services. This includes your interactions with Vaya staff members.

Good Standing

All applicants and providers must be in good standing to be considered for initial enrollment or contract renewal. Good standing will be verified as part of the credentialing, re-credentialing and/or contract renewal processes as described in Section 3 of this Manual. **We consider a provider to be in good standing if all the following criteria are met:**

- The individual or entity and any owners, directors and managing employees are not excluded from participation in any federal health care program.
- The individual or entity and any owners, directors and managing employees have no relevant criminal history findings (see Section 3 of this Manual for more information about the types of offenses that are flagged for review).
- The individual or entity and any owners, directors and managing employees did not previously own, operate or manage any provider entity that had its participation in any state's Medicaid program, the N.C. Health Choice program, the Medicare program or another Medicaid managed care program involuntarily terminated for any reason.
- The individual or entity and any owners, directors and managing employees did not previously own, operate or manage any provider entity that owes an outstanding overpayment to U.S. HHS, DHHS, Vaya or another LME/MCO.
- There are no current N.C. Health Choice, Medicare or Medicaid fines or sanction(s) in effect against the individual or entity by CMS or its contractors, or any state Medicaid agency, including, but not limited to, contract termination or suspension, referral suspension, payment suspension, moratorium, placement on prepayment review or similar actions.
- The individual or entity has an acceptable professional liability history, defined as no history of liability claims for the last five years. An unacceptable liability history is defined as: within the five-year period immediately preceding the date of application, one or more legal actions resulted in: (1) at least one judgment; (2) one settlement in an amount of $50,000 or more; or (3) two or more settlements in an aggregate amount of $50,000 or more.
- The individual or entity does not owe any outstanding payments, fees or documentation to any of the federal or state oversight authorities listed below, including, but not limited to, outstanding tax or payroll liabilities:
    - U.S. Department of Health and Human Services or any of its divisions
    - N.C. Department of Health and Human Services or any of its divisions
    - N.C. Secretary of State (if organized as a corporation, partnership or limited liability company)
    - U.S. Internal Revenue Service (IRS)
- No negative or questionable findings are identified for the individual or entity in any of the following databases/ oversight authorities:
    - U.S. HHS Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE)
    - U.S. System for Award Management (SAM) consolidated excluded parties list
    - N.C. DHHS Program Integrity Exclusion List
    - N.C. Division of Health Service Regulation (DHSR) Health Care Personnel Registry (HCPR)
    - NCTracks and/or National Plan & Provider Enumeration System (NPPES)

  - National Practitioner Data Bank (NPBD/HPDB)
  - National Technical Information Service for DEA certificates
  - Social Security Death Master File
  - DHB Program Integrity Database/ State Exclusion List
  - National Accrediting Boards (e.g. CARF, Joint Commission on Accreditation of Hospitals)
  - Boards of Licensure or Certification for the applicable Scope of Practice
- The individual or entity is not currently subject to any of the following sanctions or administrative actions issued by Vaya, state or local regulatory agencies or has not been subject to any such sanctions or administrative actions within the twelve (12) months prior to the application or thirty six (36) months for a renewal decision:
  - Vaya or other LME/MCO: Contract Termination or Suspension, Suspension of Referrals, Unresolved Plan of Correction (POC), Outstanding Overpayment, Prepayment Review, Payment Suspension
  - DHB: Contract Termination or Suspension, Payment Suspension Prepayment Review, Outstanding Final Overpayment
  - DMH/DD/SAS: Revocation of Authority to Receive Public Funds, Unresolved POC
  - DHSR: Unresolved Type A or B penalty under Article 3, Active Suspension of Admissions, Active Summary Suspension, Active Notice of Revocation or Revocation in Effect
  - N.C. Secretary of State: Administrative Dissolution, Revocation of Authority, Notice of Grounds for other reason, Revenue Suspension

For purposes of this Manual, “unresolved POC” means the provider failed to submit or implement a POC in response to a Report of Findings within the designated timeframe identified in the DMH/DD/SAS Policy and Procedure for the Review, Approval and Follow-Up of Plans of Correction, effective December 2008. For purposes of this Manual, “outstanding” means the provider failed to remit an identified overpayment or enter into an approved payment plan within the designated timeframe identified in the Notice of Overpayment.

Vaya considers an action against a provider to be final upon notification to the provider, unless the provider timely requested a reconsideration review, in which case Vaya considers the action final upon issuance of a decision by a reconsideration panel. Vaya is not required to enroll an applicant in the Vaya Closed Network or renew a Network Contract if the individual or entity has an LME/MCO sanction pending in any administrative or judicial form, including but not limited to OAH.

Vaya considers an action of DHHS or its Divisions to be final upon notification to the provider, unless the provider timely requested a reconsideration review or administrative hearing, in which case Vaya considers the action final upon issuance of a decision by the DHHS Hearing Office or OAH as applicable. Vaya is not required to enroll an applicant in the Vaya Closed Network or renew a Network Contract if the individual or entity has a DHHS sanction pending in any administrative or judicial form, including but not limited to OAH.

Vaya reserves the right to make exceptions to the good standing criteria as needed to ensure appropriate availability and accessibility of services to members.

Accessibility and Cultural Competence

An important prerequisite to network participation is the development of a Cultural Competency Plan (CCP) that includes education regarding accessibility and support services. Vaya developed a CCP and requires Network Providers to develop and implement a CCP that is respectful and supportive of the cultural and diverse needs of members, families, stakeholders, communities and other agencies. Cultural competency is a guiding principle that must be

incorporated into your mission and values and reflected in your decisions, policies, clinical protocols and established benchmarks and outcome measures. We require Network Providers to practice person-centered thinking in every aspect of service delivery to achieve cultural competence. You will be successful in achieving a culturally competent organization when the skills and abilities needed for cultural competence become a priority at every level of the organization, including leadership and your Board of Directors (if applicable).

Providers must develop and implement strategies for addressing the special needs of the Medicaid population and to increase awareness and sensitivity to the needs of persons who may be disadvantaged by low income, disability and/or illiteracy, or who may be non-English speaking. Training shall include topics such as sensitivity to different cultures and beliefs, the use of bilingual interpreters, the use of Relay Video Conference Captioning, Relay NC, TTY machines, and other communication devices for the disabled, overcoming barriers to accessing medical care, understanding the role of substandard housing, poor diet, and lack of telephone or transportation for health care needs.

Providers must provide members with verbal and written information concerning resources for transportation offered by the Medicaid Program and available in the county as well as referrals to available community services and supports. Providers must also ensure that interpreter services are made available by telephone or in-person at no charge to the member or to Vaya. A provider may submit an enhanced rate request if the interpretation or other special needs of the member imposes a cost burden on the provider, but Vaya does not guarantee approval of any particular rate enhancement request.

To develop cultural competence, individual practitioners, organizations and staff members must examine their own practices, potential barriers to services and the importance of including family and community. Family is defined specifically by each culture but is typically the primary individual or group that provides a system of support to the member. Cultural competence, including person-centered thinking, extends to the community and includes natural and informal supports in the development of services. As reflected in person-centered thinking, members, families and natural supports should participate in decisions around the member's care, to the greatest extent possible and in accordance with clinical appropriateness and confidentiality requirements.

You must work to understand the social, linguistic, ethnic and behavioral characteristics of the communities and populations you serve and systematically translate that knowledge into practices in the delivery of MH/IDD/SUD services. Relationships should be collaborative in nature and should view communities as partners. You can demonstrate your cultural competence in the following ways:

INDIVIDUALLY

- Examine one's own background and acknowledge cultural biases.
- Become educated about other cultural beliefs.
- Be open to and seek exposure to different cultural events.
- Be an active listener.
- Meet the individual where they are; do not judge.
- Acknowledge that discrimination is often a result of fear.

ORGANIZATIONALLY

- Identify and adopt appropriate cultural diagnostic tools and train staff on their utilization.
- Advertise position openings in markets where minorities are exposed to the ads.
- Evaluate outreach and marketing strategies to ensure targeted communities and populations are reached.
- Practice inclusiveness.

- Acknowledge the interactive dynamics of cultural differences.
- Continuously expand cultural knowledge and resources with regard to populations served.
- Collaborate with the community regarding service provision and delivery.
- Commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.
- Earnestly participate in initiatives to achieve cultural competence.
- Pursue the acquisition of knowledge relative to cultural competence and the provision of services in a culturally competent manner.
- Recognize and work to reduce potential barriers to treatment:
    - Stigma associated with receiving services
    - Distrust of the system
    - Perceived lack of confidentiality
    - Services not located in the community where they are needed
    - Lack of transportation
    - Poverty
    - Language
    - Fear, of discrimination or otherwise
    - Family or community shame
    - Lack of providers with a culturally appropriate or diverse staffing base

Network Providers are required to complete a Cultural Competence Self-Assessment Tool annually. Areas to be assessed include:

- Staff composition
- Physical environment
- Written materials
- Website
- Phone system
- Policies and procedures
- Training program
- Communication of the program

Identification of Service Needs

Vaya is not currently accepting applications for new enrollment unless we identify a specific service need that cannot be addressed by our network of providers. **This includes applications from currently credentialed practitioners who are interested in leaving their contracted employer and starting an independent practice.** If a specific service need is identified and approved as the result of the Network Adequacy and Accessibility Analysis or based on an internal review, Vaya may seek to add providers through a variety of means, including, but not limited to, direct provider contact, solicitation of applications via the weekly bulletin or website posting or development of a procurement process for selection of an appropriate provider.

Vaya is committed to ensuring the fiscal stability of its contracted Network Providers and will only consider applications from new applicants for MH/IDD/SUD services if service capacity is not met, i.e., there is a demonstrated community or member service need. If Vaya identifies a specific need for a provider type, specialty or location, we will post a notification to our website. Providers seeking to enroll in the Vaya Closed Network for the first time, or Network

Providers seeking to add a site or service to a Network Contract, should check the Vaya website regularly for this information.

If we cannot identify an existing Network Provider to meet a specific member need, then we will seek to recruit new provider(s) or enter into an Out-of-Network contract. If Vaya elects to pursue a formal procurement process, applicants must follow all steps identified in the applicable Request for Proposal (RFP) or Request for Information (RFI).

Otherwise, the first step is for the applicant to complete and submit a Provider Nomination Form, available on our website. If the nomination is approved, the provider will be sent an application for credentialing and enrollment that will include detailed instructions and timelines for completion.

Selection (Enrollment) Criteria

For a nomination to be approved, the applicant must meet all the following criteria as determined by Vaya, as applicable to the provider type. We specifically reserve the right to conduct an on-site review at any time to confirm provider compliance with these criteria and further reserve the right to reject any applicant or provider who does not meet these criteria as determined by Vaya:

1. There must be a need for the service the applicant is seeking to provide.
2. The applicant must meet all Vaya credentialing and/or re-credentialing requirements.
3. The applicant must be in good standing as outlined above.
4. The applicant must provide truthful and accurate information during the selection process, including in the enrollment, credentialing and/or re-credentialing application and process.
5. The applicant must adhere to evidence-based or best practices where applicable and provide culturally competent services.
6. The applicant must demonstrate efforts to implement a customer service system that ensures good communication with members and families.
7. The applicant must have a “no-reject” policy for referrals.
8. The applicant must have a robust Compliance Plan and Quality Management Plan with evidence of implementation of strategies and goals.
9. The applicant must have adequate clinical leadership according to the disability and services being provided with a sufficient supervision structure.
10. With limited exceptions, all applicants must have a HIPAA-compliant Electronic Health Record (EHR) system that supports management of authorizations and billing functions. EHRs must be capable of sending HL7 messages (versions 2 or higher) in order to communicate with the N.C. Health Information Exchange (HIE), called NC HealthConnex. Vaya prefers applicants who demonstrate compliance with the Federal Meaningful Use Standards and who can comply with clinical reporting requests.
11. The applicant must demonstrate fiscal stability, based on the most recent annual audit or other financial indicators, and defined as having: (1) a minimum of one month’s working capital or line of credit equal to the applicant’s monthly gross income or revenue; and (2) no tax liens.
12. The applicant must have the business operations and information technology infrastructure in place necessary to meet all clinical, quality improvement, billing and confidentiality standards required for providers of publicly funded healthcare services, including, but not limited to, infrastructure necessary to monitor all financial information of the company, such as debt-to-income ratio.

Network Provider Enrollment and Change Requests

Network Providers seeking to add a site or service to a Network Contract must be in good standing. The first step is to complete and submit a Provider Nomination Form, available on our website. If a need for the additional site or service has not been identified, Vaya may reject the request or may gather information related to service capacity and needs and present the request to leadership for consideration. If the nomination is approved, the Network Provider will be informed.

Network Providers may enroll additional licensed practitioners without submitting an application to add a new site or service so long as the additional licensed practitioners will be working out of existing site locations contracted with Vaya. All licensed practitioners are required to submit an application for credentialing as outlined in Section 3 of this Manual.

Existing Network Providers of Innovations Waiver services seeking to add an additional Innovations Waiver service to their contract to serve a specific participant must be in good standing. The first step is for the provider to complete and submit the Provider Nomination Form. Determinations on such requests are based, in part, on information about whether the additional Waiver service is necessary to meet a specific need. If the request is for a residential service that requires additional credentialing, it will be forwarded to the Credentialing Team to start the credentialing process. DHB guidelines require that all new applicants seeking to provide Innovations Waiver services must be nationally accredited in IDD service provision and meet all Home and Community Based Services (HCBS) requirements.

Retention (Renewal) Criteria

Vaya may choose to renew a contract in whole (all sites and services), or in part, and will strive to communicate renewal decisions to affected Network Providers at least 30 days prior to the contract end date, unless non-renewal is recommended based on fraud, waste, abuse or quality-of-care concerns, in which case the timeframe may be reduced. If the contract is not renewed, the Network Provider must cooperate with Vaya's efforts to safely and appropriately transition members to other providers in the Closed Network and must ensure that all medical records are stored, maintained and shared in accordance with federal and state laws, rules, regulations, policies, retention schedules and manuals, as well as this Manual.

In general, Vaya's policy is to renew Network Contracts unless one of the following applies: (1) renewal does not support the Comprehensive Care Center model as determined by Vaya; (2) renewal is not supported by the Network Adequacy and Accessibility Analysis, Network Access Plan or a detailed Market Analysis as determined by Vaya; (3) public funds to support the service are not available (for example, reduction in state or local funding); (4) there is excess capacity for any of the services offered by the Network Provider as determined by Vaya; (5) Vaya issued an RFP or RFI for the service(s) delivered by the Network Provider; or (6) the Network Provider meets any of the conditions outlined below, as determined by Vaya:

- The Network Provider is in breach of any provision of its current contract with Vaya, including, but not limited to, a failure to comply with Controlling Authority and any applicable Scope of Work. Contract requirements reviewed may include, but are not limited to:
    - Provision of services in accordance with all applicable state and federal laws, rules, regulations, the N.C. State Plan for Medical Assistance, the Waiver, State Service Definitions and/or Clinical Coverage Policies
    - Meeting all medical necessity and documentation requirements as set forth in Medicaid Clinical Coverage Policies, Non-Medicaid Service Definitions and/or the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2

  - Cooperation and participation with all Vaya network integrity activities (including, but not limited to, audits, investigations and post-payment reviews), as well as Vaya process for utilization review/management, quality management, incident reporting and member appeals and grievances
- The Network Provider has not billed for services in the 60 days prior to Vaya's review of the contract renewal, unless it concerns a provider of specialty or out-of-catchment area services that are delivered infrequently.
- The Network Provider is not in good standing as defined in this Manual.
- Vaya, DHB or CMS determines that the Network Provider falsified information provided on documentation submitted for re-credentialing, screening or enrollment in the Vaya Closed Network or NC Medicaid.
- Vaya issued three or more Plans of Correction against the Network Provider for the same or similar out-of-compliance findings, for example, three findings related to lack of training (even if it referred to different trainings), within a six-month period.
- Vaya identified quality-of-care concerns, Level II or III incidents or other serious grievances about the Network Provider that were not satisfactorily resolved in required timelines.
- The Network Provider has a consistent and high volume of claim denials despite technical assistance or training offered and/or provided by Vaya.
- The Network Provider did not respond (or did not timely respond) to requests for data or other information necessary for Vaya to respond to requests from the state or CMS.
- The Network Provider fails to maintain and provide proof of insurance as required under the terms and conditions of the contract.
- The Network Provider fails to attain an 85 percent or higher Routine Post Payment Review (RPPR) score.
- The Network Provider routinely fails to satisfactorily complete and upload Service Authorization Requests (SARs) that meet Vaya UM requirements (i.e., a high percentage of administrative denials proportional to the numbers of members served; generally, anything higher than 10 percent is unacceptable).
- The Network Provider routinely fails to submit requests for SARs for continuation of currently authorized services at least 14 days prior to end of existing authorization – at least 75 percent of SARs must meet this standard.
- The Network Provider failed to implement an adequate emergency response system that complies with the requirements of contracted services, including the implementation of measures to respond to emergencies on weekends and evenings for members served by the Network Provider.
- The Network Provider routinely fails to meet DMH/DD/SAS access standards and appointment wait times or fails to comply with the no-reject policy for members referred by Vaya.
- The Network Provider did not meet or is unable to meet all re-credentialing requirements, including a failure to maintain any required facility or professional license.
- The Network Provider failed to cooperate and comply with discharge and transfer requirements to ensure a smooth transfer for any member that desires to change providers or because the Network Provider cannot meet his or her special needs.

Other factors that Vaya may consider as part of the retention and renewal process include:

- Efforts to satisfactorily implement an acceptable Cultural Competency Plan, including efforts to provide culturally competent services and ensure the cultural sensitivity of staff members
- Efforts to achieve evidence-based or best practice in applicable areas of service, including the responsibilities associated with clinical and/or medical homes
- Member service and health literacy efforts to implement a system that ensures good communication with members and families
- Evidence of cooperation with, and level of participation in, member and provider satisfaction surveys

- Implementation of a robust Corporate Compliance Plan and Quality Management Plan with evidence of strategies and goals being implemented by the Network Provider
- Evidence of adequate clinical leadership according to the disability and services being provided by the Network Provider with a sufficient supervision structure
- Efforts to implement a HIPAA-compliant Electronic Health Record (EHR) system that supports management of authorizations and billing functions. EHRs must be capable of sending HL7 messages (versions 2 or higher) in order to communicate with the N.C. Health Information Exchange (HIE), called NC HealthConnex. Vaya prefers Network Providers who demonstrate compliance with the Federal Meaningful Use Standards and who can comply with clinical reporting requests.
- Demonstrated financial stability defined as having: (1) a minimum of one month's working capital or line of credit equal to the Network Provider's monthly gross income; and (2) no tax liens
- Demonstrated operations and information technology infrastructure in place necessary to meet all clinical, quality improvement, billing and confidentiality standards required for providers of publicly funded healthcare services, including, but not limited to, infrastructure necessary to monitor all financial information of the company, such as debt to income ratio

Vaya specifically reserves the right not to renew a contract with a Network Provider, for any reason, or to reduce or limit the contracted services for a Network Provider in subsequent contract terms.

SECTION 3

Credentialing and Contracting

Introduction

Credentialing is a process of primary and secondary source verification of licensure and other credentials to determine if a provider of MH/IDD/SUD services meets minimum criteria for participation in our Closed Network. Our policy is to implement standardized credentialing, re-credentialing and contracting processes in a manner that ensures internal consistency, as well as security of Sensitive Information submitted by providers. The process includes a review of licensure, education, sanctions, exclusions, criminal and liability history, insurance and other relevant documents and information (including an initial and re-credentialing site review). New providers and licensed independent practitioners are only invited to submit a credentialing application if it is determined they meet Vaya's selection criteria via the nomination process described in Section 2 of this Manual. Providers and practitioners will not be added to the Provider Directory until they are approved by the Credentialing Committee and execute a contract for network participation.

Vaya maintains standards for network participation that ensure competent, effective and quality care to our members. Stability of past operations is important. An assessment of the applicant's record of services, compliance with applicable laws, rules, regulations and standards, the qualifications and competency of any staff, the satisfaction of members and families served, systems of oversight, adequacy of staffing infrastructure, use of best practices and quality management systems will be evaluated by Vaya prior to enrollment to the extent possible and at regular intervals thereafter through Routine and Focused Monitoring. During this process, providers and practitioners may be asked to demonstrate their system of communication with members and how members and families are involved in treatment and services.

Vaya makes independent decisions about requests from providers and practitioners seeking to apply for participation in our Closed Network, nominates applicants for credentialing based on internal criteria and makes independent decisions about applications for credentialing, re-credentialing and sanctions. For more information, please visit the Credentialing page of the Vaya website at https://providers.vayahealth.com.

Vaya will electronically send all credentialing and contracting applications, forms and correspondence to the latest contact email address provided to Vaya. If the Credentialing Team learns the address provided is not accurate, we will make only one attempt to obtain a corrected address. **Please notify Vaya immediately if there is ANY change to your contact information.**

Prohibited Affiliations

Pursuant to 42 CFR § 438.610 and our DHB Contract, Vaya is prohibited from knowingly entering into a relationship with either of the following:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549; or

2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a).

A "relationship" is described as follows:

1. A director, officer, or partner of Vaya;
2. A person with beneficial ownership of five percent (5%) or more of Vaya's equity; and
3. A person with an employment, consulting or other arrangement with Vaya for the provision of items and services which are significant and material to Vaya's obligations under its contract with the State.

In addition, Vaya is prohibited from employing or contracting with providers excluded from participation in Federal health care programs, including but not limited to those excluded under Section 1128 or Section 1128A of the Social Security Act. This includes but is not limited to Medicare, Medicaid, and Health Choice. Vaya cannot knowingly submit encounter claims for services provided by excluded individuals and cannot receive Medicaid funds for such claims.

For these reasons, our Credentialing Program includes monthly checks on the exclusion status of all licensed practitioners in our Closed Network, as well as individuals identified in the credentialing application as "owners" or "managing employees" of contracted entities. If we discover that an individual billing Vaya for claims is on a prohibited affiliation list, we will immediately issue a suspension of the practitioner or provider's credentials and will seek to recover any payments made during a period of prohibited exclusion, suspension or debarment.

Overview of Provider Types

COMPREHENSIVE CARE CENTERS

Comprehensive Care Center (CCC) providers serve as the cornerstone of our community-based system of recovery-oriented care. The CCC model is designed to avoid isolated delivery of enhanced services outside of a full continuum of care and enable increased access to publicly funded safety net services, including basic outpatient therapy, medication management, screening, assessment, emergency triage, prevention, education and consultation. CCCs must provide same-day, walk-in capacity at approved sites for rapid access to assessment and treatment; deliver a full continuum of treatment services for adults and children with MH/SUD conditions; provide IDD services or coordinate IDD services through formal or informal provider relationships; provide a continuum of crisis services for all disabilities, including 24/7 telephone crisis response and first responder duties; maintain trained staff to conduct involuntary commitment first evaluations at all approved walk-in sites; establish a structure for providing or coordinating primary care services; maintain an electronic medical record that meets meaningful use standards; and accept a wide array of public and private funding, including Medicaid, Medicare, federal Block Grants, state and local funding and private insurance carriers.

CRITICAL ACCESS BEHAVIORAL HEALTHCARE AGENCIES

Critical Access Behavioral Healthcare Agencies (CABHAs) are certified by DMH/DD/SAS as clinically competent organizations with appropriate medical oversight necessary to deliver a designated continuum of mental health and/or substance use services, including the following core services: Comprehensive Clinical Assessment, Medication Management and Outpatient Therapy. Under the N.C. State Plan for Medical Assistance, only CABHAs can deliver the following enhanced services: Community Support Team, Day Treatment, Intensive In-Home and Substance Abuse Targeted Case Management. All of Vaya's comprehensive providers are certified CABHAs. Per DHHS Communication Bulletin #J248, dated May 16, 2017, the CABHA requirements will sunset and the CABHA designations will be removed from statute, the State Plan and from policy in the future. Until CABHA requirements sunset, CABHA requirements expressed herein and in your Network Provider Contract are applicable.

HOSPITALS

Hospitals contract with Vaya to deliver psychiatric inpatient, outpatient and emergency services to our members. Vaya's provider network includes community hospitals, large medical centers, national and regional health systems, private psychiatric facilities and state-operated facilities.

INTEGRATED CARE PROVIDERS

Integrated care providers offer behavioral health services from a primary care setting or a fully functional primary care clinic as part of a behavioral health setting. This typically involves a primary care physician employing (integrated) or contracting with (co-location) a Licensed Practitioner to provide outpatient treatment to individuals being served by the primary care physician (PCP). However, integrated care can also be provided by incorporating primary physical healthcare services into a behavioral health setting. Practice settings could include Federally Qualified Health Centers (FQHCs), Rural Health Centers, county Health Departments, hospital outpatient practices, behavioral health or IDD provider agencies and general primary care practices. However, Vaya requires all providers to meaningfully collaborate with all health care providers engaged in the care of the member being served and to orient assessments and referrals to meet the needs of the whole person.

PHYSICIAN PRACTICES

Physician practices may include family practices and primary care practices. These practices may be independent or part of a larger health system. Practitioners at these offices include physicians, physician's assistants, family nurse practitioners and registered nurses. These clinicians possess skills and knowledge that qualify them to provide continuing and comprehensive medical care, health maintenance, disease prevention and health education services to each member of the family regardless of sex, age or type of problem, be it biological, behavioral or social. These practices are often the point of "first contact" for someone when a medical illness, issue or concern arises. Primary care involves the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients and practicing in the context of the family and community.

SPECIALTY PROVIDERS

Specialty providers concentrate on a specific disability, population or service such as vocational services, residential services, dually diagnosed individuals, veterans, substance use, eating disorders or autism. Specialty providers fill a critical role in the Vaya network for priority populations and for those members with very specific service and support needs. Providers of Innovations Waiver services are specialty providers and are discussed more fully in Section 13 of this Manual.

OUT-OF-AREA PROVIDERS

Out-of-Area Providers are Network Providers who provide services that are not available within the Vaya catchment area or who provide services to Vaya Health Plan members who live out of our catchment area. These include specialized residential facilities that may be located out of the state.

OUT-OF-NETWORK PROVIDERS

Out-of-Network Providers are providers with whom we contract to meet the needs of specific Vaya members, either because of a need that cannot be met by a Network Provider or because the individual resides outside of our catchment area. These providers are not listed in the Provider Directory and are not eligible for referrals. **NOTE: Vaya will not pay for non-emergency services delivered by a provider who does not have a current Network Participation Agreement or Out-of-Network (OON) Agreement with Vaya.**

Credentialing Initiation

The type of credentialing or re-credentialing application and verification process depends on your provider type and whether you are an individual employed by an organization contracted with Vaya, a sole proprietor, or organized as a corporate entity, limited liability company (LLC) or partnership. Vaya accepts all credentialing forms, applications and other documentation via electronic submission unless otherwise directed or approved by a Credentialing Team representative. Submissions must include all requested and/or required information or other documentation and must be signed by the applicant no more than 180 days prior to the initial review by the Vaya Credentialing Committee. Enrollment in the NC Medicaid program (via NCTracks) is a mandatory prerequisite to credentialing, enrollment and contracting with Vaya Health. Providers who are not enrolled in NCTracks or who fail to maintain NCTracks enrollment for all required elements, including but not limited to sites (including ZIP+4), services, taxonomies, and NPIs, will be subject to denial or recoupment of reimbursement.

Applicants may call the dedicated Credentialing Hotline at 1-855-432-9139 or email Vaya at CredentialingTeam@vayahealth.com at any time during the credentialing process to inquire about the status of an application. Our goal is to respond to all inquiries within three business days.

Credentialing Process for Providers (Entities)

Within five business days following a determination that Vaya approved the nomination of a new provider applicant, the Credentialing Team will send the applicant an email that includes electronic access to the appropriate application, instructions and contact information for technical assistance. Within 60 days of receipt of this email, the applicant must submit a complete credentialing application packet that includes the information detailed below. A Network Provider seeking to add a new site or service must submit the nomination form to initiate the credentialing process:

- An attestation statement that attests the application is complete and accurate, authorizes Vaya to collect any information necessary to verify the information in the application (including consent to release Social Security Numbers and dates of birth to verification entities and to consult with others who may have information bearing on the provider's competence and/or qualifications), signifies the provider's willingness to abide by Vaya policies and procedures, releases Vaya from liability related to the credentialing process, affirms that the provider is able to send 837 HIPAA-compliant transactions and to receive 835 remittances or to participate in Vaya's claims reimbursement process and attests that the provider has a "no-reject policy" for referrals within the capacity and parameters of their competencies and agrees to accept all referrals meeting criteria for services they provide when there is available capacity
- Identification of ownership of the entity, including a list of all persons with an ownership or control interest of 5 percent or more ("owners") and a list of all parent, sister, affiliate and subsidiary entities in the entire chain of ownership, including an organizational flowchart, up to the ultimate owner of the holding company. The ownership identification must include the name, title, address, contact information, date of birth and Social Security Number of any owners, directors (including members of the board of directors), managing employee(s) and fiscal agent(s) of the entity
- A copy of the current license for each facility that is applicable for the requested service(s). A copy of the actual license must be included unless it can be primary source verified via the appropriate licensing agency website.
- A completed and signed W-9 Form
- Identification of taxation status that includes the type of business (not-for-profit, profit, partnership, etc.) and tax identification (ID) number
- List of any accreditations held by the applicant
- History of sanctions, probation or loss of accreditation or certification and disclosure of any actions that could result in a sanction, probation or loss of accreditation or certification

- History of names the entity has done business under or if business is using a "doing business as" name
- Written documentation of Source of Authority through Charter, constitution, bylaws and/or Articles of Incorporation OR a Certificate of Authority that shows eligibility to do business in North Carolina, unless either can be primary source verified
- An organizational chart that includes all departments, divisions, units, program heads/ supervisors and staff titles, as well as staffing patterns for each service for which the agency submitted an application
- Certificate of Insurance (COI) or Memorandum of Insurance (MOI) from the agency's proposed insurance carrier for all required insurance coverage, including amounts, effective dates, expiration dates, loss payee and policy number(s)
- Professional liability claims history
- Listing of Human Rights Committee members, including the names, title and contact information (excluding group practices that only provide outpatient therapy services)
- Identification of any affiliation, by contract or otherwise, with any other N.C. Medicaid provider

Credentialing Process for Hospitals

To decrease the administrative burden on hospitals/ health systems directly enrolled with DHB, we are permitted to accept and rely upon DHB's credentialing of N.C. licensed hospitals, including all facilities and sites enrolled with DHB and affiliated with the hospital/ health system in NCTracks and all practitioners billing through the hospital/health system's NPI(s). The hospital/ health system must complete and submit Vaya's Hospital Data Form. Vaya will review the completed Hospital Data Form against our accreditation and Waiver Contract requirements. Any required information not submitted to or verified by DHB must be submitted to Vaya for verification in accordance with the process outlined above. This includes, but is not limited to, Social Security Numbers and dates of birth for all owners, directors, members of the Board of Directors and managing employees.

Credentialing Process for Practitioners

PRACTITIONER TYPES

Vaya credentials two types of practitioners: (1) Licensed Independent Practitioners (LIPs) are licensed healthcare professionals, such as therapists, psychiatrists or physicians, who are contracted with Vaya to provide services, receive direct referrals from Vaya, and are personally responsible for compliance with this Manual; and (2) Licensed Practitioners (LPs) are licensed healthcare professionals who work for a provider entity contracted with Vaya and do not receive direct referrals from Vaya. Whether working independently, in professional practice groups or for large provider agencies or health systems, practitioners offer important access to outpatient care for members. All practitioners undergo rigorous credentialing to ensure the provision of high-quality, evidence-based treatment. LIPs must submit the Nomination Form and meet selection criteria as outlined in Section 2 of this Manual. Network Providers may enroll new or additional LPs at any time without going through the selection process, so long as the practitioners will be working out of a site that is already credentialed.

Any of the following fully licensed or associate practitioners seeking to provide clinical services (including, but not limited to, psychiatric care, assessment or outpatient therapy) must undergo credentialing:

- Licensed Clinical Social Worker (LCSW)
- Licensed Clinical Mental Health Counselor (LCMHC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Addiction Specialist (LCAS)
- Licensed Psychologists – (Health Service Provider-Psychologist (HSP-P))
- Licensed Psychological Associate (LPA) – (Health Service Provider-Psychological Associate (HSP-PA))

- Licensed Psychiatrist (MD, DO)
- Licensed Psychiatric Nurse (RN)
- Advanced Practice Psychiatric Clinical Nurse Specialist
- Licensed Psychiatric/ Family Nurse Practitioner providing MH/SU services under the supervision of a licensed psychiatrist (PNP or FNP) – must have psychiatric experience or experience working with the substance use population to apply as independent practitioner
- Licensed Physician Assistant (PA) providing MH/SU services under the supervision of a licensed psychiatrist
- Physician with substance use specialty or psychiatric training/experience (general physicians with no substance use or psychiatric training are not eligible to apply)
- Nurse Practitioners (providing team-based services as part of an agency)
- Physical Therapist (providing Specialized Consultative Services)
- Occupational Therapist (providing Specialized Consultative Services)
- Speech Therapist (providing Specialized Consultative Services)
- Board-Certified Behavioral Analyst (BCBA - providing Specialized Consultative Services)
- Certified Therapeutic Recreational Therapist (providing Specialized Consultative Services)

All practitioners must meet state licensure or certification requirements and hold a valid North Carolina license or certificate as listed above, unless the practitioner is seeking to provide services out of state, in which case he or she must meet all licensure or certification requirements of the state in which they are seeking to provide services.

STEP 1 – CREDENTIALING INITIATION FORM (CIF) AND COUNCIL ON AFFORDABLE QUALITY HEALTHCARE (CAQH) PROCESS

If Vaya determines that a LIP meets selection criteria, the Credentialing Team will send a Credentialing Initiation Form (CIF) invitation with instructions to the practitioner. The CIF is used to initiate the process of engaging the practitioner in the Council on Affordable Quality Healthcare (CAQH) online application process. Licensed Practitioners employed by an organization contracted with Vaya should submit the CIF directly to Vaya.

Nurse Practitioners who are seeking to be credentialed as LIPs must also submit a collaborative practice agreement (CPA) as part of their CIF. The CPA must describe the arrangement for continuous availability between the nurse practitioner and the supervising physician. The CPA should also describe the patient population being served, prescribing authority, drugs and devices that may be prescribed by the nurse practitioner and minimum standards for consultation between the nurse practitioner and the primary supervising physician, as well as the process for the annual review/re-signing of the CPA. Psychiatrists must identify completion of an approved/ accredited residency, and sub-specialty fellowship training must be documented (if taken).

For physicians, residency is the highest level of education and/or training required to be primary source verified by Vaya. Board certification is not required; however, practitioners who identify themselves as board-certified must do so in accordance with the definition of board certification for that recognized specialty board (i.e., for psychiatrists – the American Board of Psychiatry and Neurology).

For LIPs, the CIF and supporting documentation must be completed and submitted to Vaya within 60 days of invitation. If a completed CIF is not received within 60 days, the CIF will not be processed. If the CIF information is incomplete, inaccurate or conflicting, Vaya will electronically notify the practitioner of the information that is missing or incorrect. The practitioner's employer or a contact person with the employer may also be contacted to obtain additional information (if applicable). **For this reason, it is critical that the CIF contain accurate contact information.** If the practitioner does not return all necessary information within seven business days of such notification, Vaya will provide

a second electronic notification. If the practitioner does not return all necessary information within seven business days of the second notification, Vaya will not process the CIF, and the practitioner must submit a new CIF to restart the process.

Practitioners can request the status of their credentialing at any time during the process by contacting Vaya at CredentialingTeam@vayahealth.com. If Vaya receives a timely, complete CIF, the prospective practitioner will be added to the Vaya CAQH roster. CAQH notifies practitioners already registered with CAQH of Vaya's interest in viewing their online application. Vaya must be able to view the completed online CAQH application before the credentialing process can proceed. For those not already registered, CAQH sends an initial registration packet with CAQH login information. The practitioner must complete the online CAQH application and add Vaya as an authorized entity. If the CAQH application is not available within 30 days from the date that the practitioner was added to the CAQH roster, the application will not be processed. The practitioner will then need to submit a new CIF to restart the process.

STEP 2 – VAYA APPLICATION PROCESS

To complete the credentialing process, practitioners must submit a completed credentialing application packet that includes the following:

- Complete CAQH application
- Name of Network Provider with whom LP is affiliated (does not apply to LIPs)
- Copy of initial and current license(s) renewal(s)
- Copy of initial and most recent board certification, if applicable
- Copy of current DEA Certificate, if applicable
- Certificate of Insurance (COI) or Memorandum of Insurance (MOI) from the applicant's proposed insurance carrier for all required insurance coverage, including amounts, effective dates, expiration dates, loss payee and policy number(s), unless the applicant is an LP covered by his or her agency's insurance, in which case the agency is responsible for submitting proof of coverage
- Professional liability claims history
- History of sanctions or pending actions that could result in sanctions
- History of loss or limitation of privileges or disciplinary activity
- Identification of hospital affiliations or privileges (if applicable) or name of practitioner to whom the MD refers if lacking privileges
- Past five years of relevant work history, including an explanation of any gaps in employment of six months or more
- Identification of languages spoken proficiently
- Areas of specialized practice
- Disclosure of any physical, mental or substance use problems that could, without reasonable accommodation, impede the practitioner's ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients
- Copy of Educational Commission for Foreign Medical Graduate Certificate (if applicable), unless it can be primary source verified
- Identification of the practitioner's on-call designee, who must be a member of the network or otherwise approved by Vaya, with the same credentials or higher
- An attestation statement that attests the application is complete and accurate, authorizes Vaya to collect any information necessary to verify the information in the application (including consent to release Social Security Numbers and dates of birth to verification entities and to consult with others who may have information bearing on the practitioner's competence and/or qualifications), signifies the practitioner's willingness to abide by Vaya policies and procedures and releases Vaya from liability related to the credentialing process

- LIPs only – (1) an attestation statement that the LIP is able to send 837 HIPAA-compliant transactions and to receive 835 remittances or to participate in Vaya's claims reimbursement process; (2) a complete and signed W-9 form; and (3) if applicable, an attestation statement that the LIP does not transport members and/or does not employ three or more individuals

Credentialing Verification Review

Verification must be performed no more than 180 days prior to the initial review of the application by the Credentialing Committee. Applications are reviewed based on criteria specific to the provider type. Vaya's process is to verify the "primary source" of the submitted credential whenever possible. After 30 days, you can request the status of your application by contacting CredentialingTeam@vayahealth.com. We utilize the following external databases to determine the accuracy of reported credentials and/or to identify information that an applicant inadvertently or deliberately failed to disclose:

- Exclusions (OIG): https://exclusions.oig.hhs.gov/
- Exclusions (SAM): https://sam.gov/
- National Practitioner Databank: https://www.npdb.hrsa.gov/
- Social Security Death Master File: https://dmf.ntis.gov/
- NPPES: https://npiregistry.cms.hhs.gov/
- NCTracks: https://www.nctracks.nc.gov/content/public/providers/provider-recredentialing.html
- N.C. Secretary of State: https://www.sosnc.gov/search/index/corp
- NC DHHS Excluded Providers List: https://medicaid.ncdhhs.gov/excluded-providers
- DHSR Facility Licensure: http://www.ncdhhs.gov/dhsr/mhlcs/facilities.html
- DHSR Provider Penalty Tracking Database: https://providertracking.dhhs.state.nc.us
- DHSR Healthcare Personnel Registry: https://www2.ncdhhs.gov/dhsr/hcpr/
- DEA Certificates: www.deanumber.com
- N.C. Board of Licensed Clinical Mental Health Counselors (NCBLCMHC): https://portal.ncblcmhc.org/verification/search.aspx
- N.C. Marriage & Family Therapy Licensure (LMFT): https://www.ncbmft.org/verify/
- N.C. Social Work Certification and Licensure Board (NCSWCLB): www.ncswboard.org (LCSW)
- N.C. Addictions Specialist Professional Practice Board (NCSAPPB): http://ncsappb.learningbuilder.com/Public/PractitionerLookup/Search (LCAS)
- N.C. Medical Board: https://wwwapps.ncmedboard.org/Clients/NCBOM/Public/LicenseeInformationSearch.aspx
- N.C. Board of Psychology: http://www.ncpsychologyboard.org/license-verification/
- N.C. Board of Nursing: http://www.ncbon.com
- Criminal history: https://www.accurate.com/
- Joint Commission: https://www.qualitycheck.org/
- CQL The Council on Quality and Leadership: https://c-q-l.org/
- CARF: http://www.carf.org/providerSearch.aspx
- Council on Accreditation: http://coanet.org/home/
- American Board of Medical Specialties: http://www.abms.org
- Foreign Medical Graduates: www.ecfmg.org

Any documentation submitted that is older than six months (or one year for licenses) may be denied during the verification process. If additional or corrected information or documentation is required, Vaya will electronically notify you of the specific information that is needed to complete the application. **As stated above, it is critical that the application contain accurate provider contact information.** Vaya's experience is that lapses in credentialing are

primarily due to inaccurate contact information on file or failure to submit a complete application. If requested information is not returned within seven business days of this notification, Vaya will provide a second electronic notification. If requested information is not returned within seven business days of the second notification, the application will not be processed. Once Vaya receives a complete application, the Credentialing Team will complete primary/secondary source verification of information submitted, coordinate a site visit, if required, and identify any information that could impact the quality of care or services delivered to members.

Site Visits

For initial and re-credentialing applications (including new sites) from providers seeking a contract with Vaya, a site visit is required, if applicable, prior to completion of credentialing. Site visits are generally completed within 30 days of receipt of a complete application and will be based on a standardized check sheet. In the event site visit criteria are not met, the applicant will be given five business days in which to correct any deficiencies and submit documentation that the deficiencies have been corrected. Failure to submit supporting documentation within five days shall result in the application not being presented to the Credentialing Committee.

Credentialing Committee Review

The Credentialing Committee is tasked with assuring that all agency, facility and practitioner applicants meet standards for entrance into the Vaya Provider Network. The committee is chaired by Vaya's CMO and includes Vaya staff and Network Providers who represent various licensing guilds. Based on the credentialing verification, a roster is prepared that identifies all providers and practitioners ready for presentation to the Credentialing Committee, as well as any findings identified that need to be reviewed and discussed by the Credentialing Committee.

The committee meets no less than quarterly and delegates the approval of unflagged applicants to the CMO. An unflagged application is one in which there are no negative actions disclosed in the application, no negative findings identified on reviewed databases and in which the applicant meets good standing criteria, to the extent good standing can be determined at the time of credentialing verification review.

Vaya reserves the right to review other issues as determined by the CMO in consultation with the Credentialing Team. If an issue is identified, the Credentialing Committee may decide to pend the application and request additional information from the applicant. Decisions about applicants are within the sole discretion of the Credentialing Committee, subject to accreditation and Waiver Contract requirements.

If third-party verification databases are not available for timely processing, the affected applicant will be included on the monthly roster and presented to the Credentialing Committee based on the information available at the time of the meeting. The verification database will be monitored, and verifications will be completed as soon as the database becomes available. If any findings are later discovered, Vaya will promptly notify the Credentialing Committee for the purpose of evaluating the new information. This exception does not apply to the OIG, SAM, NPDB or licensing verifications.

Applicants will be notified in writing of Credentialing Committee decisions. Decisions are effective retroactive to the date that Vaya received a complete application. Credentialing approval does not guarantee the issuance of a contract with Vaya. Any services delivered prior to the effective date of the committee decision are delivered at your own risk. If credentialing or contracting is not approved, Vaya will not reimburse you for services delivered in the interim. **There is no right to appeal or contest a decision to deny an application for initial credentialing.**

Change Notifications

The data you provide during the credentialing process are used for referral purposes; therefore, it is critical that you notify us as soon as possible if any of your information changes. All Network Providers must notify Vaya of any changes to the information presented in their most recent credentialing or re-credentialing application no later than three business days after the change using the applicable request form available on Vaya's website at https://providers.vayahealth.com. This includes, but is not limited to, changes to any of the following information:

- Legal name
- Business, mailing or billing address
- Contact information, including email address, especially your credentialing contact person
- NPI or tax ID
- Licensure or privileging status
- Good standing status, including pending sanctions, citations, malpractice claims, investigations for Medicaid fraud, etc.
- Practitioner roster (remember that new practitioners hired must be credentialed by Vaya prior to billing for services)

To avoid any gaps in claim submission, Network Providers must notify Vaya of any changes in ownership or management, including, but not limited to, proposed acquisitions or mergers, as soon as practicable in advance of such change but no later than 60 days prior to the planned change.

Requests to add a new or additional site or service must go through the process described in Section 2 of this Manual. Changes in capacity or inability to accept new referrals must be reported to provider.info@vayahealth.com or the Provider Help Line at **1-866-990-9712**. If you use the MCIS slot scheduler, please notify Member Services at 1-800-849-6127.

Independent Practitioners wishing to initiate a leave of absence from the Network must notify Vaya at least 60 days prior to the desired effective date via email to provider.info@vayahealth.com. In the request, please identify the specific reason(s) for the request for a leave of absence (i.e. maternity leave, etc.). Vaya will generally approve requested leave for up to an initial six-month period, with the option for an extension. An extension to the original leave should not exceed an additional six months and must be submitted no later than 60 days prior to the expiration of the original leave of absence.

The following chart identifies changes that require credentialing review and/or a contract amendment:

TYPE OF CHANGE	CREDENTIALING REVIEW REQUIRED?	CONTRACT AMENDMENT REQUIRED?
Phone number	No	No
Primary contact person	No	No
Other cover sheet contacts	No	No
Email or website	No	No
Primary notice (mailing) address	No	Yes
Billing address	No	No
Site address	Yes	No
NPI number	Yes	No, unless ownership or name changes
Tax ID number	Yes	No, unless ownership or name changes
Additional (new) site or service	Yes	No
Remove site or service	No	No

TYPE OF CHANGE	CREDENTIALING REVIEW REQUIRED?	CONTRACT AMENDMENT REQUIRED?
Practitioner name	Yes	Yes, if LIP
Practitioner license/ certification	Yes	No, unless services also change
Facility license	Yes	No, unless services also change
Add or remove practitioner from roster	Yes	No
Withdrawal from network	No	Requires written confirmation of contract termination
Entity name change	Yes	Yes
Merger/acquisition	Yes	Yes, if name change to entity
Business license/entity type (i.e., NCSOS change)	Yes	Yes, if name change to entity
Change in ownership percentages or removal of owner(s)	Yes	No
Add or remove owner(s)/ managing employee(s)	Yes	No

Emergent Change Requests

If needed in the event of a sudden and unexpected provider closure or to respond to a significant life, health or safety risk to a member, Vaya will expedite emergent change requests. The applicable Provider Nomination Form or Provider Change Form must be completed and submitted. To ensure timely processing, we recommend that the requesting provider also call the Provider Help Line at 1-866-990-9712 or email us at provider.info@vayahealth.com to notify PN staff of the request and reason for emergent processing.

Re-Credentialing and Continuous Verification

All Network Providers, including practitioners, must be re-credentialed at least every three years or 36 months. At least 180 days prior to the applicable re-credentialing expiration date, Vaya will provide you with electronic invitation and access to the appropriate application, instructions (including deadline for submission) and contact information for technical assistance**. It is critical that you maintain accurate contact information with Vaya to avoid any lapse in credentialing.** If you do not submit a timely re-credentialing application, or if your application contains errors or information that require additional verification, your contract may be suspended on the date your credentialing with Vaya lapses and may not be reinstated until your re-credentialing is approved. During the re-credentialing process, you must sign a release of information and liability that allows Vaya to make inquiries into your background, including questions regarding criminal history, physical and mental health status and lack of impairment due to chemical dependency/substance use, loss or limitation of privileges and/or disciplinary activity and current malpractice coverage.

The process for re-credentialing is virtually identical to initial credentialing. However, applications for re-credentialing must update any information subject to change since the previous credentialing. Providers and practitioners who entered the network during the “open enrollment” process may have to provide additional information or meet higher standards during the re-credentialing process. Credentialing requirements may also change based on changes in state or federal requirements, accreditation requirements and the needs of Vaya members. Be aware that the following conditions can affect your credentialing status (this is not an exhaustive list):

- Loss of Good Standing
- Vaya determines that you breached a material term of your contract
- The Credentialing Committee determines that your general area of practice or specialty involves experimental or unproven modalities of treatment or therapy not widely accepted in the medical community

- Vaya receives a credible report of inappropriate contact with a patient of a sexual or amorous nature or a violation of other clinician/member boundaries

All practitioners are required to report disciplinary actions based on professional competency or conduct that would adversely affect your clinical privileges for a period longer than 30 days or would require voluntary surrender or restriction of clinical privileges, while under, or to avoid, investigation, to the appropriate licensing body entities (i.e., National Practitioner Data Bank (NPDB), etc.). Failure to do so will be viewed as a breach of your contract with Vaya.

We continuously review available databases against our roster of credentialed providers, practitioners, owners and managing employees. Exclusion or suspension lists, state licensing boards, the NPDB, and other credentialing databases are monitored no less than quarterly. Vaya reserves the right to monitor more frequently and to monitor other databases not listed above. Any findings identified through such continuous verification will be brought to the Credentialing Committee for review and decision.

Vaya reserves the right to suspend or terminate a Network Provider's credentials, or take other action as deemed necessary, for activity, actions and/or non-actions which are contrary to accepted standards of medical practice or contract requirements. Disciplinary actions that can be taken by the CMO and/or Credentialing Committee related to credentialing include, but are not limited to, a letter of censure, site visit, probation/increased monitoring, credentialing with contingencies/ limitations, Plan of Correction, contract suspension, suspension of referrals, revocation of credentialing status and exclusion. We also reserve the right to suspend a Network provider for up to 15 business days pending review by the Credentialing Committee/Credentialing Specialist where potential adverse medical outcome will affect a member or the populations served by Vaya.

Any decisions or disciplinary actions to suspend, revoke or otherwise change a Network Provider's credentialed status resulting from re-credentialing or continuous verification will be in writing and will include notification of the process for dispute resolution. We may also notify appropriate licensure entities and the NPDB of any disciplinary actions. This decision is made by the CMO and/or the Credentialing Committee.

Contracting

All Network Providers must execute a written agreement with Vaya before any services can be authorized or reimbursed. These agreements must be in your official legal name, as identified on the N.C. Secretary of State database (for entities) or other legal form of identification (for independent practitioners). You may not assign any of your rights, interest or title in your written agreement with Vaya without notifying Vaya in advance of the intent to transfer and without securing Vaya's written consent for the assignment of the written agreement. Failure to provide advance notice to and receive prior written consent by Vaya may result in termination of your agreement with Vaya.

A condition of Vaya's approval of an assignment of a Network Provider's written agreement to an assignee or acceptance of a successor owner for the Network Provider's assets or business operations is that the assignee or successor owner accept liability for any and all overpayments or other debts owed to Vaya by the assignor at the time of the assignment or closing, as well as liability for any overpayments identified by Vaya in the future relating back to dates of service prior to the assignment.

Provider contracts are on the state fiscal year cycle, from July 1 to June 30 of each year, with some providers being offered an automatic renewal for one year. We also implemented a unified contract template to ensure consistency across the Closed Network. The template does not include an attachment with a specific list of approved sites, services and codes. This eliminates the need for a contract amendment every time a change is made. Instead, providers must

verify that accurate sites, services and codes were correctly entered into the MCIS. Upon request, Vaya can generate a report upon request that lists all sites, services and codes associated with your contract. **Note:** Providers must submit a request to Vaya to add new billing sites or services prior to the delivery of any new services or services rendered from new sites. Providing new services and/or rendering services from a new site that is NOT approved, credentialed and incorporated in the MCIS will result in denied claims and/or adverse action.

Please note that a cover sheet and Contact Maintenance Log is included at the front of all contract packets distributed to providers. Completing this log every year helps us improve the accuracy of contact information on file for Network Providers. **However, it is your responsibility to let us know if any of your information changes after the contract is executed.**

We utilize DocuSign®, a web-based platform that provides electronic signature technology and digital transaction management services for facilitating electronic exchanges of Vaya contracts and signed documents. DocuSign® is legal, administratively efficient and automatically provides you with a scanned copy of your executed contract following execution. It lowers administrative costs, reduces contracting process timeframes, improves the tracking of executed contracts and helps ensure that contracts are executed prior to their effective date.

This Manual is incorporated into your contract with Vaya as a binding requirement. It is important that you review your contract for accuracy and read it carefully before executing. If you don't understand something in your contract, please let us know! We are available to answer questions about any of the Terms and Conditions. Questions about operational or substantive requirements should be directed to provider.info@vayahealth.com. Suggested language for future agreements and questions about insurance requirements, legal terminology or the DocuSign® contract process should be sent to Contracts@vayahealth.com.

It is your responsibility to be familiar with, understand and adhere to all requirements of your contract(s) with Vaya. Lack of familiarity or understanding is not a valid excuse for non-compliance.

Out-of-Network Agreements

In situations where Vaya determines that our Closed Network cannot meet the need for geographically accessible, appropriate and/or timely services for a specific member, we may identify a selected out of network provider to meet the need. The first step in this process is to complete the Out-of-Network Agreement Request via DocuSign®, which is found on the provider enrollment page of Vaya's website at https://providers.vayahealth.com. If the request is approved, and all necessary information is submitted, Vaya will review and/or verify the following limited credentials necessary for successful claims adjudication and to ensure the health, safety and welfare of members, as applicable to the provider type:

- OIG and SAM exclusion databases
- National Practitioner Databank (NPDB)
- DHSR Healthcare Personnel Registry (HCPR)
- DHSR facility license
- NCTracks for verification of National Provider Identifier(s) (NPIs)
- Criminal history

These verifications are not presented to the Credentialing Committee for review unless a concern is identified. If approved, the agreement will proceed to final processing and execution. Completing the abbreviated verification process described in this section does not mean the provider is a member of Vaya's Closed Network. However, Providers

who are serving multiple members under an Out-of-Network Agreement or who executed more than two OON agreements in a fiscal year may be invited to apply for membership in the Closed Network.

SECTION 4

Access to Care

Providing timely access to medically necessary services is a key function of our Closed Network. It is your responsibility to ensure that members are eligible and enrolled in a Vaya Health Plan before delivering services and/or submitting claims for reimbursement. It is also your responsibility to refer members for specialty care or to other contracted providers in response to a member request or change in level of care needed. Vaya's Eligibility and Enrollment Team and Member Services Department can help you with enrollment, referrals and appointments to avoid delays in access to care.

No Wrong Door

Vaya follows a "No Wrong Door" approach to eligibility, enrollment and access to care. This means that members can access services through our Access to Care Line or by contacting a Network Provider – there is no wrong door to access treatment. All Network Providers are required to complete eligibility determinations and request enrollment of an eligible individual into a Vaya Health Plan. Vaya's Walk-in Centers offer same-day access for triage and/or assessment at offices located in each of the counties in our catchment area.

Network Providers may conduct screening, triage and referral following the process and criteria outlined below or may link individuals requesting services to Vaya's Access to Care Line at **1-800-849-6127. In either case, all Network Providers are required to meet the applicable DMH/DD/SAS access to care timeframe based on a classification of the request as Emergent, Urgent or Routine.**

Eligibility

Individuals whose services are paid for in whole or in part by Vaya must meet eligibility criteria for a Vaya Health Plan. If you have any questions about whether someone is eligible for a Vaya Health Plan, please call the Enrollment and Eligibility (E&E) Team at 828-225-2785, ext. 2355. You can also email the team at EandE@vayahealth.com.

1915(b) MEDICAID MH/DD/SA HEALTH PLAN

Individuals who receive a qualifying category of Medicaid from Alexander, Alleghany, Ashe, Avery, Buncombe, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Swain, Transylvania, Watauga, Wilkes or Yancey counties are automatically a member of the MH/DD/SA Vaya Health Plan. In general, to be eligible for Medicaid coverage, the individual must:

- Be a U.S. citizen or provide proof of eligible immigration status; AND
- Be a resident of North Carolina and provide proof of residency; AND
- Have a Social Security Number or applied for one; AND
- Meet Category of Aid eligibility criteria as determined by the county Department of Social Services (DSS) office where the individual resides.

- NOTE: Individuals currently receiving Supplemental Security Income (SSI) benefits, Special Assistance to the Blind, Work First Family Assistance or Special Assistance for the Aged or Disabled are automatically eligible for Medicaid and do not need to apply at DSS.

* Some Medicaid Categories of Aid are not covered under the Vaya Health Plan and remain under DHB. Qualifying Categories of Aid are listed below:

- Individuals covered under Section 1931 of the Social Security Act (1931 Group, TANF/AFDC)
- Optional Categorically and Medically Needy Families and Children not in Medicaid deductible status (MAF)
- Blind and Disabled Children and Related Populations (SSI)
- Blind and Disabled Adults and Related Populations (SSI, Medicare)
- Aged and Related Populations (SSI, Medicare)
- Medicaid for the Aged (MAA)
- Medicaid for Pregnant Women (MPW)
- Medicaid for Infants and Children (MIC)
- Adult Care Home Residents (SAD, SAA)
- Foster Care Children
- N.C. Innovations Waiver Participants
- Medicaid beneficiaries admitted to Intermediate Care Facilities for persons with IDD

Note that Vaya does not cover children under age 3 except for Innovations Waiver participants.

1915(c) INNOVATIONS WAIVER HEALTH PLAN

An individual must meet all the following eligibility criteria and be enrolled in the Innovations Waiver to receive these services:

- The individual is eligible for Medicaid coverage, based on assets and income of the applicant (not including family resources) whether he/she is a child or an adult.
- The individual's residence, for purposes of Medicaid eligibility, is within one of the counties in Vaya's catchment-area.
- The individual is assigned a Waiver "slot." Note that Innovations Waiver slots are allocated by DHB to each LME/MCO. Waiver slot enrollment is approved on a first-come, first-serve basis. Vaya maintains a list of individuals wishing to be considered for participation in the Innovations Waiver, known as the Registry of Unmet Needs.
- The individual meets the requirements for ICF-IID level of care as approved by the Vaya UM Department.
- The individual lives in an ICF-IID facility or is at high risk for placement in an ICF-IID facility. High risk for ICF-IID institutional placement is defined as a reasonable indication that the individual may need such services in the near future (one month or less) in the absence of Home and Community-Based Services.
- The individual's health, safety and wellbeing can be maintained in the community through a combination of Waiver and natural supports.
- The individual qualifies for Innovations Waiver services, i.e., the services are medically necessary and appropriate for the individual. The individual must use at least one Waiver service per month for eligibility to be maintained.
- The individual and his/her family or guardian desires participation in the Innovations Waiver program rather than institutional services.
- N.C. Innovations Waiver participants must live in a private residence, with family, or in a living arrangement with six or fewer persons unrelated to the owner of the facility.

NON-MEDICAID HEALTH PLAN

Individuals who do not have Medicaid or other insurance may be eligible for non-Medicaid-funded services. Some members who have Medicaid could also qualify for these services, as long as an equivalent service is not available through Medicaid. Eligibility for non-Medicaid services is based on citizenship, income and availability of other insurance. Some non-Medicaid services, such as respite care for individuals with IDD and the Adult Developmental Vocational Program (ADVP), are not based on income. Network Providers must interview all individuals seeking eligibility for non-Medicaid services and document criteria as outlined below:

- Financial eligibility: Household income for the individual must be 300 percent or less of the most current federal poverty guidelines, based on family size. Please note that the guidelines are issued the first month of each calendar year in the Federal Register by the U.S. HHS and are a simplification of the U.S. Census Bureau poverty thresholds. The most current federal guidelines are available at: https://aspe.hhs.gov/poverty-guidelines.
- Other third-party coverage: Must be exhausted or not covered by the plan and provide proof of denial from insurer. State funds may not be used to pay for deductibles or co-payments.
- Citizenship: The individual must be a U.S. citizen or legal resident. Only exception is for emergency services as defined at 42 CFR § 438.114.

Enrollment

Individuals whose services are paid for in whole or in part by Vaya must be enrolled in a Vaya Health Plan. If you have any questions about an individual's enrollment status, please call the Vaya Enrollment & Eligibility (E&E) Team at 828-225-2785, ext. 2355. You can also email the E&E Team at EandE@vayahealth.com or call Member Services at 1-800-757-5726. It is your responsibility to make a complete and thorough investigation of an individual's ability to pay prior to requesting to enroll that person into a Vaya Health Plan. This means that you must check for the following:

- Determine if the individual has Medicaid or may be eligible for Medicaid. You are required to help individuals that may be eligible for Medicaid in applying through the applicable county Department of Social Services.
- Determine if the individual has Medicare or any other third-party insurance coverage, including insurance through a non-custodial parent, an employer or the Patient Protection and Affordable Care Act Health Insurance Marketplace.
- Determine if there is any other payor involved – worker's compensation, disability insurance, employee assistance program (EAP), court-ordered services paid for by the court or another program, non-custodial parent pursuant to a custody order, liability judgment (e.g. vehicle accident), etc.
- Note that members with third-party coverage can be enrolled with Vaya established as the secondary payor.
- Determine if the member is eligible for Vaya's Non-Medicaid Health Plan as outlined above.

After eligibility is established, Network Providers are required to enroll individuals for services without prior screening, triage or referral by Vaya. If the individual has Medicaid or was previously enrolled in a Vaya Health Plan, he or she may be eligible for publicly funded services through Vaya. If the individual was previously enrolled in a Vaya Health Plan but claims for services were not submitted for more than 90 days, you must complete a new enrollment. If the individual is not yet enrolled, then you must obtain and submit all data necessary to do so.

Required data elements include Medicaid ID number, if applicable, date of birth and identification of any other third-party payor, including Medicare. It is your responsibility to ensure that enrollment data is accurate and up to date. If enrollment data is not accurate or complete prior to service provision, your ability to successfully submit authorization requests and claims may be impacted.

Member enrollment must be performed electronically through the MCIS. **Enrollment can be verified by contacting the E&E Team at 828-225-2785, ext. 2355, Monday - Friday 8:30 am -5 pm.** Providers may also call the Access to Care Line

after hours and on weekends at 1-800-849-6127 to verify eligibility. You must complete the eligibility determination and enrollment request prior to service provision, except for crisis services provided in a documented emergency. Claims submitted for services provided prior to date of enrollment will be denied.

Member Services/Access to Care Call Center

The Member Services Department operates a toll-free, 24/7/365 Access to Care Line, for telephonic screening, crisis intervention and appointment referrals for people seeking assistance with mental health, substance use or intellectual/developmental disability issues. **This number is 1-800-849-6127.** The Access to Care Line is answered by a live person, generally within 30 seconds. During times of heavy call volume, overflow calls may be automatically redirected to another LME/MCO for backup.

Member Services also provides our members and communities with general information via the same **1-800-849-6127** toll-free number and can be used to report a compliment, complaint or concern about Vaya or any of our Network Providers. The Member Services Department is staffed by Member Services Representatives (MSRs) and Member Services Clinicians:

- MSRs are bachelor-level or non-licensed Qualified Professionals with at least two years of experience in the human services field. Their primary job responsibilities are to answer the telephone calls coming into the Access to Care Line, collect demographic information, verify insurance eligibility and complete a brief intake screening to determine the type and level of service/s most appropriate for callers. MSRs can also provide information about community resources, provide information about inpatient facilities, when appropriate, follow up to assure members discharged from inpatient facilities are engaging in the next level of care and follow up on all appointments made through the call center to assure members are attending scheduled appointments.
- Member Services Clinicians are Master's-Prepared Licensed Professionals who handle emergency and crisis intervention calls, as well as regular MSR duties. Member Services Clinicians follow all requests for emergency services until it is established that contact is made with a Mobile Crisis Management (MCM) provider, first responder or other provider. Member Services Clinicians are available to take over calls with members who are in distress.

Based on the caller's response to the greeting and questions from the MSR and/or clinician, the call may address the following issues:

- Crisis intervention, including referral to MCM
- Management and provision of referrals for Urgent and Emergent calls
- Referrals for Diagnostic or Comprehensive Clinical Assessments
- Information about community (non-treatment) resources
- Enrollment of an individual into a Vaya Health Plan
- Eligibility questions
- Recording and resolution of complaints or grievances
- General information about Vaya and public MH/IDD/SUD services available in our catchment area

Screening, Triage and Referral Process

If the member contacts Vaya's Member Services Department

If a caller does not request a clinical assessment or treatment services, the MSR will offer suggestions for obtaining natural supports and/or community services. If a caller requests a clinical assessment or treatment services, the MSR will

gather demographic information and determine whether risk indicators are present that necessitate involvement of a clinician.
If the call involves no risk indicators, the MSR offers a choice of available Network Providers and links the caller to the selected provider for an intake appointment. When risk indicators are identified, the MSR involves a clinician to determine the most clinically appropriate referral and clinical urgency with which the caller should be seen by the referred provider: Emergent, Urgent or Routine.

If the member contacts a Network Provider

If a caller does not request a clinical assessment or treatment services, you must offer suggestions for obtaining natural supports and/or community services. If a caller requests a clinical assessment or treatment services, you must gather demographic information and determine whether risk indicators are present that necessitate involvement of an appropriately licensed practitioner. If the call involves no risk indicators, you must schedule an intake appointment. When risk indicators are identified, you must ensure involvement of an appropriately licensed practitioner to determine the most clinically appropriate referral and the clinical urgency with which the caller should be seen by the Network Provider: Emergent, Urgent or Routine.

Potential risk indicators include, but are not limited to, the following:

- Report of harm to self or others or property destruction
- Statement of intent, threat or plan to harm self or others
- Report of inability to care for self or medical distress
- Substance use symptoms reported or observed, such as slurred speech or report of tactile sensations (itching, bugs crawling, etc.)
- Confusion about date, time, location, current events or recent history
- Report of hallucinations or hearing voices
- Signs of caller distress, including crying, yelling or anger
- Report of feeling anxiety, panic, hopelessness or fear
- Lethargic, unresponsive or unable to comprehend questions
- Bizarre or unusual responses
- Significant inconsistencies in history as related by member and family
- Report of recent significant loss (e.g., death of loved one)

Screening, Triage and Referral Criteria

EMERGENT SERVICE REQUESTS

If the member presents as an imminent danger to the self or others or has a moderate or severe risk related to safety or supervision, the request is classified as emergent. This determination is made based upon the member exhibiting one or more of the following indicators:

- The member has a current significant risk related to safety or supervision, as evidenced by:
  - Risk of harm without supervision, such as walking into traffic or wandering
  - Current harm without supervision
  - Impaired reality testing, such as delusions or hallucinations
  - Dangerous disruptive or bizarre behavior
- The member presents current significant risk of harm to self or others, as evidenced by:
  - Verbalized or implied threats to physically harm self or others
  - Verbalized or implied plan to physically harm self or others

  - Active cutting or burning self
  - Current self-harm or of harm to others
- The member has severe incapacitation in one or more areas of physical, cognitive or behavioral functioning related to MH/IDD/SUD issue(s), such as:
  - Actively psychotic with impaired self-care functions, as in unable to care for self on a daily basis regarding food, hygiene, toileting, etc.
  - Bizarre thought processes
  - Recent physical, cognitive or behavioral incapacitation related to MH/IDD/SUD issue(s)
- The member indicates multiple withdrawal symptoms or reports a history of severe withdrawal and current/recent heavy use or recent referral for detoxification. Symptoms include tremors, paroxysmal sweats, anxiety, agitation, tactile disturbances (itching, bugs crawling, pins, burning sensations), auditory disturbances, visual disturbances (e.g., light sensitivity, seeing things not there), headache, disorientation regarding date and/or inability to do simple math (additions).

Emergent services may be provided by a MCM Team or a Facility-Based Crisis provider. If the individual is experiencing immediate life-threatening circumstances, he or she must be referred to the nearest hospital emergency department, or 911 may be called for emergency transportation to an ED.

URGENT SERVICE REQUESTS

If the member presents no imminent danger to self or others, but the situation may become an emergency without prompt treatment, the request is classified as urgent. This is a level of clinical urgency in which the member presents with moderate risk of incapacitation in one or more areas of physical, cognitive or behavioral functioning related to MH/IDD/SUD issue(s). This determination is made based upon the member exhibiting one or more of the following indicators:

- The member has mild risk related to safety or supervision, as evidenced by significant distress due to mental illness, such as depression or anxiety, but no current plan for harm to self
- The member presents mild risk of harm to self or others, as evidenced by:
  - Superficial cutting
  - Significant distress due to mental illness, such as depression or anxiety, but no current plan for harm to self or others
- The member has mild to moderate incapacitation in one or more areas of physical, cognitive or behavioral functioning related to MH/IDD/SUD issue(s), such as recent history of hallucinations, delusions or bizarre thoughts, but none currently
- The member is at mild risk for substance use withdrawal symptoms that could escalate if not addressed within 48 hours, as evidenced by:
  - Anxiety/depression, agitation or insomnia
  - History of severe withdrawal but no recent/current substance use

Urgent services may be provided through an outpatient clinic or office, through a walk-in service, or by a MCM Team.

ROUTINE SERVICE REQUESTS

If the member presents with a need for services that is not an emergent or urgent, it is classified as routine. This is a level of clinical urgency in which the member presents with mild risk or incapacitation in one or more areas of physical, cognitive or behavioral functioning related to MH/IDD/SUD issue(s). This determination is made based upon the member exhibiting one or more of the following indicators:

- The member has mild to no risk related to safety or supervision, as evidenced by ability to care for self on a daily basis.
- The member presents no risk of harm to self or others, as evidenced by denying any thoughts or plan of harm to self or others.
- The member has mild to moderate incapacitation in one or more areas of physical, cognitive or behavioral functioning related to MH/IDD/SUD issue(s). An example is member's mental health symptoms cause distress but are not currently incapacitating.
- The member shows no indicators of significant risk for substance use withdrawal symptoms as evidenced by:
    - Mild agitation, anxiety or depression
    - Member reports minimal recent use or no substance use within the past several days
    - No history of significant withdrawal
    - Member demonstrates motivation for treatment by agreeing to attend 12-step support during the period prior to assessment

Routine services may be provided through a variety of outpatient or clinic settings or through a walk-in center.

DMH/DD/SAS ACCESS TO CARE TIMEFRAMES

If you accept a referral for services from Vaya's Member Services Department, you are required to meet the applicable DMH/DD/SAS access to care timeframe based on a classification of Emergent, Urgent or Routine.

- Emergent: This standard requires a face-to-face clinical assessment and intervention to be started within two hours and 15 minutes of communication of the service request to the referred provider.
- Urgent: This standard requires a face-to-face clinical assessment and intervention to be started within two calendar days (48 hours) of communication of the service request to the referred provider.
- Routine: This standard requires a face-to-face clinical assessment and intervention to be started within 10 business days or 14 calendar days, whichever is sooner, of communication of the service request to the referred provider.

Failure to meet these timeframes may result in referral for investigation and administrative action or sanction, up to and including termination of your contract with Vaya.

Referrals and Appointments

You are responsible for making referrals to lower or higher levels of care if the needs of a member you are serving change. You are also responsible for facilitating transition to another Network Provider if the member requests to change providers or if your clinical relationship with the member has become detrimental to his or her treatment or recovery. Vaya's Member Services Department can assist you by providing current information on Network Providers accepting referrals. Please be as clear as possible in requests for information or services to enable our MSRs to help you in the most efficient and effective way possible.

If you wish to receive regular referrals for appointments from Member Services, you must create appointment slots in the MCIS. For more information on how to complete that process and what to expect from a referral, please email Member.Services@vayahealth.com. As a Network Provider, you are required to have a "no-reject" policy for referrals made by Vaya. This means that you cannot reject referrals unless you are at capacity or do not provide the most appropriate service for the member. If you reject a referral on any other basis, you must notify us of the reason for your decision not to accept the referral.

MEDICAL NON-EMERGENCY TRANSPORTATION SERVICES

Throughout Vaya's rural catchment area, members need transportation assistance to access services. As a Network Provider, you must assist members you serve in accessing available public transportation, as well as non-emergency medical transportation available through county Departments of Social Services. DSS transportation is for medical (including MH/IDD/SUD) appointments or picking up prescriptions at a pharmacy. Riders must call two to four days in advance to arrange a ride. There is no fee for Medicaid beneficiaries. For those who are not enrolled in Medicaid, transportation depends on available space, and there is a fee. Unfortunately, there are no publicly funded medical non-emergency transportation services in the evening or on weekends.

SECTION 5
Billing and Reimbursement

This section provides a high-level overview of the provider billing and reimbursement process. For questions about claims or reimbursement issues, please contact us at 828-225-2785, ext. 2455, or at Claims@vayahealth.com.

Billing Prerequisites

Network Providers are responsible for ensuring that all billing prerequisites are met prior to submission of a claim.

- **Enrollment and member ID:** As explained in Section 4 of this Manual, the individual must be eligible for and enrolled in a Vaya Health Plan for a claim to be processed. The member ID number identifies the specific individual receiving the service and is assigned by the MCIS. For the provider to obtain this number, the individual must be successfully enrolled into a Vaya Health Plan. All claims submitted with incorrect member ID numbers, or for members whose enrollment is no longer active, will be denied.
- **Medical necessity:** All services paid with public funds must meet documented medical necessity criteria.
- **Prior authorization:** As outlined in Section 6 of this Manual, certain services must be authorized by Vaya prior to service delivery and claims submission. Vaya's claims adjudication system is specifically designed to verify authorization and other eligibility edits prior to reimbursement.
- **Coordination of Benefits:** Vaya is the payor of last resort. All other available first- and third-party payment must be exhausted prior to billing Vaya for services rendered. If the member is eligible, state funds must be exhausted prior to billing Medicaid.
- **NPI (National Provider Identifier) and taxonomy:** All providers are required to obtain an NPI number to submit billing on the CMS 1500 and UB04 forms. Best practice for successful claims submission is to obtain a separate NPI number for each site from which services are billed. Accurate NPI numbers and taxonomy codes are required for claims to be accepted and processed. Failure to comply with these guidelines may result in denied claims and/or recoupment of previously paid claims.
- **NCTracks:** Network Providers are responsible for ensuring that provider names, billing addresses, site addresses, NPI numbers and taxonomy information submitted to Vaya are verified and accurate and exactly match the information in the state of North Carolina's Medicaid Management Information System (MMIS), known as NCTracks. Failure to adhere to this requirement will result in claims denial or recoupment.
- **Documentation and service delivery requirements:** Network Providers are responsible for ensuring that services are delivered and documented in accordance with Controlling Authority outlined in your contract, including, but not limited to, DHB Clinical Coverage Policies and the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2. Please be aware that Medicaid regulations do not allow payment for services delivered to inmates of public correctional institutions. There are also restrictions concerning payment for services delivered to people admitted to facilities with more than 16 beds that are classified as Institutions of Mental Diseases (IMDs). This may include some state facilities, private hospitals, ACH and Family Care Home settings. It is your responsibility to know whether a member is admitted to an IMD at the time of service delivery.
- **Clean Claims requirement:** A clean claim is defined at 42 CFR § 447.45 as one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors

originating in Vaya's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity. It is your responsibility to ensure that all claims submitted to Vaya meet this definition.

- **Electronic Funds Transfers (EFTs):** All reimbursement to Network Providers is done through EFT. Vaya does not write paper checks to Network Providers. It is your responsibility to ensure that Vaya has accurate EFT, tax ID and W-9 information on file prior to claims submission.

Authorization Specifics

- **Date of Service (DOS):** Each authorization will contain a unique number, start date and end date. Only claims with dates of service within these specific time frames will be paid. Dates and/or units outside these parameters will be denied.
- **Type or code:** Each authorization will indicate the specific service or service code that is authorized. Each service will be validated against the authorization to make sure that the service billed matches the service authorized. Claims that fall outside of these parameters will be denied.
- **Units:** Each authorization will indicate the maximum number of units of service that is authorized for the time period in question. As each claim is being processed, the system will check to make sure that the units being claimed fall within the units of services authorized. The system will deny any claims that exceed the limits. Network Providers must establish internal procedures to monitor units of service against authorizations to avoid having claims denied due to exceeding units of service.
- **Exceptions:** There are certain services that do not require authorization at all or do not require prior authorization for an initial service period, referred to as the "pass-through" period. These services are limited in scope, and the pass-through limits are applied per member, not per provider. Section 6 of this Manual details services that do not require authorization or have a pass-through limit. Once the pass-through limit is reached for a member, then all claims submitted without an authorization will be denied. Network Providers must be constantly aware of this issue in order to avoid denied claims.

Claims Submission

METHOD

Network Providers (or your billing agents or clearinghouses) must submit all claims through the MCIS Provider Portal or through a HIPAA-compliant 837 EDI file unless your contract specifically states an alternative method. Paper claims will not be accepted from Network Providers. When a specific service is rendered multiple times in a single day, the service must be "bundled," i.e., billed using multiple units rather than as separate line items. This will prevent a duplicate billing denial. Vaya will accept only HIPAA-compliant transactions as required by law:

- Basic benefit services, outpatient therapy, enhanced services, Innovations Waiver services and non-Medicaid residential and other daily and periodic services must be submitted using the American National Standards Institute ANSI 837P (professional) format or the electronic CMS 1500 form, if billing through the MCIS Provider Portal.
- Inpatient, therapeutic leave, Medicaid-funded residential services, outpatient revenue codes and ICF-IID services must be submitted using the ANSI 837I (institutional) format or the electronic UB04 form if billing through the MCIS Provider Portal.
- Paper claims will only be accepted from out-of-network hospitals or physician groups who submit claims for services delivered in an emergency department setting. These providers will be required to submit an accurate CMS 1500 or UB04 billing form with the correct data elements.

TIMEFRAMES

For emergency department and inpatient facility claims, all claims must be submitted within 90 days of the date of discharge, unless otherwise specified in your contract. In general, all other claims must be submitted within 90 days of the date of service. **Claims in which Vaya is the secondary payor must be submitted within 90 days of the date you receive a denial from a first or third-party payor.** In the case of retroactive Medicaid eligibility, the timely filing requirement of 90 days is measured from the date that member eligibility is determined by N.C. DHHS. **Claims submitted outside of these timeframes will be denied.** Claims must be submitted no less than monthly. Network Providers are encouraged to produce routine billings on a weekly or bi-monthly schedule in conjunction with the checkwrite schedule available on our website.

837 FILE SUBMISSION

Network Providers who wish to submit using an 837 file must complete training, successfully submit and receive test files and execute a Trading Partner Agreement. Training and additional information is available at https://providers.vayahealth.com. Detailed instructions for 837 file submission are provided in the HIPAA Transaction Professional (837P) and Institutional (837I) Transaction Companion Guides, which explain the entire testing and approval process. HIPAA-compliant ANSI transactions are standardized; however, each payor can exercise certain options and require use of specific processes. The purpose of the Companion Guide is to clarify those choices and requirements so that Network Providers can submit accurate HIPAA transactions. Vaya provides the following HIPAA transaction files back to Providers: 999 (an acknowledgment receipt), 824 (a line by line acceptance/rejection response) and 835 (an electronic version of the remittance advice).

RATES

All Network Providers are reimbursed at the lesser of the Vaya published rates for the service being provided or your usual and customary charge for the services, unless otherwise stated in your contract or identified in the MCIS. In general, Vaya follows the DHB fee schedule for Medicaid services. Rate changes will be announced at least 30 days in advance unless resulting from a change imposed by the General Assembly, DHB or DMH/DD/SAS. You can submit claims for more than the published rates, but only the published or contracted rate will be paid. If you submit a claim for less than the published or contracted rate, the lower rate will be paid. It is your responsibility to monitor the publishing of rates and to make the necessary changes to their billing systems.

SITES AND SERVICES

Sites and services for which the Network Provider is approved are listed in the MCIS. Upon request, the Vaya Contracts Team can produce a report (previously called Attachment A) that identifies the sites and services associated with your contract. It is your responsibility to verify that the MCIS contains accurate information. You may only bill for sites and services listed in the MCIS or reimbursement will be denied as a non-contracted service.

CODES AND UNITS

Providers are required to use standard codes for claims submission that are approved and listed in the MCIS. Standard codes for claims submission include the following:

- Current Procedure Terminology (CPT) codes and modifiers
- Healthcare Common Procedure Coding System (HCPCS) codes and modifiers. Note that the HCPCS includes specific requirements regarding unit billing. For example, when only one service is provided in a day, providers should not bill for services performed for less than eight minutes. For any single-timed CPT code in the same day measured in 15-minute units, providers should bill a single 15-minute unit for treatment greater than or equal to eight minutes

through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then two units should be billed.

- CMS Uniform Billing Revenue codes and modifiers (UB04 submission)
- Place of Service Codes
- ICD-10 Diagnosis Codes: ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases. Diagnosis codes from the ICD-10 Code Manual must be provided to the highest level of specificity and follow the classification and diagnostic tools found in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, 2013 (DSM-V). Implementation of the ICD-10 Code Manual by Vaya Network Providers was required effective October 1, 2015.

For more information about coding and ICD-10 implementation, please see https://providers.vayahealth.com.

Coordination of Benefits

Medicaid is the payor of last resort. Providers are required to collect all first- and third-party funds **prior to** submitting claims to Vaya for reimbursement. First-party payors are the members or their guarantors. Third-party payors are any other funding sources that can be billed to pay for the services provided to the member. This can include Medicare, third-party (private) insurance coverage through a non-custodial parent, an employer or the federal Health Insurance Marketplace, worker's compensation, disability insurance, employee assistance program (EAP), court-ordered services paid for by the court or another program, non-custodial parent pursuant to a custody order, liability judgment (e.g., vehicle accident), etc.

As discussed in Section 4 of this Manual, Network Providers must conduct a comprehensive eligibility determination process whenever a member is enrolled. You must also regularly monitor and update eligibility information if circumstances change for a particular member. All first- and third-party payors must be added to the member's record by doing a client update in the MCIS.

You must bill all first- and third-party payors and make reasonable efforts to collect all first- and third-party funds prior to billing Vaya for services. You must wait a reasonable amount of time to obtain a response from the first- or third-party payor before billing Vaya. You are required to retain copies of the Electronic Remittance Advice (ERA), Explanation of Benefits (EOB) or other proof of payment or denial from the applicable payor and a record on submission of the claim either the payment or denial information. Claims must identify the amounts collected from both first- and third parties and only request payment for any remaining amount.

If the member is eligible for non-Medicaid services, those funds must be exhausted prior to billing Medicaid. The MCIS can validate third-party payors and deny or adjust the claim. For out-of-network hospitals and physician groups permitted to file paper claims with Vaya, the provider is required to submit copies of the ERA or EOB with the claim form to Vaya. If you receive reimbursement from a first- or third-party after a claim is submitted to Vaya, you must notify us and submit reimbursement within 30 days of receipt of the first- or third-party funds.

Under the 1915(b) Waiver, Network Providers are not permitted to charge a co-payment for services to Medicaid-eligible members. Once you accept referral of a Medicaid beneficiary from Vaya, you must accept Medicaid reimbursement as payment in full for the services (other than legitimate first- and third- party payments). You may not charge a Medicaid beneficiary for services delivered under your contract with Vaya if we deny authorization or

reimbursement. If you collected funds from Medicaid beneficiaries for any services delivered under your contract with Vaya, you must notify Vaya and return all funds received from the member or responsible party immediately.

Effective November 1, 2015, Vaya implemented a sliding fee scale for **non-Medicaid services only**, which means you must collect some percentage of the cost of services from members and reflect such reimbursement from the first-party payor when submitting a claim for payment for reimbursement to Vaya, as outlined below:

HOUSEHOLD INCOME	FEE
Individuals whose household income falls under 100 percent of federal poverty guidelines (FPG)	No co-payment or fee
Individuals whose household income falls between 100 and 200 percent of FPG	$1.00 co-payment per service or visit*
Individuals whose household income falls between 200 and 250 percent of FPG	$2.00 co-payment per service or visit*
Individuals whose household income falls between 250 and 300 percent of FPG	$3.00 co-payment per service or visit*

*The co-pay is applicable to each service billed to Vaya but note that for services provided and/or billed on a daily basis, the provider may choose to collect the co-pay on a weekly, bi-monthly or monthly basis, at the discretion of the provider. All co-pays collected must be tracked and reported to Vaya monthly and may be retained by the provider to offset costs.

Remittance Advice and Claims Inquiries

The ERA is the standard method of communicating back to providers exactly how each and every claim is adjudicated. ERAs will be available in the download option of the MCIS following each checkwrite and will report whether claims are approved or denied and the reason code for each denial. HIPAA regulations require Vaya to supply providers who submit 837 files with an ERA known as the 835. The 835 will electronically report claims status and payment or denial information.

Inquiries regarding the status of claims should be directed to your assigned Vaya Claims Specialist or other Claims staff at 828-225-2785, ext. 2455, or Claims@vayahealth.com. The process for appealing Vaya's denial of any claims is outlined in Section 17 of this Manual.

Network Providers are directly responsible for management of account receivables. Vaya does not make advance payments or payments outside the posted checkwrite schedule, except in documented situations in which a provider was not paid due to an error of Vaya or its vendors. We must comply with liens imposed by courts or government agencies such as the IRS or N.C. Department of Revenue.

Repayment of Funds Owed to Vaya or DHHS

You are required to pay back any overpayment identified through self-audit or by Vaya. Encounter claim(s) submitted to NCTracks that are rejected, denied or disallowed by DHHS shall be deemed an overpayment. The Finance Department works with legal counsel and the SIU to collect any identified overpayments. We reserve the right to pursue collection of funds owed to Vaya through any legal means.

The Social Security Act and your contract require you to notify us in writing of any Medicaid claims reimbursed by Vaya that must be repaid, whether due to fraud, waste, abuse or error, within five days of identification of the improper reimbursement. You must remit the overpayment within 60 days of identification of the improper reimbursement. You must either file a void claim or replacement claim, or you may choose to complete a Claims Adjustment Request Form.

The form and instructions are posted at https://providers.vayahealth.com. Upon receipt of the form, Vaya will make adjustments in the system and those adjustments will appear on your next RA.

If Vaya determines that you were reimbursed for a claim or portion of a claim that should be disallowed as a result of an error or omission unrelated to fraud, waste or abuse, including encounter claims denied in NCTracks, we will readjudicate such claims and recoup the overpayment from your claims payments. The RA will identify any such adjudication or recoupment. There is no right to request reconsideration when claims are disallowed as a result of error or omission.

If you receive a written notice that Vaya identified an overpayment based on fraud, waste, abuse, overutilization or non-compliance with your contract, including Controlling Authority, you must remit the amount owed within 30 days of the notice, unless you submit a timely request for reconsideration as outlined in Section 17 of this Manual or request in good faith a payment plan. If you fail to timely file a request for reconsideration or fail to timely submit requested financials and/or agree to a payment plan within a reasonable time after requesting a payment plan, we may recoup the funds owed from your claims payments without further notification. We are not required to approve any request for a payment plan. All payment plans will require a signed agreement and may require a promissory note and security.

Please note that the North Carolina Medicaid Fraud Control Unit/ Medicaid Investigations Division (MFCU/ MID) of the N.C. Attorney General's Office reserves the right to prosecute or seek civil damages regardless of payments you make to Vaya. If DHHS provides written notice to Vaya that you owe a final overpayment, assessment, or fine to the Department in accordance with N.C.G.S. § 108C-5, we are required to remit all reimbursement amounts otherwise due to you to DHHS until the final overpayment, assessment, or fine, including any penalty and interest, has been satisfied. In such case, Vaya will notify you that DHHS mandated recovery of the funds from any reimbursement due to you and will include a copy of the written notice from DHHS mandating such recovery.

SECTION 6

Benefit Plans and Authorization

Medicaid – The N.C. MH/DD/SAS Health Plan/ 1915(b) Waiver

Vaya's Medicaid MH/IDD/SUD benefit package includes all behavioral health services required by the 1915(b) Waiver and the N.C. State Plan for Medical Assistance. Vaya's Medicaid 1915(b) Benefit Plan is available on our website at https://providers.vayahealth.com.

Vaya also offers (b)(3) services, which are Medicaid services funded through the savings achieved by Vaya through efficient management of the 1915(b)/(c) Waiver. Unlike regular Medicaid, (b)(3) services are not an entitlement, meaning they can only be authorized if funding is available to pay for these services. Denials based on lack of funding may not be appealed. A list of Vaya's available (b)(3) services is available at https://providers.vayahealth.com. **Vaya's compensation structure for employees and contractors who perform utilization review or utilization management activities does not provide incentives to deny, limit or discontinue medically necessary services to any member.**

Innovations – The N.C. Innovations Waiver Health Plan/1915(c) Waiver

N.C. Innovations is a 1915(c) Home and Community-Based Services (HCBS) Waiver. Vaya's Innovations Waiver benefit package includes all services required by the 1915(c) Waiver and N.C. DHB Clinical Coverage Policy No: 8P. Vaya's Medicaid 1915(c) Benefit Plan is available at https://providers.vayahealth.com.

Non-Medicaid Benefit Plan

Vaya's Non-Medicaid Benefit Plan includes services funded with state single stream, federal Block Grants and county dollars. The services managed by Vaya act as a public safety net. Vaya is committed to making sure resources benefit the people who need it most. Vaya targets non-Medicaid funds toward people who meet priority population criteria based on screening, triage and referral information. Priority populations are groups of people with the most severe types of mental illness, severe emotional disturbances and substance use disorders with key complicating life circumstances, conditions and/or situations.

Non-Medicaid services are not an entitlement. Vaya can only fund services under this benefit plan within the resources allocated to us. Other than crisis or emergency services, non-Medicaid services are generally not available to undocumented persons. Residential treatment is generally not covered under the Non-Medicaid Benefit Plan. If funds are available, exceptions may be made in limited circumstances where there is an identified, specific, significant health and safety risk to an individual, immediate family member or the community, when the requested service is designed to treat the individual's disorder, and no other funds are available.

Vaya's Non-Medicaid MH/SU and IDD benefit plans are available on our website at https://providers.vayahealth.com.

Prior Authorization

Please note that not all services require prior authorization. Vaya does not require you to obtain prior authorization for the following services:

- Outpatient therapy: Prior authorization is not required for group or individual
- Multi-Systemic Therapy (MST) services
- Psychological testing: Prior authorization is not required for up to eight units for adults and up to 16 units for children in any 12-month period. After these limits are reached, prior authorization is required. However, prior authorization is still required for psychological testing paid for with non-Medicaid funds.
- MCM services: The first eight hours per episode of care do not require authorization.
- Medicaid-funded inpatient services: The first seven days per episode of care do not require prior authorization. Prior authorization for continued inpatient services after the first seven days is required.
- Facility Based Crisis (FBC) services: The first seven days per episode of care do not require prior authorization. Non-Medicaid funded FBC services do not require prior authorization.
- Substance Abuse Intensive Outpatient Program (SAIOP): If a member receives more than two full treatment episodes in one state fiscal year, then authorization is required to begin a third episode within the fiscal year.
- Psychosocial Rehabilitation: This does not include psychosocial rehabilitation paid for with non-Medicaid funds, which does require prior authorization.
- Outpatient Opioid Treatment: This does not include outpatient opioid treatment paid for with non-Medicaid funds, which does require prior authorization.
- Supported Employment/Long-Term Vocational Services: Medicaid (b)(3) funded services do not require prior authorization for the first 64 units (16 hours). Authorization for continued services must occur after the 64 units. Non-Medicaid funded IPS-Supported Employment services do not require authorization. Note that Medicaid beneficiaries must access Medicaid (b)(3) Supported Employment funded services.
- Medicaid-funded (b)(3) Peer Support: Prior authorization is not required for group or individual.
- Medicaid-funded (b)(3) Respite (unless requesting Emergency Need Respite, which requires prior authorization before admission)
- Medicaid-funded psychiatric inpatient services: The first seven days per episode of care do not require prior authorization. A notification of admission is required to access pass-through days. Non-Medicaid funded psychiatric inpatient services do not require prior authorization for the first three days per episode of care. A notification of admission is required to access pass-through days.

All other services require prior authorization unless otherwise identified in your contract. Note that practitioners may freely communicate with members about their treatment, regardless of benefit coverage limitations.

PROVIDER RESPONSIBILITY

Requesting authorization, supporting the request with required documentation and demonstrating medical necessity is the responsibility of the provider who will be delivering the service. Before requesting authorization for services, the first step is to complete a Comprehensive Clinical Assessment addressing the elements required by the applicable DHB Clinical Coverage Policy. All providers must use the electronic Service Authorization Request (SAR) form to request prior authorization. Vaya can only process a complete, valid request. If the form is not completed fully, including all required administrative and clinical information, the SAR may be returned, delayed or denied.

Vaya staff may refer Network Providers who routinely fail to timely and fully complete SARs for investigation, as this directly impacts continuity of care for the members we serve. Requesting authorization is the responsibility of the provider who will deliver the service. Please note that providers cannot request authorizations on behalf of another

provider. Behavioral Health Clinical Home providers generate and submit the service plan for all services for a given member but may request authorization only for those services that they provide.

HOW DO I COMPLETE AND SUBMIT A SERVICE AUTHORIZATION REQUEST?

- A SAR must be submitted for each service requiring authorization.
- Except for requests based on retrospective Medicaid eligibility, all SARs must have a service start date that is on or after the date of SAR submission.
- To facilitate communication with Vaya about SARs, please include the name of the individual who is providing the service or who is most knowledgeable about the case, along with that person's telephone number, at the end of the Justification for Service Request field in the MCIS.
- All SARs must be submitted electronically via the MCIS. In documented instances where electronic transmittal is not possible, Vaya may accept transmittal via facsimile, U.S. mail or hand delivery. It is your responsibility to maintain documentation evidencing the date the request was submitted.
- **Network Providers can request specific technical assistance about SAR submission by contacting Vaya's Utilization Management Team at 1-866-990-9712, option 5.**

WHEN DO I SUBMIT A SERVICE AUTHORIZATION REQUEST (SAR)?

- Initial requests: SARs must be submitted at least 14 days prior to the requested start date of services, except for inpatient or other expedited requests. SARS for outpatient services should not be submitted more than 30 days before the requested effective date (exception: Innovations Waiver services requests may be submitted up to 45 days before the requested effective date)
- Periodic services: For routine services, requests to renew an existing authorization must be submitted at least 14 days prior to the end of the previous authorization to avoid a gap in authorization or payment. It is your responsibility to submit a SAR for each subsequent service authorization request prior to the expiration of the current authorization and to conduct a clinical review of the member's ongoing need for services.
- **All Network Providers are required to submit at least 85 percent of initial and continuing requests more than 14 days before the requested start date or end of prior authorization, except for crisis or inpatient requests, and requests that meet criteria for expedited review.**
- Inpatient and Facility-Based Crisis authorizations: If continued authorization is requested, the request and supporting documentation must be submitted to Vaya 24 hours prior to the lapse of the current authorization, unless the renewal date falls on a weekend or official Vaya holiday, when the request may be submitted the next business day for retrospective review.
- Retrospective requests: In situations in which the beneficiary did not have Medicaid at the time the service was provided, but later obtains Medicaid eligibility with an effective date that encompasses the dates that the service was provided, the SAR and all associated documentation must be submitted no later than 30 days following the notification of the Medicaid eligibility determination. Any authorization information from a different vendor or LME that were applicable during the period of services to be reviewed should be included with the request.
- Expedited Requests: If you believe that taking the time for a standard review could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, you may request expedited processing of the request. Clinical justification of the risk of harm should be submitted with the request.

WHEN DOES VAYA RETURN A SAR AS UNABLE TO PROCESS?

Vaya can only process SARs if we receive a complete, valid request. If any of the following information is missing, incomplete or incorrect, we will return the SAR as unable to process. Note that many of these elements are required fields in the electronic SAR.

- Member name, address, date of birth and identification number
- Identification of provider who is to perform the service and the service and/or procedure code requested
- Requested effective dates for service to be delivered
- Documentation or signatures required by federal or state laws, rules or regulation

Other reasons we may return a SAR as unable to process include, but are not limited to:

- Identical or duplicate request, i.e., the provider submits two requests for the same service/same dates for a member OR two different providers submit the same request for the same member, in which case Vaya will process the first request received and return the second request as unable to process
- Member not enrolled in a Vaya Health Plan
- Inconsistent or conflicting information in the request and supporting documentation, i.e., name and Medicaid Identification Number (MID) do not match
- Diagnosis or service not covered by applicable benefit plan, i.e., you submit a request for a non-behavioral health service that is only covered by DHB (e.g., radiology)
- Funding is not available for a non-Medicaid or (b)(3) service
- Service does not require prior authorization

An "unable to process" notification does not include appeal rights. Please note that Vaya will not retroactively review SARs that are re-submitted following an "unable to process" notice.

SUPPORTING DOCUMENTATION

You are responsible for understanding what documentation is required to be submitted with a SAR. This information can be found in the Medicaid Waiver, applicable DHB Clinical Coverage Policies and DMH/DD/SAS Service Definitions and other references listed on the authorization section of our website at https://providers.vayahealth.com/. Requests that are missing required information may result in an administrative denial, which means there is no clinical review, but the member receives a notice with appeal rights.

In addition to required documentation, Network Providers are strongly encouraged to submit any and all information that will support a finding of medical necessity. We will consider all relevant information that is submitted. **Our experience is that many providers wait to submit required or helpful supporting information until after a denial is issued. This delays care for members and creates more work for you.**

SERVICE PLANS

Some services require the development and submission of a service plan. Approved plan formats include the Person-Centered Plan (PCP) and Care Plan, also referred to as an Individual Support Plan (ISP), used with Innovations Waiver participants. For members receiving MH/SU services, plans must be submitted by the Behavioral Health Clinical Home provider.

If a member you are serving does not have a Behavioral Health Clinical Home, then you must collaborate with other providers in developing the service plan. For Innovations Waiver participants, the plan is submitted for approval by the assigned Vaya care manager (previously known as a care coordinator). Service plans must be submitted to Vaya upon development of the initial plan following the initial assessment, at least annually thereafter, and whenever significant changes occur in the member's situation and/or plan of care, including all changes to recommended services.

LEVEL OF CARE/PLACEMENT CRITERIA

Vaya requires that all SARs include results from the following clinical decision support tools as applicable to the member or service being requested:

- Level of Care Utilization System (LOCUS©) for individuals age 18 and older and Child and Adolescent Level of Care Utilization System (CALOCUS©) for children ages 5 to 17. The LOCUS© and CALOCUS© are assessment and placement instruments developed by the American Association of Community Psychiatrists (AACP) with input from the American Academy of Child and Adolescent Psychiatry (AACAP). As of February 1, 2013, these assessment tools must be used to assess level of care for individuals with mental health, emotional or behavioral health needs and are required for all SARs submitted to Vaya. For more information about these tools, please see: http://www.locusonline.com.
- Child and Adolescent Needs and Strengths (CANS-MH) is used for children under age 5 with mental, emotional, behavioral health or intellectual/developmental disability needs. For more information about the CANS tool, please see: http://praedfoundation.org/tools/the-child-and-adolescent-needs-and-strengths-cans.
- N.C. Support Needs Assessment Profile (NC-SNAP), which is a needs assessment tool that, when administered properly, measures an individual's level of intensity of need for IDD supports and services. The NC-SNAP was developed by DHHS and officially adopted in 1999 as the requisite tool for determining an individual's intensity of need for IDD services. As part of the shift to the resource allocation model, Vaya and other MCOs are in the process of phasing out the use of NC-SNAP in favor of the Supports Intensity Scale® (SIS®).
- Supports Intensity Scale® (SIS) is a tool developed by the American Association on Intellectual and Developmental Disabilities (AAIDD) that measures the individual's support needs in personal, work-related and social activities to identify and describe the types and intensity of the supports an individual requires. The SIS® was designed to be part of person-centered planning processes that help all individuals identify their unique preferences, skills and life goals. All Vaya SIS® assessors are trained by AAIDD in administration of the SIS®. For more information about the SIS®, please see Section 13 of this Manual or http://aaidd.org/sis.
- American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC), which are the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with substance use/addiction and co-occurring conditions. For more information about ASAM criteria, please see: https://www.asam.org/asam-criteria. .

NOTE: Completion of one of the above approved leveling tools is required even for services that do not require prior authorization.

INITIAL REVIEW PROCESS

All requests are initially reviewed by UM care reviewers. The first step is to determine if the request is valid or should be returned as "unable to process." If the request is valid, the next step is to determine if the request contains all required information. If information is missing, we will either contact you and request more information or issue an administrative denial. Administrative denials are not reviewed for medical necessity but will contain appeal rights. **"Unable to process" and administrative denials must not exceed 10 percent of your monthly SAR submissions.**

If we ask for more information, you will have up to three business days to submit the additional information. If the request contains all required information, we will review to determine if medical necessity criteria are met. All requests for Medicaid members under age 21 are also reviewed against Early Periodic Screening, Diagnostic and Treatment Program (EPSDT) criteria (discussed below). We will never ask you to withdraw or modify a request, although you may decide to do so at any time if you decide there is a different service that would be more clinically appropriate.

If we determine that the request meets medical necessity and/or EPSDT criteria, the care manager will approve the SAR, resulting in generation of an electronic authorization letter, available in the MCIS for your review. Please consult Vaya system training information or contact the Vaya ServiceDesk for assistance in accessing authorization information. The authorization will contain provider and client identification, tracking numbers for reference (authorization number), the name and total number of units of the service authorized and effective dates. You are responsible for notifying the member when a service is approved. We do not send notifications to members unless the request is denied (in whole or in part). **Note that authorization does not guarantee payment. Payment by Vaya is subject to other requirements and limitations set forth in your contract, this Manual and any other guidance or manuals published by Vaya.**

PEER REVIEW

If a UM Clinician is unable to approve a request based on medical necessity or EPSDT, it will be referred to a licensed doctoral-level psychologist or physician for a Peer Review. Peer Reviewers review the SAR and all information submitted with it when making medical necessity determinations. Additionally, the Peer Reviewer may contact you for a peer-to-peer review in order to obtain additional information or to better understand the information submitted.

When conducting peer-to-peer reviews, Peer Reviewers will call you and identify themselves as calling on behalf of Vaya to discuss an authorization request for a specific member. If unable to contact the appropriate provider representative on the first attempt, a Peer Reviewer may try again to make contact at a later time. However, because of the tight turnaround time requirements for authorization decisions, the window to conduct peer-to-peer discussions is usually short. If the Peer Reviewer is unable to reach you or does not think that a peer-to-peer conversation is necessary, he or she will make a decision based on the information submitted with the SAR.

If Vaya issues a medical necessity denial without having conducted a peer-to-peer discussion, you may request one within three business days of the denial notice. This will ordinarily be with the clinical Peer Reviewer that made the initial decision but if that individual is not available, another equivalent Peer Reviewer will be made available to talk with you. This discussion is not an appeal of the adverse benefit determination but, rather, an opportunity to discuss the decision and the reasons that Vaya could not approve the request. However, if based on the peer-to-peer discussion, the Peer Reviewer determines that a different decision should have been made, he or she may change the initial decision.

HOW MUCH TIME DOES VAYA HAVE TO REVIEW THE SAR?

- Routine reviews: We will issue a decision within 14 days after we receive a complete SAR. We can extend the deadline up to 14 additional days under certain circumstances, but this is rare.
- Expedited reviews: You can request an expedited review of a SAR if you believe that adherence to the standard timeframe could seriously jeopardize a member's life, health or ability to attain, maintain or regain maximum function. If expedited review criteria are met, we must complete the expedited review within 72 hours of the request. We can extend the deadline up to 14 additional days under certain circumstances, but this generally does not occur as it defeats the purpose of an expedited review.
    - If we agree that the request meets expedited criteria, we will notify you and/or the member of our decision by phone. We will send a written decision no more than three days after the phone notification.
    - If we don't agree that expedited review is necessary, we will notify you and the member of our decision and process it within the 14-day timeframe. Denial of expedited review cannot be appealed, but you or the member can file a grievance if you disagree with our decision.
- Inpatient hospitalization and Facility-Based Crisis Reviews: We will issue a decision within 72 hours of the initial request. If we receive a request to extend a current course of treatment more than 24 hours before the end of the current authorization, we will make every effort to issue a decision within 24 hours.

Note that the above timeframes apply regardless of whether the request is for a prospective (i.e., the service is not currently authorized for the member), concurrent (i.e., the service is currently authorized for the member) or retrospective (i.e., the service was already delivered and the provider is seeking authorization to ensure reimbursement) authorization.

Medical Necessity

Vaya uses medical necessity criteria when making authorization decisions. Under our Waiver Contract, medical necessity is defined as treatment that is:

- Necessary and appropriate for the prevention, diagnosis, palliative, curative or restorative treatment of a mental health or substance use condition; and
- Consistent with Medicaid policies and national or evidence-based standards, N.C. DHHS-defined standards, or verified by independent clinical experts at the time the procedures, products and the services are provided; and
- Provided in the most cost-effective, least restrictive environment that is consistent with clinical standards of care; and
- Not provided solely for the convenience of the member, member's family, custodian or provider; and
- Not for experimental, investigational, unproven or solely cosmetic purposes; and
- Furnished by or under the supervision of a practitioner licensed (as relevant) under state law in the specialty for which they are providing service and in accordance with Title 42 of the Code of Federal Regulations, the Medicaid State Plan, the North Carolina Administrative Code, Medicaid medical coverage policies and other applicable federal and state directives; and
- Sufficient in amount, duration and scope to reasonably achieve its purpose; and
- Reasonably related to the diagnosis for which it is prescribed regarding type, intensity, duration of service and setting of treatment.

Within the scope of the above guidelines, medically necessary treatment must be designed to:

- Be provided in accordance with a person-centered service plan, which is based upon a comprehensive assessment and developed in partnership with the individual (or in the case of a child, the child and the child's family or legal guardian) and the community team;
- Conform with any advanced medical directive prepared by the individual/LRP;
- Respond to the unique needs of linguistic and cultural minorities and furnished in a culturally relevant manner; and
- Prevent the need for involuntary treatment or institutionalization.

Early Periodic Screening, Diagnostic and Treatment Program (EPSDT)

EPSDT is a part of the federal Medicaid law that requires state Medicaid programs to pay for regular screenings and certain services for children under age 21, even if the services are not included in the N.C. State Plan for Medical Assistance or the 1915(b)/(c) Waiver. Services approved under EPSDT must be medically necessary to correct or ameliorate a defect, physical or mental illness or condition identified through the screening and must meet all of the following criteria:

- Must fall within a category of services listed at Section 1905(a) of the Social Security Act. This means that most Innovations Waiver services are not covered under EPSDT; and
- Must be medical in nature; and
- Must be generally recognized as an accepted method of medical practice or treatment; and
- Must not be experimental or investigational; and
- Must be safe and effective.

We will review all requests submitted for Medicaid services for children under age 21 against these criteria. Please remember that all requirements for prior approval apply to EPSDT services. In addition to coverage of behavioral health services that are not traditionally covered by Vaya, service coverage by the EPSDT benefit also means that utilization management policy, Waiver and Clinical Coverage Policy limits on hours, units and visits that apply to adults may not apply to children under age 21 if the request meets EPSDT criteria. However, the Innovations Waiver annual budget limit cannot be exceeded under EPSDT. If you believe that a child you are serving would benefit from a behavioral health service that is not covered under the Waiver, you can submit an EPSDT Non-Covered Service request using the form available at https://providers.vayahealth.com.

Decision Notices

Our review of the SAR may result in a full approval, partial approval or a full administrative or clinical denial. If we issue a partial approval or denial of a SAR, the member will receive a written notice that includes appeal rights and a form to request reconsideration. All written notices are sent via certified mail to the address on file in our system. If a member moves and fails to notify his or her county DSS office, it will be hard for the member to receive the notice and file a timely appeal.

Please help us make sure that members understand they need to keep their address current with DSS and accept certified mail from Vaya. The effective date of the decision is the date the notice is mailed, except that if a service is terminated or reduced before the current authorization expires, the effective date will be no sooner than 10 days after the date the notice is mailed. Please note that if you request services in excess of a Medicaid policy or Waiver limit for an adult member, we will not provide appeal rights for any portion of services requested over the limit for adult members.

Reconsideration and Appeal Process

As a Network Provider, it is your responsibility to understand and help members with the reconsideration and appeal process. Members or legally responsible persons (LRPs) who submit an oral request for reconsideration of a Medicaid adverse benefit determination (ABD) no longer need to follow up with a written request. All ABD notices sent to the member or LRP will continue to include the DHHS-required Reconsideration Request Review Form. Providers requesting a reconsideration of an ABD on behalf of a member may submit oral or written requests for the appeal as long as the member or LRP provides written consent authorizing them to file the appeal on their behalf. Members and providers, acting on a member's behalf and having the member's or LRP's written permission, must continue to file written (not oral) appeals of an ABD with the Office of Administrative Hearings (OAH). While we encourage providers to assist members filing a reconsideration or appeal of a non-Medicaid adverse decision, providers may not file the reconsideration or appeal on the member's behalf. Vaya does not engage in retaliation of any kind against a member, a Network Provider, a family member or other person who requests a reconsideration, appeal or expedited review.

More detailed information about the appeal process is included in the Member & Caregiver Handbook available on our website. However, we included an overview of the appeal process below for your reference. It is very important for members to follow exactly all procedures and timelines outlined in the notice. Members must go through the Vaya reconsideration process before filing a Medicaid appeal with the OAH or non-Medicaid appeal with DMH/DD/SAS.

The first step is to request a reconsideration review of the Vaya decision. Oral or signed requests for reconsideration must be received by Vaya within 60 days of the notice for Medicaid services. Signed requests for reconsideration must be received by Vaya within 15 working days of the notice for non-Medicaid services. Requests may be submitted as follows:

- By fax at 1-833-845-5616
- By mail to Vaya Health, Attn: Member Appeals, 200 Ridgefield Court, Asheville, NC 28806
- By email to member.appeals@vayahealth.com
- In person at Vaya's Asheville office, 200 Ridgefield Court, Asheville, NC 28806
- By phone at 1-800-893-6246, ext. 1400
- For assistance, please call the Member Appeals Team at 1-800-893-6246, ext. 1400.

We always send an acknowledgement letter when we receive a reconsideration request, unless an expedited reconsideration is requested and accepted. If the member does not receive an acknowledgement letter, please contact us right away to follow up. Reconsideration requests are reviewed by a healthcare professional with appropriate clinical expertise in treating the member's condition or disorder who was not involved in the original decision and is not a direct subordinate of the initial decisionmaker(s). As part of the process, members can request a copy of their records from Vaya, and new or additional information will be accepted and considered.

For Medicaid appeals, we will issue a written decision (called a notice of resolution) within 30 days of receipt of a timely request. The reconsideration can be expedited if we agree that a member or LRP's request for an expedited review meets the expedited review criteria or if the ordering provider or another qualified provider with knowledge of the member's medical condition indicates that adherence to the standard timeframe could seriously jeopardize a member's life, health or ability to attain, maintain or regain maximum function.

If the request to expedite is necessary, we will complete the expedited review, attempt to notify the member of our decision by phone and notify you and the member by written decision within 72 hours of the request. If we do not agree that expedited review is necessary, we will notify you and the member of our decision and process it within the applicable appeal timeframe. Vaya will make reasonable efforts to provide members prompt oral notice and will provide a written notice within two calendar days when Vaya denies a request for an expedited appeal. The member/LRP may file a grievance of this decision but may not otherwise appeal the denial of a request for expedited resolution.

Similar to the process for review of service authorization requests, the timeframe to issue a written decision (for either a standard or expedited appeal) may be extended by up to 14 calendar days if the member requests the extension or Vaya demonstrates that there is need for additional information and the delay is in the member's interest. If Vaya extends an appeal resolution timeframe, we will make reasonable efforts to give the member prompt oral notice of the delay and will notify in writing of the extension within two calendar days. If a member disagrees with the extension, they have the right to file a grievance.

For non-Medicaid appeals, we will issue a decision within seven (7) business days of receipt of a timely request.

If a member disagrees with our decision, he or she can either: (1) for Medicaid services, file an appeal with OAH within 120 days of the date of the Vaya notice of resolution or (2) for non-Medicaid services, file an appeal with DMH/DD/SAS within 11 calendar days of the Vaya appeal decision letter date. Instructions and an appeal form are included with the decision notice.

There is no "maintenance of service" under Medicaid managed care or for non-Medicaid services. However, if Vaya reduces, suspends or terminates a current authorization, Vaya will continue a Medicaid member's benefits if all of the following conditions are met:

- A timely request for reconsideration is made;
- The member remains Medicaid-eligible;

- The reconsideration involves the termination, suspension, or reduction of a previously authorized service;
- The services were ordered by an authorized provider;
- The authorization period for the services has not expired; and
- A timely request (meaning on or before the later of within 10 calendar days of the Notice of Adverse Benefit Determination or the intended effective date of Vaya's proposed decision) for services to continue is made.

If the member meets all of the above conditions, and Vaya authorizes continuation of benefits, the benefits will be continued (so long as the original authorization period has not expired) until one of the following occurs:

- The member withdraws the reconsideration or appeal request;
- The member does not request a State Fair Hearing and continuation of benefits within 10 days from the date of the Notice of Resolution; or,
- A State Fair Hearing decision adverse to the member is issued.

If a member decides to appeal a Vaya decision, and the decision is upheld, Vaya has the right to recover from the member, spouse or parent (if under 18) the cost of services furnished during the reconsideration and appeal process.

SECOND OPINION

Medicaid beneficiaries have the right to a second opinion if the person does not agree with the diagnosis, treatment or the medication prescribed. Members are informed of this right in the Member & Caregiver Handbook published by Vaya and available on our website. If a second opinion is requested, you must refer the member to Vaya's Utilization Management Department.

Vaya Clinical Practice Guidelines

All utilization management decisions are consistent with clinical practice guidelines adopted by Vaya. Vaya is not required to adopt a guideline for every service we manage, but all guidelines are adopted through a Clinical Advisory Committee that includes provider and CFAC participation. Guidelines are based on valid and reliable clinical evidence (evidence-based practices) or a consensus of licensed professionals.

We also may adopt clinical practice guidelines promulgated by nationally recognized peer review organization such as the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP).

Clinical practice guidelines are designed to guide providers on how to follow national and community standards of practice. Providers are expected to maintain or advance the quality of services through the demonstration of practice consistent with the adopted clinical practice guidelines and suggested best practices. Clinical practice guidelines are not a substitute for the advice of a healthcare professional or the utilization reviewer or peer reviewer making medical necessity determinations. Guidelines are available at https://providers.vayahealth.com.

Physician Directed Treatment Services

Vaya values the role of physician leadership in the provision of medically necessary and medically directed services. This section of the Manual, developed by our Chief Medical Officer in consultation with our Clinical Advisory Committee, outlines Vaya's requirements for services that require physician oversight. Vaya's Network Performance & Integrity Department will periodically validate adherence to these requirements, including during investigations prompted by complaints from members and families.

PHYSICIAN TEAM LEADERSHIP AND ON-SITE SERVICES

Medically Necessary Services for physician directed levels of care such as inpatient, Facility Based Crisis (FBC), Assertive Community Treatment Team (ACTT) and Psychiatric Residential Treatment Facility (PRTF) require clinical oversight and direct participation with the treatment team. This cannot be managed primarily through use of telemedicine, unless specific waivers are authorized by Vaya (such as challenges in service delivery related to a State of Emergency resulting from a pandemic or national disaster).

- For inpatient services, the attending psychiatrist needs to be physically present for daily rounding.
- For FBC, the service delivery plan must include active physician oversight. If clinical care is primarily provided by mid-level practitioners, the physician is responsible for ensuring quality care is available with on-site medical staff presence at least three days per week.
- For ACTT services, the psychiatrist must be in the community at least 50% of the time, directly evaluating patients and guiding the team.
- For PRTF level of care, the psychiatrist must be onsite at least weekly to directly evaluate patients, lead team meetings and provide milieu management.

TELEMEDICINE GUIDANCE

Physicians are encouraged to follow telemedicine guidance provided by the North Carolina Medical Board (the Board). Telemedicine can be a useful tool for increasing access to care, expanding specialty expertise and reducing patient cost. However, the Board cautions that telemedicine providers will be held to the standards of care applicable to their area of specialty, with the same requirements for quality and outcomes as occurs with in-person care.

SCHEDULE II MEDICATIONS

Physicians must comply with the Board's policy for the use of Schedule II medications. This includes checking the North Carolina Controlled Substance Registry Service (directly or through delegation) when prescribing Schedule II medications and being cognizant of potential medication misuse or diversion.

Comprehensive psychiatric care includes competencies in serving all disability groups with various comorbidities and requires effective communication and collaboration with all healthcare providers involved with each patient. Comprehensive psychiatric care includes use of appropriate medications based on best practice principles, after completion of a thorough history, record review and clinical exam. Appropriate medications may include stimulants, benzodiazepines and opiates. It is not acceptable for Vaya providers to adopt or implement a policy of advising members that Schedule II medicines are never prescribed.

Not all members with substance use disorders require transfer to a higher level of care. Ambulatory detoxification is a part of outpatient psychiatry and should occur in the context of appropriate risk assessment and monitoring.

For members receiving Medication Assisted Treatment (MAT) for Opioid Use Disorders, the standard of practice in North Carolina includes use of treatment contracts, random urine drug screenings and pill counts when indicated. Medication assists the treatment and is not the whole treatment. Treatment goals should include improved functionality and progress toward a meaningful life. Regular physician oversight includes monthly treatment plan reviews and face-to-face evaluations when treatment goals are not being achieved. Outpatients who are stable with MAT should be continued on medications as appropriate when hospitalized, with use of medication reconciliation by the attending physician.

PHYSICIAN SUPERVISION OF MID-LEVEL PRESCRIBERS

Mid-level practitioners provide key services to Vaya members. Current North Carolina licensure requires utilization of Collaborative Practice Agreements (CPAs), which define both scope of practice and required supervision and

consultation. While Schedule II medications can provide life-saving treatment, they can also significantly increase risk of adverse outcomes. Vaya recommends that the CPA specifically address what consultation is required between the physician and mid-level prescriber for Schedule II medications, with delineation of required documentation of discussion and review of risk/benefit issues for members who: 1) are not in recovery with their substance use disorder; 2) have a history of psychosis; 3) have a history of aggressive behavior/domestic violence/criminal involvement; and/or 4) are on three or more maintenance antipsychotic medications.

COMMUNITY SAFETY/POPULATION HEALTH

Vaya supports treatment planning that minimizes the risk of addiction. Physician leadership is critical to the health of our population. More deaths occur annually in North Carolina from opiate overdoses than from motor vehicle accidents. Prevention and early intervention are the first steps to reduce the current prevalence of addiction. For persons with addiction and/or a chronic illness, use of a multi-modal treatment plan provides the best chance for return to a meaningful life and avoidance of disability and premature death.

SECTION 7
Member Rights and Empowerment

The protection and promotion of member rights and empowerment is a crucial component of our service delivery system. Vaya Network Providers must always respect member rights, provide members continual education regarding their rights and support members in exercising their rights to the fullest extent possible.

Member Rights

Under the U.S. and N.C. Constitutions, N.C.G.S. Chapter 122C, Article 3, APSM 95-2: DMH/DD/SAS Client Rights Rules In Community Mental Health, Developmental Disabilities And Substance Abuse Services, effective July 1, 2003, and other applicable federal and state laws, rules and regulations, Vaya Health Plan members have the following rights:

- The right to receive information in accordance with federal Medicaid requirements
- The right to confidentiality and privacy
- The right to be treated with respect and recognition of your dignity
- The right to humane care and freedom from mental and physical abuse, neglect and exploitation
- The right to live as normally as possible while receiving care and treatment
- The right to be free from unwarranted searches of your person or seizure of your possessions
- The right to be free from unnecessary or excessive medication, which shall not be used for punishment, discipline or staff convenience, and which shall be administered in accordance with accepted medical standards and only upon the order of a physician or other medical practitioner, as documented in your health record
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- For enrollees who live in adult care homes, the right to report any suspected violation of your rights to the appropriate regulatory authority as outlined in N.C.G.S. § 131D-21
- The right to be free from any form of discrimination prohibited by federal or state laws, rules and regulations
- The right to freedom of speech and freedom of religious expression
- The right to exercise the same civil rights as any other citizen, including the right to vote, marry, divorce, make a will and buy, sell and own property, unless you have been adjudicated incompetent
- The right to be free from the threat of unwarranted suspension or expulsion from treatment
- The right to consent to or refuse treatment, except in a medical emergency or an involuntary commitment
- The right to receive treatment in the most natural, age-appropriate and least restrictive environment possible
- The right to participate with your treating providers in making healthcare decisions
- The right to participate in the development and periodic review of your written person-centered treatment or habilitation plan that builds on individual needs, strengths and preferences
- The right to have an individualized treatment or habilitation plan implemented within 30 days of admission to any inpatient or residential facility
- The right to ask questions of Vaya or your treating providers at any point in the process and receive accurate information

- The right to participate in a candid discussion with your treatment providers about medically necessary treatment options and alternatives for the relevant diagnosis or condition, regardless of benefit coverage limitation
- The right to be informed in advance of the benefits or risks of treatment choices and to a second opinion, at no cost to you
- The right to receive information on available treatment options and alternatives, presented in an appropriate way that you are able to understand
- The right to decide among relevant treatment options and express preferences about future treatment decisions, regardless of benefit coverage limitation
- The right to be informed of the cost of services at the first visit or during scheduling of the first appointment
- The right to voice complaint(s) or file a grievance about Vaya or about the care and treatment you receive from providers
- The right to receive written notification from Vaya about adverse decisions on requests for prior authorization
- The right to file an appeal with Vaya of the denial, reduction, suspension or termination of a service and to request a State Fair Hearing if you disagree with Vaya's final decision
- The right to receive interpretation or translation services and other accommodations needed for accessibility, free of charge
- The right to a current listing of network providers and access to a choice of providers from within the network, to the extent possible or required by law
- The right to receive information about Vaya, our providers and your rights and responsibilities presented in a manner appropriate to your ability to understand
- The right to recommend changes to Vaya's policies and services. If you wish to do so, please contact our Member Services Department at 1-800-849-6127 or write us at: Vaya Health, 200 Ridgefield Court, Asheville, NC 28806.
- The right to receive a written notice from Vaya of any "significant change" at least 30 days before the intended effective date of the change. This is a change that requires modifications to the N.C. State Plan for Medical Assistance, the 1915 (b)/(c) Waiver or Vaya's contract with NC Medicaid.
- The right to make instructions for mental health, substance use disorder or IDD treatment in advance to use if you become incapable of making such decisions. The forms used to do this are called advance directives. The N.C. Secretary of State provides forms you can use to create advance directives online at www.sosnc.gov/divisions/advance_healthcare_directives.
- The right to be furnished, consistent with the scope of services of Vaya's Waiver Contract, healthcare services in accordance with federal law

Vaya strictly prohibits retaliation by Vaya staff or Network Providers against any member who exercises any of the rights described in this Section.

Member rights can only be restricted for reasons related to a member's care or treatment by their treatment team. A restriction of member rights must go through a Human Rights Committee for approval. Any restriction must be documented and maintained in the member's medical record.

Rights of Individuals in 24-Hour Facilities

Members admitted to or living in a 24-hour licensed facility, including but not limited to Mental Health or IDD Group Homes, Adult Care Homes, Psychiatric Hospitals and State-Operated Healthcare Facilities, have the rights listed above and have the right to:

- Receive necessary medical care if they are sick. If their insurance does not cover the cost, they will be responsible for payment.
- Receive a reasonable response to requests made to facility administration or staff
- Receive upon admission and during the stay a written statement of the services provided by the facility and the charges for these services.
- Be notified if the facility is issued a provisional (temporary) license or notice of revocation (reversal) of license by DHSR.
- Send and receive unopened mail and have access to writing material, postage, and staff assistance if requested.
- Contact and consult with a member advocate, legal counsel, private physicians, and private MH/IDD/SUD professionals of his or her choice (at their own expense and at no cost to the facility)
- Contact and consult with a client advocate if there is a client advocate.
- Contact and consult with their parent or legal guardian at any time if they are under 18 years of age.
- Make and receive confidential telephone calls, at their own expense and at no cost to the facility.
- Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. Visiting hours must be available for at least six hours each day, two hours of which must be after 6:00 p.m. If they under age 18, visitors cannot interfere with school or treatment.
- Communicate and meet with individuals that want to communicate and meet with them. This may be under supervision if their treatment team believes it is necessary.
- Make visits outside the facility unless the member's Person-Centered Plan indicates that this is not recommended or the member was committed to the facility while under order of commitment to a DPS correctional facility OR as the result of the member being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the member was found not guilty by reason of insanity or incapable of proceeding;
- Be outside daily and have access to facilities and equipment for physical exercise several times a week;
- Keep, and have access to individual storage space for, their personal clothing and lawful possessions, that can be locked and only accessible by them, the administrator or supervisor-in-charge;
- Participate in religious worship if they choose;
- Keep and spend a reasonable sum of their own money;
- Retain a driver's license, unless otherwise prohibited by law; and
- Not to be transferred or discharged from the facility except for medical/ health or non-payment reasons unless they have committed illegal acts, pose a safety threat to themselves or others, or the transfer or discharge is mandated by state or federal law.

North Carolina's Adult Care Home Bill of Rights also outlines the rights of individuals residing in an ACH to include an individual's right to associate and communicate privately and without restriction with people and groups of his or her own choice.

Anyone receiving services in a licensed facility has the right to express a concern or grievance without fear of retribution. Concerns or grievances may also be brought forward by a guardian or anyone else authorized to speak on behalf of the person who is receiving services. DHHS Long-Term Care Ombudsmen serve as advocates for individuals living in ACHs throughout North Carolina. In addition, the DHHS Division of Health Service Regulation (DHSR) monitors complaints regarding licensed facilities.

Individuals living in State-Operated Healthcare Facilities are afforded all state and federal civil rights, including rights under: Article 3 of N.C.G.S. Chapter 122C, the Individuals with Disabilities Education Act (IDEA), The Americans with Disabilities Act (ADA), The Rehabilitation Act, the Civil Rights of Institutionalized Persons Act (CRIPA), and Title VI of the Civil Rights Act. Consumer Advocates are located in each State-Operated Healthcare Facility and are available to

individuals and their families 24 hours a day, 7 days a week. Each State-Operated Healthcare Facility also has a Human Rights Committee that is appointed by the DHHS Secretary. These committees work to protect the rights of the people being served by the Facility. The Consumer Advocates are available to follow-up on any matters that are of concern to the Human Rights Committees.

Grievances, Complaints and Concerns

All Network Providers are required to implement and maintain an internal process to address any grievances, complaints or concerns related to services provided. This process must be in writing, well-publicized and communicated to all members upon admission to treatment and upon request. Any unresolved grievances, complaints or concerns, or violation of member rights should be reported to the Vaya Grievance Resolution & Incident Team (GRIT) by calling (828) 225-2785 extension 1600 and/ or by contacting the appropriate state or federal official:

DHHS Customer Service Center
Phone: 800-662-7030 (English or Spanish)

DHHS Office of Privacy and Security
Phone: 919-855-3000
Fax: 919-733-1524
Online Reporting: https://security.ncdhhs.gov/
Email: DHHS.Security@dhhs.nc.gov
Mailing Address: 2015 Mail Service Center, Raleigh, NC 27699-2015
Physical Address: 695 Palmer Drive, Raleigh, NC 27603

Office of the State Long Term Care Ombudsman
Phone: 919-855-3400
Fax: 919-715-0364
Website: http://www.ncdhhs.gov/aging/ombud.htm
Mailing Address: 2101 Mail Service Center, Raleigh, North Carolina 27699-2101

N.C. Division of Health Service Regulation (Licensed Facilities)
Complaint Hotline: 1-800-624-3004 (within N.C.) or 919-855-4500
Complaint Hotline Hours: 8:30 a.m. - 4:00 p.m. weekdays, except holidays.
Fax: 919-715-7724
Mail: 2711 Mail Service Center, Raleigh, NC 27699-2711
Online Reporting: https://info.ncdhhs.gov/dhsr/ciu/filecomplaint.html

U.S. Department of Health and Human Services Office for Civil Rights
Phone: 1-800-368-1019
TDD toll-free: 1-800-537-7697
Address: 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201
Email: OCRPrivacy@hhs.gov.

Vaya Health Plan members can also file a grievance or complaint directly with Vaya about any matter other than authorization decisions, either verbally or in writing. You must publicize the process for contacting Vaya to report a grievance, complaint, concern or potential rights violation:

- Telephone – Call the Access to Care Line 1-800-849-6127
- Telephone – Call the Vaya Compliance Hotline at 1-866-916-4255 (this option allows for anonymous reporting)
- Mail – Vaya Health, Attn: Grievance Resolution & Incident Team, 200 Ridgefield Court, Suite 206, Asheville NC 28806
- Email – ResolutionTeam@vayahealth.com
- Online through EthicsPoint – www.vayahealth.ethicspoint.com (this option allows for anonymous reporting). EthicsPoint™, an online compliance intake platform, is used as a compliance concern and complaint/grievance reporting mechanism for members, community stakeholders, providers and Vaya staff. The EthicsPoint™ platform assigns an individualized report key to each case as well as a password, which must be maintained as staff at Vaya do not have access to update or retrieve passwords.

We frequently receive anonymous complaints. Occasionally we may receive a grievance or complaint about a Network Provider from one of your employees. We will not share the employee name with you unless ordered to do so by a court. **Retaliation by Network Providers or Vaya against individuals who report concerns or file grievances or complaints is strictly prohibited.** Regardless of the source, we take all grievances and complaints very seriously and strive to resolve them to the best of our ability. Categories of grievances and complaints we receive include concerns about:

- Quality of Care
- Access
- Attitude/Service
- Billing/Financial
- Quality of Practitioner Office Site

If we receive a grievance or complaint about a Network Provider, our first step is usually to email you, get more information and try to resolve the issue, unless: (1) the grievance or complaint involves an allegation of fraud, in which case the SIU will be notified; or (2) the grievance or complaint involves serious health and safety issues, in which case the CMO will be notified and take immediate action as determined necessary. You must keep documentation on all grievances or complaints you receive, including date received, summary of the concern and resolution information. Network Providers are required to respond to requests for information from the GRIT within ten (10) days of a request for information. If you do not respond within this timeframe, a decision regarding the grievance or complaint will be made without your input and you may be referred for follow-up and potential sanction.

Based on the nature of grievances and complaints we receive, Vaya may also choose to investigate a Network Provider or make a referral to another agency, such as the Division of Health Service Regulation (for licensed facilities). Investigations may be announced or unannounced. More information about those investigations can be found in Section 16 of this Manual.

Vaya makes every effort to resolve member grievances and complaints within 30 days. Under federal law, we have up to 90 days to resolve a Medicaid grievance. Individuals who file a grievance or complaint receive written notification about the resolution and may appeal the findings. The appeal is reviewed internally by an appropriate Vaya staff member or licensed clinician and there is no right to appeal further (for example to DHHS or the Office of Administrative Hearings).

Non-Discouragement

Vaya staff and Network Providers are prohibited from discouraging a member from exercising his or her rights, including, but not limited to, the rights to request services, submit a plan of care the member agrees with, file reconsiderations or appeals, ask for expedited review, lodge complaints or grievances with DHHS or Vaya or report

suspicious billing or potential fraud, waste or abuse. Network Providers are specifically prohibited from discouraging a member from filing grievances or complaints with Vaya. Discouragement includes intentionally providing material misinformation to a member. However, Vaya staff and Network Providers can offer alternative services, if appropriate; engage in clinical, treatment or educational discussions with members; explain that a request for services may be denied and suggest alternative services; and explain the appeal process, including Vaya's right to recover the cost of services furnished during an appeal.

Informed Consent and Advocacy

Vaya does not prohibit or otherwise restrict a healthcare professional acting within the lawful scope of practice from advising or advocating on behalf of a member. You should always:

- Advocate for medically necessary care or treatment options.
- Provide information the member needs to decide among all relevant treatment options.
- Encourage the member to participate in decisions regarding his or her healthcare and to express preferences about future treatment decisions through advance directives and crisis plans.

You must obtain informed consent from individuals prior to starting any service or course of treatment. This means that you must explain potential risks, benefits and consequences of treatment and non-treatment options, including any potential side effects of medication, as well as alternatives to the recommended treatment. You must also include individuals in treatment team meetings and development of their service plan. Members can refuse any treatment, refuse to take part in research studies, stop or discontinue services at any time or discharge themselves from your care unless: (1) it is an emergency situation, (2) services are being provided under an inpatient or outpatient involuntary commitment order, (3) treatment is ordered by a court of law or (4) the member is under age 18, is not emancipated and the guardian or legally responsible person (LRP) gives permission.

Right to Privacy and Security

Vaya Network Providers must ensure the confidentiality, privacy and security of all member health records in accordance with the Health Insurance Portability and Accountability Act of 1996, the HIPAA Privacy Rule, HIPAA Security Rule, 42 C.F.R. Part 2, N.C.G.S. 122C, Article 3 and other federal and state laws, rules and regulations. You must also ensure that all employees and contractors maintain the confidentiality of persons receiving services and other information received in the course of providing services.

This means that Network Providers and their employees and contractors must not discuss, transmit or narrate in any form any member information of a personal nature, medical or otherwise, except as authorized in writing by the member/Legally Responsible Person (LRP), or as permitted by applicable federal and state confidentiality laws, rules and regulations. It is your responsibility to know what information can be disclosed, to whom and under what circumstances.

All electronic communications to or from members, or that contains protected health or other sensitive information about members, must be sent via a secure electronic mail system such as Zixmail. Please be aware that the HIPAA Privacy Rule requires all healthcare providers to develop and distribute a Notice of Privacy Practices that provides a clear, user-friendly explanation of individuals' rights with respect to their health information and the privacy practices of the healthcare provider.

More information and model notices are available at http://www.hhs.gov/ocr/privacy/hipaa/modelnotices.html. We may ask to see a copy of your notice at an on-site review. Vaya's Notice of Privacy Practices is available on our website.

Rights of Minors

Please be aware that under North Carolina law, a minor (a person under age 18) has the right to agree to some treatments without the consent of his or her parent or guardian, including treatments for:

- Venereal (sexually transmitted) diseases
- Pregnancy (but not abortion, which requires consent of at least one parent)
- Use of alcohol or controlled substances
- Emotional disturbance

24-Hour Facilities

Network Providers who operate 24-hour treatment facilities must provide the member with a document that explains the specific rules for that facility, including rules that cover hygiene, grooming, living environment, personal funds and storage and protection of clothing and possessions. Vaya 24-hour facility providers must explain and provide a copy of these rules to individuals within 72 hours of admission. Please refer to Subchapter 27F of the 10A North Carolina Administrative Code, Section .0100 through .0105 for more information about this requirement.

Guardianship

Individuals who cannot make and communicate important decisions about their personal and financial affairs may be declared incompetent and be assigned a guardian to help them exercise their rights. If you are serving someone who may need a guardian, you should talk to their family members about options or file an adult protective services report with the county DSS office. Guardianship does not necessarily mean the person loses all rights – it can be limited to protect those rights that are within the comprehension and judgment of the individual. For example, a guardian of the estate may be appointed to help the individual manage financial affairs, while the person retains the right to make decisions about healthcare, housing and other personal matters. Representative payees are another option to help someone who needs assistance managing their finances. A finding of incompetence is not permanent. An individual's rights can be restored if they can prove they are able to manage their own affairs and make and communicate important decisions. Partial restoration of some rights is also an option.

North Carolina's guardianship laws are found at Chapter 35A of the General Statutes. You should be aware of the following provisions, at a minimum:

- N.C.G.S. § 35A-1201(5) states that "Guardianship should seek to preserve for the incompetent person the opportunity to exercise those rights that are within his comprehension and judgment, allowing for the possibility of error to the same degree as is allowed to persons who are not incompetent. To the maximum extent of his capabilities, an incompetent person should be permitted to participate as fully as possible in all decisions that will affect him." This is the public policy of North Carolina. **This means that you must do your best to ensure that persons you are serving who are deemed incompetent are included to the fullest extent possible in treatment team meetings and other venues where decisions about his or her care are made.**
- N.C.G.S. § 35A-1213(g) states that an employee of a treatment facility may not serve as guardian for a ward who is an inpatient in or resident of the facility in which the employee works. This means that employees of psychiatric residential treatment facilities, group homes, Alternative Family Living homes, Family Care Homes, Adult Care Homes, halfway houses and other community-based residential facilities licensed by DHSR cannot serve as the guardian for someone who resides at or is receiving inpatient treatment from the facility.
- N.C.G.S. § 35A-1213(f) states that an individual who contracts with, or is employed by an entity that contracts with, an LME/MCO for the delivery of MH/IDD/SUD services may not serve as a guardian for a ward for whom the

individual or entity is providing these services. **In general, this means that Vaya Network Providers cannot serve as guardians for Vaya Health Plan members being served by the provider, practitioner or staff member.** There are some limited exceptions:

- A member of the ward's immediate family (meaning a spouse, child, sibling, parent, grandparent or grandchild) who contracts with Vaya or works for a provider agency can still serve as guardian; or
- A licensed family foster care provider or a licensed therapeutic foster care provider who was appointed to serve as a guardian on or before January 1, 2013; or
- A biologically unrelated individual who was appointed to serve without compensation as a guardian on or before March 1, 2013.

Firearms and Concealed Carry Permits

Under federal and state law, individuals with a history of substance use, involuntary commitment or certain criminal history may be denied the right to purchase a firearm or to carry a concealed weapon. Clerks of Court in North Carolina are required to report the following types of findings to the National Instant Criminal Background Check System (NICS):

- Involuntary commitment for inpatient or outpatient mental health or substance use treatment
- A finding that an individual is not guilty by reason of insanity
- A finding that an individual is mentally incompetent to proceed to criminal trial
- A finding that an individual lacks the capacity to manage his or her affairs due to marked subnormal intelligence or mental illness, incompetency, condition or disease

In addition to the NICS check, persons who apply for a permit to carry a concealed weapon in North Carolina must give consent for the details of any mental health and substance use treatment and hospitalizations to be released to law enforcement. We process hundreds of authorization and release forms every year in order to check the health information in our care, custody and control for records that might disqualify someone for a concealed carry permit. Behavioral health providers also routinely receive signed authorization and release forms from local sheriff's departments asking for this information. Cooperating with mental health screening for gun permits is an important role in the public system and another reason why records retention and maintenance is a critical function under your contract with Vaya.

Restrictive Intervention

Vaya prohibits the use of restrictive interventions by Network Providers except as specifically permitted by each member's Person-Centered Plan (PCP) or Care Plan, as applicable, or on an emergency basis. "Prone" restraints or any techniques whereby the restrained individual will end up in a face-down position are entirely prohibited. If a restrictive intervention is used three or more times within a 30-day period or is used as a therapeutic treatment designed to reduce dangerous, aggressive, self-injurious or undesirable behaviors to a level which will allow the use of less restrictive treatment or habilitation procedures, it must be included in the member's PCP or ISP, as applicable, as a planned restrictive intervention. Otherwise, it must be reported to Vaya's HRC and/or in the state's Incident Response Improvement System (IRIS), as applicable. All restrictive interventions or devices utilized must comply with Article 3 of N.C.G.S Chapter 122C.

Client Rights Committee

Agencies contracted for participation in the Vaya Closed Network are required to establish and maintain a Client Rights Committee (also called a Human Rights Committee) in accordance with N.C.G.S. § 122C-164 and 10A NCAC 27G .0504.

The Client Rights Committee must establish a process for the reporting of restrictive interventions used by the agency, including seclusion, restraint and isolation time-out, as well as a review procedure for member grievances; alleged violations of the rights of individuals or groups, including cases of alleged abuse, neglect or exploitation; concerns regarding the use of restrictive interventions; and failure to provide needed services. Network Providers are required to submit the minutes of their Client Rights Committee meetings to Vaya on a quarterly basis. Prior to submission, you must de-identify any information that is not in relation to Vaya Health Plan members. The Vaya Human Rights Committee (HRC) is responsible for the monitoring and oversight of Agency Client Rights Committee functions.

Advance Directives

Advance directives are legal forms that allow individuals to make decisions about end-of-life care and plan ahead with regard to health treatment, including psychiatric treatment. Vaya complies with all state and federal laws and regulations related to advance directives, including Article 23 of Chapter 90 of the General Statutes, and updates information to reflect changes in state law as soon as possible. Vaya does not condition provision of care or discriminate against members based on whether or not they have executed an advance directive.

The State of North Carolina has a specific form that can be used for individuals to create an advanced directive for mental health treatment, known as the Psychiatric Advanced Directive, or PAD. The PAD enables individuals to plan ahead for mental health treatment they might want to receive if they experience a crisis and are unable to communicate for themselves or make voluntary decisions of their own free will.

You are responsible for educating members about the ability to create advance directives and assisting members who express the desire to create a PAD. If you are assisting a member in completing a PAD, plan on several meetings to thoroughly think about crisis symptoms, medications, facility preferences, emergency contacts and preferences for staff interactions, visitation permission and other instructions. Below are some helpful tips and information:

- The statutory form can be found at N.C.G.S. § 122C-77. More information about the PAD is available at: https://www.samhsa.gov/sites/default/files/a_practical_guide_to_psychiatric_advance_directives.pdf
- The member must sign the PAD in the presence of **two** qualified witnesses. The signatures must be acknowledged before a notary public. The witnesses may not be the attending physician, the mental health treatment provider, an employee of the physician or mental health treatment provider, the owner or employee of a health care facility in which the member is a resident, the member's spouse or someone related to the member.
- The PAD becomes effective upon its proper execution and remains valid unless revoked.
- The PAD is not designed for people who may be experiencing mental health problems associated with aging, such as Alzheimer's disease or dementia.
- A PAD can include a person's wishes about medications, electroconvulsive therapy (ECT), admission to a hospital, restraints and whom to notify in case of hospitalization.
- The PAD may include instructions about paying rent or feeding pets while the member is in the hospital.
- The member can include the name of their treating psychiatrist or clinician with instructions for the ED to call him or her and follow their instructions if the member is unable to speak for himself/herself or is confused.

Upon being presented with a valid PAD, the provider must make it a part of the person's medical record. The attending provider must act in accordance with the statements expressed in the PAD when the person is determined to be incapable, unless compliance is not consistent with generally accepted or best-practice standards of treatment to benefit the member, availability of the treatments or hospital requested, treatment in case of an emergency endangering life or health or when the member is involuntarily committed to a 24-hour facility and undergoing

treatment as provided by law. If the provider is unwilling to comply with all or part of the advance directive, he or she must notify the member and record the reason for noncompliance in the patient's medical record.

The Vaya Member and Caregiver Handbook includes more information about the PAD and other forms of advance directives, including the Health Care Power of Attorney and living wills.

8

SECTION 8

After-Hours Requirements and Crisis Prevention/Response

The Crisis Continuum

There is a strong continuum of services available to help support and stabilize members in crisis. Crisis services include Mobile Crisis Management (MCM) team, Facility Based Crisis (FBC), non-hospital detoxification, walk-in crisis, NC START or use of a hospital ED for reasons related to psychiatric illness or substance use. As a Network Provider, you must be aware of the resources available, how to access crisis response services, implement them to fit the nature of the member's crisis and understand your role and responsibilities within the crisis continuum. Vaya contracts with three MCM teams to cover our entire catchment area. There are walk-in centers in each county, operated by Vaya's contracted Comprehensive Care providers, where members can go to receive same-day assessment and treatment. There are also FBC centers in three counties that serve the region. As discussed below, basic benefit providers may utilize MCM for face-to-face assessment and intervention if the provider's phone response does not reduce the crisis.

First responders/enhanced services providers must assess members in crisis face-to-face and consider all other alternatives to hospitalization, such as use of family or community resources, initiation of medication or medication adjustments, safety planning, arranging follow-up, etc., prior to contacting MCM or Vaya's Member Services Department/call center. Interventions should focus on the least restrictive options, starting with walk-in centers, MCM, FBC or detoxification facility, before considering inpatient hospitalization. If the first responder's assessment is that the member needs an inpatient level of care, some hospitals will consider direct referrals from the community provider. All alternatives should be attempted prior to going to the ED. Options become more limited once a person enters the ED. A list of regional walk-in centers, MCM providers and FBC centers for detox or crisis stabilization are available on our website at www.vayahealth.com.

Comprehensive Crisis Plan Development

All Network Providers are required to develop Comprehensive Crisis Plans (CCPs) for members they serve as part of the person-centered planning process. In addition, all Network Providers must follow the state's Comprehensive Crisis Intervention and Prevention Plan guidance: http://crisissolutionsnc.org/wp-content/uploads/2014/01/crisis-crisisplnmemo8-20-14.pdf. The CCP must be created with input and participation from the member and natural supports and include provider and support person contact information, prevention and early intervention strategies for the member to utilize and must include member-identified strategies to be utilized by professionals if and when the member needs to access crisis services. It is designed to be one section of a Person-Centered Plan (PCP) or Care Plan that can also be easily extracted as a stand-alone document for ease of distribution.

WHO IS REQUIRED TO HAVE A COMPREHENSIVE CRISIS PLAN?

Network Providers MUST ensure that ALL individuals with Person-Centered Plans (PCPs) also have completed CCP and Intervention Plans. In addition, all members who are at significant risk of crisis events – including those receiving only

basic benefit services – must have a CCP in place. This would include persons who have received inpatient psychiatric or substance use treatment, been arrested, attempted suicide or used crisis services within the past year.

A CCP is also required for all Innovations Waiver participants, as well as individuals diagnosed with an IDD who are not enrolled in the Innovations Waiver but meet one of the following conditions:

- The individual was referred to or discharged from NC START; or
- The individual was referred to or discharged from a State Developmental Center or ICF-IID; or
- The individual received two unplanned restraints in one quarter.

HOW AND WHEN IS THE CCP UPDATED AND SHARED?

Individuals receiving services must be provided with a copy of the plan and all pertinent crisis contact/after-hours numbers to utilize in an emergency. CCPs are "living documents" and must be reviewed and updated as needed. Plans are required to be updated annually and whenever a member's medications or natural supports change or other significant change occurs that impacts crisis planning. CCPs should be reviewed after every crisis event (such as utilizing MCM, an ED stay and/or a psychiatric hospitalization) and updated as needed. Network Providers must upload all completed CCPs to the member's MCIS profile labeled with member's initials_CCP_Date (YYMMDD), for example: JD_CCP_20151001, and identified as document type "Crisis Plan." This enables the plan to be easily retrieved and shared in a crisis. Where permitted under applicable privacy laws, Vaya may share a member's CCP with an ED or a MCM provider to help alleviate or respond to a crisis situation. For this reason, it is critical that CCPs be uploaded as soon as possible following completion or any updates to the plan.

Members enrolled in Complex Care Management also have crisis plans with their care managers. See Section 9 for more information on the relationship between the Care Management crisis plan and behavioral health provider's crisis plans.

After-Hours Coverage Requirements

All Network Providers are required to maintain appropriate after-hours and emergency coverage and to respond in a timely and appropriate manner to any member who is in crisis. **911 should never be the first line of contact for a behavioral health issue, unless the emergency is life-threatening.** The level of coverage required is based on the array of services you provide, as follows:

PROVIDERS OF BASIC BENEFIT SERVICES

Providers of basic benefit services (e.g., outpatient clinics or LIPs) and other services without first responder requirements must have capacity to provide 24/7 telephonic crisis intervention/response to members they serve.

- Basic benefit providers must offer an answering service or voicemail with the provider's after-hours contact number. The message must not direct members to 911 or the ED unless their emergency is life-threatening. All members must be provided with the mobile/pager/answering service number of the clinician who is on call. If the provider is using an answering service, the provider must return the call to the member within one hour. After-hours recordings and voicemail messages must include the applicable emergency contact information.
- Crisis plans must be developed with all members and include the provider's daytime and after-hours/emergency contact information, along with helpful strategies to mitigate crisis. Members should have copies of the crisis plan and pertinent contact/crisis after-hours numbers for providers.
- Basic benefit providers responding to members in crisis must have 24/7 access to crisis plans and other information in the member's treatment record to guide crisis intervention.

- Basic benefit providers must be able to respond telephonically but may access MCM services for the member if telephone contact cannot mitigate the crisis.

BEHAVIORAL HEALTH CLINICAL HOME AND PROVIDERS OF ENHANCED SERVICES

Behavioral Health Clinical Home (BHCH) and providers of enhanced services are required to have "first responder" capability for their members, in accordance with the applicable DHB Clinical Coverage Policy for the enhanced service being provided.

- All the above stipulations listed for basic benefit apply to BHCH and enhanced services providers.
- In addition, these providers must be available 24/7 to respond to members receiving services from them both telephonically and face-to-face for crisis response, as needed.
- BHCH and enhanced service providers (IIH, MST, CST, ACTT, SAIOP, SACOT) must respond with a face-to-face contact if telephone contact is not successful in mitigating the crisis.
- First responders are responsible for obtaining involuntary commitment (IVC) petitions, if necessary. See Section 11 of this Manual for more information about the IVC process.

WHO AND WHAT ARE CLINICAL HOME PROVIDERS?

The philosophy behind the use of the term "clinical home" is based on the need for each member to have one provider who assumes overall responsibility for that person's treatment and service coordination. The BHCH is the cornerstone of the member's treatment and fulfills key roles, including:

- Conduct and periodically update a Comprehensive Clinical Assessment.
- Develop a treatment plan/PCP with the member's participation and input from natural supports that addresses the member as a whole person.
- Develop a CCP as outlined above.
- Revise the treatment plan/PCP and CCP when service needs, medication or other significant life circumstances change.
- Coordinate service provision for the member, including management and monitoring of services and taking responsibility for a team approach to treatment and service provision.
- Coordinate any support services that the member may need in addition to formal treatment services.
- Submit all necessary paperwork to Vaya, including enrollment and authorization forms.
- Provide crisis response and serve as a first responder.

Providers of the enhanced services below assume the BHCH and first responder functions for members immediately upon admission to these services:

- Intensive In-Home (IIH)
- Multisystemic Therapy (MST)
- Community Support Team (CST)
- Assertive Community Treatment Team (ACTT)
- Substance Abuse Intensive Outpatient Program (SAIOP)
- Substance Abuse Comprehensive Outpatient (SACOT)

Other BHCH providers may include providers of Day Treatment and Psychosocial Rehabilitation, as well as 24-hour residential treatment providers. Outpatient therapists assume clinical home functions if outpatient services are being

delivered and none of the above services are a part of the member's PCP. If the individual is not connected with another provider upon discharge, the BHCH will retain emergency response duties for 60 days post-discharge.

RELATIONSHIP BETWEEN FIRST RESPONDERS AND MOBILE CRISIS

Vaya contracts with three Comprehensive Care Center providers to deliver MCM and other crisis services throughout our catchment area. **Network Providers with first responder responsibilities, including the comprehensive care providers, should not use MCM as the first responder, even if it is their own MCM team.** This does not meet the intent of a first responder. The first responder function should be separate. MCM, which is a higher-level service, should only be utilized once the first responder attempted telephonic intervention or a face-to-face assessment **and** implementation of the CCP, without success. However, note that ACTT providers have more intensive crisis responsibilities under DHB Clinical Coverage Policy No. 8A-1 and should only call MCM if all other alternatives are exhausted.

INNOVATIONS WAIVER PROVIDERS OF DIRECT CARE SERVICES

All Innovations Waiver providers are required to respond to emergencies/crises on weekends and evenings as outlined in the applicable Innovations Waiver service definition. Under DHB Clinical Coverage Policy No. 8P, providers of the following services are required to have capacity to offer primary crisis services for emergencies that occur with participants in their care 24 hours per day, 7 days per week, or have an arrangement (memorandum of agreement) with a primary crisis services provider:

- Community Living and Support
- In-Home Intensive Supports
- In-Home Skill Building
- Personal Care
- Residential Support services

Please note the following:

- Providers of the above-listed services must train members and their paid/unpaid supports in how to access the designated crisis responder. The designated crisis responder's contact information must be clearly outlined in the participant's Care Plan and be accessible in the participant's home setting or settings where he or she receive services.
- The minimum standard is that the provider must first assess by phone to determine if face-to-face support is needed. The assessment will include determining if crisis response services are necessary. The provider is responsible for knowing how to access crisis response services and implement them to fit the nature of the crisis.
- MCM is not considered a primary crisis responder for individuals receiving the above-listed services unless, after an initial assessment, the responsible provider feels that MCM is needed to assist with ED diversion.
- Members have the right to select another crisis response services provider from within the Closed Network.
- Care Plan crisis plans must be inclusive of mental health or medical health supports and their contact information. All providers listed on a crisis plan must know and understand their role in a crisis for that participant, including MCM. Crises can occur in the form of mental health, behavioral or medical needs.

DIRECT CARE PROVIDERS OF STATE-FUNDED IDD SERVICES

Direct care providers of non-Medicaid IDD services, such as Individual Habilitation/Personal Assistance, must also develop appropriate crisis plans for persons they serve. Members and their support persons must be trained in implementing the plan, and all individuals/providers included in the crisis plan must know and understand their role in crisis response.

Individuals with an IDD who are not receiving services or linked to a provider should utilize MCM in a behavioral health crisis. Any eligible individual who is linked to MCM for emergency response will be connected with a provider for follow-up services as needed. Vaya's Member Services Department can assist with linking members you serve to an IDD provider.

Frequently Asked Questions

Who is the first responder in situations where several providers are involved?

This should be clearly outlined in the crisis plan. There are times when several providers are serving the same member. During the crisis planning process, roles and contacts should be clearly defined and detailed in collaboration with the individual and his or her family, friends or other natural supports identified in the plan.

What if the case is closed or transferred? Or the member has not been seen in a long time?

This is a complicated and often frustrating concern. The spirit and intent of first responder is that the professional with the most knowledge and established relationship is best prepared to assist in crisis. As a general rule, Vaya requires all providers to respond for a member who was seen or treated by the provider in the previous 60 days. Until the case is accepted by a new provider and the member is seen there, it is not officially transferred, and the original provider would be in the best position to act as first responder. If a case is closed without referral to another service, and the member experiences a crisis within 60 days, the provider must respond and use the crisis opportunity as a means of evaluating and re-engaging the member.

When should an MCM team be called to handle a member who is in crisis?

Vaya will contact and refer to MCM if the first responder is not accessible to assure the member receives timely engagement in crisis services. Providers may consult and refer directly to MCM after their first responder intervention failed to safely manage the crisis and/or divert from the hospital. Providers are not required to go through Vaya's Member Services Department to make a referral to MCM.

Should first responders go to the ED? When is this appropriate?

The provider must be available to consult by phone with the ED. Often, this is all that is needed. However, if the provider determines that their member needs a higher level of care and has exhausted other alternatives (MCM, Facility-Based Crisis, detox, crisis bed, etc.) must accompany the individual to the ED and provide a warm hand-off, sharing clinical and resource information to assist in the evaluation process. The first responder must stay in contact with the ED behavioral health clinicians/case managers to actively participate in treatment planning and work toward appropriate disposition. The availability of the first responder will often play an important role in the decision about whether to hospitalize some members. A hospital physician may be more willing to consider diversion if the first responder is there and able to make specific arrangements for prompt and aggressive follow-up if the member is not hospitalized.

Does Vaya need copies of the crisis plans every time they are updated?

Yes. Vaya Network Providers must upload CCPs and PCPs into the MCIS to support continuity of care, both at the time of first signature and whenever revisions are made. Crisis plans must be updated when the PCP is updated or when there is any significant change in functioning (e.g., a crisis event or hospitalization). As stated earlier, updated plans should be uploaded to the MCIS. As with any revision to the PCP, a signature is required.

Crisis Prevention and Education Efforts

As a Network Provider, you must participate in crisis prevention and education efforts to minimize crises experienced by members you serve, reduce stigma and educate the community about services you offer. These efforts should include

but are not limited to: crisis plan development and implementation; required after-hours response and first responder duties; local Crisis/Emergency Department Initiative (CEDI) committee activities; development of prevention, education and outreach programs; and distribution of educational material and brochures on mental illness, IDD and substance use disorders.

SECTION 9

Complex Care Management (CCM)

Vaya provides Complex Care Management (CCM) services for eligible members who opt-in to the program to help ensure they are linked to the services and supports they need to stay well and live their best life. CCM targets populations with chronic, unresolved and complex physical, behavioral health and social determinant needs. The primary goal is to improve the overall health of individuals through proactive identification (also known as risk stratification), participation in clinical and specialty care, personal self-care, health risk assessment and engagement in a person-centered, interdisciplinary care plan that addresses all life domains.

In accordance with 42 CFR § 438.208(b), Vaya performs coordination of care for all Medicaid enrollees, including those dually eligible for Medicare and Medicaid. Vaya's contracts with DHB and DMH/DD/SAS also mandate specific CCM services for specialty populations as defined below. In addition, Vaya uses multiple internal and external methods to identify members who qualify for CCM services. **Not all members will qualify for an assigned care manager to perform CCM functions.** For example, lack of housing or diagnosis of TBI by itself does not qualify a person for an assigned care manager regardless of disability group or funding source.

Vaya Total Care is the CCM model developed and implemented by Vaya Health. This model provides a team-based approach to integrated healthcare through promotion of correct diagnosis, efficient use of resources, reduction of recidivism, and monitoring for and containing substandard care. Vaya's unique tools and integrated approach help better identify members in need of support and avoid duplicating the work of other systems. The model includes risk stratification and predictive analytics to identify members who may benefit from CCM. Care Managers (CMs) work with members and care teams to complete a comprehensive Health Risk Assessment, facilitate medication reconciliation, facilitate an integrated care team, implement a shared care plan, identify health and recovery goals, develop a crisis plan that identifies behavioral and physical health crises and plans to manage those crises, and link members to services. The aim is to help members prevent health deterioration and avoid costly urgent or emergent care. As children/youth receiving CCM transition into adult services, the care manager supports this transition through ensuring effective information and data are exchanged to support the member's needs.

Vaya provides CCM for Medicaid Special Health Care Needs populations, Complex Care populations, and High Risk/High Cost populations. These specialty populations are defined through contract and regulatory standards, including 42 CFR § 438.208 and N.C.G.S. § 122C-115.4(5), and identified through Vaya's risk stratification (RS) process. CCM is available for members who have Medicaid, are dually eligible for Medicaid/Medicare and who are uninsured, if they meet the applicable population criteria.

Medicaid Special Health Care Needs Populations (Mandatory)

The following Special Health Care Needs Populations are currently identified in the contract between Vaya and DHB:

- Intellectual and/or Developmental Disabilities (IDD)
  - Innovations Waiver participants: Members who are assigned a Vaya Innovations Waiver slot are assigned a care manager and receive specific CM services as part of the Waiver, including but not limited to plan of care development and regular health and safety monitoring. If a Waiver slot becomes available for an individual on the Registry of Unmet Needs, CM will begin development of a plan of care.
  - Members who are functionally eligible for, but not enrolled in, the Innovations Waiver and who are not living in an ICF-IID. Note that although individuals in ICF-IIDs are not eligible for an assigned care manager, Vaya staff members participate in the annual Plan of Care meetings for members who reside in ICF-IIDs and are appropriate for community placement.
  - Members with an IDD diagnosis who are currently, or have been within the past 30 days, in a facility operated by the Department of Public Safety, Division of Adult Correction and Juvenile Justice (DPS), for whom Vaya has received notification of discharge.
- Children with Complex Needs are Medicaid-eligible children between the ages 5 and 21 with a co-occurring IDD and MH disorder who are at risk of not being able to enter or remain in a community setting. The term "at risk" is defined for this purpose as acts or behaviors that present a substantial risk of harm to the child or to others.
- Child Mental Health (MH): MH disorders due to a physiological condition, psychotic disorders, mood (affective) disorders (including bipolar I/II disorder), anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders, behavioral syndromes associated with physiological disturbances and physical factors, sexual functioning disorders, impulse control disorder, oppositional defiant disorder, reactive attachment disorder, other behavioral/emotional disorder, eating disorders, tic disorders, sleeping disorders, gender identity disorders, paraphilias, child psychological abuse (suspected or confirmed), child neglect, sexual abuse, and physical abuse (suspected or confirmed). *For questions regarding specific diagnostic codes email* CCMProgramAssistants@vayahealth.com*;* AND
  - A current CALOCUS© Level of VI; OR
  - Who are currently, or have been within the past 30 days, in a mental health or substance use residential level III or IV group home, PRTF, inpatient hospital setting, or a facility operated by DPS (including a Youth Development Center and Youth Detention Center), for whom Vaya received notification of discharge. This target group may also include children who are at imminent risk for entering these levels of care. CCM partners with DSS and DJJ to identify and engage high-risk children and their families in services to reduce out-of-home placements and connect to appropriate services.
- Adult MH: schizophrenia, schizoaffective, unspecified brief psychotic disorder, major depressive disorder, persistent mood disorder, bipolar disorder, other mood disorder, and posttraumatic stress disorder (PTSD). *For questions regarding specific diagnostic codes email* CCMProgramAssistants@vayahealth.com*:* AND a current LOCUS© Level of VI.
- Substance Use Disorders: Members with a SUD diagnosis and current American Society of Addiction Medicine Patient Placement Criteria (ASAM- PPC) Level of III.7 or II.2-D or higher.
- Opioid Use: Members with an Opioid Use diagnosis who report having injected drugs within the past 30 days.
- Co-occurring Diagnoses: Members with co-occurring diagnoses related to MH, IDD and/or SUD including but not limited to the following:
  - Members with both an MH diagnosis and a SUD diagnosis and a current LOCUS©/CALOCUS© of V or higher, or current ASAM-PPC Level of III.5 or higher; or
  - Members with both an MH diagnosis and an IDD diagnosis and current LOCUS©/CALOCUS© of IV or higher; or
  - Members with both an IDD diagnosis and a SUD diagnosis and current ASAM PPC Level of III.3 or higher.
- At-Risk for Crisis: At-Risk populations include the following:

  - Members who do not appear for scheduled appointments and are at risk for inpatient or emergency treatment; or
  - Members for whom a crisis service has been provided as the first service; or
  - Members discharged from an inpatient psychiatric unit or hospital, PRTF or FBC center.
  - Primary Care Case Management (PCCM): Vaya collaborates with the Department's PCCM vendor and may provide CM to members who do not meet Special Health Care Needs Population criteria through any mechanism it so chooses, but shall not duplicate case management functions required to be performed by providers who receive Medicaid funding, as outlined in DHB Behavioral Health Clinical Coverage Policies.
- U.S. Department of Justice/ Transitions to Community Living Initiative (TCLI): Members eligible for TCLI are eligible for CM services. Vaya will assign a care manager to the TCLI member on or before the 90th day after they have transitioned to an independent living setting. This ensures that adequate services remain in place, according to the member's needs. CM is provided to TCLI members under the same rules, guidelines, processes and procedures as for all other members, including but not limited to discharge criteria. As with all members, TCLI members may receive CM for more than 90 days following transition if appropriate to their unique needs.

Complex Care Population (Optional)

The Complex Care Population includes the Medicaid and Medicaid/Medicare enrollees who Vaya identifies as eligible for CM due to risk stratification for complex, multi-morbid chronic healthcare conditions not currently identified in the contract between Vaya Health and DHB. Eligibility and interventions for this optional population are based on availability of resources.

Non-Medicaid High-Risk/ High-Cost Populations (Within Available Funding)

Pursuant to its contract with DMH/DD/SAS and N.C.G.S. § 122C-115.4(b)(5), Vaya provides CM services, **within available funding and resources as outlined at N.C.G.S. § 122C-2**, to uninsured/ underinsured (non-Medicaid) members who meet the following criteria:

- Members who meet the definition of a "high risk consumer" set forth at N.C.G.S. § 122C-115.4(f)(1): an individual who was assessed as needing emergent crisis services three or more times in the previous 12 months. For purposes of high-risk eligibility, "emergent crisis services" means MCM team intervention, FBC admission or ED primary behavioral health intervention.
- Members who meet the definition of a "high cost consumer" set forth at N.C.G.S. § 122C-115.4(f)(2): an individual whose treatment is expected to incur costs in the top 20 percent of all members in a specific disability group.
- Members without a Behavioral Health Clinical Home who are being discharged from state facilities, hospitals, or emergency/ crisis/ detoxification services who have no other payer and are not engaged with a behavioral health provider. A member is considered to have a BH Clinical Home if any non-crisis service has been delivered to the member within the 60 days prior to discharge AND Vaya assigned a CM. CM activities may include participating in on-site inpatient discharge planning for members participating in treatment in state hospitals or alcohol and drug abuse treatment centers (ADATCs); coordinating with local DSS and DJJ agencies, law enforcement, primary care, etc., until the member is connected to a BH Clinical Home. Additionally, within available funding Vaya prioritizes members transitioning from institutional or incarceration settings. **Network Providers must make every effort to ensure that appointments are available for these high-risk individuals.**
- Members who live in State Developmental or Neuro-Medical Treatment Centers: Vaya CM staff participate in annual Plan of Care meetings for members who reside in a State Developmental or Neuro-Medical Treatment Center and are appropriate for community placement.

- Outpatient Commitments: When notified by the applicable Clerk of Court, CM provides coordination for individuals who are under an Outpatient Commitment (OPC) order, regardless of insurance type (Vaya is responsible for individuals with private insurance who live in Vaya's catchment area and are on an OPC).
- If the individual is enrolled in a Vaya Health plan, the CM will determine if the member is receiving services from a behavioral health provider through all available sources. If the member has a BH provider, the CM will notify the member's provider to inform them of the member's OPC status. The provider should make reasonable attempts to engage the member in treatment. If it is determined that the individual is not receiving services from a behavioral health provider, the CM will connect the individual to Member Services.

Referral and Assignment Process for Complex Care Management

Vaya uses a variety of methods to identify members eligible for CCM. Members are identified through risk stratification, internal business processes and from internal/external referrals. External referrals are accepted from the member, relative and/or caregiver; community/social service agencies; practitioners, physical health and behavioral health providers and prescribers; Medical Management Programs such as disease management programs, UM programs, health information lines or similar programs that can identify needs for complex case management; and Discharge Planners. To make a referral for CCM services, a Vaya Care Management Referral Form (available on the Vaya Health website) should be completed and submitted to CCMProgramAssistants@vayahealth.com. Instructions can be found directly on the referral form. The referral request will be reviewed for eligibility as follows:

1. Vaya expedites responses to referrals from medical providers, PCCM care managers and state and local agencies, including but not limited to local DSS and DJJ offices.
2. CCM referrals are routed to the regional CM Manager, who reviews it for eligibility for CCM services.
3. If the member does not meet eligibility criteria, the CM Manager sends a secure email to the referral source notifying him or her of the determination and reasons for ineligibility for CCM services and of the member's right to file a grievance. Because CCM services are an administrative function and are not an entitlement, there is no right to appeal if Vaya determines that a member is not eligible for CCM. Individuals who are dissatisfied with the decision may file a grievance or complaint or contact the CM manager to discuss.
4. If eligible, the CM manager assigns the individual to a CM and contacts the member and/or LRP to initiate services within a reasonable timeframe. Assignments are made based on county of residence and CM caseload diversity. In general, Vaya will not process requests for a change in the assigned CM absent a compelling reason, such as a documented instance of inappropriate behavior or interaction by the CM. Vaya will not re-assign CMs in response to requests based on discriminatory reasons such as race, color, religion, sex, gender, sexual orientation, ethnic or national origin, age, disability, handicap, genetic information or parental status.
5. Once assigned, if a member does not have an assigned behavioral health home, the CM will offer choice of provider to the member/LRP. The CM will not offer personal opinions or recommendations regarding provider choice or interview providers for the member. If a member requests a specific recommendation, the CM will explain their role as an objective party.

Complex Care Management Program

CCM functions may be provided by a BH clinician who specializes in the needs of members with MH/IDD/SU diagnoses, QPs with MH/IDD/SUD specialties, RN care managers who specialize in medically complex or medically fragile service needs, IDD QP care managers and/or certified peer support specialists (PSS). CMs may directly perform an identified task or follow up to ensure that tasks are completed by a member of the interdisciplinary, integrated care team (ICT), which includes the behavioral health provider. Care decisions are driven by what is best for the member based on ethical and best practice, not the convenience of the provider or caregiver/ LRP. Vaya's CCM practices include, but are not limited

to, assessment, care plan development, crisis plan development, tasks and interventions, referral and linkage, risk and disease management and monitoring. CCM processes also address the following:

1. Team Structure: The CM is part of the ICT that consists of the member/ LRP and anyone they choose/ allow, including but not limited to the behavioral health provider, primary care provider, and in consultation with any specialists caring for the member.
2. Scheduling: Care team meetings may convene electronically, telephonically or in person and target the goals of the plan of care. CM staff make reasonable accommodations to meet (telephonically or in-person) at times and locations convenient to the member/ LRP and their family based on acuity and member care needs. Times set for meetings should be based on legitimate scheduling challenges for a member or their supports. For example, if a member or LRP works regular business hours Monday through Friday, it is reasonable for the CM to meet with the member after regular business hours during the week or a weekend day if requested. **However, this flexibility is not an entitlement when a member and their ICT can meet within regular business hours.**
3. Safety: If the member's or natural support's behavior or home environment presents a risk to the health, safety or wellbeing of the assigned CM, Vaya reserves the right to hold meetings in a neutral location, such as the Network Provider's office and/or include a CM manager in the meeting. Dangerous home environments include locations where unsecured or illegal weapons, illegal substances, dangerous animals are present or where residents have or have recently had any communicable conditions that present a risk for face-to-face interactions. We will not tolerate physical, emotional or verbal abuse of Vaya staff by members, natural supports or Network Providers. This includes, but is not limited to, profanity, yelling, disrespect, inappropriate physical interactions or violations of personal space. In such cases, we reserve the right to immediately terminate the meeting or telephone call and report such behavior to the Network Provider or NPI Department for investigation.
4. Social Determinants of Health. Vaya recognizes that SDoH are the primary driver of health disparities, and that a member who lacks stable housing and is unemployed or under-employed will have increased risk factors related to poverty, potential trauma exposure, stress and difficulty in accessing appropriate medications, preventive care or engaging in therapy. Within available resources, CMs may work with a member to improve or obtain adequate living conditions, education or employment, nutrition, engage in healthy activities and/or address transportation needs.
5. Crisis Response: CCM is not a crisis intervention. In cases where a member has an existing treatment relationship, the provider should be the initial crisis contact. However, providers should notify the assigned CM if a member experiences a crisis so that the CM can evaluate, in collaboration with the ICT, what additional service needs and crisis plan adjustments are needed once the member's crisis has been addressed. CMs support continuity of care to the degree possible in cases of local disasters or emergencies.

Discharge from an Assigned Care Manager

Discharge from CCM is a collaborative process between Vaya, the member/ LRP and the ICT. If the discharge is a planned and scheduled event, the discharge/transition is part of the ICT planning. If discharge from CCM is not a planned event, and the member disengages from the process, the CM will notify the member (if possible) and ICT of the discharge. Members may be discharged from CCM due to a variety of events. A member may be reassigned to CCM at any point they meet criteria. Note that Innovations Waiver participants will not be discharged from IDD Care Management unless their Innovations Waiver slot is terminated.

Network Provider Care Coordination Responsibilities

Network Providers must fully cooperate with Vaya's Care Management and integrated care activities, including, but not limited to, the following:

- Actively participate in interdisciplinary team meetings convened or arranged by the CM and/or include the CM in team meetings convened or arranged by you.
- Provide at least 24 hours prior notice to the CM of the date, time and place of any treatment team or discharge planning meeting involving a member with an assigned CM.
- Provide accurate and timely information to the CM regarding the member's participation in treatment and clinical progress.
- Work with the CM and child and family or adult planning team in developing an appropriate, whole-person plan of care (Care Plan or PCP), including crisis planning for individuals regardless of disability type. Treatment plans must address MH, SUD/addiction, IDD, medical, dental and specialty needs, as well as include evidence of medication reconciliation across all care providers and a detailed, cross-system CCP using evaluations, assessments and collateral information.
- Develop and implement treatment and/or supports strategies to address assigned areas of responsibility from the Care Plan.
- Develop step-down and discharge plans within the first month of admission.
- Take the primary role in transitions to other levels of care.
- Notify the assigned CM whenever a member receiving CCM services is admitted to an ED, FBC or inpatient unit.
- Provide accurate information to members and their families regarding clinical coverage policies and levels of care that are typically most effective at treating or supporting a member's treatment or habilitative needs and helping a member and his or her family plan for multiple treatment options.
- Complete, timely and accurately, all appropriate or required level of care/clinical decision support tools identified in Section 6 of this Manual, including, but not limited to, the LOCUS©, CALOCUS©, CANS-MH, NC-SNAP, SIS® and ASAM placement criteria.
- Work with Vaya, PCCM, primary care providers and other Vaya-contracted providers regarding a member's medical management, shared roles in the care and crisis plan, exchange of clinically relevant information, annual exams, coordination of services, case consultation and problem-solving, as well as identification of medical home for persons in need.
- Follow the process for admissions to a State Developmental Center. Any application for a State Developmental Center must be coordinated with the LME/MCO. The member/ LRP or Network Provider must provide Vaya with all information necessary to determine if application to a State Developmental Center should be made for a complete admission packet to be submitted. Assigned IDD CMs and our Olmstead CMs will review the application to ensure all other reasonable lower levels of care were exhausted first. Vaya must provide a letter of support for an application to be accepted. For individuals who are accepted into a State Developmental Center, the Olmstead CM will follow the individual through discharge. **State Developmental Centers are not considered long-term or lifetime residential placements,** and individuals must be reviewed quarterly for discharge consideration. Each member accepted for admission to a State Developmental Center will be accepted only under a MOA for one year. All individuals will be discharged with the date stated on the MOA.
- If the member has a BH home and receives services that include certain care coordination, care management or case management activities per the applicable NC Medicaid Clinical Coverage Policy, DMH/DD/SAS state services definition or the Network Provider's contract with Vaya, CM staff will ensure the member's care coordination/ management needs are met via the Network Provider and that activities are not duplicative. A failure to provide required care coordination services or cooperate with assigned CMs may result in a referral for investigation and may lead to administrative action or sanction, up to and including termination of contract. In cases in which there is not an identified BH Home, the assigned CM will provide certain CM activities and functions outlined in Vaya's contracts with DHB and DMH/DD/SAS according to the type of population.

Complex Care Management Teams

Vaya provides CCM through community-based MH/SUD/IDD teams. The CCM Department also includes the Acute Response Team, the Geriatric and Adult Mental Health Specialty Team (GAMHST), the Housing Supports Team, the Olmstead and Supports Intensity Scale (SIS®) Team and the TCLI Team.

MH/SUD/IDD TEAMS

Mental Health, Substance Use Disorder and Intellectual and Developmental Disability Teams provide Complex Care Management to high-risk, high-cost and special healthcare populations. Staff in MH/SUD/IDD teams include licensed behavioral health clinicians, Registered Nurses (RNs), qualified professionals (QPs), and peers.

ACUTE RESPONSE CARE MANAGEMENT TEAM

The Acute Response Care Management Team provides onsite discharge planning from psychiatric inpatient settings for Vaya members. This team reports to an RN and consists of both licensed behavioral health clinicians and QPs who are embedded at local hospitals and state facilities to ensure cohesive transitional care to the community. In addition, the Acute Response CMs work to reduce or divert inappropriate ED utilization and help providers, members, families and stakeholders with members experiencing an acute crisis or emergent care need.

GERIATRIC AND ADULT MENTAL HEALTH SPECIALTY TEAM (GAMSHT TEAM)

The Geriatric and Adult Mental Health Specialty Team (GAMHST team) includes registered nurses, licensed clinicians and qualified mental health professionals who provide education and consultation for family caregivers and professional staff of a variety of community agencies (e.g., senior centers, adult day care programs, Departments of Social Services, Veteran Affairs, home health agencies, law enforcement) and all levels of long-term care in Vaya's catchment within available resources. Providers are encouraged to make referrals to GAMHST for caregivers of individuals age 60 and older who are experiencing mental illness, substance use, dementia or emotional/ behavioral challenges to enhance caregiver's skills, knowledge and awareness of resources. The team also serves caregivers of younger adults with a dementia diagnosis. For professionals, the program offers contact hours approved by the N.C. Division of Health Service Regulation (DHSR).

The GAMHST referral form can be found at https://providers.vayahealth.com, and questions can be emailed to Geriatric.Team@vayahealth.com.

HOUSING SUPPORTS TEAM

Vaya believes that having a safe and stable place to live is an integral part of wellbeing and recovery. One of the primary barriers that prevents members from remaining stable and avoiding a crisis is lack of housing. Our Housing Supports Team helps minimize member crises by assisting providers and members with this key social determinant of health. This Team also works with community partners to provide knowledge, resources and training about housing and residential options, works to increase housing resources through partnerships with affordable housing providers, and focuses on improving quality of life for eligible individuals who qualify for specialty housing programs administered by Vaya, including but not limited to the Transitions to Community Living Voucher, the Permanent Supportive Housing program, Non-Medicaid Residential Services, the Housing Supports Grant, the Independence Project and the Integrated Supportive Housing Program. **Housing supports are not an entitlement, and funds are limited.**

Network Providers are required to collaborate with Vaya's housing efforts and must:

- Participate in or refer landlords and other stakeholders to Vaya's housing initiatives.
- Assist members as needed to remain stably housed.

- For providers who are contracted to provide State-Funded Residential Services (SFRS):
  - Maintain a current list of members for whom the agency is receiving SFRS funding.
  - Submit Unused Bed Day Census reports monthly.
  - Notify Vaya of vacancies within one day.
  - Follow guidelines for the SFRS referral process.
- For providers who signed a Memorandum of Agreement (MOA) to make referrals into the Permanent Supportive Housing (PSH) Program:
  - Provide ongoing services to PSH referred participants as needed and provide monthly reports of those services.
  - Communicate regularly with the housing coordinator when changes occur, such as the participant's stability, income, household composition, etc.

OLMSTEAD & SUPPORTS INTENSITY SCALE® (SIS®) ASSESSMENT TEAMS

Using wraparound supports, the Olmstead Team supports members transitioning from long-term institutional care to a home of their choosing. SIS® Assessment Team members are certified through the American Association on Intellectual and Developmental Disabilities (AAIDD) to provide standardized assessments to members participating in the Innovations Waiver. Effective November 1, 2016, all Innovations Waiver participants must have a valid (performed within the last three years) SIS® score in place as part of the annual plan of care approval process.

TRANSITIONS TO COMMUNITY LIVING INITIATIVE (TCLI) TEAM

In western North Carolina, Vaya Health operates the Department's Transitions to Community Living Initiative (TCLI), which gives eligible adults (18 years or older) with serious mental illness (SMI) or serious and persistent mental illness (SPMI) who are living in an institution or at risk of institutional placement (i.e., homeless or living in unstable housing) the opportunity to live in the home and community of their choice. TCLI stems from a 2012 settlement agreement between the State of North Carolina and the U.S. Department of Justice. The TCLI Team is a specialty CCM team that serves eligible TCLI participants and links them with wraparound mental health and other support services that help them live in a home rather than a facility. This team includes In-Reach staff supervised by a Certified Peer In-Reach Manager, and QPs/ Transition Coordinators supervised by a Transition Coordination Manager.

TCLI allows eligible individuals to engage in leased housing, learn everyday skills, take part in community activities and develop lasting relationships. Participants receive behavioral health services, employment assistance and help becoming part of the community. Through job skills and employment programs, people identify their interests and prepare to find a job in a competitive workplace. Vaya's TCLI program focuses on six areas:

- **In-reach and Transition:** Education and discharge planning for people living in ACHs and state psychiatric hospitals. Providers who are contracted to deliver ACTT, Tenancy Supports, SE or other services associated with the TCLI program must actively participate with Vaya's In-Reach and Transition activities.
- **Diversion:** Information on housing options for people with serious mental illness at risk of admission to an ACH.
- **Housing:** Community-based, supportive housing with assistance for tenants.
- **Supported Employment**: Assistance in preparing for, identifying and maintaining paid, competitive employment alongside people without disabilities.
- **Quality Management:** Use of data to measure progress and results.
- **Assertive Community Treatment/Tenancy Support:** Intensive, community-based behavioral health treatment. This is person centered and includes a variety of services to include at least one service considered as a Tenancy Support. Tenancy Support services include: Transition Management Services (TMS), Critical Time Intervention (CTI), Community Support Team (CST) and Assertive Community Treatment Team (ACTT). Tenancy Support services should

focus on rehabilitation skills intended to increase and restore an individual's ability to live successfully in the community and maintain tenancy. The services should focus on increasing the individual's ability to live as independently as possible, managing the illness, and reestablishing his or her community roles related to the following life domains: emotional, social, safety, housing, medical and health, educational, vocational, and legal.

What is the process if a Network Provider would like a member to be considered for TCLI?

Members who are eligible for TCLI consideration must meet specific criteria for referral (formerly PASRR; currently RSVP). This referral is made online at https://www.socialserve.com/nc/rsvp. If the individual has a guardian that is considered a "guardian of the person or general guardian" but NOT the "guardian of the estate," that guardian MUST be notified BEFORE making the referral.

- Members must be at risk for admission into an ACH or other adult living facility.
- Members must have a SMI/SPMI diagnosis; and may have other co-occurring MH/ SU/BH needs.
- Members must be eligible for Medicaid in North Carolina.
- Members must have an income of $2,000 or below.
- Members must be 18 years old and willing to accept a minimum of one tenancy support per month.

If you are working with a member who you would like to refer for consideration into TCLI, please complete an RSVP Referral. Referrals will be screened by Vaya's Member Services department within 30 – 45 days.

What is the process if a Network Provider is working with a member who is not yet housed, but involved with TCLI?

The preliminary visits for TCLI begin with In Reach staff and ongoing assessment of housing needs, mental health supports, and supported employment options. During this time, it is important that Network Providers support the member and the In-Reach staff with honesty of needs, historical obstacles, and future goals and strengths. The Network Provider should begin collaborating with the assigned TCLI staff to continue options counseling in order to reach the goal of identifying and moving the member into supportive, independent living. Network Providers should attend meetings (as needed), complete and produce all supporting verification documentation, assist with identifying housing, and assist with the move.

What is the process if a Network Provider is working with a member who is already housed with TCLI?

The primary role of the Network Provider in working with a member who has been housed as part of TCLI is to help the member maintain housing by providing tenancy supports and ensuring that the member integrates into their community, creating a meaningful day. Cleanliness, safety and security, visitor management, medication routines, and lease obligations should be practiced and enacted. Tenancy Support providers must provide a monthly update to the Transition Coordinator about the member and alert the Transition Coordinator to all significant housing or health-related events, including but are not limited to: member is hospitalized, experiences a serious illness or new diagnosis, has lost housing, is homeless, has incurred a lease violation(s), has unpaid bills that could result in loss of lease, has law enforcement or other legal interactions, or has been in elopement or unaccounted for more than 72 hours.

What if the member is losing housing or at risk of losing housing?

If the member is at risk of losing housing or losing housing, please convene a team meeting and include the Transition Coordinator in eviction avoidance planning. Network Providers are responsible for partnering with TCLI staff to help resolve and prevent disputes between landlords and TCLI participants that could lead to eviction.

Are there any requirements for Network Providers related to Supported Employment?

Yes. The primary outcome of Supported Employment (SE) is competitive employment in an integrated setting (50 percent or more non-disabled) consistent with an individual's strengths, resources, priorities, concerns, abilities, capabilities, interests and involving informed choice. To establish a valued sense of integrity and purpose within SE/Long

Term Vocational Support (LTVS), Network Providers must participate in trainings to implement evidence-based SE within your organization as applicable and help gather/ collect and report requested data to Vaya for use in determining needs and barriers to employment within our catchment area.

For providers who are contracted to provide SE or ACTT services, you must provide SE program data that includes member development/phase of service (i.e. job development, creation of small business/micro-enterprise, placement or LTVS) and outcomes, including the number of individuals who obtained jobs, the member's start date, hours worked, wages, benefits and pertinent employer information. Reporting must be submitted electronically on a quarterly basis to Vaya via email at: SupportedEmployment@vayahealth.com.

SECTION 10

Emergency Services and Hospital Requirements

Vaya contracts with licensed hospitals across the state of North Carolina and in neighboring states. These may include large health systems with multiple hospital facilities and physician practices, as well as county hospitals, state facilities, private psychiatric hospitals and PRTFs for children and adolescents. We routinely accommodate Out-of-Network Agreements with hospitals and facilities to cover medically necessary inpatient psychiatric treatment for our members. We also reimburse hospitals and facilities for medically necessary emergency department and crisis services provided to our members, even if the hospital or facility is not contracted to participate in our Closed Network. **This section of the Manual is applicable to all hospitals, 24-hour inpatient facilities (excluding PRTFs) and providers of emergency and crisis stabilization services who receive reimbursement from Vaya.** The requirements of this section are designed to help reduce inpatient admissions and lengths of stay so members can be connected with a community-based provider and resume recovery as soon as possible.

Emergency and Crisis Stabilization Services

Vaya provides reimbursement for emergency and crisis stabilization services for eligible Medicaid beneficiaries at any time, without regard to prior authorization or whether the provider is contracted with Vaya. However, the treatment must fall within the scope of services covered under the 1915(b)/(c) Waiver. For example, Vaya will not reimburse a provider for cancer treatment based on the member having a behavioral health diagnosis. Medical treatment provided in the ED that is unrelated to behavioral health is the responsibility of DHB. If you are unsure about whether a service should be billed to Vaya or to DHB, please refer to the Department's Mixed Services Payment Protocol, attached to all hospital contracts and available on our website.

"Emergency services" means covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition as defined at 42 CFR § 438.114(a). We do not limit what is considered an emergency medical condition based on lists of diagnoses or symptoms. We consider FBC services to fall within this definition.

Crisis stabilization or "post-stabilization care" services generally means covered inpatient and outpatient services that are provided to maintain the stabilized emergency medical condition. Requests for reimbursement for emergency services must be presented to Vaya within 90 days of treatment or discharge (whichever is later). We will not require you to enter into a contract for reimbursement, but we will ask you to complete a billing enrollment form to obtain information required for our financial records. **You may not bill Medicaid members (or otherwise hold them liable for payment) for screening and treatment that was needed to diagnose an emergency medical condition or to stabilize the individual.**

If the individual was not enrolled with Vaya at the time of service delivery but is eligible for a Vaya Health Plan, Vaya will enroll them as soon as possible. The date of enrollment will be the date the emergency or post-stabilization care

services were provided. However, individuals must be enrolled in our system before they can receive additional, non-crisis services.

Emergency Department Admission Notification

If a member of a Vaya Health Plan, or someone who you believe may be eligible for a Vaya Health Plan, presents at an ED or FBC in a behavioral health crisis, the facility must inform Vaya of the admission via a daily report to their designated Vaya point of contact and/or by calling the Vaya Member Services Department at **1-800-849-6127**. The hospital ED or facility where the individual is receiving treatment is ultimately responsible for assessment and disposition of individuals in their care. However, Vaya's Acute Care Response Team is available to provide ED and FBC staff with consultation, coordination with the individual's BHCH and education on possible resources for appropriate treatment.

You must allow Vaya CMs and hospital liaisons access to Vaya Health Plan members while in the ED or FBC to participate in diversion from inpatient admission, discharge planning, bridging to outpatient service engagement, crisis planning, etc. Likewise, if the member has a treatment relationship with a Vaya Network Provider, you must allow that provider access to the member while in the ED or FBC to help facilitate diversion from inpatient care.

You must notify Vaya whenever a Vaya Health Plan member is discharged from the ED or FBC within 24 hours of discharge. If a member who presented to the ED or FBC with a behavioral health issue is discharged, you must arrange for a follow-up appointment with the individual's BHCH, or, if there is no BHCH, with an appropriate outpatient or other behavioral health provider within five business days of discharge. Vaya Member Services staff can assist with arranging the follow-up appointment for members who are not yet connected with services. Please call the 24/7 Access to Care line at **1-800-849-6127** for assistance with appointments.

Inpatient Admission Notification and Authorization of Stay

Vaya generally honors a seven-day "pass through" for inpatient psychiatric treatment. This means that we do not require prior authorization for the first seven days of an inpatient stay. However, we reserve the right at any time to conduct post-payment review to verify the medical necessity of any inpatient stay and may identify an overpayment if it is determined that inpatient treatment was not medically necessary or delivered in accordance with all requirements of the Controlling Authority listed in your contract or Out-of-Network Agreement, including, but not limited to, DHB Clinical Coverage Policy No. 8B.

Regardless of the seven-day pass-through period, you must notify Vaya within 48 hours of any inpatient admission of a Vaya Health Plan member so we can immediately link the member to a community-based provider or work with the member's existing provider on discharge planning. Effective discharge planning is critical to reduce the cycle of readmission for some of our members with serious and persistent mental illness. **You must notify us of an inpatient admission by electronically submitting a SAR to the MCIS within 48 hours of admission.** We reserve the right to deny authorization and reimbursement of the initial seven-day pass-through period if you fail to notify us of the individual's admission within this timeframe.

Certification for continued hospitalization or services include the number of extended days or units or service, the next anticipated review point, the new total number of days or services approved and the date of admission or onset of services. Requests for continued stay must be submitted electronically via the MCIS. The following information must be included in SARs: original admission information (including category of disability and diagnostic profile), reasons for requesting continued stay (including current risk factors and medical necessity criteria), current medications, name of

attending physician, anticipated discharge date and plan that notes step-down services and discharge living arrangement. For members with primary diagnoses of SUD, Vaya requires the following: current vital signs, Clinical Institute Withdrawal Assessment for Alcohol (CIWA or CIWA-Ar) score and/or Clinical Opiate Withdrawal Scale (COWS) score as applicable, current withdrawal symptoms and results of UDS. You must also attach the Regional Assessment and Referral Form (RARF) or other demographic and clinical information on which the admission decision was made. Requests must be received **by noon of the last authorized service day**. Failure to submit timely SARS may result in non-covered service days.

There may be times when CMs need to contact inpatient staff for additional information to make a medical necessity decision. Failure to respond in a timely manner to these requests may result in longer request processing times and/or referral to peer review.

Criterion V Reviews

In the event that not all of the criteria for a continued acute stay in an inpatient psychiatric facility as specified in 10A NCAC 25C. 0302 are met for beneficiaries through the age of 17, Vaya may authorize continued stay in an inpatient psychiatric facility at a post-acute level of care to be paid at an established residential rate if the facility and program services are appropriate for the beneficiary's treatment needs and provided that all of the Criterion V conditions are met. Criterion V is approved only when the beneficiary has a history of sudden de-compensation or measurable regression and experiences weakness in his or her environmental support system, which is likely to trigger a de-compensation or regression.

Retrospective Authorization

In the event that you admit a patient who is not Medicaid-eligible on or before admission, and the patient is retroactively determined to be Medicaid eligible for a time period that would cover the inpatient stay, you can request a retrospective authorization review as follows. You must submit **a cover letter, a print screen from NCTracks showing the date of Medicaid eligibility determination and a paper copy of the full closed medical record** to the following address within 90 days of the eligibility determination:

Vaya Health
Attn: Inpatient Review Team
200 Ridgefield Court
Asheville, NC 28806

Clinical records may also be submitted via secure fax to 828-348-4141.

It is your responsibility to routinely check NCTracks for the eligibility status of Medicaid beneficiaries. We will not process requests for retrospective authorization received outside of this timeframe.

Treatment Coordination and Discharge Planning Requirements

Discharge planning begins at the time of the initial assessment and is an integral part of every member's treatment plan, regardless of the level of care being delivered. The discharge planning process includes use of the member's strengths and support systems, the provision of treatment in the least restrictive environment possible, the planned use of treatment at varying levels of intensity and the selected use of community services and support, when appropriate, to assist the member with functioning in the community. Involvement of family members and other identified supports, including primary care doctors or community behavioral health providers, require the member's written consent.

Hospitals and facilities contracted with us must cooperate fully with our care management and discharge planning efforts, including, but not limited to, coordination with the member's primary care provider, BHCH or other community-based behavioral health provider, as well as participation in interdisciplinary team meetings facilitated by Vaya. Specific requirements include the following:

- You must regularly schedule treatment and discharge planning meetings for members in 24-hour inpatient care.
- You must provide Vaya and the member's BHCH, or other designated community behavioral health provider, with at least 24 hours prior notice of the date, time and place of any treatment team or discharge planning meeting regarding a Vaya Health Plan member. If a member declines to permit notice to Vaya or the provider, this must be documented in the medical record.
- You must allow any assigned Vaya complex CM, hospital liaison, crisis coordinator, BHCH or designated community behavioral health provider to attend and actively participate in treatment team and discharge planning meetings regarding members. If a member declines to permit access to Vaya or the provider, this must be documented in the medical record.
- You must notify Vaya, the BHCH and/or the designated community behavioral health service provider at least 24 hours prior to the intended date and time of any discharge of a member from inpatient care. If a member declines to permit notice to Vaya or the provider, this must be documented in the medical record.
- In those instances where formulary medication was used previously and proven ineffective for a member, you must request a pharmacology consultation by contacting Vaya's CMO prior to discharge. The consultation process will include review of available treatment alternatives that can facilitate ongoing medication adherence and effective treatment. **Medicaid members should not be discharged with prescriptions for medication that are not covered by Medicaid.**
- Once the discharge date is determined, you must schedule a follow-up appointment with the BHCH or designated community behavioral health service provider (if the member has an active treatment relationship pre-dating admission) or request that Vaya's Member Services Department do so. The follow-up appointment must be scheduled to occur within five days of discharge.
- At the time of discharge, you must complete the discharge section of the patient module in the MCIS and provide the member, Vaya and the assigned community behavioral health provider with the following critical patient discharge information:
    - Reason for hospitalization
    - Significant findings
    - Procedures and treatment provided
    - Admission and discharge diagnoses
    - Member's demographic information
    - Member's discharge condition (including level of risk to self/others)
    - Discharge medications and Medication Reconciliation Form (dosage and amounts, when refills needed)
    - Recommended follow-up care (both medical and psychiatric)
    - Recommended revisions to CCP (if any)
    - Name of discharging physician with contact information
    - Any other information requested by Vaya at the time of discharge

Vaya staff will review the status of the discharge plans at each review to assure that a discharge plan exists, was developed with member input and includes individualized goals and language specific to the member. Goals in a discharge plan must be specific, realistic, comprehensive, timely, objective and measurable.

SECTION 11
Involuntary Commitment

In North Carolina, courts can issue involuntary commitment orders when a person is dangerous to self or others and a psychiatrist or psychologist determines the individual meets commitment criteria set forth at N.C.G.S. Chapter 122C, Article 6. Courts can also order that an individual who meets criteria be placed under an outpatient commitment, which would require the person to obtain treatment on a regular basis while living in the community. This section describes the involuntary commitment processes for inpatient, substance use and outpatient treatment and your role as a Network Provider in that process.

Involuntary Commitment Process

If the BHCH or first responder is unable to mitigate a member's crisis, and the individual is a danger to self or others, yet is not willing to seek stabilization voluntarily, you are responsible for initiating an involuntary commitment (IVC) petition. The affidavit and petition form are available on the website of the Administrative Office of the Courts: http://www.nccourts.org/Forms/Documents/661.pdf.

Who can file a petition for involuntary commitment?

A petition can be filed by any person who has knowledge that a person meets criteria. However, if the petitioner is a physician, psychiatrist or eligible psychologist, it can be notarized.

What are the criteria for involuntary commitment?

To file a petition for involuntary commitment, the petitioner must have knowledge that the person is mentally ill and dangerous to self or others OR is a substance user and is a danger to self or others. An IDD diagnosis, in and of itself, is not considered sufficient criteria for commitment.

What should the petition include?

The petition must contain facts to support the petitioner's belief that the individual (referred to as the "respondent") meets criteria for commitment, including evidence of significant history of harm to self or others when unstable, if available. Best practice is to avoid conclusory statements and to specifically designate the facility where law enforcement is to transport the member once located (e.g., hospital ED, FBC center, other IVC-designated facility, etc.).

Where, how and when is the petition filed?

Every county has its own procedure, so it is important to check with the Clerk of Court's office where the petition is to be filed before initiating the process. The petition must be filed in the county where the individual resides. IVC petitions are generally taken out with the Clerk of Court or local magistrate. In some counties, only the magistrate can accept an IVC petition. The petition can be filed at any time, including after regular business hours.

After-hours petitions are always taken out with the local magistrate. Contact information for Clerks of Court and magistrate's offices are available on county websites and through the Administrative Office of the Courts at https://www.nccourts.gov/locations.

What happens if the IVC petition is accepted?

If the magistrate or Clerk of Court agrees that the petition meets criteria for involuntary commitment, he or she will issue a custody order for law enforcement to transport the individual to an area facility – typically an ED or other IVC-designated facility, which can include an FBC – for evaluation, or to any physician locally available. The custody order must be served within 24 hours of issuance. This means that if the individual cannot be located within 24 hours, a new petition must be filed.

What happens after the individual is picked up by law enforcement?

The individual must receive an evaluation from a "first evaluator" within 24 hours of presentation to the facility. The first evaluator can be a physician, psychiatrist, eligible psychologist or Certified First Evaluator or First Commitment Evaluator (certified through a rigorous process – LCSW, LCAS with limitations or psychiatric NP). The first evaluator can do one of the following: (1) stop the process and release the respondent if he or she determines the individual does not meet IVC criteria; (2) recommend inpatient mental health commitment; (3) recommend outpatient MH commitment; or (4) recommend substance abuse (SA) commitment.

If recommending SA commitment, the first evaluator can release the respondent pending a hearing and refer him or her to an outpatient provider, or the first evaluator can hold the respondent at a 24-hour facility pending a court hearing (a 24-hour treatment facility must be named on the form and accept the respondent). The decision to release or recommend outpatient MH or SA commitment must be documented and reported to the Clerk of Court using Form 572: Examination and Recommendation to Determine Necessity for Involuntary Commitment.

What happens if the first evaluator recommends inpatient commitment?

If the evaluator recommends inpatient commitment, law enforcement must transport the respondent to a 24-hour facility (inpatient unit) for care and treatment. If a 24-hour facility is not immediately available OR appropriate to the respondent's medical condition, the respondent can be temporarily detained under appropriate supervision at the site of the first evaluation for up to seven days from issuance of custody order **OR** released upon further examination by a physician, psychiatrist or eligible psychologist:

- If seven days pass, the commitment process is terminated at that time or can be restarted with a new petition. If a doctor or an eligible psychologist is new petitioner, the doctor or psychologist must conduct a new examination and may not rely upon the prior examination.
- The interim evaluation cannot be performed by other mental health professionals who perform initial examinations under the Waiver. The decision to release or recommend outpatient MH or SA commitment must be documented and reported to the Clerk of Court using Form 572: Examination and Recommendation to Determine Necessity for Involuntary Commitment, as well as a Notice of Commitment Change Form.

What happens when a 24-hour facility is located?

The 24-hour facility must accept the respondent for admission. Once that occurs, and the respondent is transported, an MD evaluator must complete a second evaluation within 24 hours of presentation to the 24-hour facility. Following the second evaluation, the second evaluator can: (1) stop the process and release the respondent if he or she determines the individual does not meet IVC criteria; (2) recommend inpatient MH or SA commitment; or (3) recommend outpatient MH or SA commitment and release the respondent pending the OPC hearing.

The individual may also be given the option to sign in voluntarily. The decision to release or recommend outpatient MH or SA commitment must be documented and reported using Form 572 and the Notice of Commitment Change Form.

If the respondent is released, he or she is returned home via law enforcement or may arrange his or her own transportation. **Network Providers may not decline inpatient admission based on an individual's transportation options post-discharge.**

What happens after the respondent is admitted to an inpatient unit on IVC?

The 24-hour facility sends the petition and paperwork to the Clerk of Court in the county where the facility is located. A District Court hearing must be held within 10 days of an individual being taken into custody by law enforcement. If the court finds by clear, cogent and convincing evidence that the individual meets inpatient mental health commitment criteria, it may order inpatient commitment for up to 90 days at the initial hearing, a maximum of 180 days at the first rehearing and a maximum 365 days at second or subsequent rehearing. Commitment can be inpatient, outpatient or a combination of the two.

For SA commitment, a District Court hearing must be held within 10 days of the date the respondent was taken into custody. Commitment is to the treatment of a physician rather than to a 24-hour facility. Treatment may be on either an inpatient or outpatient (OPC) basis, as determined by the physician. SA commitment has a maximum term of 180 days, with a maximum of one-year SA commitment at a second and subsequent rehearing. SA commitment can include up to 45 consecutive days of inpatient treatment without a supplemental hearing.

Can an OPC be initiated without first requiring the respondent to be committed for an inpatient stay?

Yes. An OPC can be initiated during the involuntary commitment process by an MD or licensed psychologist on the first evaluation after the initial petition and not as part of any facility discharge. In such cases:

- The first evaluator must complete an Examination and Recommendation to Determine Necessity for Involuntary Commitment Form, check all appropriate OPC boxes in all sections and identify the name and address of the proposed outpatient treatment provider using Form 572.
- The first evaluator must also give the member an appointment time and date for the follow-up examination with the outpatient treatment provider.
- The initial petition and the first evaluation must be returned to the Clerk of Court prior to the follow-up appointment with the proposed provider.
- The Clerk of Court will schedule a hearing and notify the respondent and the proposed outpatient treatment center of the hearing date.
- If the member fails to show for the follow-up OPC appointment, the proposed provider must attempt follow up and, if that fails, may file a Request for Transportation Order and Order (Outpatient Fails to Appear for Pre-hearing Examination AOC-SP-224), available at: http://www.nccourts.org/Forms/Documents/853.pdf.
- The proposed provider's MD or licensed psychologist must complete another examination to determine if the individual continues to meet the criteria for OPC.
- If the member is still in need of an OPC, the proposed provider's MD, licensed psychologist or designated clinician will attend the OPC hearing, where the judge will decide whether to continue the OPC. In some instances, the judge may order the examining MD or licensed psychologist to provide face-to-face testimony at the OPC hearing. This OPC hearing is held within 10 days of the initial MD's evaluation.
- If the individual appears for the follow-up examination appointment and no longer meets the criteria for OPC, the MD or licensed psychologist should complete the Notice of Commitment Change Form and send to the Clerk of Court, with a copy to the assigned Vaya CM. This form is currently available on the archived DHHS website at: https://www.ncdhhs.gov/ivc.

Outpatient Commitment Responsibilities

Outpatient Commitment (OPC) can be ordered for individuals who are deemed mentally ill; capable of surviving safely in the community with available supervision from family, friends or others; in need of treatment to prevent further deterioration; and whose current mental illness limits or negates the ability of the individual to make an informed decision to seek voluntary treatment or comply with recommended treatment. Failure to comply with an OPC order may result in an order to law enforcement to take the individual into custody and present him or her to an inpatient facility for an evaluation.

Members placed on OPC are likely to be individuals with high-risk behaviors about whom there is also a concern regarding treatment compliance. The goal is to assure that a strong effort is made to provide appropriate follow-up for these individuals. Vaya requires Network Providers to meet the following requirements for members who are on OPC. However, please be aware that some counties, specific magistrates and Clerks of Court have developed specific procedures and workflows for working with OPCs. Network Providers are responsible for adhering to established procedures and workflows applicable to the county where the OPC was issued.

You must perform a face-to-face assessment within five working days of notification that a member you are serving is under OPC order, followed by ongoing outpatient face-to-face assessment and follow-up treatment at the level clinically appropriate to the member's needs and condition. Some members may need daily contact, while others may need weekly contact. No member shall be seen less than once every two weeks unless he or she is in a 24-hour, supervised setting (Family Care Home, Group Home) and are stable. If you determine that the individual can be seen less than bi-weekly (two times per month), an MD/licensed psychologist/FNP/PA must assess the need to continue the OPC and document the contact.

What is the process if a Network Provider is considering discharging a member on OPC?

If you determine that the individual no longer meets criteria to continue the OPC, the MD/licensed psychologist/FNP/PA must complete a Notice of Commitment Change Form. Once completed, you must send one copy to the Clerk of Court in the county the court order dictates (which is the county of supervision) and one to the assigned Vaya CM, who will log the termination of commitment. If the individual was initially committed as a result of conduct resulting in the individual being ***charged with a violent crime***, including a crime involving an assault with a deadly weapon, and was found Incapable to Proceed (ITP), a hearing must be scheduled to make any changes in the commitment. If you are unsure about the reason for the initial commitment, you must contact the Clerk of Court's office for clarification.

What if the member clearly refuses and fails to adhere to treatment recommendations?

If the individual clearly refuses and fails to adhere with all or part of the prescribed treatment, while continuing to meet commitment criteria, you should make all reasonable efforts to engage his or her compliance and document those efforts in a letter prepared by the treating clinician. The clinician's letter should be sent to the Clerk of Court where the commitment is being supervised, along with a Request for Supplemental Hearing (Outpatient Clearly Refuses to Comply with Treatment AOC-SP-221), available at: http://nccourts.org/Forms/Documents/856.pdf. A copy must also be sent to the assigned Vaya CM.

What if the member fails to comply but does not clearly REFUSE to comply with treatment?

If the member fails to comply but does not clearly refuse to comply (i.e., the individual has a pattern of scheduling appointments but does not show up) you may request the court to order the member taken into custody for the purpose of a face-to-face evaluation. This option is only available if you know where the member can be located. To do this, you must complete a Request for Transportation Order and Order (Outpatient Fails but Does Not Clearly Refuse to

Comply with Treatment) AOC-SP-220 available at: http://nccourts.org/Forms/Documents/857.pdf. It must be sent to the Clerk of Court where the commitment is being supervised, with a copy to the assigned Vaya CM.

What if the member does not comply with treatment and cannot be located?

If the member is non-compliant and cannot be located for a pick-up order, you must attempt the following reasonable professional efforts:

- First, you must be able to demonstrate supporting documentation and/or billing for at least one of the following **within 72 hours (excluding weekends/ official Vaya holidays)** of the initial missed appointment:
  - A face-to-face visit in the member's home
  - A rescheduled office appointment with the clinician that the member keeps
  - A phone conversation with the member about the services being offered
  - At least one face-to-face attempt to contact the member at his or her last known address
  - A follow-up letter sent to the member at his or her last known address
- Second, assuming the above-listed attempts to locate the member are unsuccessful, you must attempt face-to-face contact once per week for the first two weeks, then one more attempt two weeks later (the fourth week).
- If the member's last known address is a homeless shelter, or someone else who resides at the last known address states that the member does not reside at the last known address, the above three face-to-face attempts should be made at local homeless shelters. Any information provided to you by a family member or another person regarding the member's location must also be pursued.

What if these reasonable professional efforts are unsuccessful?

You must document the efforts made, including three attempts at face-to-face contact over a four-week period, in a letter to the Clerk of Court's office in the supervising county, complete a Notice of Commitment Change and send the form to the Clerk of Court, with a copy to the assigned Vaya CM. Remember that if the member is initially committed as a result of conduct resulting in the individual being ***charged with a violent crime***, including a crime involving an assault with a deadly weapon, and the member was found Incapable to Proceed (ITP), a hearing must be scheduled to make any changes in the commitment.

If you are unsure about the reason for the initial commitment, you must contact the Clerk of Court's office for clarification. If the member's case is active, you must keep the case open for 60 days from last contact. If the member cannot be located within 60 days from last contact, you may discharge the member from services and notify Vaya using the normal discharge documentation and procedures.

What is the review process for continuation of OPC?

Prior to the expiration of the OPC, the Network Provider clinician must review the case with an MD/licensed psychologist/FNP/PA and determine if the member still meets the criteria for OPC and whether it needs to be extended. If the member has been compliant and no longer meets the criteria, the duration of the OPC will naturally expire. If you determine that the member continues to meet the criteria for the OPC and a rehearing is needed, then the MD/licensed psychologist will need to complete an Examination and Recommendation to Determine Necessity for Involuntary Commitment, Form 5-72-09, available at https://www.ncdhhs.gov/documents/mhddsas-legal-forms-hospitals. . This form, along with a completed Request for Hearing Form, must be submitted to the Clerk of Court, with a copy to the assigned Vaya CM.

What if the member moves to another state while under OPC?

If the member moves to another state, you must document this change in the medical record, complete a Notice of Commitment Change and send it to the Clerk of Court's office, with a copy to the assigned Vaya CM. Remember that if

the member is initially committed as a result of conduct resulting in the individual being ***charged with a violent crime***, including a crime involving an assault with a deadly weapon, and the member was found Incapable to Proceed (ITP), a hearing must be scheduled to make any changes in the commitment. If you are unsure about the reason for the initial commitment, you must contact the Clerk of Court for clarification.

What if the member moves to another MCO catchment area?

If the member plans to relocate to another county within the state that is outside of Vaya's catchment area, you must request the Clerk of Court in the county where the OPC is supervised to schedule a hearing prior to the move. The MD/licensed psychologist must complete a new Examination and Recommendation to Determine Necessity for Involuntary Commitment and send it to the Clerk of Court's office with a completed Request for Hearing Form, with a copy to the assigned Vaya CM.

What if the member relocates to another county within Vaya's catchment area?

If the member is moving to a new county and wants to receive services from a new provider, the original provider must connect the member to a new provider. The original provider's OPC responsibilities do not end until the new provider accepts the member for services. If the member is moving to a new county but staying with the same provider organization, the current provider must arrange for all necessary transition of paperwork and contact information. As outlined above, the law requires **any** move from one county to another to be done through the court, and a hearing must be requested for OPC transfer to the new county.

What if the member wants to change providers?

If the member wants to receive services from a different Network Provider, the original provider must connect the member to a new provider. The original provider's OPC responsibilities do not end until the original provider confirms that the new provider accepts the member for services.

Substance Abuse Commitment

Involuntary Substance Abuse (SA) commitments generally take a great deal of coordination between community-based outpatient providers (SAIOP, SACOT, etc.) and potential inpatient treating facilities (state Alcohol and Drug Abuse Treatment Facilities, local FBC or detoxification facilities). A SA commitment order is a hybrid of inpatient and outpatient care. SA commitments are for 180 days, of which 45 consecutive days can be inpatient. If longer inpatient time is needed, a re-hearing must be held.

At this hearing, 90 days can be ordered inpatient. Members under SA commitment who do not comply with treatment can be picked up by law enforcement, evaluated in the community and then admitted to a 24-hour treatment facility if inpatient criteria are met (without a new petition). In such cases, the Network Provider must complete Request for Transportation Order and Order (Committed Substance Abuser Fails to Comply with Treatment or is Discharged from 24-Hour Facility AOC-SP-223), available at: http://www.nccourts.org/Forms/Documents/854.pdf, and submit it to the Clerk of Court's office, with a copy to the assigned Vaya CM.

Once the pick-up order is issued, the member will be located by law enforcement and brought to you for evaluation. Please remember to file this request early in the day to allow for sufficient time for the individual to be presented for a face-to-face evaluation. If, upon evaluation, you determine that the member meets inpatient criteria, you can arrange for the individual to be admitted to an inpatient SA treatment facility. Similar to the OPC process, each county may have a different process for SA commitments and pick up orders. As a Vaya Network Provider, it is your responsibility to understand and follow the applicable county process.

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SECTION 12
Transition, Discharge and Provider Closures

Network Providers are required to refer members for specialty care or to other contracted providers in response to a member request, change in member's level of care or change in the Network Provider's status within the Closed Network. You must ensure continuity of care for members in such circumstances, limit potential disruption in services and cooperate with all transition and discharge activities, including, but not limited to, complying with all referral and documentation requirements. In the event of a provider closure (voluntary or involuntary), the same requirements apply. **Network Providers are required to notify Vaya 60 days in advance of a voluntary closure of a site, service or regional or statewide business operations.** Upon receipt of such notice, we will send you a written confirmation of withdrawal from the network, confirming the effective date of your contract termination.

Member Request

In the event that a member requests to change providers, you must assist the individual in transitioning to the new provider of his or her choice. This includes providing them with a list of alternate providers, making the new appointment or working with Vaya's Member Services Department to obtain an appointment with the new provider and ensuring all health records necessary to ensure continuity of care are shared with the new provider as soon as possible. It is not acceptable to discourage a member from selecting a new provider or practitioner or to charge a fee for the transfer of medical records.

Change in Level of Care

In the event that you determine a member's needs have changed, such that the current service or level of care that you provide is no longer clinically appropriate, you must offer education and assistance to the member about available options and best practices. Once a new service and/or service provider is identified, you must assist the individual in transitioning to the new provider of his or her choice as outlined above. It is never acceptable to maintain an individual in a service or level of care that is not medically necessary solely because you are not contracted to offer the service or level of care that would be more appropriate.

Discharge from Licensed Facilities

In accordance with N.C.G.S. § 122C-63, providers must notify the member and Vaya if you intend to close an IDD residential facility or to discharge a member from an IDD residential facility **at least 60 days prior** to the closing or discharge. Members residing in other non-IDD 24-hour licensed facilities such as mental health group homes or adult care homes must be provided with **at least 30 days' notice** prior to closure or discharge. These timeframes are necessary to protect continuity of care and give the member time to find a new place to live. Vaya strictly enforces these timeframes and will report any violation to DHSR.

Voluntary Provider Closure

In the event that a Network Provider is **voluntarily** closing a site, service or operation, the following information must be communicated in writing to provider.info@vayahealth.com:

- Whether the entire organization is closing, or only a part of it, and which part(s) or site(s), as well as whether you are closing all operations within the state of North Carolina
- The date of site closure, end of operations or effective date of specific service elimination
- A list of the names and dates of birth of affected members and the services they are currently receiving
- Which notifications you made and when (e.g., to government agencies, to members, to other providers) and the method of such notifications
- A list of members currently receiving medication management services, with prescription due dates. We strongly encourage you to issue 90-day prescriptions to individuals prior to closure or service termination, when medically appropriate.
- Whether you made any arrangements for referral of Vaya members to other providers
- Identity and contact information for the primary person within the organization responsible for coordination of member referrals
- A written plan for the transfer to the receiving provider for affected members, including a master list of such individuals
- A list of credentialed practitioners who will no longer be employed by you, if applicable
- A list of employees who will continue to have access to the MCIS during the closing process, and the date such access should be terminated

In voluntary closure situations, you must send a written notification to members/ LRPs advising of the closure, including effective date, must immediately begin to work on referrals of members to other service providers. Vaya will also send a written notice to affected members and/or LRP. If you did not provide any services to Vaya members and had no active service authorizations within the preceding 90 days, no notification to members is necessary.

Involuntary Provider Closure

In the event that Vaya decides not to renew your contract, site or service, or if Vaya decides to terminate or suspend your contract, you will receive a written notice with instructions regarding member transition. It is not acceptable to interfere with or prevent member transition in such circumstances or to discourage the member from transitioning to another Network Provider. The written notice will include a form you must complete and submit within five days of receipt of the notice to help us gather the following information:

- A list of the names and dates of birth of affected members and the services they are currently receiving
- A list of members currently receiving medication management services, with prescription due dates. We strongly encourage you to issue 90-day prescriptions to individuals prior to closure or service termination, when medically appropriate.
- Whether you made any arrangements for referral of Vaya members to other providers
- Identity and contact information for the primary person within the organization responsible for coordination of member referrals
- A written plan for the transfer to the receiving provider for affected members, including a master list of such individuals
- A list of credentialed practitioners who will no longer be employed by you, if applicable
- A list of employees who will continue to have access to the MCIS during the closing process, and the date such access should be terminated

For involuntary closure situations, Vaya will provide assistance with member referrals, but transition is still your primary responsibility. We will also send a written notice to affected members and/or guardians explaining our decision and the transition process, including notification of other provider choices available, if any.

Members receiving active treatment for acute or chronic behavioral health conditions may continue to receive services with the Provider through the period of active treatment, or for 90 calendar days after the closure/change in services, whichever is less. The Provider must notify UM of the members undergoing active treatment, and the transition plan for such members. For continuing services to be authorized by UM, the Provider must agree to continue treatment for an appropriate period of time based on the transition plan goals, share ongoing information about treatment plan progress with UM, continue to follow UM policies and procedures, and charge only the required copayment, if applicable.

Closure Responsibilities

In the event a Network Provider closes its operations in the Vaya Network, whether the closure is voluntary, the result of termination, acquisition by another provider, non-renewal, bankruptcy, relocation to another state or any other reason, you must comply with the following requirements:

- If requested by the receiving provider, you must actively participate in treatment team, transition and/or discharge planning meetings until such time as all members in your care are transitioned or discharged.
- You may be subject to a final post-payment review to occur within 60 days of contract non-renewal/termination/ withdrawal.
- Regardless of the reason for closure, you are required to retain, or arrange for the retention of, all original member service records. You must submit a written plan for maintenance and storage of all records of services provided to Vaya Health Plan members at least 30 days prior to the end date of your contract, as well as a master records list that includes the member's name, service record number, date of birth, last date of service, Medicaid number and county of Medicaid origin, if applicable.
    - Records must be stored in an environment that ensures the continued preservation and safeguarding of records to protect their privacy, security and confidentiality for the duration of the statutorily required record retention period.
    - The written plan must include a copy of your record storage log and documentation that outlines where the records are stored, the designated custodian of records and contact information for the custodian of records.
    - Vaya has the sole discretion to approve or disapprove any such plan. If the plan is not approved, we may require you to arrange for electronic or paper copies of such records to be transferred to our possession within 15 days of the request. Even if Vaya or a receiving provider accepts such copies, you are still required to maintain the original records in a secure environment. You must provide a copy of the paper record storage log and contact information for a staff person who will assist with Vaya taking possession of the records. Records must be transferred in an organized and searchable format.
- Paper record storage logs must include the:
    - Name of provider
    - Date of storage
    - Series/box number (box 1 of 3)
    - Start date and the end date of the contents in the box
    - Record type or the name of the individual. Record type refers to the classification of the particular information contained in the box. Please store records of the same type in the same box.
    - Record ID number or any other identifying number or information

  - Date of birth recorded for individual service records. In the case of personnel records, the employee's date of birth is to be recorded for quick reference.
  - Timeframe of the information stored in a particular box. For example, you would record an admission of 1/2/09 – 9/13/09 or an employment period of 2/12/09 – 12/13/09, or a specific timeframe (e.g., October 2002 Cost Reporting, etc.).
- All claims for services must be submitted within 60 days of contract non-renewal, termination or withdrawal. Claims will be adjudicated on the published checkwrite schedule, unless Vaya suspends your final payment to ensure compliance with all transfer and closure requirements outlined in this section:
  - If you fail to comply with member records transfer or other referral or transition obligations, we reserve the right to withhold any remaining payments that may be due until such time as the Vaya Legal and Compliance Department approves release of funds.
  - If you fail to submit an acceptable records management plan, we reserve the right to withhold any remaining payments that may be due until such time as the Vaya Legal and Compliance Department approves release of funds.
  - If you owe any outstanding overpayments or other amounts to Vaya, we will apply any remaining payments that may be due against your accounts receivable before releasing any funds remaining.

Records Retention

In addition to applicable documentation and records requirements found in federal and state laws, rules and regulations, the N.C. State Plan for Medical Assistance, DHB Clinical Coverage Policies and the DMH/DD/SAS State Service Definitions, all Network Providers must follow the DMH/DD/SAS Records Retention and Disposition Manual (APSM-10-5) for record and documentation requirements.

Network Providers must retain the original service records of adult members for 11 years after the date of the last encounter. Service records of members who are minors and who are no longer receiving services shall be retained for 12 years after the minor has reached the age of majority (18 years of age). Required time periods for retaining and maintaining records may be more stringent for grant-funded services, and Network Providers are required to comply with the most stringent schedule applicable to the funding source. Records involved in any open investigation, audit or litigation shall not be destroyed, even if the records met retention. Following the conclusion of any legal action, investigation or audit, the records may be destroyed if they meet the retention period in the schedule. Otherwise, they should be kept for the remaining time period. Upon expiration of the retention period, records must be securely disposed of, such as by shredding by a HIPAA-compliant vendor.

Vaya will not be liable for records not stored, maintained or transferred as outlined above. Abandonment of records is a serious HIPAA and contractual violation that can result in sanctions and financial penalties. We are required to report abandonment of records to DHB Program Integrity.

SECTION 13

The N.C. Innovations Waiver

This section provides a general overview of the N.C. Innovations Waiver for Network Providers who may not be familiar with services for individuals with an intellectual and/or developmental disability (IDD). As we move forward with integrated care, it is important that Network Providers develop relationships across the service system in order to treat the whole person, including learning more about treating individuals with co-occurring MH/SUD and IDD needs. This section also includes requirements specific to providers of Innovations Waiver services.

What is the N.C. Innovations Waiver?

The N.C. Innovations Waiver is a home and community-based services (HCBS) waiver that allows individuals with an IDD to receive services in the community instead of institutions (including state facilities, such as J. Iverson Riddle Developmental Center, or Intermediate Care Facilities, known as ICF-IIDs). The Waiver includes many services and supports designed to integrate the person with disabilities into his or her community and help him or her to be as independent as possible.

How does someone become eligible for Innovations Waiver services?

N.C. Innovations is a capitated, or "slot-based" program. Slots are allocated by DHHS, and Vaya is required to serve a set number of individuals each year through Innovations. Unfortunately, there is more demand for the program than there are available slots. Because of this, we maintain a waitlist for N.C. Innovations called the Registry of Unmet Needs. Eligibility is determined by availability of a slot and an approval process that requires formal assessment of cognitive and adaptive functioning conducted by licensed psychologists, psychological associates or physicians as appropriate, based on the disability of the participant.

What is the Registry of Unmet Needs?

The Registry of Unmet Needs is a list of persons that are considered potentially eligible for N.C. Innovations.

What does potentially eligible mean?

To be considered potentially eligible for N.C. Innovations requires documentation of an IDD or a closely related condition, other than mental illness, and information about the resulting impairment to adaptive functioning.

What is an intellectual disability?

Intellectual disability involves impairments of general mental abilities that impact adaptive functioning. Typically, this includes individuals with an intelligence quotient (IQ) of 70 or below that impacts abilities in the conceptual, social and practical domains of adaptive functioning in a clinically significant way. Intellectual disability is considered a chronic condition and must manifest during the developmental period, typically prior to age 22. It often co-occurs with other mental conditions, such as depression, attention-deficit/hyperactivity disorder and autism spectrum disorders.

What does clinically significant mean?

Clinically significant is usually defined as deficits in cognitive ability or adaptive function that is two standard deviations below what a typically developing person would score on standardized tests that are administered by psychologists. With intelligence tests, a score of 70 is two standard deviations below the average. Scoring is similar for standardized tests of adaptive functioning.

What is a closely related condition?

"Closely related conditions" refers to individuals who have a severe, chronic disability that is attributable to cerebral palsy, epilepsy or any condition, other than mental illness, found to be closely related to an intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with an intellectual disability. The condition must be chronic and manifest before age 22. There must be documentation that the person has substantial functional limitation in three of the six identified major life activities. Autism spectrum disorder is an example of a related condition when it is not co-occurring with an intellectual disability.

What are the six major life activities?

1. Self-care (ability to take care of basic life needs, such as food, hygiene and appearance)
2. Understanding and use of language (ability to both understand others and to express ideas or information to others, either verbally or non-verbally)
3. Learning (ability to acquire new behaviors, perceptions and information and to apply experiences to new situations)
4. Mobility (ambulatory, semi-ambulatory, non-ambulatory)
5. Self-direction (managing one's social and personal life and ability to make decisions necessary to protect one's life)
6. Capacity for independent living (age-appropriate ability to live without extraordinary assistance)

How long do individuals wait for an Innovations Waiver slot?

There are currently more than 1,000 individuals waiting for N.C. Innovations Waiver services in Vaya's catchment area. Vaya is allocated a very limited number of slots each year by DHHS. The number of slots available varies based on several factors, including legislative actions regarding the state Medicaid budget, lifespan and support needs of current Waiver participants and geographic location. **Vaya cannot fund slots using our 1915(b)/(c) Waiver savings or other non-Medicaid funds.** Therefore, it is very difficult to predict the length of wait for Innovations services. While waiting, a person who is identified as potentially eligible may receive Medicaid (b) in lieu of services, Long-Term Community Supports (LTCS), state-funded IDD services and/or services available due to the savings realized through managed care, such as Respite, Supported Employment and Community Networking funded through (b)(3) dollars.

Can someone be terminated from the Waiver?

There are several reasons why Vaya might terminate a slot. For example, Innovations participants must receive at least one service per month to avoid possible termination from the Waiver. These services are authorized because they were determined necessary to ensure the health and safety of the person receiving services. If they are not being provided, we must question whether the person remains eligible, being mindful of the long waiting list for services. We may also terminate a slot based on the participant/ LRP or family member's failure or refusal to comply with Innovations Waiver requirements, including, but not limited to, monitoring and service plan development and implementation.

Why is it called a Waiver?

It is called a "waiver" because CMS waived some of the requirements of the Social Security Act that traditionally apply to Medicaid. For example, the Innovations Waiver includes services and supports such as home modification and respite, which are not within the scope of services traditionally covered by Medicaid.

When did the Waiver program start?

The N.C. Innovations Waiver was originally approved in 2008 for use as part of the Piedmont Behavioral Health (PBH) 1915(b)/(c) waiver model in five counties. The previous HCBS waiver in North Carolina was known as the CAP-MR/DD Waiver, later called the CAP-I/DD Waiver. Both the CAP-I/DD Waiver and the Innovations Waiver were drafted by DHB and approved by CMS through a waiver application process. The rest of the state continued to operate under the CAP-I/DD Waiver until the 1915(b)/(c) waiver model was expanded statewide beginning in 2012. Vaya began Waiver operations on July 1, 2012.

Are there any guidelines or polices for the Waiver?

DHB issued an Innovations Technical Manual to serve as a guide on June 25, 2012. This document was revised in September 2013 and ultimately replaced by Clinical Coverage Policy No. 8P, originally effective August 1, 2014. Clinical Coverage Policy No. 8P has been revised several times since coming into effect – it is your responsibility to stay abreast of changes to DHB Clinical Coverage Policies.

Will there be any changes to the Waiver?

The Waiver was amended multiple times, including effective August 1, 2013 and November 1, 2016, and renewed July 1, 2019. Any changes to the Waiver must be approved by CMS and are posted to the DHB website for public comment.

Does the Waiver contain any service limits?

Yes. Below is a summary of current limits. Note that some, but not all, limits may be exceeded for children under age 22 under the EPSDT benefit (discussed at section 6 of this Manual).

- The Innovations Waiver has a **$135,000** annual budget ceiling per participant established by DHB and approved by CMS. Any request to exceed that limit will result in denial of the plan. If an individual's needs cannot be met under the $135,000 cost limit, they should be evaluated for referral and placement in an ICF-IID.
- Adults age 22 and over who live in private homes cannot be authorized for more than 84 hours per week for any combination of Community Networking, Day Supports, Supported Employment and/or Community Living and Support.
- Children through age 21 who live in private homes cannot be authorized for more than 54 hours per week during the school year, or 84 hours per week when school is not in session, for any combination of Community Networking, Day Supports, Supported Employment and/or Community Living and Support. If the individual is 18 or older and graduated with a diploma (graduation with a degree/occupational course of study/GED indicating a standard course of study) then the individual may access the adult level of limits on sets of services.
- Adult and child beneficiaries who live in private homes with intensive support needs may request authorization from the LME/MCO for up to an additional 12 hours per day of In-Home Intensive Supports or Community Living and Support to allow for 24 hours per day of support. There are specific criteria for approval of this service, based on the individual's assessment results, and it must be reviewed every 90 days.
- Adults age 22 and over who receive Residential Supports cannot be authorized for more than 40 hours per week for any combination of Community Networking, Day Supports and Supported Employment services.
- Children through age 21 who receive Residential Supports cannot be authorized for more than 20 hours per week during the school year, or 40 hours per week when school is not in session, for any combination of Community Networking, Day Supports and Supported Employment services.
- Individual Goods and Services cannot exceed $2,000 per plan year.
- Payment for attendance at classes and conferences may not exceed $1,000 per plan year for participants (under Community Networking).
- Reimbursement for attendance at classes and conferences may not exceed $1,000 per plan year for caregivers (under Natural Supports Education).

- Community Transition funds are limited to $5,000 over the duration of the Waiver.
- Assistive Technology Equipment & Supplies, as well as Home Modifications, are limited to expenditures of $50,000 over the duration of the Waiver.
- Vehicle Modifications funds are limited to expenditures of $20,000 over the duration of the Waiver.

Do all Waiver participants receive Care Management?

Yes, Vaya is required to assign a CM to each Innovations Waiver participant. The CM must conduct monthly monitoring visits to ensure services are being delivered appropriately and in accordance with the Care Plan and Waiver requirements, and to ensure the health and safety of individuals on the Waiver. Most monitoring is done face-to-face, although telephonic monitoring may occur as needed. The CM also works with the family/ LRP and service provider to develop and submit a Care Plan during the participant's birth month.

Is respite available under the Waiver?

Yes. Respite services provide periodic or scheduled support and relief to the primary caregiver(s) from the responsibility and stress of caring for the individual. Respite may also be used to provide temporary relief to individuals who reside in licensed and unlicensed AFLs, but it may not be billed on the same day as Residential Supports. The service enables the primary caregiver to meet or participate in planned or emergency events, including planned rest time for him- or herself and/or family members. Respite may be utilized during school hours for sickness or injury. Respite may include in- and out-of-home services, inclusive of overnight, weekend care or emergency care (family emergency-based, not to include out-of-home crisis). The primary caregiver is the person principally responsible for the care and supervision of the beneficiary and must maintain his or her primary residence at the same address as the beneficiary. This service may not be used as a daily service in Individual Support. Respite care may not be provided by any person who resides in the beneficiary's primary place of residence. The cost of 24 hours of Respite care cannot exceed the per diem rate for the average community ICF-IID. Respite is not available to individuals who reside in licensed facilities that are licensed as 5600B or 5600C. **Staff sleep time is not reimbursable.** If providing Nursing Respite, the worker must be a licensed RN or licensed LPN in North Carolina.

Emergent Need Respite Beds shall serve as a temporary placement for adult individuals (age 18 and up) with IDD and/or co-occurring MH/SU disorders who are either being diverted from, or needing to be discharged from a hospital/emergency department setting and who are deemed stable and ready for discharge. The beds should be a step-down from, or diversion to, a hospital. The site may also be used for individuals who live in group or family settings in order to maintain their current residential setting (and when Respite has been determined not available/ appropriate). Referral for Emergent Need Respite is made through Innovation member's CM.

Are there copayments for Innovations Waiver services?

No. Providers may not charge a co-payment for the services available through the N.C. Innovations Waiver.

Innovations Provider Responsibilities

PRIOR AUTHORIZATION

All Innovations Waiver services, with the exception of crisis services, require prior authorization by Vaya. Innovations providers work with the assigned CM to acquire prior authorization for services.

- Innovations providers are required to actively participate in the development of the Care Plan by attending meetings scheduled by the CM and/or the person receiving Innovations Waiver services.
- A Care Plan will be developed at the time an individual is admitted. Services must be implemented within 45 days of Care Plan approval.

- A new Care Plan, to be implemented on the first day of the month following the individual's birth month, will be developed on an annual basis thereafter.
- The Care Plan is developed using a person-centered planning process and must verify a proper match between the participant's needs and the service and/or supports provided. All services, paid and unpaid, (including natural supports) should be reflected in the Care Plan. CMs will never ask someone to sign a plan of care the member or family disagrees with, but he or she may provide education about Waiver limits.
- The Care Plan is signed by the CM, the person receiving Innovations Waiver services and/or the LRP, if applicable. Other persons that participate in the development of the Care Plan may sign, if desired.
- Upon completion, the CM submits the Care Plan to the Vaya Utilization Management Department for approval. The Care Plan must be reviewed against medical necessity criteria and service definitions found in DHB Clinical Coverage Policy No. 8P. The CM also completes and submits an electronic SAR for each distinct service.
- The Innovations provider is responsible for ensuring prior authorization is acquired prior to the provision of Innovations Waiver services. The Innovations provider must implement services on the effective date of the authorization within the parameters outlined in DHB Clinical Coverage Policy No. 8P – N.C. Innovations.

PERSON-CENTERED PLANNING

All Innovations providers are required to actively participate in the person-centered planning process. The Care Plan outlines long-range outcomes for the person receiving Waiver services. The CM, in collaboration with the person-centered planning team, is responsible for developing the long-range outcomes. The Innovations provider is responsible for developing the short-range goals that help the person receiving services achieve the identified long-range outcomes. Each short-range goal must include the strategies and interventions that direct support professionals will use to help the person receiving services achieve the goal. Innovations providers are responsible for monitoring delivery of the services authorized in the Care Plan. This includes regular review and, as necessary, adjustment of short-range goals to enable the person receiving services to achieve his/her highest success. Innovations providers are also responsible for ensuring direct support professionals receive supervision as required by DHB Clinical Coverage Policy No. 8P.

SCHEDULING

The Innovations Waiver is expected to leverage natural and community supports and foster the development of stronger natural support networks that enable Innovations Waiver participants to be less reliant on formal support systems. To achieve these outcomes, the Innovations Waiver requires that providers ensure that services and/or supports are rendered to participants in accordance with an established schedule or plan. The Care Plan indicates the average weekly hours of service and/or supports to be used and the total number of authorized units in an approval period. Vaya sends authorizations to the providers identified in the Care Plan for the rendering of identified services and/or supports. The community-based service provider is charged with implementing the Innovations participant's Care Plan by providing services and/or supports that enhance the participant's quality of life, as defined by the participant.

The weekly schedule is a tool that is used in plan development. The purpose of the schedule is to help determine what is important to/for an Innovations Waiver participant. To meet requirements of the Innovations Waiver, natural and community supports should be scheduled first, along with the participant's interests and habits. Because of the goals embedded in the Waiver of leveraging natural and community supports, formal supports should be built around natural and community supports. The weekly schedule must consider many things such as when a person learns best and when they need breaks. The weekly schedule informs the Care Plan. The weekly schedule reflects the generally scheduled hours of service each day. It is a projection of the Innovations Waiver participant's typically scheduled week and a guide for consideration during mandated monitoring conducted by Vaya. Thus, there is flexibility around service and/or supports delivery that allows for non-routine deviations due to illness, participant choice or unexpected events.

Deviations are made only at the request of the participant – not for provider convenience. Deviations must be documented by the provider agency. If there is to be a routine/ongoing deviation to the schedule due to changes in the participant's wants or needs, we recommend that the person-centered planning team update the weekly schedule to reflect the change. Such updates will encourage better communication between all parties. Under no circumstances should the schedule be amended based on the needs of the provider agency. Unless there is a change to the total number of hours per year, the updated schedule does not need to be submitted to or approved by Vaya's Utilization Management Department.

Once the schedule is established, only changes initiated by the participant or LRP may occur. Post-payment reviews and focused monitoring reviews will audit documentation, and a Plan of Correction may be required if there are findings related to deviations from the schedule. Clear notation on grids, services notes or on a QP communication log serve as evidence of adherence to the intent of the Innovations Waiver.

DOCUMENTATION

Innovations providers are required to document services as outlined in DHB Clinical Coverage Policy No. 8-P, the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2, and as specified in this Manual. This includes, but is not limited to, adequate documentation of required staff training and service notes that include time in/time out.

BACK-UP STAFFING

During the person-centered planning process, an agency Back-up Staffing Plan is developed. Back-up staffing is not required for all Innovations Waiver services. For example, a Back-up Staffing Plan is not required for Respite services. The provider's Back-up Staffing Plan must be indicated in the "Agency Back-Up (mandatory)" section of the Care Plan. The Innovations provider is required to provide this information during the person-centered planning process. The Care Plan should also explain how the person receiving services needs shall be met when there is failure to provide back-up staffing, especially in the event of an emergency. The person receiving services cannot waive the Innovations provider's responsibility to identify the mandatory Back-up Staffing Plan. However, the person receiving services may choose to decline back-up staffing offered by an Innovations provider. Failure to provide mandatory agency back-up staffing is considered a Level I Incident. It is the responsibility of the provider agency to create an internal system to track their Level I Incidents. As outlined in 10A NCAC 27G .0602 - .0604, documentation of Level 1 Incidents must be available upon request by Vaya. In addition, providers must submit the Innovations Incident Reporting For Failure to Provide Back-Up Staffing Form on the 15th and the last day of the month to backupstaffing@vayahealth.com.

Examples of Back-up Staffing Level 1 Incidents include but are not limited to:

- Regularly scheduled direct support professional is out due to illness. Back-up direct support professional is offered, but the person receiving services did not want to work with the offered direct support professional.
- Regularly scheduled direct support professional quit. Back-up direct support professional was offered, but the person receiving services did not want to work with the offered direct support professional.
- Regularly scheduled direct support professional quit. No back-up direct support professional was offered or available, and regularly scheduled services do not occur.
- Direct support professional or person receiving services did not notify the supervisor that regularly scheduled services did not occur until several days after the fact.
- New regularly scheduled direct support professional is in the process of being hired. Back-up direct support professional offered during interim but was declined.

Service breaks are not considered Level 1 Incidents. Service breaks occur when a participant misses services for holidays, family vacations, weather conditions, illnesses or scheduling conflicts that cause a brief interruption in services. Service breaks must be documented by the Innovations provider and monitored by the CM. Examples of service breaks include, but are not limited to:

- The person receiving services had a doctor's appointment, and services were not provided.
- The person receiving services went on vacation and did not receive services.
- The person receiving services is not utilizing all authorized service units available. A person-centered planning meeting should occur to review the needs of the person receiving services. If the service continues to be a need, other Innovations providers may be considered.

Guidance for Using Protective Devices

Innovations Waiver services are home and community-based services provided to persons with IDD in the home and community of his or her choice. These services are provided to individuals who would otherwise receive services in an intermediate care facility for individuals with intellectual disabilities. Because of this, many of the rules that Innovations Waiver service providers must follow are written for facilities. This causes confusion for individuals receiving, providing and monitoring N.C. Innovations services. The purpose of this section is to clarify the application of rules regarding protective devices to home and community-based Innovations Waiver services.

Protective devices, as defined at 10A NCAC 27C .0102(b)(20), are devices used to provide support for persons who are medically fragile or to enhance the safety of persons that are self-injurious. Vaya must ensure that protective devices are monitored in accordance with 10A NCAC 27E .0105. Sometimes, protective devices are used to control the behavior of individuals. Protective devices that are used to control a person's behavior must be treated as a restrictive intervention and must be monitored in accordance with 10A NCAC 27E .0104. Vaya provider contracts require all provider agencies to have a Human/Client Rights Committee in accordance with 10A NCAC 27G .0504. To ensure adherence to these rules, we require the following for all Innovations Waiver participants:

1. During development of the Care Plan, the team will consider all material supports the person needs to live successfully in the community. These needs will be documented in Section B – Material Supports of the Risk/Support Need Assessment. The identified material support needs will be discussed by the Care Plan team. Some material support needs may be identified as a protective device. Each material support considered in the discussion must be identified as either a protective device or behavioral control in the medical/behavioral "What others need to know to best support me …" section of the Care Plan.
2. If a material support is identified as a protective device, the provider agency must review the material support(s) through their Human/Client Rights Committee annually in conjunction with development of the Care Plan.
3. If any member of the person's Care Plan team expresses concern that the material support is being used for behavioral control, the provider agency must review the material support through their Human/Client Rights Committee in accordance with 10A NCAC 27E .0104.
4. When the CM is monitoring services, the participant/LRP signature on the Care Plan will constitute consent for material support items deemed protective devices by the Care Plan team. Material items that are deemed protective devices will not automatically be considered a restrictive intervention. However, if monitoring reveals that a protective device appears to be used for the purpose of behavioral control, the CM will complete an investigation referral. If monitoring reveals potential abuse or neglect of the participant, the CM will file an APS report with the applicable county Department of Social Services.

Relative as Direct Support Employee (RaDSE)

The N.C. Innovations Waiver is designed to leverage existing natural and community supports while fostering the development of stronger natural support networks. This enables Innovations participants to be less reliant on formal support systems. However, there are times when it is necessary for relatives/LRPs who share a home with the Waiver participant ("relative") to provide paid supports to ensure that the participant is able to remain in the home and community of his or her choice, particularly in our more rural communities. For this reason, DHB Clinical Coverage Policy No. 8P – NC Innovations allows for Innovations providers to employ relatives to provide Community Living and Support services within specific parameters. A relative is defined as an individual related by blood or marriage to the Waiver beneficiary but does not include biological or adoptive parents of a minor child, stepparents of a minor child and the spouse of a Waiver beneficiary. Waiver beneficiaries receiving Residential Supports are seen as being in an out-of-home placement and therefore not covered under the RaDSE policy in the Waiver.

However, having relatives provide paid supports is not the preferred option for adults on the Innovations Waiver. It is our hope that relatives are allowed to be just that – relatives – and provide the same natural supports as they would for any family member. Some of the questions family members and employing providers should ask are:

- Is this about the participant's wishes, desires and needs, or is it about supplementing a family member's income?
- As an adult, is it appropriate or best for the participant to be with mom and dad throughout the day?
- If a family member supports an individual from birth onward into adulthood, does the individual learn to adapt to different people and increase his/her flexibility and independence?
- If a participant with a disability is always supported by a family member, what happens when that caregiver becomes unable, through age, disability or death, to care for the participant? Who else knows how to interact with and care for the participant?
- Can a family member be a barrier to increased community integration or friendship development?
- Does having a family member as direct support staff expand the participant's circle of support or risk shrinking it?

Innovations providers must acquire prior approval from Vaya before employing a relative to provide services to a Waiver beneficiary under the following circumstances:

- For a new or continuing RaDSE to provide more than 40 total hours per week of Waiver service to a participant residing in the same home (e.g., RaDSE provides 45 hours of CLS/week to the participant)
- For multiple RaDSEs to provide a combined total of more than 40 hours per week of Waiver service to a participant residing in the same home as the RaDSEs (e.g., RaDSE A provides 25 hours of CLS/week to the participant and RaDSE B provides 20 hours of CLS/week to the same participant, for a combined total of 45 hours of CLS/week)
- For a new or continuing RaDSE to provide more than 40 total hours per week of Waiver service to multiple participants residing in the same home (e.g., RaDSE provides 25 hours of CLS/week to Participant A and 20 hours of CLS/week to Participant B, for a combined total of 45 hours of CLS/week)

In general, there are only two circumstances where a relative should provide paid supports. They are when:

- No other staff is reasonably available to provide the service, or
- A qualified staff is only willing to provide the service at an extraordinarily higher cost than the fee or charge negotiated with the qualified family member or legal guardian.

Therefore, requests for relatives to provide paid supports will require documented efforts of attempts to find direct support professionals through multiple Innovations providers. Ordinarily, a relative will not be approved to provide more than 40 hours of paid supports per week (or seven daily units per week). The relative or legal guardian is not to be reimbursed for any activity that would be provided to a person without a disability of the same age. Additional paid

supports by a relative may be authorized to the extent that another provider is not available or is necessary to assure the participant's health and welfare.

A provider employing a RaDSE to provide 40 or fewer hours per week of CLS to a Waiver beneficiary is not required to obtain prior approval, but the provider must report the RaDSE to the Vaya-assigned CM for the member and must ensure that the paid supports section of the Care Plan and Section A of the Risk/Supports and Needs Assessment include the following information:

- The name of the RaDSE
- The relationship of the RaDSE to the Waiver beneficiary
- The number of hours per week of CLS Waiver service being provided by the RaDSE

The procedure for prior approval must be initiated by the Innovations provider through DocuSign®: (1) at least five business days prior to a new RaDSE requesting to provide services, and (2) on an annual basis, at least four calendar weeks prior to the start of the Waiver participant's plan year for a continuing RaDSE. Complete instructions and the link for beginning the process is available at https://providers.vayahealth.com. The form requires the Innovations provider to enter detailed information that will provide Vaya with all information necessary to approve or deny the request. Completion of the form will generate a prior approval request. The form will be reviewed for complete information and a decision rendered within 14 days. If the provider does not receive a timely response to its request, it is the provider's responsibility to follow up with Vaya's Provider Network Department to determine the status of the provider's request for the RaDSE and ensure it receives approval. Please note this form is required to be submitted annually and should be submitted in conjunction with the annual Care Plan. Approval in one year does not guarantee approval in subsequent years.

Vaya will review location information and attestations indicated on the request form, and an authorization decision will be made based on this information. For approvals, the Innovations provider will receive the approved DocuSign® form. For denials, the Innovations provider will receive the denied DocuSign® form and a formal letter that explains the decision. Rejections due to improper or incomplete requests will not be followed by a formal letter. If the request is rejected because of incomplete information, the provider may resubmit. **Please note that the N.C. Office of Administrative Hearings has determined that RaDSE decisions are not appealable, but you or the participant may file a grievance by calling the Vaya Access to Care Line 1-800-849-6127.**

The Innovations provider is responsible for communicating Vaya's RaDSE decision to the affected participant and relative. It is important to remember that relatives who are direct support professionals are employees of the Innovations provider and must comply with all requirements applicable to provider staff. The Innovations-qualified professional is required to provide supervision as outlined in DHB Clinical Coverage Policy No. 8P - NC Innovations. Supervision includes clear communication regarding authorization decisions resulting from this relative as direct support employee prior approval procedure.

Vaya will review RaDSE data collected quarterly. These data will be used to inform network development decisions. Vaya is invested in ensuring a quality network of Innovations providers that, to the fullest extent possible, work toward increasing natural home and community connections for individuals with an IDD. Requests to employ relatives should be made only after all other options were exhausted with multiple providers.

Questions regarding RaDSE requirements may be addressed to: RaDSE@vayahealth.com.

Alternative Family Living (AFL) Requirements

- The AFL provider must be an agency. Individuals and independent practitioners may not contract with Vaya to operate an AFL.
- The AFL provider must maintain personnel files for all employees, including documentation of required training(s), healthcare personnel registry and criminal background checks for both primary staff and back-up staff.
- The AFL site must be the primary residence of the AFL caregiver (includes couples or single person) who receives reimbursement for cost of care.
- If the AFL caregiver serves more than one member or a member under age 18, the site must be licensed by DHSR. If the AFL is serving a single individual at an unlicensed site, it cannot provide services to another member while licensure is pending.
- A Back-up Staffing Plan must be in place, and the back-up staff must be employees of the AFL provider.
- The AFL provider and caregiver must cooperate with required annual health and safety reviews completed by the Vaya Contract Performance Unit.
- AFL providers must notify the assigned CM prior to moving a member to a new AFL site. Failure to do so may result in adverse action, including, but not limited to, an overpayment finding and/or contract termination.
- All AFL providers must meet Vaya insurance requirements, including coverage for general liability, property and automobile liability.
- All documentation for service provision must meet requirements of Controlling Authority and be readily available for review upon request.
- The AFL caregiver may not be a relative (by blood or marriage) of the member receiving services.
- A member may not receive residential supports while living in a private home with his/her relatives (by blood or marriage).

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SECTION 14
Block Grant Requirements

If your agency receives federal Substance Abuse or Mental Health Block Grant funds from Vaya, you are responsible for meeting Federal Block Grant (FBG) requirements. It is your responsibility to know whether you receive these funds. To be eligible for FBG funds, you must be a nonprofit entity. You will be monitored by DMH/DD/SAS and Vaya for adherence to the FBG requirements. To ensure you are prepared to meet all requirements, please refer to the DHHS Block Grant audit information available on the Department's website.

You are responsible for responding to all standard reporting requirements and any additional information DMH/DD/SAS or Vaya request regarding provision of FBG services. You must participate in annual required training. In addition, you are responsible for ensuring all financial documentation is filed accurately and in a timely manner.

Mental Health Block Grant Requirements

The following requirements must be implemented by Network Providers for individuals, services and/or programs funded with Federal Mental Health Block Grant dollars. It is your responsibility to know whether these requirements apply to your organization:

- Evidence that individuals served with FBG funds have a principal or primary diagnosis of Serious Mental Illness or Severe Emotional Disturbance (SED)
- Evidence of member, youth and/or family involvement in treatment planning and system of care
- Evidence that the services provided are comprehensive and integrated for individuals with SED or with multiple and complex needs
- Member records containing a signed release of information that is time-limited (no more than 12 months) with clear reference to the specific information to be released and specific language regarding the prohibition of re-disclosure
- Evidence that funds are used to provide access to services to underserved mental health populations, including homeless persons, rural populations and older adults
- Evidence of implementation of evidenced-based treatment services
- Evidence that services are provided to meet the needs of specific eligible mental health populations
- Demonstration of a system and policies to prevent inappropriate disclosure of individual records

Substance Abuse Prevention and Treatment Block Grant Requirements

The following requirements must be implemented by Network Providers for individuals, services and/or programs funded with Federal Substance Abuse and/or Prevention Block Grant dollars, as well as certain programs funded with state service dollars. It is your responsibility to know the requirements that apply to your organization.

Please note that this section includes the general requirements that apply to all Substance Use Prevention and Treatment populations/ programs, as well as specific population/program requirements.

Additional requirements may be included in your contract with Vaya for specific programs or populations listed below. Please refer to the scope of work in your contract to verify any additional requirements. It is your responsibility to be aware of and comply with all requirements of your contracts with Vaya.

GENERAL REQUIREMENTS

(Note: Not all general requirements apply to prevention-only services. Please refer to your contract for verification of requirements.)

- A Comprehensive Clinical Assessment that includes the required elements of DHB Clinical Coverage Policy 8C must be completed for all individuals served.
- Recommendation regarding target population/benefit plan that is consistent with NC Tracks eligibility criteria must be completed for all individuals served.
- American Society of Addiction Medicine (ASAM) Patient Placement Criteria (Third Edition, 2013) must be utilized during the admission process to establish the appropriate type and level of care based on all six dimensions of multidimensional assessment.
- In the case of an individual with co-occurring disorders, any co-occurring mental health condition(s) must be addressed as part of the treatment continuum.
- The medical record must contain a signed, valid consent for release of information that includes an expiration date of no more than 12 months following signature, along with clear reference to the specific information to be released, and 42 CFR Part 2 requirements, including specific language that prohibits re-disclosure of information relating to substance use issues.
- Connection with or referral to a primary care physician must be completed and documented. Evidence of a signed, valid consent for release of information to the physician must be in the medical record if a referral was made.
- Tuberculosis (TB) screening must be completed at the time of admission. If the screening indicated presence of TB symptoms, the medical record must include evidence of documentation of symptoms and referral for appropriate follow-up testing and/or other services and counseling the member about TB. You must meet all state TB reporting requirements while adhering to federal and state confidentiality requirements.
- Priority for admission for treatment must be as follows:
    - Pregnant injecting drug users
    - Pregnant substance abusers
    - Injecting drug users
    - All others
- The organization must widely publicize the availability of treatment services for women and admission preference for pregnant women. This can include street outreach programs, ongoing public service announcements, regular advertisements in local/regional print media, posters placed in targeted areas and frequent notification of availability of such treatment that is distributed to the network of community-based organizations, healthcare providers and social services agencies.
- The organization must make continuing education available to employees who provide services for this population, covering substance use treatment, state and federal confidentiality requirements and disciplinary action that may occur upon inappropriate disclosure.

- The organization must have in effect a secure system to protect member records from inappropriate disclosure in connection with any activity supported through FBG funds.
- The organization must have a Drug-Free Workplace Policy in effect.
- The organization must complete initial and subsequent N.C. Treatment Outcomes and Program Performance System (NC-TOPPS) at required intervals.

WOMEN'S SET-ASIDE FUNDING REQUIREMENTS

These services are targeted for pregnant women and/or women with dependent children, including women who are attempting to regain custody of their children. The following requirements shall be demonstrated either through direct provision or a documented sub-contractual arrangement with an appropriate provider:

- Individuals served must have a principal or primary DSM-5 substance use diagnosis.
- Primary medical care needs are addressed, including referral for prenatal care and, while women are receiving such services, childcare.
- For individuals with children, primary pediatric needs and therapeutic needs of the children are addressed, including, but not limited to, immunizations, developmental needs, abuse (sexual or physical) and neglect.
- Gender-specific substance use disorder treatment and other treatment therapeutic interventions that may address issues of relationships, sexual and physical abuse, parenting and childcare while women are receiving these services
- Sufficient case management and transportation to ensure that women and children have access to the services outlined above
- Timely admission or referral to appropriate services
- Member assessed for pregnancy
- Active outreach programs and priority admissions directed toward pregnant women who are substance abusers
- Written program description for pregnant women and women with dependent children that includes the following:
    - Treating the family as a unit
    - Provision for primary medical care and primary pediatric care services
    - Provision of gender-specific substance use disorder treatment
    - Provision for therapeutic interventions for children in the custody of women in treatment
    - Provision of sufficient case management and transportation to access services

REQUIREMENTS FOR PROGRAMS THAT PROVIDE SERVICES TO PREGNANT WOMEN

- Admission preference shall be given for pregnant women.
- Priority admission shall be given to pregnant IV drug users.
- The organization must make interim services available within 48 hours to pregnant women who cannot be admitted into needed services with provider agency or other appropriate treatment provider because of lack of capacity or availability. The purpose of interim services is to reduce the adverse health effects of substance use, promote the health of the member and reduce risks of transmission of disease. When appropriate, interim services shall include:
    - The organization provides counseling and education about HIV and TB infection, the risks of needle-sharing, the risks of transmission to sexual partners and infants and steps that can be taken to ensure that HIV and TB transmission does not occur.

- The organization makes referrals for prenatal care and HIV and TB treatment services, if necessary.
- The organization provides counseling on the effects of alcohol and other drug use on the fetus.

REQUIREMENTS FOR PROGRAMS THAT PROVIDE SERVICES TO PERSONS IDENTIFIED AS IV DRUG USERS

- Priority admission must be given to each individual who requests and needs treatment for IV drug use. This means that IV drug users shall be admitted to a program through the provider agency or referral to another appropriate program no later than 14 days after making the request for admission.
- If there is no such program with capacity to admit the individual, the member must be admitted within 120 days after the date of such request. For these members, interim services, including referral for prenatal care (if indicated), must be made available to the person no later than 48 hours after the request for admission and continue until the member is admitted into treatment. At a minimum, interim services shall include counseling and education about HIV and TB, the risks of needle-sharing, the risks of transmission to sexual partners and infants and steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV and TB treatment services, if necessary.
- For individuals in need of treatment for IV substance use who cannot be placed in comprehensive treatment within 14 days, the program shall develop a mechanism for maintaining contact with the individual awaiting admission.
- If a person cannot be located for admission into treatment, or if a person refuses treatment, that person may be taken off the waiting list and need not be admitted within the initial 120-day period. If the individual later requests treatment, and placement on a waiting list is necessary, interim services are to be provided, and placement in treatment program would need to occur within 120 days of the latter request.
- If the program is at capacity for this population, you must establish a waiting list that includes a unique identifier for each IV drug user seeking treatment, including those receiving interim services while awaiting admission.
- The organization must notify DMH/DD/SAS and Vaya when the program reaches 90 percent capacity for this population.
- The organization must carry out activities to encourage individuals in need of such treatment to undergo treatment, which may include the following:
  - Use outreach models that are scientifically sound or an approach which can be reasonably expected to be effective.
  - Select, train and supervise staff to provide outreach.
  - Contact, communicate and follow up with high-risk substance abusers, their associates and neighborhood residents.
  - Promote awareness among injecting drug users about the relationship between injecting drug abuse and communicable diseases, such as HIV.
  - Recommend steps that can be taken to ensure that HIV transmission does not occur.
  - Encourage entry into treatment.

PRIMARY PREVENTION SERVICES REQUIREMENTS

Primary prevention programs are those directed at individuals who are not determined to require treatment for a substance use disorder (SUD). Such programs are aimed at educating and counseling individuals on SUDs and providing activities to reduce the risk of substance use.

- Priority shall be given to populations that are at risk of developing a pattern of such abuse.
- The organization must ensure that programs receiving priority develop community-based strategies to discourage use of alcoholic beverages and tobacco by individuals to whom it is unlawful to sell or distribute such beverages or products.
- The organization must develop and implement comprehensive prevention programs that include a broad array of prevention strategies directed at individuals not identified to need treatment.
- Services must include activities and services provided in a variety of settings for both the general population, as well as targeting sub-groups who are at high risk of substance use.
- In implementing these provisions, prevention providers shall use a variety of the following defined strategies:
  - Information dissemination
  - Education
  - Alternatives
  - Problem identification and referral
  - Community-based process
  - Environmental
- The organization must use evidence-based prevention practices in the provision of services.
- The organization must deliver evidence-based programs to selected and indicated populations.
- Vaya will ensure that a total of 48 hours of Synar Amendment activities are conducted every six months through all contracted prevention providers. Synar Amendment activities are those designed to reduce youth access to tobacco products through community collaboration, merchant education, law enforcement and related activities or media/ public relations. At the beginning of each fiscal year, Vaya will notify each contracted prevention provider of the number of required hours that must be devoted to Synar Amendment activities per six months.

WORK FIRST/CPS SUBSTANCE ABUSE INITIATIVE REQUIREMENTS

This initiative serves DSS Work First Program, Food and Nutrition Services and Child Protective Services referrals.

- A qualified substance use professional must be devoted to this initiative.
- A clinician with a professional license whose permitted scope of work includes substance use disorders must conduct Comprehensive Clinical Assessments. Vaya requires that this individual be an N.C. Substance Abuse Professional Practice Board-licensed or associate-licensed Clinical Addictions Specialist (LCAS or LCAS-A).
- The SUDDS V or other pre-approved alternative assessment instrument must be utilized for each member.
- A signed, valid consent for release of information between the member's referring county Department of Social Services and the organization must be in place to communicate information regarding assessment recommendations, disposition and treatment compliance.
- Monthly reports indicating treatment compliance must be submitted to DSS for each member being served.

JUVENILE JUSTICE SUBSTANCE ABUSE MENTAL HEALTH PARTNERSHIP (JJSAMHP) REQUIREMENTS

- Each member must meet the requirements of the designated target population/benefit plan of Child Substance Abuse Disorder.
- For uninsured members, the organization must require documentation of application for N.C. Medicaid/Health Choice.

- The organization must have a signed, valid consent for release of information with the Division of Juvenile Justice for each child being served.

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SECTION 15
Compliance and Quality Management

This section provides a high-level overview of your compliance and quality management requirements as a Vaya Network Provider. It is not intended to summarize every legal standard that applies to providers of MH/IDD/SUD services. You are required under your contract with Vaya to be familiar with all federal and state laws, rules, regulations and payor program requirements applicable to your provision of services, including, but not limited to, the following laws, rules and regulations, as amended from time to time (referred to in your contract as "Controlling Authority"):

- Title XIX of the Social Security Act (the "Act") and its implementing regulations, including those set forth at 42 CFR Parts 438, 441, 455 and 456 concerning care coordination, access to care, utilization review, clinical studies, utilization management, care management, quality management and disclosure requirements.
- The N.C. State Plan for Medical Assistance
- The N.C. combined Medicaid Waiver authorized by CMS pursuant to sections 1915(b) and 1915(c) of the Act
- All federal and state civil and criminal laws, rules and regulations governing the provision of publicly funded health care services
- The Anti-Kickback Law codified at 42 U.S.C. § 1320a-7b(b) and its implementing regulations
- The Ethics in Patient Referral Act, 42 U.S.C. § 1395nn and its implementing regulations (applicable only to physicians)
- The federal False Claims Act, 31 U.S.C. §§ 3729 – 3733 and its implementing regulations
- The N.C. Medical Providers False Claims Act, N.C.G.S. § 108A-70-10 *et seq.*
- Applicable provisions of N.C.G.S. Chapters 108A, 108D, 122C, 131D and 131E
- All federal and state member rights and confidentiality laws, rules and regulations, including, but not limited to:
    - N.C.G.S. §§ 122C-52 through 56
    - The N.C. Identity Theft Protection Act, N.C.G.S. §§ 75-61 *et seq.*
    - The DMH/DD/SAS Client Rights Rules in Community Mental Health, Developmental Disabilities and Substance Abuse Services, APSM 95-2
    - The DMH/DD/SAS Confidentiality Rules, APSM 45-1
    - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations at 45 CFR Parts 160, 162, and 164
    - Confidentiality of Substance Use Disorder Patient Records laws and regulations codified at 42 U.S.C. §290dd-2 and 42 CFR Part 2
- Medical and/or clinical coverage policies promulgated by DHHS in accordance with N.C.G.S. § 108A-54.2
- The Americans With Disabilities Act of 1990
- Titles VI and VII of the Civil Rights Act of 1964
- Section 503 and 504 of the Vocational Rehabilitation Act of 1973
- The Age Discrimination Act of 1975
- The Drug Free Workplace Act of 1988

- State licensure, accreditation and certification laws, rules and regulations applicable to your operations
- DMH/DD/SAS Rules for MH/DD/SA Facilities and Services, published as APSM 30-1 and codified at Title 10A of the North Carolina Administrative Code
- DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2
- The Record Retention and Disposition Schedule for DMH/DD/SAS Provider Agencies, APSM 10-5
- The Records Retention and Disposition Schedule for State and Area Facilities, APSM 10-3
- The DHHS Records Retention and Disposition Schedule for Grants
- This Vaya Health Provider Operations Manual
- Any other applicable federal or state laws, rules or regulations in effect at the time MH/IDD/SUD services are rendered to Vaya Health Plan members

Compliance Program

The Patient Protection and Affordable Care Act requires all healthcare providers to establish and implement a compliance program. You must develop a formal Compliance Plan that includes procedures designed to guard against fraud and abuse. The plan should include the following elements, at a minimum:

- An internal audit process to verify that services billed were furnished by appropriately credentialed staff and appropriately documented
- Assurance that staff performing services under your contract with Vaya are not excluded from participation in federal health care programs under either Section 1128 or 1128A of the Social Security Act
- Written policies, procedures and standards of conduct that articulate your commitment to comply with the Controlling Authority listed above
- Designation of a compliance officer and compliance committee
- A training program for the compliance officer and organization employees
- Well-publicized systems or mechanisms for reporting suspected fraud and abuse by employees and members and protections for those reporting
- Provisions for internal monitoring and auditing
- Procedure for response to detected offenses and for the development of corrective action plans
- Reporting to oversight and law enforcement agencies, including Vaya

For more information and guidance about your compliance responsibilities as a healthcare provider that accepts public funding, please refer to the U.S. Health and Human Services' Office of Inspector General Compliance Resource Portal page at: https://oig.hhs.gov/compliance/compliance-resource-portal/.

Vaya develops and maintains a written Compliance Plan that includes the OIG "Seven Effective Elements" and is approved by the Vaya Board of Directors. We have a designated Compliance Officer and Vaya Compliance Committee that are accountable to senior management, as well as procedures to ensure the compliance of Vaya and the Provider Network, including the establishment of monitoring and auditing systems that are reasonably designed to detect conduct in violation of applicable federal and state laws, rules, regulations, guidelines, policies and standards.

Prevention of Fraud, Waste and Abuse

Healthcare fraud, waste and abuse affects each and every one of us. It is estimated to account for up to 10 percent of the annual expenditures for healthcare in the U.S. We are responsible for preventing, monitoring and guarding against fraud, waste and abuse of public funds and ensuring that all services and claims paid by Vaya are in compliance with Controlling Authority and Generally Accepted Accounting Principles at the point of delivery and/or payment.

Medicaid fraud is estimated by the U.S. Office of Management and Budget to cost taxpayers more than $15 billion annually. According to the National Association of State Medicaid Fraud Control Units (NAMFCU), perpetrators of Medicaid fraud run the gamut from the solo practitioner who submits claims for services never rendered to large institutions that exaggerate the level of care provided to their patients and then alter patient records to conceal the resulting lack of care. CMS, NAMFCU and other organizations identify the following as typical schemes that providers use to defraud the Medicaid program:

- **Billing for services not provided:** A provider bills for services or items never rendered or furnished.
- **Medical identity theft:** A provider uses stolen identity to bill for services not provided, including the billing of services allegedly rendered to someone who was discharged from care or is deceased.
- **Billing for unnecessary services or tests:** A provider falsifies the diagnosis and symptoms on patient records and billings to obtain payments for unnecessary services, laboratory tests or equipment.
- **Billing for services that lack documentation:** A provider bills for services for which the provider knows that required documentation is absent or inadequate.
- **Double billing:** A provider bills both Medicaid and a private insurance company (or member) for the same treatment, or two providers request payment on the same member for the same procedure on the same date.
- **Upcoding:** A provider bills at a level of complexity that is higher than the service actually provided or documented. For example, billing for 60-minute therapy sessions when you only spend five minutes or fewer with the member.
- **Unbundling:** A provider bills for services separately (using multiple procedure codes) rather than using the fixed daily "bundled" rate or single comprehensive code.
- **Billing for unreasonable or inflated hours:** A provider inflates the amount of time a spent with patients (for example, a psychiatrist who bills for more than 24 hours of psychotherapy treatment on a day).
- **Falsifying credentials:** A provider misrepresents the license or credentials of a practitioner in order to bill Medicaid.
- **Substitution of generic drugs:** A pharmacy knowingly bills Medicaid for the cost of a brand-name prescription when, in fact, a generic substitute was supplied to the member at a substantially lower cost to the pharmacy.
- **Billing for more expensive procedures than were performed:** A provider bills for a comprehensive procedure when only a limited one was administered or bills for expensive equipment and actually furnishes cheap substitutes.
- **Kickback:** A hospital requires another provider, such as a laboratory or ambulance company, to pay a certain portion of the money received for rendering services to patients in the facility. Or, a provider induces Medicaid beneficiaries to enroll with the provider or request services in exchange for gifts or payments. Examples include gift cards, vacation trips, personal services and merchandise, leased vehicles and direct payments.
- **False cost reports:** A provider includes personal expenses in Medicaid cost reports. These expenses often include the cost of personal items.

All Network Providers must monitor for the potential for fraud, waste and abuse and take immediate action to address reports or suspicion. We use the following federal and state definitions and guidance in evaluating suspected fraud, waste or abuse reported to Vaya:

Fraud

Fraud is defined as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law" (42 CFR § 455.2). The term "fraud" includes misappropriation and other irregularities, including dishonest or fraudulent acts; embezzlement; forgery or alteration of negotiable instruments, such as checks and drafts; misappropriation of an agency's, employee, customer, partner or supplier assets; conversion to personal use of cash, securities, supplies or any other agency assets; unauthorized handling or reporting of agency transactions; and falsification of an agency's records, claims or financial statements for personal or other reasons. The

above list is not all-inclusive but intended to be representative of situations involving fraud. Fraud may be perpetrated not only by an agency's employees, but also by agents and other outside parties.

Waste

Waste involves the taxpayers not receiving reasonable value for money in connection with any government-funded activities due to an inappropriate act or omission by player with control over, or access to, government resources. Waste goes beyond fraud and abuse, and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight (from the Office of Inspector General).

Abuse

Abuse is defined as "provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary costs to the Medicaid program" (42 CFR Part § 455.2). Abuse is also defined at 10A NCAC 22F .0301 to include "any incidents, services, or practices inconsistent with accepted fiscal or medical practices which cause financial loss to the Medicaid program or its beneficiaries, or which are not reasonable or which are not necessary including, for example, the following:

1. Overutilization of medical and health care and services.
2. Separate billing for care and services that are part of an all-inclusive procedure or included in the daily per-diem rate.
3. Billing for care and services that are provided by an unauthorized or unlicensed person.
4. Failure to provide and maintain proper quality of care, appropriate care and services, or medically necessary care and services within accepted medical standards for the community.
5. Breach of the terms and conditions of participation agreements, or a failure to comply with requirements of certification, or failure to comply with the provisions of the claim form."

For more information, please refer to the following helpful Fraud, Waste and Abuse Toolkit for providers, created by CMS and available at: https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html.

False Claims Act

The Social Security Act, as amended by the Deficit Reduction Act of 2005, requires that Vaya establish an education plan for our employees, managers, contractors and agents about state and federal false claims laws and whistleblower protections. 42 U.S.C. § 1396a(a)(68). We offer this education to our providers via this Manual, Provider Bulletins and training opportunities. If you receive more than $5 million in Medicaid funds annually, you are also required to establish and implement an education plan for your employees, managers, contractors and agents that includes written policies and detailed guidance on the federal False Claims Act, state false claims laws and the rights and protections afforded whistleblowers under the FCA and its state counterparts.

The Federal False Claims Act (FCA), 31 U.S.C. §§ 3729 – 3733, was enacted in 1863 by a Congress concerned that suppliers of goods to the Union Army during the Civil War were defrauding the Army. The FCA provided that any person who knowingly submitted false claims to the government was liable for double the government's damages, plus a penalty for each false claim. Since then, the FCA has been amended several times to increase the penalties.

The FCA covers fraud involving any federally funded contract or program, with the exception of tax fraud, which is covered by a separate IRS whistleblower program. **Under the FCA, it is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent.** As of August 1, 2016, FCA civil penalties increased

to between $10,781.40 and $21,562.80 per claim, plus three times the amount of damages that the federal government sustains because of the false claim. Under the civil FCA, each instance of an item or a service billed to Medicare or Medicaid counts as a claim, so fines can add up quickly. The fact that a claim results from a kickback or is made in violation of the Stark law also may render it false or fraudulent, creating liability under the civil FCA as well as the Anti-Kickback Statute or Stark law.

Under the civil FCA, no specific intent to defraud is required. The civil FCA defines "knowing" to include not only actual knowledge, but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. There also is a criminal FCA (18 U.S.C. § 287). Criminal penalties for submitting false claims include imprisonment and criminal fines. Practitioners can go to prison for submitting false health care claims. The OIG also may impose administrative civil monetary penalties for false or fraudulent claims.

The civil FCA contains a whistleblower provision that allows a private individual to file a lawsuit on behalf of the United States and entitles that whistleblower to a percentage of any recoveries. Whistleblowers could be current or former employees, patients or competitors.

Compliance Hotline

You are required to establish a system or mechanism for your employees, contractors and individuals receiving services to report potential fraud, waste, abuse or violations of the FCA. You must also ensure that your employees, contractors and persons receiving services are aware of the following mechanisms to report potential fraud, waste, abuse or violations of the FCA directly to Vaya or other oversight authorities:

- Call the Vaya Confidential Compliance (Fraud and Abuse) Hotline at 1-866-916-4255 (24 hours a day, seven days a week, allows for anonymous reporting). Reports may also be made by calling any Vaya office number and asking for the Compliance Officer.
- Report online at www.vayahealth.ethicspoint.com (allows for anonymous reporting).
- Call the N.C. Medicaid Fraud, Waste and Program Abuse Tip-Line at 1-877-DMA-TIP1 (1-877-362-8471).
- Call the U.S. Office of Inspector General's Hotline (to report fraud) at 1-800-HHS-TIPS (1-800-447-8477).

We encourage all members and Network Providers to report any suspicious billing practices or other activity you think may be fraud, waste or abuse (including Medicaid beneficiary fraud). Reporters can remain anonymous or leave their name, but detailed information will help us with our investigation. If you contact us, please provide the name/MID of the member involved, the name of the provider, the date(s) of service and the amount of claims billed or paid, as well as a description of the fraudulent or suspicious activity. Network Providers may not intimidate or impose any form of retribution against an employee, agent or member who utilizes our reporting system in good faith to report suspected violations.

Continuous Quality Improvement

Vaya is committed to working in collaboration with our Network Providers to achieve the highest standards of quality in service delivery. We understand the important role of quality improvement in promoting member safety and high-quality treatment. We maintain a strong commitment to continual improvement of our programs and services, as well as the services provided directly to members. We accomplish this by continually:

1. Monitoring member safety and quality according to an established standard
2. Assessing the ability to achieve these measurable standards
3. Improving member safety and quality by implementing targeted interventions

Vaya must comply with numerous quality, satisfaction, performance indicator and financial reporting requirements under our DHB and DMH/DD/SAS contracts, including requirements to measure and report indicators in the following domains: access, availability, quality of care, quality of services, appropriateness of services, system performance and satisfaction.

Vaya maintains a Quality Improvement Committee (QIC) that includes representatives from Vaya staff, members and Network Providers. QIC develops an annual Quality Management Plan for the Vaya system with input and feedback from relevant stakeholders. The QM plan includes the Program Description, Evaluation and Workplan. Vaya makes this information available to Network Providers, practitioners, members and stakeholders on the Vaya website. A printed copy of the information can be provided upon direct request to Vaya. Providers can obtain a copy of this document on the Vaya Provider Central website or by emailing provider.info@vayahealth.com.

The Board of Directors also maintains a Regulatory Compliance and Quality Committee that regularly hears reports on these measures. In addition, Vaya is routinely monitored by our accrediting bodies, the DHHS Intra-Departmental Monitoring Team (IMT), and an External Quality Review Organization (EQRO).

The continual self-assessment of services and operations, as well as the development and implementation of plans to improve outcomes for members, is a value and requirement for all Network Providers. You are required to be in compliance with all federal and state quality assurance and performance improvement standards, including, but not limited to:

1. The establishment of a formal quality committee to evaluate services, plan for improvements and assess progress made toward goals. The assessment of need, as well as the determination of areas for improvement, must be based on accurate, timely and valid data. Your quality assurance (QA) and quality improvement (QI) system will be evaluated through focused monitoring and post-payment reviews.
2. Maintenance and submission of client rights committee minutes, if applicable.
3. Development and execution of an annual Quality Improvement Plan which will be evaluated through focused monitoring and post-payment reviews.
4. Participation in performance improvement projects required under our DHB and DMH/DD/SAS contracts.
5. Reporting incidents and following up, as needed.
6. Cooperating with Vaya's grievance, monitoring and program integrity activities.
7. Actively participating in provider and member satisfaction surveys.

Satisfaction Surveys

It is important to us that members, relatives, natural supports and other community stakeholders are satisfied with the services you provide and with our management of services. There are various ways this satisfaction can be measured. The goal of these initiatives is to gather feedback on the performance of Network Providers. This information can then be used to identify needed services, training or other quality improvement initiatives.

Abuse, Neglect and Exploitation

Children receiving services from you, or whose parents, guardians or caretakers are receiving services from you, may be at higher risk for potential abuse, neglect and/or exploitation. Adults with disabilities may also be more vulnerable to abuse, neglect and exploitation. County Departments of Social Services receive and evaluate reports to determine whether children and disabled adults need protective services. Income is not a factor in the protective services process. The reporting of suspected child abuse or neglect or suspected abuse, neglect or exploitation of disabled adults is mandated by separate statutes in North Carolina.

Please note that reporting **is not optional** and is required in any instance in which a Network Provider has "cause to suspect" abuse or neglect of a juvenile, regardless of whether another individual, entity or agency may have also reported the suspected abuse, neglect or exploitation. Reporting is also required in any instance where a Network Provider has "reasonable cause to believe" a disabled adult is in need of protective services. The statutes provide immunity from liability to anyone who files a report in good faith. Medical or clinical privilege is not an acceptable excuse for the failure to report.

NOTE: If a report alleges the involvement of you, your employee or contractor in an incident of abuse, neglect or exploitation, you must ensure that members are protected from involvement with that staff person until the allegation is proved or disproved. You must take swift, appropriate action if the report of abuse, neglect or exploitation is substantiated.

Provider Exploitation and Boundary Issues

10A NCAC 27C .0102 defines exploitation as the "use of a client's person or property for another's profit or advantage." In keeping with this definition, Vaya considers provider exploitation to be the illegal or improper act of using a Vaya Health Plan member or their resources for monetary or personal benefit, profit or gain, by a Network Provider (including its owners, employees, agents or contractors). Examples include, but are not limited to:

- Asking or requiring a member to perform a job function for the agency or staff (e.g., the owner of a provider agency asking or requiring members to perform office, household, lawn or farm work that benefits the owner)
- Requesting or encouraging a member to purchase items for the agency or staff
- Accepting a valuable gift from the member
- Using a member's money for agency or personal use
- Using a member's identity for any impermissible reason, including personal gain

Vaya does not tolerate provider exploitation of our members. Any allegations of exploitation will be thoroughly investigated and may result in administrative action or sanction, up to and including termination of your contract with Vaya.

Boundary issues occur when providers establish more than one relationship with members, whether professional, social, or business. Not all dual and multiple relationships are unethical. For example, it is not uncommon for providers to have unanticipated or unavoidable contact with members in supermarkets, sporting events, or other local venues; ordinarily, these encounters are brief and fleeting and do not pose any significant ethical challenge. Some dual relationships and boundary issues, however, raise serious and troubling ethical questions (e.g., intimate/ sexual contact, personal gain, emotional/ dependency issues). Other issues may arise because of providers' genuinely altruistic inclinations (e.g., giving members gifts at holiday time). On occasion, such gestures may be misinterpreted and trigger boundary confusion.

Vaya recognizes that the vast majority of our providers are dedicated, caring, principled and extraordinarily kind people who would never knowingly exploit or confuse our members. Our expectation is that Network Providers will use good judgment, consistent with current ethical standards and licensure rules, to make appropriate decisions that avoid the potential for exploitation or boundary confusion.

NOTE: Some information in this section was taken from "Managing Boundaries and Dual Relationships" by Frederic G. Reamer, PhD, March 4, 2002, *Social Work Today*, https://www.socialworktoday.com/news/eoe_030402.shtml.

Health Information Technology and Security

In today's information age, the provision of high-quality services is often dependent upon the use of electronic health records (EHRs) instead of paper medical records to maintain people's health information, as well as other systems that involve information technology. Health information technology (health IT) makes it possible for healthcare providers to better manage patient care through secure use and sharing of health information. As our healthcare system shifts toward integrated, whole-person care, health IT will become even more important. For more information about health IT, please refer to https://www.healthit.gov.

As a Network Provider and covered entity under HIPAA, you are required to comply with the HIPAA Privacy Rule discussed elsewhere in this Manual, as well as the HIPAA Security Rule and the HIPAA Breach Notification Rule. The HIPAA Security Rule established a national set of security standards for protecting "electronic protected health information" (e-PHI). The Security Rule requires covered entities to maintain reasonable and appropriate administrative, technical and physical safeguards for protecting e-PHI. Specifically, covered entities must:

1. Ensure the confidentiality, integrity and availability of all e-PHI they create, receive, maintain or transmit;
2. Identify and protect against reasonably anticipated threats to the security or integrity of the information;
3. Protect against reasonably anticipated, impermissible uses or disclosures; and
4. Ensure compliance by their workforce.

The HIPAA Breach Notification Rule, 45 CFR §§ 164.400-414, requires covered entities and their business associates to provide notification following a breach of unsecured PHI. For more information about your responsibilities under the Security Rule and Breach Notification Rule, please refer to: https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations and https://www.hhs.gov/hipaa/for-professionals/breach-notification/index.html.

You are also required to have and maintain high-speed internet connectivity, provide complete and accurate data in all submissions to Vaya, follow Vaya's technical support procedures, including accessing the ServiceDesk, completing MCIS Provider Portal Training and adhering to the Vaya Software Platform Access/ User Addendum to your contract. Use of any MCIS is a privilege and comes with certain responsibilities, including the responsibility to prevent sharing of logins, to ensure your staff complete necessary training, and to notify us if an individual with a login leaves your employment.

Health Information Exchange

In 2015, the N.C. General Assembly established a state-managed Health Information Exchange Authority (NC HIEA) to oversee and administer the N.C. Health Information Exchange Network (N.C.G.S. § 90-414.7). Housed within the N.C. Department of Information Technology's (DIT) Government Data Analytics Center (GDAC), the N.C. HIEA operates North Carolina's statewide health information exchange – now called NC HealthConnex. NC HealthConnex is a secure, standardized electronic system in which providers can share important patient health information. The use of this system promotes the access, exchange and analysis of health information and enables participating organizations to save time, reduce paperwork, facilitate more informed treatment decision-making and improve health data analytics. Ultimately, the use of the HIE is designed to lead to improved care coordination, higher quality of care and better health outcomes across the state.

Originally, the legislation required that all providers of "services rendered to Medicaid and other State-funded health care program beneficiaries" must be connected to the HIE by specific deadlines to continue to receive payment with "Medicaid or other State-funded health care funds." However, N.C. Session Law 2019-23 (HB 70) established that certain providers of Medicaid or State-funded health care services "are not required to connect to the HIE Network or submit data but may connect to the HIE Network and submit data voluntarily". These providers include:

1. Community-based long-term services and supports providers, including personal care services, private duty nursing, home health, and hospice care providers.
2. **Intellectual and developmental disability services and supports providers, such as day supports and supported living providers.**
3. **Community Alternatives Program waiver services (including CAP/DA, CAP/C, and Innovations) providers.**
4. Eye and vision services providers.
5. Speech, language, and hearing services providers.
6. Occupational and physical therapy providers.
7. Durable medical equipment providers.
8. Nonemergency medical transportation service providers.
9. Ambulance (emergency medical transportation service) providers.
10. Local education agencies and school-based health providers.

Under this Session Law, the DHHS Secretary is also authorized to grant exemptions to additional classes of providers, "for whom acquiring and implementing an electronic health record system and connecting to the HIE Network … would constitute an undue hardship." **Except as otherwise provided in the legislation, all other providers of Medicaid and State-funded health care services must be connected to the HIE and shall begin submitting demographic and clinical data by June 1, 2020.** However, the Department is authorized to grant extensions of time to the deadline "upon the request of a provider or entity that demonstrates an ongoing good-faith effort to take necessary steps to establish such connection and begin data submission." No exemption or extension shall extend beyond December 31, 2022, except for the voluntary provider types listed above.

For more information about the HIE, please refer to https://hiea.nc.gov/.

Documentation and Clinical Coverage Policy Requirements

All Vaya Network Providers are required to strictly adhere to the documentation requirements outlined in the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2. Medicaid service provision requirements are specified in Clinical Coverage Policies (CCPs) promulgated by DHB. Many of the CCPs also include specific documentation, training and other requirements. It is the responsibility of each provider to be familiar with and follow CCP requirements. Unfortunately, Vaya monitoring activities have identified trends of non-compliance with respect to the following. Please ensure that you and your staff understand and comply with these requirements, as applicable to your delivery of services:

- In all instances in which the CCP requires "annual" training, this means that the individual must receive the required training at least once every 365 days, NOT once each calendar year.
- In all instances where the CCP requires a service note for a specified period of time, the note must reflect, at minimum, the required amount of billable services. Non-billable services can be listed in the note so long as the required amount of billable services is fully documented. If the provider wishes to document non-billable activities, the service note must specify the time spent on billable versus non-billable activities.
    - EXAMPLE: The Intensive In-Home (IIH) service definition requires a service note documenting a minimum of 120 minutes of billable services in order for the provider to bill the LME/MCO for one unit of IIH. If the service note documents a total of 120 minutes but includes non-billable activities, then 120 minutes of billable activities are not documented. This may result in an overpayment finding.
- Failure to comply with the face-to-face contact, team composition or full-time employee (FTE) requirements of any service definition will result in an overpayment finding. Individuals will not be considered to meet the FTE requirement if they are fulfilling additional roles within the agency or otherwise (for example, performing outpatient

therapy, diagnostic or clinical assessments or serving as Day Treatment staff) unless the agency can document that the individual spent at least 40 hours per week on FTE activities covered by the applicable service definition.

  - EXAMPLE: IIH services must be delivered by a three-person team. Only the lead is required to have face-to-face interventions; however, there must be evidence that two additional team members participated in the treatment during that month of services, whether face-to-face or ancillary.

- Providers who deliver case management as a component of another enhanced service (e.g., ACTT, CST, Day Treatment, IIH) must ensure that therapeutic intervention(s) remain the primary focus of service delivery where clinically appropriate. A pattern of notes that only document case management (with little to no evidence that therapeutic services were provided) may trigger a review.

Monitoring to Ensure Quality of Care

Vaya must ensure the provision of high-quality services by our Network Providers. This includes monitoring member health and safety, conducting investigations, monitoring and resolving grievances and incidents, protecting member rights, ensuring provider qualification, evaluating member satisfaction, assessing outcomes to determine efficacy of care, using evidence-based and best practices and implementing preventive health initiatives. We are also charged with conducting compliance reviews and audits of medical records, administrative files, the physical environment and other areas of Network Provider service delivery, including cultural competency reviews. These monitoring and program integrity activities are discussed in the next section.

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SECTION 16

Audits, Monitoring and Investigations

At Vaya, we want to ensure that tax dollars are spent wisely and that members receive high-quality, appropriate care. We are obligated to prevent fraud, waste and abuse of public funds, as well as to investigate complaints we receive and monitor your delivery of services. We accomplish this through monitoring and program integrity activities that include, but are not limited to, billing audits, post-payment reviews, investigations, focused monitoring, data mining/ trend analysis and a process for reporting concerns and requesting investigations.

Vaya employees are strongly encouraged to report any instance of potential fraud, waste or abuse occurring at Vaya or by a Network Provider. We offer a robust internal reporting process and evaluate all referrals and concerns that are reported. Likewise, it is the responsibility of each Network Provider to conduct self-audits and report any instances of fraud, waste or abuse discovered. Network Providers must also publicize Vaya's Compliance Hotline (1-866-916-4255) for staff and members to report potential fraud, waste or abuse.

While ensuring quality and preventing fraud, waste and abuse is the responsibility of every Vaya employee and provider, Vaya has three teams primarily responsible for these activities: the Special Investigations Unit (SIU), the Network Performance Unit (NPU), and the Grievance Resolution & Incident Team (GRIT).

The Special Investigations Unit (SIU)

Under our DHB Waiver Contract, we are required to have a Special Investigations Unit (SIU) that is responsible for program integrity activities, including identification, detection and prevention of fraud, waste and abuse. All allegations of fraud, waste or abuse received by Vaya are routed to the SIU for review and investigation. The SIU also conducts data mining and data analytics and systematically monitors paid claims to look for trends and patterns suggestive of fraud, waste or abuse. If we determine that a complaint, allegation or trend rises to potential fraud, we must forward the information and any evidence collected to DHB, who will make a determination whether the allegation is credible and whether to make a referral to the Medicaid Investigations Division (MID) of the N.C. Attorney General's Office. If we determine there is no potential fraud, but that waste or abuse is present, we will continue with our investigation. In making these determinations, we use the federal and state definitions and guidance described in the previous section.

The SIU may conduct their investigations as a desk review. The investigation may also include an announced or unannounced site visit at the provider's office. The first step in most investigations is to request records documenting service delivery. If you receive a request for records from the SIU, you must respond within the timeframe stated in the letter. The letter will also include a contact number for you to reach the investigator assigned to the case. If the review of records from the initial request indicates a high percentage of out-of-compliance findings or reveals other concerns or potential waste or abuse, we may issue another records request to expand the scope of the review. Please call us if you have any questions about the records request or investigation process. If you do not return records as requested, we

may determine that all claims reimbursed for the dates of service and individuals under review constitute an overpayment.

The SIU will review the records and determine if any overpayment is due, which primarily includes a determination of whether the documentation submitted is in compliance with Controlling Authority and supports the billing of services. We employ licensed practitioners on staff who may also review claims against medical necessity requirements. As stated in section 6 of this Manual, authorization is not a guarantee of payment. If the SIU determines that medical necessity was not present at the time of service delivery based on the documentation you provide, we may identify an overpayment. Vaya's Finance Department and certified accountants can also assist SIU with the review of compliance with coordination of benefits requirements, financial reports, financial statements and adherence to Generally Accepted Accounting Principles.

There are times when a SIU investigation referral identifies areas of potential waste or abuse of Medicaid or Non-Medicaid funds that may be corrected by a Vaya initiated provider self-audit. A cooperative effort serves a common interest of protecting the financial integrity of the Medicaid Program while ensuring proper payments to providers. Any overpayments a provider identifies during a Vaya initiated self-audit are not subject to reconsideration. Should a provider choose not to participate in a Vaya initiated self-audit an investigation may be initiated by SIU. At any point during a Vaya initiated self-audit, SIU may determine that an investigation is warranted.

Recovery Audit Contractors (RACs) for the Medicaid program may also audit providers in our Closed Network and may work collaboratively with Vaya on identification of overpayments. DHB shall require RACs to give Vaya prior written notice of such audits and the results of any audits as permitted by law.

You will be notified in writing if the SIU identifies an overpayment based on abuse, waste, overutilization or non-compliance with your contract, including Controlling Authority. Notifications will include the amount owed, process for dispute resolution, and deadline and mechanism for repayment, as well as the process for requesting a payment plan. The Finance Department is responsible for collection of overpayments and will work with Vaya's Legal & Compliance Department to pursue collection whenever practicable. We may pursue a variety of collection options, including withholding of future claims payments, invoicing and collection from the Network Provider (with collection efforts to include initiating legal action and obtaining a judgment and execution of the judgment against the Network Provider for the amount), or referring the assessment to a third-party collection agency.

The Network Performance Unit

The Network Performance Unit (NPU) conducts health and safety site reviews, focused monitoring, post-payment reviews and complaint and grievance investigations of Network Providers. These monitoring and investigation activities may result in a plan of correction or adverse action described below, based on the outcome of the investigation or review. Findings may also trigger a report to:

- The Vaya SIU to review potential fraud, waste or abuse
- DHSR or other non-North Carolina licensure agencies (licensure or healthcare personnel registry violations)
- DHB, DMH/DD/SAS or other behavioral health MCOs in North Carolina
- CMS (for potential fraud, waste or abuse of Medicare funds)
- County Departments of Social Services (abuse, neglect or exploitation)
- Provider accrediting bodies
- Practitioner licensure or certification boards
- Law enforcement

SITE REVIEWS OF UNLICENSED OR UNACCREDITED PROVIDERS

The NPU conducts health and safety site reviews as part of the initial enrollment and re-credentialing process and whenever a Network Provider requests to add a new site to their contract. During the enrollment site visit, we will evaluate your readiness to provide services using a Site Review Tool mandated by DHHS. Vaya requires that all Network Providers meet the following standards, at a minimum, for office sites where members are seen:

- Physical accessibility: Sites are handicapped accessible.
- Physical appearance: Office site is well-maintained, neat and clean.
- Office hours are prominently posted.
- Adequacy of waiting and offices/examining room space:
  - Waiting and examining rooms are well-lit.
  - Adequate seating is available.
- Availability of appointments:
  - 24-hour, life-threatening emergency coverage is provided for members under your care.
  - Emergent care appointments are within two hours.
  - Urgent care appointments are within 48 hours.
  - Routine care appointments are within 14 days.
- Adequacy of treatment record-keeping:
  - Provider is in compliance with all Controlling Authority.
  - Medical records shall be maintained in a secure/confidential filing system.
  - Medical records shall not be commingled.
  - Medical records shall contain legible file markers.
  - Medical records are easily located.

The NPU Site Review Specialists also complete annual site reviews of Unlicensed AFL sites in accordance with DHHS requirements.

POST-PAYMENT REVIEWS (PPRs)

Vaya evaluates Network Provider compliance and performance utilizing the DHHS post-payment review (PPR) tool. We must complete a PPR of every provider in our network at least once every two years. The purpose of these reviews is to evaluate clinical documentation to ensure services were provided appropriately, within established benchmarks and clinical guidelines, and that those services are consistent with pre-authorization (when required) and the PCP/treatment plan.

PPR is a process that involves a retrospective review of a sample of services and may be conducted on site or as a desk review. Information from the member's record (including assessment information, treatment plan and progress notes) is evaluated against medical necessity criteria. The outcome of these reviews may indicate areas in which additional provider training is needed, that services were provided that did not meet medical necessity and situations in which the member did not receive appropriate services or needed care.

NOTE: Vaya uses both focused and routine PPR, as well as a sampling process across Network Providers, in its PPR methodologies. For more information about the PPR process, including the review tools, please refer to http://www.ncdhhs.gov/MHDDSAS/providers/providermonitoring/index.htm. Because Vaya strives to be transparent throughout the PPR process:

- You will be notified of the scheduled review date in writing 21-28 calendar days prior to the date of the review.

- You will be notified of the specific service records needed for the review no less than seven business days prior to the date of the review.
- Reviews will include an opening and exit conference. Any follow-up to be completed by the Network Provider or Vaya are reviewed during the exit conference**. You must present all information by the conclusion of the monitoring event.** After the review is concluded, any additional information submitted will not be used to change any established scores or out of compliance findings, but it may be considered in implementation of a plan of correction (if required).
- You will be notified in writing of the results of the PPR within 15 days of completion of the review. Monitoring tools are scored automatically in accordance with the guidelines provided with the tools. The tools will state if you did not meet threshold standards.
- Vaya will issue a plan of correction or adverse action in response to any of the following failures to meet threshold standards:
    - Any score below 85 percent on a sub-tool or sub-section of the PPR tool
    - Monitoring that reveals systemic compliance issues, as determined by Vaya

FOCUSED MONITORING

We conduct focused provider monitoring: (1) in response to significant indicators and/or reported trends that you may not be in compliance with Controlling Authority identified in your contract, including, but not limited to, the 1915(b)/(c) Waiver, DHB Clinical Coverage Policies, DMH/DD/SAS Service Definitions, the DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2, N.C. Administrative Code provisions governing delivery of MH/IDD/SUD services and any other service-specific standards, contract or administrative requirements; (2) to verify your contract compliance; and/or (3) in response to priorities for compliance verification as identified by utilization, costs and needs. Focused monitoring may also be conducted in conjunction with DHHS divisions, other MCOs or other Vaya departments.

- A focused monitoring can be conducted as a desk review or as an announced or unannounced site review.
- On-site reviews will include an opening and exit conference similar to a PPR. Any follow-up to be completed by the Network Provider or Vaya are reviewed during the exit conference**. You must present all information by the conclusion of the monitoring event.**
- You will be notified in writing of the results of the focused monitoring within 15 days of completion of the review.

GRIEVANCE AND COMPLAINT INVESTIGATIONS

As discussed in section 7 of this Manual, Vaya will investigate any complaint or grievance that we are unable to resolve informally or that we determine is not appropriate for informal resolution. If information gathered during the informal resolution process suggests misuse of public funding or beneficiary or provider fraud, waste or abuse, it will be referred to the Vaya SIU. However, if information gathered during the informal resolution process suggests that your practices do not meet required standards as defined by applicable federal and state laws, rules, regulations, manuals, service definitions, contract requirements and policies, the grievance or complaint will be referred to the NPU. **Referrals to the NPU team will also be made in situations in which there are concerns requiring immediate on-site monitoring to assess the health and safety of members.**

- Investigation of complaints and grievances may be desk or on-site reviews and may be announced or unannounced.
- On-site reviews will include opening and exit conferences similar to a PPR. Any follow-up to be completed by the Network Provider or Vaya are reviewed during the exit conference. **You must present all information by the conclusion of the monitoring event.**
- You will be informed of the results of the investigation in writing within 15 days of completion of the investigation.

NOTE: Vaya specifically **reserves the right** to issue an educational or warning letter, Plan of Correction (POC) or adverse action, up to and including termination of your contract(s) with Vaya, in response to any findings from a site review, PPR, focused monitoring, complaint or grievance investigation or other program integrity activity conducted by Vaya. Any claim/date of service cited as out-of-compliance in the PPR tool or otherwise will be reported to the SIU for overpayment determination. **We are not required to issue a warning letter or give you the opportunity to complete a POC prior to issuing an adverse action.**

WHAT IS A PLAN OF CORRECTION (POC)?

The POC is a written document developed by you in response to a Report of Findings from Vaya. The POC must specify how you will address each out-of-compliance finding, violation or deficiency identified by Vaya. The POC must be approved by the NPU as adequately addressing the issues in need of correction. Vaya will conduct monitoring to ensure that the plan is implemented and fully integrated into your operation(s) and that all deficiencies were corrected and are unlikely to re-occur. We follow the process and timelines outlined in the DHHS Policy and Procedure of the Review, Approval and Follow-Up of Plan(s) of Correction currently available on the archived DHHS website at: https://www.ncdhhs.gov/providers/provider-info/health-care/plan-of-correction. Failure to submit or implement an acceptable POC or substantially minimize or eliminate deficiencies may result in sanction up to and including termination from the network.

Grievance Resolution & Incident Team (GRIT)

Vaya is required to monitor certain types of incidents that occur involving Network Providers and other providers who operate within our catchment area. An incident is an event which is not consistent with the routine operation of a facility or service or the routine care of a member and that is likely to lead to adverse effects upon a member. Incidents are classified into three categories according to the severity of the incident**.** Network Providers are required to document and maintain internal records of all Level I incidents and make them available upon request. **Network Providers are required to report all Level II and Level III incidents in the state's Incident Response Improvement System (IRIS) as explained more fully at 10A NCAC 27G .0604.** Providers must give Vaya verbal notification of a member's death within 24 hours. Failure to do so is a violation of your contract and the N.C. Administrative Code. Out-of-state providers who do not have access to IRIS must submit paper copies of the incident report to DHHS and to Vaya.

Network Providers must implement procedures through their own internal Quality Management process that ensure review, investigation and follow-up for each incident that occurs. This includes:

1. A review of all incidents on an ongoing basis to monitor for trends and patterns
2. Strategies aimed at the reduction/elimination of trends/patterns
3. Documentation of the efforts at improvement, as well as an evaluation of ongoing progress
4. Assurance that mandatory reporting requirements are followed

All Level III incidents that occurred while the member was receiving services require a formal internal team review process initiated within 24 hours and require that notification of the Level III incident be made to the GRIT within 24 hours by: facsimile to 828-398-4407, by email incidentreport@vayahealth.com or by calling 828-225-2785 and asking for an Incident Report Specialist.

Vaya receives and tracks all incident reports filed in IRIS that involve providers operating in our catchment area. Upon receipt, we review incidents for completeness, appropriateness of interventions and achievement of short- and long-term follow-up for the member and the Network Provider's service system. If an incident reviewer determines corrections are needed, a request for corrections will be emailed to the individual that submitted the incident. All

requests must be returned in a timely manner. Non-compliance with requests and timelines may result in a plan of correction in accordance with Vaya's Policies and Procedures.

All member deaths and Level III incidents will be reviewed by Vaya's Critical Incident Review Committee (CIRC), which is chaired by our CMO. The CIRC may request more extensive documentation regarding the member if deemed necessary. You must cooperate with this process and submit records as requested. Network Providers are required to develop and maintain a system to collect and track documentation on any incident that occurs in relation to a member. If concerns are raised related to the member's care or services, or your response to an incident, the CIRC will refer the matter for potential investigation.

- For more information about IRIS and your reporting responsibilities, please refer to: http://www.ncdhhs.gov/providers/provider-info/mental-health/nc-incident-response-improvement-system.
- For IRIS resources, including the Incident Response and Reporting Manual and NC IRIS Technical Manual, please refer to: http://www.ncdhhs.gov/document/iris-resources.

The GRIT is also responsible for receiving and responding to all grievance and complaints filed by or on behalf of a member as referenced in Section 7 Member Rights and Empowerment.

Suspensions for Health and Safety Reasons

Vaya is required by our accrediting body to suspend your contract if our CMO or another Senior Clinical Staff Person determines that a Network Provider may be engaged in behavior or practicing in a manner that appears to pose a significant risk to the health, welfare or safety of any member. If a decision is made to suspend referrals or your contract for health and safety reasons, we will make best efforts to notify you within one business day of the decision. The notice will include the basis for our determination, the effective date of the suspension and instructions to discontinue the delivery of services until further notice and direct members in urgent need of services to contact the Access to Care Line at **1-800-849-6127**.

Following issuance of the emergency suspension notice, we will complete a full investigation into the allegations and issue a final decision. We make every effort to expedite these investigations, but we will not compromise the outcome to complete the case quickly.

- In the event that the allegations are found to be unsubstantiated, your contract will be reinstated immediately retroactive to the date of suspension, and we will send you a written notice to this effect.
- If any of the allegations are substantiated, Vaya will make a determination about further action. This may be a POC all the way through full contract termination. We are not required to offer you a POC. You will be notified in writing of the outcome of the investigation and any decision to require a POC or issue an administrative action or sanction.

Adverse Actions

We strive to ensure any adverse action issued against a Network Provider is fair, reasonable and consistent. We may issue an adverse action in response to any finding that you are out of compliance with applicable federal and state laws, rules, regulations, manuals, policies or guidance, this Manual, contracts between you and Vaya and any other applicable payor program requirements. However, we reserve the right to issue an adverse action at any time and for any reason we deem appropriate. Adverse actions issued by Vaya fall into two categories: Administrative Actions and Sanctions.

What is an Administrative Action?

This is an action against a Network Provider that does not result in a change to your status within the Closed Network. Examples of potential administrative actions include but are not limited to:

- **Moratorium on the Expansion of Sites or Services:** An administrative action whereby you may not apply to add additional sites or services to your contract, and may not respond to any Vaya procurement activity, including an RFP or RFI
- **Payment Suspension:** An administrative action whereby we continue to process your authorizations and claims, but your payments will be suspended (wholly or partially) for a designated time period not to exceed six months, unless payment suspension is required by 42 C.F.R. § 455.23, in which case the suspension period remains in effect until the N.C. Department of Justice Medicaid Fraud Investigations Division completes its investigation and/or legal proceedings related to the alleged fraud are completed
- **Probation (increased monitoring):** An administrative action whereby you may be placed on probation with increased monitoring for a specified period of time, not to exceed one year

What is a Sanction?

A Sanction is an action against a Network Provider, and/or its Owners and/or Managing Employees, based on professional competence or conduct or resulting in a change to your status within the Closed Network. Examples of potential sanctions include, but are not limited to:

- **Contract Suspension:** A sanction whereby your contract is suspended, and the Network Provider is prohibited from participating in the Vaya Closed Network for a period of time, during which all enrollees served are transitioned to other Network Provider(s). This includes a Suspension to Ensure Health and Safety issued by the CMO. Vaya will not make referrals or process new authorizations during any period of Suspension. Claims for services delivered on or after the effective date of the Suspension will not be processed.
- **Credentialing actions:** These are described more fully in section 3 of this Manual.
- **Exclusion from Participation in Closed Network:** A sanction whereby the Network Provider's network contract is terminated, and the provider is prohibited from re-applying for participation in the Closed Network. Network Providers who fail to provide the required written notice of network withdrawal and/or contract termination within the prescribed timeframe are automatically subject to exclusion by the Regulatory Compliance Committee.
- **Limiting or Suspending Referrals:** A sanction whereby Vaya does not refer new or additional members to a Network Provider, only makes a limited number or type of referrals, or only makes referrals to specific services and/or sites.
- **Site or Service Specific Termination:** A sanction whereby one or more sites and/or services are terminated from the Network Contract.
- **Termination from Closed Network:** A sanction whereby the Network Contract is terminated for all sites and services.

Our adverse action decisions are based on fair, impartial and consistent factors, including, but not limited to, documentation or other evidence tending to show one or more of the following:

- The provider violated a contractual, legal and/or administrative requirement, including, but not limited to, documentation, billing or other requirements set forth in DHB Clinical Coverage Policies and Manuals and DMH/DD/SAS Service Definitions and Manuals.
- The provider meets the "substantial failure to comply" standard as defined by 10A NCAC 26C .0502(6).
- The provider violated professional and/or ethical standards, including tolerating or covering up such violations on the part of its employees.
- The provider engaged in unlawful acts, including orchestrating, promoting, tolerating or covering up any illegal activity on the part of its employees.
- The provider is jeopardizing the health and safety of members.

Automatic (Immediate) Termination

We may revoke your credentials and/or suspend or terminate your contract immediately upon notice of any of the following occurrences:

- DHSR issues a revocation, suspension or Type A1 penalty against your license to operate or provide services.
- CMS issues an Immediate Jeopardy finding against your facility.
- Your accrediting body suspends or revokes your accreditation.
- Your licensing or certification authority suspends or revokes your license or certification.
- DHHS or another state Medicaid agency suspends or terminates your participation in a state Medicaid program or the N.C. Health Choice program.
- Another LME/MCO suspends or terminates your participation in its behavioral health network.
- CMS suspends or terminates your participation in the Medicare program.
- DHHS issues a payment suspension against you in accordance with 42 CFR § 455.23.
- DHHS issues a revocation of your ability to receive state and federal funding in accordance with 10A NCAC 26C .0504.

Notification of Adverse Action

We will always send you a written notice if we issue an adverse action. Depending on the nature of the decision, we may also call you. Notices will identify the nature and effective date of the adverse action, the basis for the decision, an explanation of how to initiate the dispute resolution process and how to submit additional information, as well as the timelines for doing so. All notifications are sent via electronic mail to the primary email contact on file with Vaya. If you do not signify acceptance of the email within one business day, the notification is sent via trackable mail. For purposes of calculating the appeal timeframes described in the next section, we consider that correspondence is received by you on the date of the attempted email delivery, regardless of whether you signify acceptance, unless it was sent to the wrong address based on a Vaya error, in which case the date it was sent to the correct address shall apply.

On a monthly basis, we are required to notify DHB of all denials of a provider's application to join our network and any termination of a Network Provider's contract, as well as any action taken against a Network Provider for program integrity reasons. We will also notify other behavioral health LME/MCOs operating in North Carolina and any applicable accrediting bodies or licensing boards.

SECTION 17
Dispute Resolution

Policy Statement

Vaya's policy is to implement a fair, consistent, respectful, timely, objective and impartial process to address significant disputes or problems with Network Providers, including Administrative Actions and Sanctions. Dispute resolution will be available to any Network Provider who wishes to initiate the process in response to an action or issue that is within the scope of this section. Our dispute resolution process includes methods for you to present relevant information, as well as clear timeframes from initiation through issuance of a written decision.

Scope

This dispute resolution process does not apply to appeals filed by a member, LRP or personal representative (including a Network Provider) contesting decisions of Vaya to deny, reduce, terminate or suspend a covered service in accordance with N.C.G.S. Chapter 108D and 42 CFR Part 438, Subpart F. Those decisions are handled through Vaya's member reconsideration and appeals process explained in section 6 of this Manual.

This dispute resolution process is only available to Network Providers, with the exception of the process for contesting claim denials, which is open to all providers who submit claims to Vaya.

Can a Network Provider appeal every dispute it has with Vaya?

No. The following issues may not be appealed through Vaya's reconsideration process and are not subject to dispute resolution:

- Refusal to process or denial of an initial application for credentialing;
- Credentialing effective date;
- Refusal to process or denial of a request to participate in the Closed Network;
- Refusal to renew or extend a provider's participation as a Network Provider beyond the terms of such provider's network contract(s);
- Refusal to process or denial of a request to add a site or service to an existing network contract;
- Refusal to award a service, program and/or funding as part of any Vaya procurement process;
- Any agreed-upon adjustment to earnings targets for non-fee-for-service shadow claims;
- Issuance of a warning letter, educational letter, technical assistance letter, Report of Findings or Plan of Correction (POC) that does not change the provider's status within the Closed Network;
- A decision to place a provider on prepayment review;
- Formal report to oversight authorities of known or suspected violations, including, but not limited to, the following:
    - Federal Centers for Medicare and Medicaid Services, known as CMS (Medicaid or Medicare fraud);
    - DHB Program Integrity or the Medicaid Investigations Division of the N.C. Department of Justice (Medicaid fraud);
    - Division of Health Service Regulation (licensure or healthcare personnel registry violations);

- DMH/DD/SAS (summary suspension and/or revocation of authorization to receive public funding for the provision of MH/IDD/SUD services);
- County Departments of Social Services (abuse, neglect and exploitation);
- Provider accrediting bodies;
- Practitioner licensure or certification boards; or
- Law enforcement.

Network Providers also may not appeal or initiate dispute resolution in response to a "direct and contractually or administratively explicit consequences" of violating a contract and/or administrative requirement, such as a contract termination or suspension based on the following:

- Notification from the U.S. HHS Office of Inspector General, the N.C. Department of Health and Human Services (DHHS) or other oversight agency of exclusion from participation in state or federally funded healthcare programs, including Medicare, N.C. Health Choice, Medicaid in any state or a Medicaid managed care program (including, but not limited to, a PIHP operated by another LME/MCO);
- Immediate Jeopardy finding issued by CMS;
- Action taken by DHHS or any of its divisions to terminate, suspend or revoke a contract or provider status;
- Loss of required facility or professional licensure, accreditation or certification; or
- Federal, state or local funds allocated to Vaya are revoked or terminated in a manner beyond the control of Vaya for any part of the contract period.

What can be appealed?

This dispute resolution process is available to any Network Provider who wishes to initiate it in response to any of the following:

- Any Notice of Administrative Action, Overpayment or Sanction issued by Vaya against a Network Provider as described in Section 16 of this Manual;
- An emergency contract suspension or suspension of referrals issued by the CMO against a Network Provider to protect the life, health, safety or welfare of any member/ enrollee as described in Section 16 of this Manual;
- A Notice of Credentialing Action (NCA) issued by the Vaya Credentialing Committee to revoke or restrict the credentials of any Network Provider or credentialed practitioner (which may include an owner or managing employee of the Network Provider) as described in Section 3 of this Manual;
- Final notification of a claim denial;
- Payment withholding of a 1/12 shadow claim payment in regard to a non-Medicaid funded contract by and between Vaya and a Network Provider; and
- Any other significant dispute that cannot be resolved informally and which has direct implications for the Network Provider, unless excluded as described above.

Any requests for reconsideration concerning disputes that do not obviously fall into a category listed above will be reviewed by Vaya for determination of whether it is a valid dispute, and, if so, whether it should be categorized as administrative or clinical. If the appeal is determined to be invalid or untimely, Vaya will send you a written notification no later than fourteen (14) calendar days after the Reconsideration Review unless there are documented extenuating circumstances for the Network Provider or Vaya.

If the due date falls on a day the Vaya Administrative Office is closed (holiday, weekend, inclement weather, etc.), the notice will be issued the next day the Vaya Administrative Office is open. The letter will explain why the issue raised is not subject to the dispute resolution process, is untimely or is otherwise invalid.

Dispute Resolution Overview

There are three tracks for dispute resolution: Administrative Actions, Provider Sanctions and Claim Denials. Each track offers a mechanism for the provider to request a Reconsideration Review by a three-person panel that was not involved in the initial or prior decision of the subject of the dispute. Providers may request a Reconsideration Review by at least one level of panel review. For requests for Reconsideration Review of a Provider Sanction or a Claim Denial, the provider may request review from a first- and second-level panel.

Reconsideration Reviews for Provider Sanctions shall include one panel member who is a clinical peer selected from the Vaya Closed Network (i.e., a practitioner with equivalent credentials or qualifications as the practitioner who initiated the appeal, or, with respect to agencies, facilities or hospitals, a qualified individual employed by a Network Provider that provides the same or similar services as are the subject of the dispute and/or the provider that initiated the appeal). Peer participation is a requirement of Vaya's accrediting body.

Provider Sanction disputes are of a **clinical** nature that pertain to your professional conduct or competence in relation to matters such as, but not limited to, the following:

- The appropriateness or quality of professional services including assessment, treatment, consultation and referral;
- The appropriateness of interactions between a treating professional and a member; or
- Other professional conduct, including as required by laws, rules, regulations, contract requirements policy or manual (e.g., failure to exercise professional judgment in disclosing therapeutic information).

Administrative Action disputes are of an **administrative or non-clinical** nature that pertain to matters such as, but not limited to, the following:

- Claims and billing;
- Adequacy of documentation, facility or staffing; or
- Compliance with laws, rules, regulations, contract requirements, policy or manuals.

Disputes found in favor of the Network Provider at any level do not need to go to the next level. Reimbursement will continue during the dispute resolution process **unless** a payment suspension is issued for any reason, including receipt of a credible allegation of fraud or abuse (42 CFR § 455.23), or Vaya believes continued reimbursement is likely to increase any overpayment amount due.

How do I request reconsideration?

A Reconsideration Request Form ("Form") will be included with any written notification of an administrative action or sanction you receive from Vaya ("Notice"), except for claim denials, which are discussed below. You must submit a signed, fully completed Reconsideration Request Form ("Form") with all documentation to support the Network Provider's position within thirty (30) calendar days of the date of the applicable notification. The Form must be signed by the disputing practitioner or an authorized representative of a provider organized as a corporate entity.

You must select the type of panel meeting you prefer (in-person, desk review or virtual), and identify all persons you plan to bring to the meeting. Only one reconsideration request may be submitted per dispute or Notice.

The Form and all documents you wish to be reviewed with your reconsideration must be sent electronically to ProviderReconsiderations@vayahealth.com

What is the deadline to request reconsideration?

You have 30 days to request reconsideration from the date of the applicable Notice. We will consider our action final if a fully completed and signed reconsideration request is not received at the address listed in the Form by 5:00 p.m. on the 30th day following mailing of the Notice. Extensions of the time for filing will not be granted. It is your responsibility to ensure delivery and provide proof of mailing, if needed.

What happens after I submit a Request for Reconsideration?

If we receive a signed, complete, timely request, we will send you a written notification with the date, time and location of the panel meeting. If you are represented by legal counsel, the notice will be sent to your legal counsel, and we will do our best to accommodate his or her schedule.

How do I submit additional documentation for consideration by the panel?

Any documentation you wish to be considered by a panel must be submitted electronically.

- For all Reconsideration Reviews, documentation supporting the justification for provider's position must be submitted at the same time the Reconsideration Request Form is submitted.
- For claim denials, documentation for the first level review must be submitted with the request for reconsideration. Documentation for the second level review must be submitted at least five (5) days prior to the date of the scheduled second level review.

Your time is valuable. If documentation you submit prior to the review supports overturning Vaya's decision, we will notify you and cancel the panel meeting.

Panel Meeting Process

Are all reconsiderations in person?

No. You may request that your panel meeting be conducted virtually by teleconference or video conference, in-person or paper (desk) review. For reconsideration reviews specific to shadow claim disputes, a desk review is the only type of panel meeting available.

How soon will the panel meeting be scheduled?

- For sanctions, the panel meeting will be scheduled to occur no later than fourteen (14) calendar days after receipt of the request unless there are documented extenuating circumstances for the Network Provider or Vaya.
- For overpayments, the panel meeting will be scheduled to occur between 60 and 90 days from the date of the Notice of Overpayment.
- For administrative issues (including non-Medicaid shadow claim disputes), the panel meeting will be scheduled to occur no later than 30 days from the receipt of the request for reconsideration
- For Level 1 reviews for Claim Denials, the panel meeting will be scheduled to occur no later than 60 days from the receipt of the Level 1 request for reconsideration, and no later than 30 days from the receipt of a Level 2 request for reconsideration.

For all of the above, if the last day for the review to be held falls on a day the Vaya Administrative Office is closed (holiday, weekend, inclement weather, etc.), the meeting may be scheduled the next day the Vaya Administrative Office is open.

Can I reschedule if needed?

Once scheduled, panel meetings will not be rescheduled unless there are documented extenuating circumstances, which include, but are not limited to, death, serious illness, severe inclement weather or unavailability of a clinical peer. If you need to request that a panel meeting be rescheduled, approval of the extension will be dependent upon your signed agreement that you will not use our decision to reschedule the panel meeting as a basis to challenge the validity of the reconsideration decision.

If the reconsideration is postponed or otherwise rescheduled due to extenuating circumstances, the documentation due date does not change, but you may be granted up to a 15-day extension on this deadline at the discretion of the panel facilitator.

Do I need an attorney?

We cannot make that decision for you. You may want to consider the amount or issue at stake. A Vaya attorney is usually present at all panel meetings, except for claims denial reconsiderations. However, panel meetings are informal and non-adversarial. Witnesses are not sworn, and cross-examination is not permitted.

You must notify us in advance of the number of persons who will be present. The number of participants may be limited to accommodate meeting room space. All participants will be required to sign our visitor log, which includes a confidentiality disclaimer.

How long will the panel meeting last?

In general, the meeting timeframe will be limited to a maximum of two hours, with additional time scheduled for the panel to deliberate. For disputes involving a large volume of claims, additional time may be scheduled.

Is the meeting recorded?

No. The meeting may not be recorded by audio or video means. A designated staff person will take minutes for the meeting.

What happens at an in-person panel meeting?

The panel facilitator will provide an opening statement explaining the agenda and requesting all parties present to state their name and title. A Vaya staff person will first present our view of the dispute in an objective manner. You may then present a narrative summary of the facts, evidence or arguments in support of your position. It is helpful to refer to documentation or laws, rules, regulations or policies in support of your position.

Throughout the presentations the panel members will review relevant documentation and may ask you questions. Vaya's legal counsel may provide advice or counsel to Vaya staff or panel members at any point in the process. At the end of the meeting, the facilitator will ask you to sign an attestation acknowledging that the agenda and role(s) of each person present were explained, that all parties were able to present their information fully, and in a fair and equitable manner, and that the anticipated timing for a written decision was shared.

What happens at a video conference meeting?

A video conference meeting generally follows the same process as an in-person meeting using video conferencing technology such as Microsoft Teams. We will send you the attestation via DocuSign and ask that you sign immediately following the meeting.

What happens at a virtual panel meeting?

A virtual meeting conducted by teleconference or videoconference generally follows the same process as an in-person meeting. We will send you the attestation in advance of the meeting and ask that you return it via email immediately following the meeting.

What happens at a desk review?

Desk reviews consist of a scheduled meeting where the panel reviews documentation, deliberates and reaches a decision without hearing presentation(s) from Vaya staff or the Network Provider. While reviewing documentation, the panel may contact Vaya staff, legal counsel or providers to ask specific questions necessary to reach a decision. A designated staff person will take minutes for the meeting.

How and when does the panel reach a decision?

Following the meeting, the panel will deliberate and vote on a determination to uphold, revise or overturn the decision or pend for more information. Vaya legal counsel may be present during the deliberation to answer legal questions. All three panel members must be present for a vote to take place, and determinations are reached by majority vote. Vaya's Executive Leadership Team (ELT) is authorized to overturn or revise the decision of any Vaya reconsideration panel.

Following panel deliberations, the facilitator shall issue a decision notice based on instruction from the panel or ELT and following review by Vaya legal counsel. The written decision will be sent to you via secure electronic transmission no later than 14 days after the panel meeting, excluding official Vaya holidays, unless additional time is needed due to extenuating circumstances. The date of the decision letter is the date of the final decision by Vaya.

Are panel meetings confidential?

Vaya is a government entity subject to the N.C. Public Records Act, N.C.G.S. Chapter 132. While there are some exceptions (for example, sensitive information or competitive health information), some of our written material can be produced in response to a public records request. We are also required to notify DHB whenever we terminate or suspend a provider's participation in our network. However, to protect confidentiality, uphold professionalism and preserve objectivity for second-level panels, panel members and participating staff will refrain from discussing the review with providers, peers or colleagues who are not on the panel or directly participating in the process, except as necessary to respond to requests from members or their families/ caregivers impacted by the dispute.

Is the panel decision final?

Other than first-level claim decisions as outlined in the "Disputing Claim Denials" section below, panel decisions on **administrative** actions are final and may not be appealed any further with Vaya. However, if you are not satisfied with the first-level decision issued about a **sanction**, you may request reconsideration by a second level panel within 10 days of the date of the decision. If you do not request a second-level panel review by 5:00 p.m. on the 10th day after the date of the first-level decision, the sanction decision will be final.

Please note that Vaya will assess late payment penalties and monthly interest if you do not pay back an identified overpayment within 30 days after the issuance of a final overpayment decision.

How does the second-level panel process work?

The second-level panel will include different panel members, but otherwise the process is the same. Within 14 days from the date we receive a signed, complete, timely request for reconsideration of a first-level sanction decision, excluding official Vaya holidays, we will schedule a second-level panel, unless there are documented extenuating circumstances for you or Vaya. We will notify you of the date and time of the scheduled panel meeting in writing.

Please note that the second-level decision is final and may not be appealed further with Vaya.

Can I file an appeal with the OAH if I am dissatisfied with Vaya's decision?

You will need to check with your legal counsel on options for appealing Vaya's final decision. Our position is that OAH lacks jurisdiction over disputes between Vaya and Network Providers.

Disputing Claim Denials

What is a claim denial?

This is a request for payment that is received as clean and processed by Vaya, but which does not meet all the required criteria to be approved for payment. Notification of Claim Denials will be transmitted to you via Electronic Remittance Advice (ERA) or other final notification of payment, payment denial, disallowance, payment adjustment or notice of program or institutional reimbursement. You must submit all requests for reconsideration of claim denials within 30 days from this notification (usually the RA).

Where can I find the Reconsideration Request Form?

The Level 1 Request for Reconsideration of Claim Denial Form ("Level 1 form") can be found on the Vaya website or may be requested from a Vaya representative. The submitted form must include specifics regarding the claim(s), including, but not limited to, the member's name, member record number, date of service, service code, claim header information and all other relevant information regarding the claim.

If a signed, complete Level 1 form is not received within the required 30-day period, Vaya's action to deny the claim is final without further written notification. Level 1 forms will only be accepted electronically which can be sent to claimsreconsideration@vayahealth.com.

When will a panel meeting be scheduled?

Level 1 Claim Denials are reviewed through a desk review process. Vaya will schedule a Level 1 Desk Review panel meeting to occur within 60 days, excluding official Vaya holidays, from the receipt of a signed, complete and timely Level 1 form, unless there are documented extenuating circumstances for you or Vaya. In the event the Level 1 panel determines it does not have the information necessary to make a decision, the level 1 decision will be pended until the additional information is received as requested. Based on the information available, the panel will issue a written decision to either uphold, overturn or adjust the original claim denial determination within 60 days from the date of the initial Level 1 Desk Review.

What if I disagree with the Level 1 decision?

If you are dissatisfied with the Level 1 reconsideration decision, you can submit a written request for a Level 2 Reconsideration Review. The form to request Level 2 reconsideration will be attached to the Level 1 reconsideration decision.

You must submit a signed, complete Level 2 form within 30 days from the date of the Level 1 decision. In the Level 2 form, you must specify whether you will participate in the Level 2 reconsideration in person, telephonically or by submitting additional documentation. If a signed, complete Level 2 form is not received within the required 30-day period, Vaya's decision is final without further written notification.

When will the Level 2 panel meeting be scheduled?

Vaya will schedule a Level 2 Reconsideration Review panel meeting within 30 days, excluding official Vaya holidays, from the receipt of a signed, complete and timely Level 2 form, unless there are documented extenuating circumstances for

you or Vaya. If you do not attend the Level 2 Reconsideration Review meeting (in person or by phone) or do not submit additional information with your Level 2 Reconsideration Request, the Level 2 reconsideration will not be held, and the Level 1 reconsideration decision will become final.

If a Level 2 review is held, the Level 2 panel will issue a decision to uphold, overturn or adjust the Level 1 Reconsideration decision based on the information available. The panel will issue a written decision within 30 days from the date of the Level 2 Reconsideration Review. The Level 2 Claim Denial Decision is final and may not be appealed further with Vaya. Please consult with your legal counsel on options for appealing Vaya's final decision.

APPENDIX A
Provider Advisory Council Code of Ethics

Vaya Health Provider Advisory Council (PAC) Code of Ethics

PREAMBLE

The PAC shall facilitate an open exchange of ideas, shared values, goals and visions and bring forward concerns and solutions while promoting collaboration, ethical operations, mutual accountability and quality services. The PAC strives to achieve best practices to empower members within our community to achieve their personal goals. PAC members commit to:

- Assure that their staff adhere to this Code of Ethics;
- Provide support to other member agencies; and
- Advocate for the further development of resources on a local and state level for members served.

PURPOSE

PAC members agree to abide by this Code of Ethics. Member agencies shall:

- Become familiar with and encourage their Board of Directors, owners and staff to adhere and follow the Code of Ethics;
- Agree that actions which violate the Code would be considered unethical;
- Agree that a lack of knowledge is not a defense for unethical conduct;
- Strive to achieve the highest standards of professional conduct;
- Acknowledge that all member agencies be committed to best practices in their specific area through involvement with continued education and review of relevant research;
- Report in writing any direct knowledge of perceived violations of the Code of Ethics;
- Offer age-appropriate services, which promote dignity and empower the individual; and
- Reflect the beliefs, values, heritage and customs of individuals supported by offering culturally competent services.

PAC members will discuss known violations of standard ethical practices by members with the offending colleague or agency director. In the event that this does not resolve the issue, the member shall consult with the Ethics Committee of the PAC regarding his or her responsibility.

CORE VALUES

The PAC embraces the following core values, which serve as the foundation of the Provider Advisory Council:

- **Integrity:** Provide accurate and truthful representation.
- **Competence:** Honor responsibilities to achieve and maintain the highest level of professional competence for members and those in their employ.

- **Professional Conduct:** Promote the dignity and autonomy of the profession, maintain harmonious inter-professional and intra-professional relationships and accept the profession's self-imposed standards. All professional relationships should be directed to improving the quality of life of the individuals who receive supports from the member agency.
- **Individual Value, Dignity and Diversity:** Provide supports and services that promote respect and dignity of each individual supported.
- **Social Justice:** Assure that the right of individuals and those who make decisions regarding services to them are provided with complete and accurate information on which to make choices.
- **Social Capital:** Network Providers support the importance of social capital in each individual supported.
- **Partnership:** Network Providers will work together in partnership to develop and achieve an individual's desired outcomes.

ETHICAL PRINCIPLES

The following broad principles are based on the Core Values of the PAC. These principles set forth ideals to which all Network Providers should aspire.

VALUE:

INTEGRITY – Provide accurate and truthful representation

ETHICAL PRINCIPLE:

Network Providers will not knowingly permit anyone under their supervision to engage in any practice that violates the Code of Ethics. Network Providers will not engage in dishonesty, fraud, deceit, misrepresentation of themselves or other providers, or any form of conduct that adversely reflects on their profession, the PAC, or on the Network Provider's ability to support members professionally. Network Providers will not commit unethical practices that include, but are not limited to, deceptive billing, falsification of documentation, commission of a felony, gross neglect and fiduciary impropriety.

VALUE:

COMPETENCE – Honor responsibilities to achieve and maintain the highest level of professional competence for themselves and those in their employ

ETHICAL PRINCIPLE:

Network Providers will represent their competence within their scope of practice. Network Providers will engage in only those aspects of the profession that are within the scope of their competence, considering their level of education, training and experience. Network Providers will allow individual staff to provide only those services that are within the staff member's competence, considering the employee's level of education, training and experience. Network Providers will demonstrate compliance with state and federal rules, regulations and laws regarding standards for training and credentials for supports provided.

VALUE:

PROFESSIONAL CONDUCT – Uphold the dignity and autonomy of the profession, maintain harmonious inter-professional and intra-professional relationships, and accept the profession's self-imposed standard. All professional relationships should be directed to improving the quality of life of the individual who receives support from the member agency.

ETHICAL PRINCIPLE:

Network Providers will not participate in activities that produce a benefit for themselves over the individuals they support or may potentially support, always giving priority to professional responsibility over any personal interest or gain. Network Providers will make all reasonable efforts to prevent any incidents of abuse, neglect and exploitation.

Abuse means the infliction of mental or physical pain or injury by other than accidental means, or unreasonable confinement or deprivation by an employee of services, which are necessary to the mental or physical health of the individual. Temporary discomfort that is a part of an approved and documented treatment plan or use of a documented emergency procedure shall not be considered abuse. Neglect means the failure to provide care or services necessary to maintain the mental or physical health and wellbeing of the individual. Network Providers will promptly report and thoroughly investigate all allegations of abuse, neglect and exploitation. Under no circumstance will the support relationship between the program, staff and individuals receiving services, and/or their families or legal guardian, be exploited. Exploitation is defined as the illegal or unauthorized use of a service user or a service user's resources for another person's profit, business or advantage. Network Providers will train staff to recognize and report any suspected incidents of abuse and neglect and exploitation.

VALUE:
INDIVIDUAL VALUE, DIGNITY AND DIVERSITY – Provide supports and services, which promote respect and dignity of each individual served

ETHICAL PRINCIPLE:
Network Providers will comply with all federal and state rules and laws related to confidentiality and protected health information, including but not limited to, N.C.G.S. 122C; -52 through 122C-56, the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the HIPAA final administrative simplification regulations codified at 45 CFR Parts 160, 162 and 164; and 42 CFR Part 2. Network Providers will not discriminate in their relationships or services provided to individuals receiving supports, contractor and colleagues on the basis of race or ethnicity, gender, age, religion, national origin, sexual orientation or disability. Network Providers will provide individuals and families a means of submitting grievances that is fair and impartial. Network Providers will comply with N.C.G.S. § 35A – 1201, which allows for individuals who are adjudicated incompetent to be involved in decisions and choices that impact their lives.

Network Providers will make all reasonable efforts to ensure individuals and families participate in the development and revision of any plan for services. Network Providers will not abandon individuals and families. Network Providers will consistently demonstrate efforts to assure that their services eliminate the effects of any biases based upon individual and cultural factors. Network Providers will support the recovery and self-determination of each individual.

VALUE:
SOCIAL JUSTICE – Assure the rights of individuals receiving supports and others who make decisions regarding services are provided with complete information on which to make their choices

ETHICAL PRINCIPLE:
Network Providers will accurately portray their services and capacities through public and private statements. Network Providers will not engage in false and deceptive representation of their services. Network Provider's marketing strategies will not offer inducements to primary individuals receiving supports or their legal representatives in exchange for business gained. Network Providers will accurately portray their ownership, board of directors and management through public and private statements. Network Providers will follow required laws and standards regarding the hiring of staff. Network Providers will not make initial contact with employees of other providers for the purpose of offering employment to that individual employee for the purpose of gaining clients. This does not preclude the individual client to make a choice. Network Providers will use the standards means of advertising for hiring staff.

VALUE:
SOCIAL CAPITAL – Network Providers support the importance of social capital for each individual supported
ETHICAL PRINCIPLE:

Network Providers will support and promote opportunities for individuals they support to develop valued relationships with members of the community in which they live or work. Network Providers will support and promote opportunities for individuals they support they be treated with respect and dignity within the community they live or work. Network Providers will support and promote opportunities for individuals they support developing roles in the community in which they live or work.

VALUE:

PARTNERSHIP – Network Providers will work together in partnership to develop and achieve individual desired outcomes

ETHICAL PRINCIPLE:

Network Providers shall collaborate to share resources that enhance the functions of the Network to develop solutions for gaps in services and will work in partnership:

- To assure continuity of care for members, and
- To assure linkage for services, and
- With members, stakeholders, parents, significant others and Vaya to support the attainment of each individual's goals.

APPENDIX B
Acronyms and Glossary

Commonly Used Acronyms and Glossary of Terms

1/12 shadow claim payment	Also known as a capitation payment. This is a predetermined payment established by contract. It is disbursed to the provider in 12 monthly payments and is intended as a prepayment for state-funded capitation services. Providers submit claims to Vaya the same as a fee-for-service claim. Providers are not paid for individual capitated service claims; the claims serve as proof that a service was rendered.
Abuse	Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for healthcare. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.
Access to Care	The ability to obtain an array of available and needed treatments, services and supports
Accreditation	Certification by an external entity that an organization has met a set of standards
Adverse Benefit Determination	As defined in 42 CFR 438.400(b), adverse benefit determination (previously referred to as a managed care "action") means: (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; or (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.
Adjudicate	A determination to pay or reject a claim
Ancillary Services	Services and supports designed to address Social Determinants, including but not limited to public welfare benefits such as Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Women, Infants and Children (WIC) program, utility assistance, food banks, housing, etc..
Appeal	A request for review of an Adverse Benefit Determination
Authorized service	Medically necessary services pre-approved by Vaya Health

Basic benefit plan	The basic benefit package includes services available to Medicaid-eligible individuals and, to the extent resources are available, to non-Medicaid individuals according to local business plans. These services provide brief interventions for individuals with acute needs. The basic benefit package is accessed through a simple referral from Vaya through its screening, triage and referral system.
Capitation	Also known as sub-capitation. A predetermined payment is disbursed to the provider. Providers submit claims for capitated services to Vaya to serve as proof a service was rendered.
Care manager (previously referred to as care coordinator)	Vaya employee assigned to conduct care coordination functions described at 42 CFR § 438.208(c), including referral, linkage, treatment and discharge planning
Catchment area	Geographic service area; a defined group of counties
Claim	A request for reimbursement under a benefit plan for services
Clean claim	A "clean claim" is a claim that can be processed without obtaining additional information from the service provider or a third party. It does not include a claim under review for medical necessity or a claim from a provider under investigation by a governmental agency for fraud or abuse.
Client	Also referred to as "consumer", "enrollee", "member" "participant" or "patient". Means an individual receiving services funded by Vaya or as defined in N.C.G.S. § 122C-3 (6).
CMO	Chief Medical Officer (Vaya)
CMS-1500	Health insurance claim forms. The CMS-1500 form is the official standard Medicare and Medicaid health insurance claim form required by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health & Human Services.
Coordination of benefits (COB)	Process of obtaining payments from third-party payors (such as primary or secondary insurance) prior to billing the payor of last resort.
Credentialing	The review process to approve applicants for participation in Vaya's network of providers
CSRA (formerly CSC)	The fiscal agent for the N.C. Department of Health and Human Services who is responsible for the State's MMIS
CUR	Client Update Request
DDE	Direct data entry, such as keying a claim directly into the MCIS
Denial	A request for payment that is received as clean and processed by Vaya but that does not meet all required criteria to be approved for payment. It is transmitted to the network provider via a remittance advice (RA) or other final notification of payment, payment denial, disallowance, payment adjustment or notice of program or institutional reimbursement.
DHB	N.C. Division of Health Benefits
DMH/DD/ SAS	N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services
DSS	(N.C.) Division of Social Services or (county) Department of Social Services
Dx	Diagnosis
ECS	Electronic claims submission

EDI	Electronic data interchange
Eligibility	A determination that a person meets the requirements to receive services as defined by the payor
Enhanced benefit plan	Includes services that are available to Medicaid-entitled individuals and non-Medicaid individuals meeting medical necessity criteria. Enhanced benefit services are accessed through a person-centered planning process. Enhanced benefit services are intended to provide a range of services and supports that are more appropriate for individuals seeking to recover from more severe forms of mental illness and substance use and with more complex service and support needs.
Enrollment	Action taken by the N.C. Division of Health Benefits (DHB) to add a Medicaid beneficiary's name to the monthly enrollment report. Also refers to an action by Vaya to add a non-Medicaid client to the Vaya non-Medicaid Health Plan.
Enrollment period	The timespan during which a beneficiary is enrolled with Vaya as a Medicaid waiver-eligible beneficiary
EOB	Explanation of benefits
Fee-for-service	A payment methodology that associates a unit of service with a specific reimbursement amount
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.
HIPAA	The Health Insurance Portability and Accountability Act of 1996
IDD	Intellectual and/or developmental disability
Licensure	A state or federal regulatory system for service providers to protect public health and welfare. Examples include licensure of individuals by professional boards, such as the N.C. Psychology Board or the N.C. Substance Abuse Professional Practice Board. Examples also include licensure of facilities that provide MH/IDD/SUD services by the N.C. Division of Health Service Regulation (DHSR). Licensure may apply to both individuals and facilities.
LME (Local management entity)	A local political subdivision of the state of North Carolina established under Chapter 122C of the North Carolina General Statutes that is responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level. An LME shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources.
Managed benefit	Services that require authorization from Vaya Utilization Management (UM)
MCO (managed care organization)	An umbrella term for health plans that provide healthcare in return for a predetermined monthly fee and coordinate care through a defined network of providers, practitioners and hospitals
N.C. Innovations Waiver	The North Carolina 1915(c) Home and Community-Based Waiver for people with I/DD.
N.C. MH/DD/SAS Health Plan	The North Carolina 1915(b) Medicaid Managed Care Waiver for M/IDD/SUD services.

NC START	N.C. Systematic Therapeutic Assessment, Respite and Treatment. NC START provides prevention and intervention services to adults with intellectual and/or developmental disabilities and complex behavioral health needs.
NC-SNAP	N.C. Support Needs Assistance Profile. NC-SNAP is a needs assessment tool that, when administered properly, measures an individual's level of intensity of need for developmental disability supports and services.
NC-TOPPS	N.C. Treatment Outcome Program Performance System. Refers to the program used by DMH/DD/SAS to measure outcomes and performance for substance use and mental health clients. NC-TOPPS captures key information on a person's current episode of treatment, aids in evaluation of active treatment services and provides data to meet federal performance and outcome measurement requirements.
Network Provider	A provider of MH/IDD/SUD services who is credentialed by Vaya and has a contract in effect for participation in the Vaya Closed Network to provide services to Vaya Health Plan members.
NPI (National Provider Identification)	A National Provider Identifier or NPI is a unique 10-digit identification number issued to healthcare providers in the United States by the Centers for Medicare & Medicaid Services (CMS).
NPPES	National Plan and Provider Enumeration System
Out-of-area provider	A contracted provider who delivers services to a Vaya Health Plan member outside of the Vaya catchment area
Out-of-network provider (OON)	A provider that has been approved as an out-of-network provider under Vaya's out-of-network policy and procedure and has executed a client-specific OON agreement with Vaya; however, these providers are not considered members of the Vaya provider network and are not available as service choices for Vaya members.
Overpayment	Any amount paid by Vaya to a provider to which the provider is not entitled, including, but not limited to, claims and expenses determined to be out-of-compliance. An overpayment includes payment that should not have been made and payments made in excess of the appropriate amount.
Patient Monthly Liability (PML)	If a member's income is more than the cost of care in a long-term facility at the Medicaid rate, the member must contribute some income to the cost of care in the form of PML.
Place of service (POS)	Place of service; the facility or area where a service is rendered
Plan of Care	A single, unified plan that addresses the Member's integrated care needs related to Physical Health, Behavioral Health, Social Determinants, Ancillary Services and includes participation from all Healthcare Providers and other individuals/ organizations involved in the Member's life. The Plan of Care must address all applicable social, civil or legal requirements and does not negate a Member's right to privacy under federal and state law. The Plan of Care may also be referred to as a Person-Centered Plan (PCP) or an Individual Support Plan (ISP).
Population Health Management	The use of aggregated data to identify, analyze and impact specific health conditions, health disparities and improve member outcomes and reduce unnecessary costs through advocacy, investment in cost effective strategies to decrease disease prevalence and/or health disparities for identified populations, measuring and improving health outcomes, developing and implementing educational approaches and practice guidelines to improve clinical decision making and evidence-based practice in service and support approaches.

Primary diagnosis	The most important or significant condition of an individual at any time during the course of treatment in terms of implications for the individual's health, medical care and need for services
Prior authorization	The act of authorizing specific services before they are rendered
Re-adjudication	A claim that has completed the adjudication process is queued for another adjudication in the MCIS. Process can be initiated on a claim-by-claim basis by claims specialist or in a batch adjudication.
Reconsideration	A review of a previous finding or decision by Vaya based on the provider's reconsideration request and any additional materials presented by the provider.
Recoupment	Any formal action by Vaya to begin recovery of an overpayment with or without advance official notice by reducing future payments to a provider
Re-credentialing	The review process to determine if a provider continues to meet the criteria for participation in the Vaya Closed Network
Referral Screening Verification Process (RSVP)	The process used to determine whether a Medicaid beneficiary who is referred to or seeking admission to Adult Care Homes licensed under N.C.G.S. § 131D-2.4 is screened to determine whether the individual has a Serious Mental Illness (SMI) or Severe and Persistent Mental Illness (SPMI) as defined by the State of North Carolina's 2012 settlement with the U.S. Department of Justice.
Remittance advice (RA)	A document outlining claims status and payment that includes approved claims, denied claims, sub-capitated claims and recoupments (credit memos)
Replacement Claim	A replacement claim is essentially a new claim. It is submitted with a resubmit reference number, which is typically the claim header ID of the claim to be replaced. Once the replacement is submitted, the original referenced claim is automatically voided (reverted), and the new replacement claim replaces the original. This is used when a correction is needed on an approved original claim.
Revert	Also known as a 'void,' a revert renders the claim null and invalid. When a claim is reverted, it remains available for reference, but no further action can be taken with the claim. A revert can be performed standalone or as an automatic response to a submitted replacement claim.
Risk Stratification	Risk stratification is a process that helps identify members for CCM or care coordination by integrating a range of data sources calculated by various predictive models and current condition indicators. At Vaya, the risk stratification process focuses on behavioral health while incorporating physical health information to create a whole person driven stratification process. Risk stratification output can be used to monitor overall population health, highlight areas of major concern, and monitor outcomes over time.
Service Authorization Request (SAR)	A request for authorization of services. If approved, a SAR becomes an authorization.
Service location	Any location where a member may obtain a covered service from a Network Provider
Social Determinants	The World Health Organization defines social determinants as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

Spend-down	Medicaid term used to indicate the dollar amount of charges a Medicaid member must incur before Medicaid coverage begins during a specified period of time
STR	Screening, triage and referral. This also refers to a page in the MCIS enrollment module.
Sub-capitated	Also known as “capitated.” A predetermined payment is disbursed to the provider. Providers submit claims for capitated services to Vaya to serve as proof that a service was rendered.
Third party payor	An individual, entity or program that is or may be liable to pay for all or part of the payments made by Vaya to a provider
Third-party billing	Services billed to an insurance company, Medicare or other third-party payor
UB-04	The federal Office of Management and Budget and the National Uniform Billing Committee have approved the UB-04 claim form, also known as the CMS-1450 form. The UB-04 claim form accommodates the National Provider Identifier (NPI) changes.
Utilization Management (UM)	A process based on medical necessity criteria to regulate the provision of services in relation to the needs of individuals. This process should guard against under-utilization, as well as over-utilization, of services to assure the frequency and type of services fit individual needs.
Vaya Total Care (VTC)	VTC originated as a whole person care one-county pilot with the following objectives: Develop meaningful data exchange; Create a portable, shared care plan beyond the walls of a single healthcare system or shared electronic health record; Use risk stratification and predictive analytics reflecting behavioral health, intellectual/developmental disability factors as well as traditional healthcare factors; Create a Care Management infrastructure designed to support members with complex, co-morbid behavioral health and physical health conditions; and develop a whole person care provider and managed care organization (MCO) workforce training initiative for providers/prescribers to expand service capacity and population knowledge. Today, VTC is Vaya’s model of care for Complex Care Management.

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