2565 Good Faith Provider Contracting

Department: Population Health Admin	**Original Effective Date:** 01/12/2009
ID Approval Authority: Not Assigned	**Last Review/Revision Date:** 10/19/2021
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Policy

It is the policy of Vaya Health (Vaya), to enter into a valid, legally appropriate, written, and signed agreement, in Good Faith, with each Vaya Network Provider [N-NM 7, QI-3], in accordance with 42 CFR §438.214, Vaya's contract(s) with the NC Department of Health and Human Services (NCDHHS) and accreditation standards governing Network Management and Quality Improvement. The purpose of this policy is to outline the standards by which Vaya concludes whether a Good Faith Effort has been made in negotiating/ executing a Network Contract and to outline the business process and timeframes by which new or amended Network Provider Agreements will be requested, developed, negotiated, issued, executed, stored, and tracked. Requests for written agreements with Out-Of-Network (OON) Providers must follow the process outlined in the Vaya Out of Network Authorizations and Contracting policy.

Definitions

Accreditation Body(ies) mean National Council on Quality Assurance (NCQA) and/or URAC.

Alternative Payment Methodologies means Non-Fee-For-Service ("FFS") payment methodologies that include, but are not limited to, non-unit cost reimbursement invoice-based, sub-capitation, bundled rates, per member per month, performance-based arrangement, or 1/12 allocation, in which the Network Provider may have additional or alternative financial responsibilities (such as the submission of shadow claims and invoices) other than FFS claims submission to be eligible for payment. Generally, this is used for non-Medicaid contracts, but any source of funding is eligible for an alternative payment methodology. It also means a Medicaid non-FFS payment methodology agreed upon between Vaya and a hospital/health system, in which the Open Network hospital provider may have alternative financial responsibilities other than FFS claims submission to be eligible for payment for non-behavioral health claims. Such alternative payment methodology for (a) critical access hospitals and for hospitals in Vaya's Region designated by the North Carolina Department of Commerce for 2019 as economically depressed counties shall be permissible after the first 4 years of the Managed Care Contract, and (b) for all other hospitals, including non-critical access hospitals located in Buncombe, Haywood, Henderson, or Watauga county shall be permissible after the first 2 years of the Managed Care Contract.

Applicant means, consistent with the definition in N.C.G.S. § 108D-1(3), any provider of Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plan ("Tailored Plan") services who seeks to participate in the Vaya Network.

Behavioral Health and Intellectual/ Developmental Disability (I/DD) Tailored Plan ("Tailored Plan") means a capitated prepaid health plan that meets all the requirements of Article 4 of Chapter 108D of the North Carolina General Statutes and arranges for medical, pharmacy, long term services and supports (LTSS), behavioral health, I/DD, TBI, and other services and supports to be delivered to Medicaid and NC Health Choice enrollees as authorized under the waiver agreement between North Carolina and CMS pursuant to Section 1115 of the Social Security Act.

Closed Network means as consistent with N.C.G.S. §108D-1(6) and N.C.G.S. §108D-23, the network of credentialed providers that have contracted with Vaya to furnish MH/SUD/IDD/TBI services to Members and who are listed in the Vaya Provider Directory, regardless of funding source.

Closed Network Applicant means an Applicant who seeks to participate in the Closed Network.

Closed Network Contract means the document(s), including any attachments or addenda, signed by all parties in accordance with Vaya's applicable policies that specifies the terms and conditions of the relationship between Vaya and a Closed Network Provider.

Closed Network Provider means, in accordance with 42 C.F.R. § 438.2 and N.C.G.S. § 108D-1, an appropriately credentialed provider, group of providers, or entity delivering MH/SUD/IDD/TBI Services that has a Closed Network Contract with Vaya, and, because of the Managed Care Contract, receives Medicaid funding directly or indirectly to order, refer, or render covered services and participate in the Closed Network. A Closed Network Provider is not a subcontractor by virtue of the Closed Network Contract.

Exclusion List means a list Vaya must check to determine the exclusion status of all providers and ensure that the Vaya does not pay federal funds to excluded persons or entities, including the State Exclusion List; U.S. Department of Health and Human Services, Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE); The System of Award Management (SAM); The Social Security Administration Death Master File (SSADMF); To the extent applicable, National Plan and Provider Enumeration System (NPPES); and the Office of Foreign Assets Control (OFAC).

Fee-for-Service (FFS) means a payment model in which a contracted Network Provider is paid a fee for clean claim(s) for services delivered to Members, in accordance with a restricted list of codes, services and rates. FFS-only Network Contracts do not require budget verification by the Vaya Finance department.

Good Faith or **Good Faith Efforts** means:

(i) the application of Objective Quality Standards established by NCDHHS;
(ii) the application of mandatory contracting clauses required by NCDHHS and Accreditation Bodies;
(iii) the development and maintenance of an Open Network and a Closed Network that meet NCDHHS

availability, accessibility, and quality goals and requirements;

(iv) the consideration of whether an Applicant or Network Provider refuses to accept Vaya's Network reimbursement rates, which shall not be lower than any applicable rate floor required by the Managed Care Contract unless mutually agreed to an alternative reimbursement or methodology;

(v) the exclusion of any provider in its Network that is not currently enrolled in North Carolina Medicaid consistent with provider, disclosure, screening, and enrollment requirements of 42 CFR Part 455 Subpart B and E and the Managed Care Contract or of any provider appearing on one of the Exclusion Lists;

(vi) the application of risk analysis and mitigation;

(vii) the consideration of the responsiveness of a Closed Network Applicant or Open Network Applicant for an initial Network Contract or a Closed Network Provider or Open Network Provider seeking renewal or amendment of a Network Contract; and

(viii) in the case of Medical Services, the application of Vaya's policies applicable to contracting with any Open Network Applicant or renewal of an Open Network Contract with any Open Network Provider;

(ix) in the case of Pharmaceutical Services, the terms and conditions of the PBM Contract, as well as PBM's policies applicable to contracting with any Open Network Applicant or renewal of an Open Network Contract with any Open Network Provider, considering all facts and circumstances surrounding an Open Network Applicant's or renewing Open Network Provider's, as applicable, willingness to contract before determining that such an Open Network Applicant or renewing Open Network Provider has refused Vaya's or the PBM's contracting effort;

(x) in the case of NEMT Services, the terms and conditions of the NEMT Contract, as well as the NEMT Broker's policies applicable to contracting with any Open Network Provider or renewal of an Open Network Contract with any Open Network Provider, considering all facts and circumstances surrounding an Open Network Applicant's or renewing Open Network Provider's, as applicable, willingness to contract before determining that such an Open Network Applicant or renewing Open Network Provider has refused Vaya's or the NEMT's contracting effort.

Indian Tribe means as defined in the Indian Health Care Improvement Act (IHCIA) Section 4(14), 25 U.S.C. § 1603(14).

Managed Care Contract means the contract between Vaya and NCDHHS concerning Vaya's operation of the BH I/DD Tailored Plan and provision of health benefits coverage for Medicaid, Health Choice and Non-Medicaid-funded Members and Recipients.

Medical Services mean physical health services that do not constitute either MH/SUD/IDD/TBI Services or Pharmaceutical Services. For the purpose of this policy only, Medical Services also includes physician-administered drug services, and some outpatient pharmacy services (e.g., pharmacy services offered onsite at a Network Provider directly contracted with Vaya, such as a FQHC or opioid treatment clinic or office-based opioid treatment).

Member includes the term "Enrollee" as referenced in 42 CFR Part 438 and also refers to any of the following, as applicable to the Tailored Plan services delivered by a Network Provider: (a) a Medicaid or NC Health Choice

beneficiary whose Medicaid or NC Health Choice eligibility arises from residence in a county located within the Region and who is enrolled in a Vaya Health benefit plan, including, but not limited to, N.C. Innovations Waiver participants; and (b) a state-funded services recipient who is eligible for and enrolled in the Vaya state-funded benefit plan, including individuals who receive MH/SUD/IDD/TBI Services funded with state, county, and/or federal block grant dollars.

MH/SUD/IDD/TBI Services mean those mental health, substance use disorder, intellectual and/or developmental disabilities, and traumatic brain injury services covered by Vaya under the Managed Care Contract.

Network is the Closed Network and Open Network collectively.

Network Contract or Network Provider Agreement means the document(s), including any attachments or addenda, signed by all parties in accordance with this policy that specifies the terms and conditions of the relationship between Vaya and a Network Provider or between a Subcontractor and its provider. Closed Network Contracts and Open Network Contracts are types of Network Contracts.

Network Provider (or Participating Provider) means, in accordance with 42 C.F.R. §438.2 and N.C.G.S. §108D-1(27), an appropriately credentialed provider, group of providers, or entity delivering BH I/IDD Tailored Plan services that has a Network Provider Agreement with Vaya, and, because of contracts between NCDHHS and Vaya, receives Medicaid or non-Medicaid funding directly or indirectly to order, refer or render covered services and participate in the Network. A Network Provider is not a subcontractor by virtue of the Network Provider Agreement.

Non-Emergency Medical Transportation (NEMT) Broker means the entity to which Vaya delegates the administration of NEMT Services and development and maintenance of an Open Network of providers of NEMT Services pursuant to the terms and conditions of the NEMT Contract.

NEMT Contract means the contract between Vaya and the NEMT Broker for the NEMT Broker's scheduling and administration of NEMT Services and provision of an Open Network of providers of NEMT Services.

NEMT Services: Transportation services arranged by the NEMT Broker to take eligible Members to scheduled, medically necessary appointments and other Value-Added services on a non-emergent basis.

NC Health Choice means the NC Health Choice Health Insurance Program for Low Income Children authorized by N.C. Gen. Stat. § 108A-70.25 and as set forth in the North Carolina State Plan of the Health Insurance Program for Children and authorized under Social Security Act Title XXI.

Objective Quality Standards mean the standards approved by the Department and provided to Vaya through the Provider Enrollment File (PEF) by which Vaya and/or Vaya's Subcontractor determines whether to contract with any Open Network Applicant or renew an Open Network Contract with any Open Network Provider. The following is required as part of Objectivity Quality Standards that contracted facilities, except for the residential

provider facilities noted below, implement a Tobacco-Free Policy covering any portion of the property on which the Network Provider operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. Contracted facilities that are owned or controlled by the provider and which provide ICF-IID services or residential services that are subject to the Home and Community Based Services final rule are exempt from this requirement.

Open Network means the network of providers of non-MH/SUD/IDD/TBI Services that have contracted with Vaya or our Subcontractor to respectively furnish such services to Members.

Open Network Applicant means any non-MH/SUD/IDD/TBI Applicant who seeks to participate in the Open Network.

Open Network Contract means the document(s), including any attachments or addenda, signed by all parties in accordance with Vaya's applicable policies, or in the case of Subcontractors, Subcontractors' applicable policies, that specifies the terms and conditions of the relationship between Vaya or its Subcontractor and an Open Network Provider.

Out-of-Network Agreement means a written contract with an Out-of-Network Provider.

Out-of-Network Provider means a provider that has not been approved for participation in the Network but has entered into a written contract with Vaya to provide services to specific member(s).

Pharmaceutical Services mean Medicaid and NC Health Choice pharmaceuticals or pharmacy services, including outpatient pharmacy, required to be covered by Vaya under the Managed Care Contract and do not constitute either Medical Services and/or MH/SUD/IDD/TBI Services.

Pharmacy Benefits Manager (PBM) means the entity to which Vaya delegates the administration of Pharmaceutical Services and development and maintenance of an Open Network of providers of Pharmaceutical Services pursuant to the terms and conditions of the PBM Contract.

Pharmacy Benefits Manager (PBM) Contract means the contract between Vaya and the PBM for the PBM's administration of Pharmaceutical Services, provision of an Open Network of providers of Pharmaceutical Services, and performance of other functions delegated by Vaya.

Region means the geographic part of the State of North Carolina served by Vaya pursuant to the Managed Care Contract as of the Effective Date consisting of Alamance, Alexander, Alleghany, Ashe, Avery, Buncombe, Caldwell, Caswell, Chatham, Cherokee, Clay, Franklin, Graham, Granville, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Person, Polk, Rowan, Stokes, Swain, Transylvania, Vance, Watauga, Wilkes, and Yancey counties.

Standard Plan means as defined in N.C. Gen. Stat. § 108D-1(36), a capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all the requirements of Article 4 of Chapter 108D of the North Carolina General Statutes except for the requirements pertaining to a BH I/DD Tailored Plan.

Subcontractor means as defined in 42 CFR § 438.2, an individual or entity that has a contract with Vaya that relates directly or indirectly to the performance of Vaya's obligations under the Managed Care Contract. Subcontractor also includes an entity with whom Vaya has an arrangement whereby Vaya uses the products and/or services of that entity to fulfill some of its obligations under the Managed Care Contract. A Network Provider is not considered a Subcontractor by virtue of a provider participation agreement with Vaya. Both the NEMT Broker and PBM are Subcontractors.

Tobacco-Free Policy means a Network Provider's tobacco-free policy includes a prohibition on smoking combustible tobacco products and the use of non-combustible tobacco products, including electronic cigarettes, as well as prohibiting Network Providers from purchasing, accepting as donations, and/or distributing tobacco products (combustible and non-combustible products including electronic cigarettes) to the clients they serve.

Value-Added Services: Services in addition to those covered under the Medicaid Managed Care benefit plan that are delivered at the health plan's discretion and are not included in capitation rate calculations. Value added services are designed to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care.

Procedure

Section I: General Requirements

1. All contracts with Network Providers must be in writing.
2. All Network Contracts shall comply with all applicable federal and state laws, rules, and regulations, accreditation requirements, and payor program requirements including, but not limited to, the Tailored Plan Contract.
3. Vaya shall not reimburse any provider for services delivered in the absence of an executed Network Contract or Out-Of-Network Contract or valid extension thereof, unless as required by 42 CFR §438.114(c)(i) or as authorized by the President & Chief Executive Officer ("CEO"), General Counsel & Chief Compliance Officer ("General Counsel"), Executive Vice President & Chief Financial Officer ("CFO") or their respective designee.
4. The Contracts and Legal Teams within the Legal Department shall be responsible for development of Network Contract templates and all contract development, drafting, gathering, verification, routing, execution and tracking in accordance with this policy and procedure.
5. Provider Network Operations (PNO) and Provider Network Management (PNM), collectively referred to as "Provider Network" or "PN", shall be responsible for development of scopes of work (SOWs), value-based performance incentives and penalties, performance standards, and other non-financial attachments to Network Contracts, subject to review by Vaya legal counsel or designee.
6. The Finance department shall be responsible for conducting the pre-audit required by the Local Government Budget and Fiscal Control Act, N.C.G.S. Chapter 159, Article 3 ("Pre-Audit"), and for generating and approving any financial attachments to Network Contracts.

7. Vaya shall implement and maintain a contracts and/or Subcontractor lifecycle management software platform ("Platform") that captures the following data elements at minimum: Contractor name; the date(s) of all signatures and routing; the date on which the contract was executed by all parties; the date on which the provider welcome packet and enrollment notice were sent; the effective beginning and termination or expiration date of the contract; and any other reporting elements deemed necessary or advisable by the NCDHHS, an Accreditation Body, and/or Compliance, Legal, PN, or Quality Departments.
8. Vaya staff who regularly utilize the Platform will be trained in its use by the Contracts Team and/or the MIS Department, and the Contracts Team will be available to provide technical assistance on use of the Platform as needed or will transfer the staff to the MIS Department for assistance.
9. All Vaya policies applicable to contracting with any Closed Network Applicant or renewal of a Closed Network Contract with any Closed Network Provider, including, but not limited to, Vaya's Credentialing Program Description policy, Tailored Plan Credentialing policy, Out of Network Authorizations and Contracting policy, and Selection and Retention of Providers policy, shall be applied for contracting with Closed Network Applicants or renewing or extending the Network Contracts with Closed Network Providers.
10. In the case of non-MH/SUD/IDD/TBI Services, Good Faith must be exercised by Vaya in negotiating and executing: (i) an Open Network Contract with an Open Network Applicant or (ii) the renewal or extension of an Open Network Contract with any Open Network Provider.
11. In the case of services that Vaya has subcontracted (e.g., PBM, NEMT), all such Subcontractors must exercise Good Faith in negotiating and executing: (i) an Open Network Contract with an Open Network Applicant or (ii) the renewal of an Open Network Contract with any Open Network Provider.
    A. Vaya delegates Network contracting for Pharmaceutical Services to the PBM and NEMT Services to the NEMT Broker and requires the Subcontractor to make a Good Faith attempt to contract with any willing and eligible provider. In addition, Vaya requires the Subcontractor to make Good Faith attempts to contract with enough providers, including, but not limited to, Indian Health Care Providers (IHCP) as defined by 42 C.F.R. § 438.14(a) to satisfy access requirements for members eligible to use them while allowing out of network access to providers without penalty for Members eligible to use them.
    B. Vaya's PBM Contract and NEMT Contract require the Subcontractor to make network contracting decisions based solely upon the credentialing information provided by NCDHHS.
    C. Vaya will review the Subcontractor's contract template for network providers prior to contracting to ensure uniform billing and reimbursement requirements and prevent preferential treatment of Subcontractor owned or operated providers.
12. Except for out of network emergency services, post-stabilization services, and services provided during transitions in coverage, Vaya and its Subcontractors shall not reimburse an Out-of-Network Provider more than ninety (90%) of the Medicaid Fee-for-Service rate if Vaya or the has made a Good Faith Effort to negotiate and execute an Open Network Contract with the provider, but the provider has refused that contract.
13. If Vaya or its Subcontractor does not make a Good Faith Effort to contract with the Out-of-Network Provider in accordance with this policy, Vaya and its Subcontractor shall reimburse an Out-of-Network Provider at one hundred percent (100%) of the Medicaid Fee-for-Service rate unless Vaya has exercised its authority to maintain a Closed Network for MH/SUD/IDD/TBI Services as set forth in N.C. Gen. Stat. § 108D-23.

14. Pursuant to N.C. Gen. Stat. § 143-48 and Executive Order 150 (1999), Vaya invites and strongly encourages network participation with businesses owned by minorities, women, disabled individuals, disabled business enterprises, and nonprofit work centers for the blind and severely disabled. Vaya shall make Good Faith efforts to seek out and pursue opportunities to utilize Historically Underutilized Business (HUB), as that term is defined in N.C. Gen. Stat. § 143-128.4.
15. Vaya shall make Good Faith efforts to contract with IHCPs and demonstrate that a sufficient number of IHCPs are participating in its Network to ensure timely access to Pharmaceutical Services, Medical Services, and MH/IDD/SUD Services for the members of federally recognized Indian Tribes and other individuals eligible to receive services at IHS facilities.
16. Neither Vaya nor its PBM shall not deny a pharmacy the opportunity to participate in the Open Network as required by N.C. Gen. Stat. § 58-51-37(c)(2). However, if a pharmacy fails to meet NCDHHS's Objective Quality Standards, neither Vaya nor the PBM is required to contract with the non-compliant pharmacy.
17. Vaya will not require individual practitioners, as a condition of contracting with Vaya, to agree to participate or accept other products offered by Vaya, or its Subcontractors, nor shall Vaya, or its Subcontractors, automatically enroll the provider in any other product offered by Vaya, or its Subcontractors.
18. Using the applicable contract template or contract amendment template, Vaya will offer to contract with an Applicant or Network Provider in writing by sending the provider a contract or contract amendment to execute. The contract shall have the provisions described in Section III below, including the standard provisions required to be included per the Managed Care Contract. Amendments will maintain the inclusion of any such required provisions.
19. If within thirty (30) days the Applicant or Network Provider rejects the request or fails to respond either verbally or in writing, Vaya shall consider the request for inclusion in the Network rejected by the Applicant or Network Provider. If discussions are ongoing, or the contract is under legal review, Vaya shall not consider the request rejected.
20. If the Applicant or Network Provider requests negotiation of the contract within 30 days from the date the Network Contract is sent, Vaya shall negotiate in Good Faith.
21. If, however, (a) an Applicant or Network Provider who requests negotiation of the contract (i) does not provide proposed edits to the contract within 30 days of the request to negotiate, unless a longer period is agreed to by Vaya, or (ii) is unresponsive to Vaya's negotiation efforts for long period of time (e.g. months); or (b) in Vaya's opinion after three rounds of negotiations are completed, continued efforts to negotiate a contract would be unproductive or ineffective for the parties to reach an agreement on reimbursement rates or mandatory or reasonable contract language (e.g., demanding Vaya to do more than required, eight percent per diem interest for underpayments, etc.), then Vaya shall consider Applicant's or Network Provider's actions or inactions to be a rejection of Vaya's offer for them to be, or remain, a Network Provider and Vaya shall be deemed to have acted in Good Faith during the negotiations and shall be permitted to terminate negotiations. Termination of negotiations for the reasons described in this Section I., Paragraph 19 shall not be considered a declination of contracting by Vaya and therefore does not require appeal rights be given the provider.
22. During contract negotiations with an Applicant or Network Provider, Vaya will, without NCDHHS's prior approval, make changes to a previously approved provider contract template, except for changes to the following standard provisions expressly required in the Managed Care Contract to be included in a Network Contract:

A. Assignment: Provisions on assignment of the contract must include that:
    I. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the BH I/DD Tailored Plan.
    II. The BH I/DD Tailored Plan shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred before the delegation or transfer.
B. Government Funds: The contract must include a statement that the funds used for provider payments are government funds.
C. Interpreting and Translation Services: The contract must have provisions that indicate:
    I. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the member.
    II. The provider must ensure the provider's staff is trained to appropriately communicate with patients with various types of hearing loss.
    III. The provider shall report to the BH I/DD Tailored Plan, in a format and frequency to be determined by the BH I/DD Tailored Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.
D. Providers of Perinatal Care: For all contracts with a provider of perinatal care, a provision that outlines the model for perinatal care consistent with the Department's Pregnancy Management Program. All contracts with Obstetricians shall include a statement that the contracted provider agrees to comply with the Department's Pregnancy Management Program Government funds
E. Managed Care Contract, Section VII. Attachment M.2. Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members
F. Managed Care Contract, Section VII. Attachment M.4. Pregnancy Management Program Policy for Medicaid and NC Health Choice Members
G. Managed Care Contract, Section VII. Attachment M.5. Care Management for High-Risk Pregnancy Policy for Medicaid and NC Health Choice Members
H. Managed Care Contract, Section VII. Attachment M.6. Care Management for At-Risk Children Policy for Medicaid and NC Health Choice Members

23. During contract negotiations with an Applicant or Network Provider, Vaya will make changes to the following standard provisions previously approved in Vaya's provider contract template only when directed by NCDHHS:
    A. Compliance with state and federal laws: The Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and the Company's managed care contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state and federal funds. The Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this contract, or any violation of the Vaya's contract with NC DHHS could result in liability for money damages, including liquidated damages, and/or civil or criminal penalties and sanctions under state and/or federal law.
    B. Hold Member Harmless: The Provider agrees to hold the member harmless for charges for any covered service. The Provide] agrees not to bill a member for medically necessary services covered by Vaya so long as the member is eligible for coverage.

C. Liability: The Provider understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, Vaya, its employees, agents, or subcontractors. Further, the Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to the Provider by Vaya or any judgment rendered against Vaya.
D. Non-discrimination Equitable Treatment of Members: The Provider agrees to render Provider Services to members with the same degree of care and skills as customarily provided to the Provider's patients who are not members, according to generally accepted standards of medical practice. The Provide] and Vaya agree that members and non-members should be treated equitably. The Provider agrees not to discriminate against members on the basis of race, color, national origin, age, sex, gender, LGBTQ status, or disability.
E. Department authority related to the Medicaid program: The Provider agrees and understands that in the State of North Carolina, the Department of Health and Human Services is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance. The Division of Health Benefits is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the two programs.
F. Access to provider records: The Provider agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the Contract(s) between Vaya and the Provider and any records, books, documents, and papers that relate to the Contract(s) between Vaya and the Provider and/or the Provider's performance of its responsibilities under this contract for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NC DHHS deems necessary for contract enforcement or to perform its regulatory functions:
    I. The United States Department of Health and Human Services or its designee;
    II. The Comptroller General of the United States or its designee;
    III. The North Carolina Department of Health and Human Services (NC DHHS), its Medicaid Managed Care program personnel, or its designee
    IV. The Office of Inspector General
    V. North Carolina Department of Justice Medicaid Investigations Division
    VI. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;
    VII. The North Carolina Office of State Auditor, or its designee
    VIII. A state or federal law enforcement agency and
    IX. Any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.

The Provider shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other Program Integrity activities conducted by the NC Department of Health and Human Services.

Nothing in this section shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services Office of

Inspector General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation.

G. Provider ownership disclosure: The Provider agrees to disclose the required information, at the time of application, and/or upon request, in accordance with 42 C.F.R.§ 455 Subpart B, related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any federal health care programs. The Provider agrees to notify, in writing, Vaya and the NC Department of Health and Human Services of any criminal conviction within twenty (20) days of the date of the conviction.

H. N.C.G.S. § 58-3-225, Prompt claim payments under health benefit plans: The Provider shall submit all claims to Vaya or its Subcontractors for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, the Provider's failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for the Provider to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.

    I. For Medical claims (including BH):
        a. Vaya shall within eighteen (18) Calendar Days of receiving a Medical Claim notify the provider whether the claim is clean or pend the claim and request from the provider all additional information needed to process the claim.
        b. Vaya shall pay or deny a clean medical claim at lesser of thirty (30) Calendar Days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.
        c. Vaya shall pay or deny a medical pended claim within thirty (30) Calendar Days of receipt of the requested additional information.
    II. For Pharmacy Claims:
        a. Vaya shall within fourteen (14) Calendar Days of receiving a pharmacy claim pay or deny a clean pharmacy claim or notify the provider that more information is needed to process the claim.
        b. Vaya shall pay or deny a pharmacy pended claim within fourteen (14) Calendar Days of receipt of the requested additional information.
    III. If the requested additional information on a medical or pharmacy pended claim is not submitted within ninety (90) days of the notice requesting the required additional information, Vaya shall deny the claim per N.C.G.S. § 58-3-225 (d).
        a. Vaya shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).
    IV. If Vaya fails to pay a clean claim in full pursuant to this provision, Vaya shall pay the Provider interest and liquidated damages. Late Payments will bear interest at the annual rate of eighteen (18) percent beginning on the date following the day on which the claim should have been paid or was underpaid.

V. Failure to pay a clean claim within thirty (30) days of receipt will result in Vaya paying the Provider liquidated damages equal to one (1) percent of the total amount of the claim per day beginning on the date following the day on which the claim should have been paid or was underpaid.

VI. Vaya shall pay the interest and liquidated damages from subsections (X) and (X) as provided in that subsection and shall not require the Provider to requests the interest or the liquidated damages. During contract negotiations with an Applicant or Network Provider, Vaya will, in its discretion, make changes to any provision that is not required by the Managed Care Contract, so long as the change does not conflict with any requirements in the Managed Care Contract or state or federal law, or materially conflict with Vaya's business operations applicable to Network Providers.

Section II: Contract Initiation and Development

1. In the case of MH/SUD/IDD/TBI Services, contract initiation and development for contracting with any Closed Network Applicant or renewing a Closed Network Contract with any Closed Network Provider shall be conducted in accordance with Vaya's Tailored Plan Credentialing Policy and Selection and Retention of Providers.
2. In the case of non-MH/SUD/IDD/TBI Services, contract initiation and development for contracting with any Open Network Applicant or renewing an Open Network Contract with any Open Network Provider shall be conducted in accordance with Vaya's Tailored Plan Credentialing Policy.
3. In the case of sub-contracted Subcontractor Services, contract initiation and development for contracting with any Open Network Applicant or renewing an Open Network Contract with any Open Network Provider shall be conducted in accordance with Subcontractor's applicable policies and the terms and conditions of the Subcontractor Contract.
4. Within three (3) business days following approval for contracting by the Provider Network Participation Committee as outlined in Vaya's Tailored Plan Credentialing Policy, the Credentialing Team must initiate a request for a new Network Contract in the Platform.
5. Within one (1) business day following approval of credentialing associated with a request for change for an existing Network Provider, the Credentialing Team will determine if a new or amended Network Contract is required.
   A. If a new or amended Network Contract is determined necessary, the Credentialing Team must initiate a request in the Platform within three (3) business days of such determination as outlined below.
   B. If the credentialing requires a data entry change in the claims system only and does not require any changes to the Network Contract, the Credentialing Team shall update the claims system within three (3) business days of such determination. Examples of data entry change only include but are not limited to:
      VII. Data was incorrectly entered into the claims system but is correct on the current Network Contract;
      VIII. Change in practitioner's agency/group practice affiliation; or
      IX. Additions of sites and/services to an existing Network Provider's Network Contract.

6. Any PNO staff member, after obtaining approval from PNO leadership, may submit a request for an amendment or addendum to any existing Network Contract by initiating a request in the Platform. Other departments who wish to amend a Network Contract, add a new SOW, or make other changes impacting a Network Contract, must route such request through PNO. The Contracts Team will only process requests for new or amended Network Contracts from Executive Leadership, the PNO department, or the Legal Team.
7. Development of non-Medicaid funding allocations:
   A. Allocation of Non-Medicaid funding is determined by the Network & Services Management Committee (NSMC) prior to the beginning of each State Fiscal Year ("SFY"). Allocations may be changed or amended at any point during the SFY by the NSMC.
   B. If non-Medicaid funds are recommended for allocation to a provider not currently in the Vaya Closed Network, the request for enrollment process should be followed.
   C. If non-Medicaid funds are recommended for allocation to a Network Provider who does not have an existing non-Medicaid contract OR a Network Provider seeks to add additional sites or services to a non-Medicaid contract, the Network Provider must complete and submit the Request for Enrollment Form.
   D. If changes are made to any existing non-Medicaid funding allocation, a contract amendment is required, and PNO must submit a request as outlined in Section II. All funding changes must be approved by the NSMC following review by the Rate Setting Committee.
8. Development of Network Contracts utilizing non-Medicaid TBI funding:
   A. TBI purchases of $500.00 or less may be made with a Vaya credit card in accordance with the Vaya Out of Network Authorizations and Contracting policy.
   B. For TBI purchases between $501.00 and $4,999.99, the requestor must comply with the Vaya Out of Network Authorizations and Contracting policy.
   C. For TBI purchases of $5,000.00 or more, depending on the purchase, the requestor must comply with the Out of Network Authorizations and Contracting policy as applicable.
9. Any PNO or Credentialing Team staff requesting a new or amended Network Contract must initiate a request in the Platform as follows:
   A. Select the "Documents" tab, then select "Docs" and then utilize the "Create" function.
   B. Complete the "Initiator Verification" step in the Platform Workflow.
10. The "Initiator Verification" step, which is part of the initiator's request, in the Platform workflow must be completed by the earlier of any of the following: (i) at least ten (10) business days prior to the requested start date of the new or amended Network Contract, (ii) within three (3) business days following the Provider Network Participation Committee's approval to credential an applicant who seeks enrollment as a Network Provider, or (iii) within three (3) business days following the Credentialing Team's determination that a new or amended Network Contract is required as a result of a request for change, unless:
    A. There is a demonstrated health, safety, or compliance risk to Vaya or to a member that would be mitigated by the earlier execution of such Network Contract; or
    B. The CEO, CFO or General Counsel/ designee approves a different timeframe.
11. The next step in the Platform workflow is for the Contracts Team to review the request for completeness and accuracy, ensuring that the request incorporates and/or attaches all information and details necessary to process an accurate Network Contract, including but not limited to the following:

   A. The provider's correct, full legal name, without abbreviations or shorthand as identified on the provider enrollment file;
   B. The provider's official mailing address and the email address that should be used for electronic signature routing; and
   C. The applicable funding source/ type of contract (e.g., fee-for-service, Medicaid-only, Medicaid & State funded, etc.).
   D. Any attachments specific to the provider (e.g., Finance attachments, Scope(s) of Work, etc.). If the Network Contract includes Alternative Payment Methodologies, the PNO staff member must assign a task in the Platform workflow to the designated Finance department staff member requesting an approved financial attachment to upload.
      I. The attachment must identify designated amounts, allocations, and payment requirements to be incorporated into the Network Contract.
      II. The Finance department staff member is responsible for verifying that the financial attachment is supported by allocations in the service budget developed by the NSMC.
      III. The PN department staff member is responsible for verifying that the financial attachment and scope of work match.

12. Within three (3) business days of completion of the "Initiator Verification" step, the Contracts Team is responsible for approving or declining the request:
    A. If the request is missing information necessary to generate a Network Contract, it will be declined, and the requestor will receive an electronic workflow notice. The requestor must then incorporate any missing information necessary to generate a Network Contract and re-initiate the request. The 10-day timeframe for completion is restarted effective the date the request is re-initiated.
    B. If the request is complete, the Contracts Team will proceed to the preparation, negotiation, and execution of a Network Contract.
13. The Contracts Team creates a Network Contract, amendment or extension utilizing the applicable contract template(s) as outlined in Section III, incorporating all necessary attachments and appendices, and the Network Contract is electronically routed for signature in the following order:
    A. Provider;
    B. CFO or designee (Executive Director of Finance) for Pre-Audit. Note that all Network Contracts involving Alternative Payment Methodologies require Pre-Audit <u>prior</u> to routing to the provider;
    C. CEO or designee;
    D. Contracts Team for electronic storage and tracking.
14. The Contracts Team will track progress while the Network Contract is in the electronic signature loop. The electronic signature platform will send automatic reminders to signatories every 24 hours following initial contract routing.
15. If the provider seeks to negotiate terms and conditions of the Network Contract or amendment, the General Counsel or designee will be consulted. No changes to a Network Contract or amendment template shall be made without express permission of the CEO, General Counsel, or designee.
16. Upon completion of the electronic signature process:
    A. The fully executed Network Contract will be automatically routed to the provider;
    B. The Contracts Team will forward the email with the executed agreement and any attachments to the Data Team;

C. The Data Team will update MCIS as needed;
D. The Contracts Team will update the Platform, as needed, store and track the Network Contract in the Platform and/or the Vaya Employee Resource Network, where relevant staff will be provided access to the Network Contract.
E. PN must notify Vaya senior leadership, or other impacted staff, of any newly contracted Network Providers, or changes to existing Network Provider contracts, as necessary.

<u>Section III: Contract Templates and Minimum Requirements</u>

1. The Contracts Team will utilize a master Network Participation Provider Agreement template developed by the Legal Team and approved by NCDHHS. The Legal Department will make all changes requested by NCDHHS as a condition of approval, whether the template has been utilized in contracting with a Network Provider. Vaya will discontinue use of previously submitted contract templates once an amended version is approved by NCDHHS.
2. If a new contract template is developed at, any time, Vaya will submit the new template to the Department for approval at least ninety (90) days before use with a Network Provider.
3. The Legal Team reviews templates no less than annually.
4. Templates will be designed to address each of the following provider types at minimum:
   A. Licensed Independent Practitioner (LIP);
   B. Agency/Facility; and
   C. Hospital and/or Health System.
5. All Network Contracts will contain the following elements at minimum:
   A. Full legal name of all individuals or entities that are a party to the contract [N-NM 9(a)];
   B. Correct and complete address where notices are to be sent (generally, the administrative headquarters);
   C. The following or substantially similar Pre-Audit statement: "This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act, N.C. Gen. Stat. § 159-28."
   D. Name and signatures of:
      I. Vaya CFO or designee;
      II. Authorized signatory for the provider, usually the CEO;
      III. Vaya CEO, or a designee
   E. Conditions for participation as a Participating Provider [N-NM 9(b)];
   F. Obligations and responsibilities of Vaya and the Participating Provider, including any obligations for the Participating Provider to participate in Vaya's management, grievance, complaint and/or other programs [N-NM 9(c)];
   G. Events that may result in the reduction, suspension, or termination of network participation privileges [N-NM 9(d)];
   H. The specific circumstances under which Vaya may require access to members' medical records as part of Vaya's programs or health benefits [N-NM 9 (e)];
   I. Health care goods and/or services to be provided and any related restrictions [N-NM 9(f)];
   J. Requirements for claims submission and any restrictions on billing of members [N-NM 9(g)];
   K. Participating Provider payment methodology and fees [N-NM 9(h)];

L. Mechanisms for dispute resolution by Participating Providers [N-NM 9(i)];
M. Term of contract and procedures for terminating the contract [N-NM 9(j)];
N. Requirements with respect to preserving the confidentiality of protected health information [N-NM 9(k)];
O. Prohibitions regarding discrimination against members [N-NM 9(l)];
P. Requirement that the Participating Provider comply with all applicable federal and state laws, rules, regulations, and payor program requirements, including but not limited to the Vaya Provider Operations Manual;
Q. All mandatory provisions required to be included by the Managed Care Contract, including but limited to, the provisions set forth in Section II., Paragraph 20A.-H. and Paragraph 21A.-H above;
R. The NCDHHS IHCP Addendum template for IHCPs; and
S. To the extent applicable and accepted by the contracting party, indemnification and/or exculpatory terms that have been reviewed and approved by the General Counsel or designee.

6. The Network Contract shall not include:
    A. Any clauses or language that could restrict Participating Providers from discussing matters relevant to Members' health care [N-NM 8(a)]
    B. Any clauses or language that prohibits or restricts a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient regarding:
        I. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
        II. Any information the Member needs to decide among all relevant treatment options.
        III. The risks, benefits, and consequences of treatment or non-treatment.
        IV. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
    C. A definition of "medical necessity" that emphasizes cost or resource issues above clinical effectiveness [N-NM 8(b)]
    D. Any exclusivity or non-compete provisions in contracts with providers or otherwise prohibit a provider from providing services for or contracting with any other BH I/DD Tailored Plan
    E. Any provisions prohibited by N.C. Gen. Stat. § 58-50-295.
7. In addition to the Network Contract, the Contracts Team shall assemble all other applicable attachments, appendices or other documents requiring signature, including but not limited to:
    A. Scope(s) of Work;
    B. Vaya Value Based performance metrics;
    C. Compensation Schedule;
    D. Specific Provider Type Attachments (e.g., advanced medical homes, care management agencies, IHCPs, MH/SUD/IDD/TBI Services providers, non-Medicaid non-Fee-for-Service providers, primary care and specialty care physical health providers, local health departments, pregnancy management programs, laboratories, imaging service providers, and dental providers)
    E. Finance Attachments;
    F. Federally Required Certifications;
    G. Electronic Funds Transfer (EFT) Form;
    H. Access Agreements for Vaya software platforms;

I. Trading Partner Agreement (TPA);
J. IRS Form W-9;

Section IV: Contract Renewals

1. NSMC is responsible for making recommendations about whether to renew Medicaid Network Contracts in accordance with the Vaya Out of Network Authorizations and Contracting policy and Network Access Plan. Executive Leadership Team is responsible for reviewing and either approving, amending, or rejecting NSMC recommendations.
2. Renewals of non-Medicaid funded Network Contracts are made by the NSMC based on available federal, state, county, and grant funding allocations and applicable provisions of the Vaya Out of Network Authorizations and Contractingpolicy
3. ELT, or its designee, must notify the Contracts and Procurement Team of non-renewals for Network Contracts at least thirty (30) days prior to the termination date of any Network Contract. Failure to meet this deadline may result in issuance of contract extensions or non-payment of claims. Vaya shall not pay any claims for services delivered after the termination date of any Network Contracts, unless reimbursement is approved by the CEO or CFO or respective designee, a valid extension has been executed by Vaya and the Network Provider, or in accordance with the requirements of 42 CFR §438.114(c)(i).
4. The PNO department is responsible for preparing comprehensive lists identifying the Network Providers selected for renewal and the types of contract (e.g., non-Medicaid/ Medicaid, length of term, specific attachments/appendices) for the Contracts Team to generate the contracts. Any changes to the Network Contract terms (i.e., sites, services, or funding allocation) require PNO to initiate a request in the Platform through the procedure described above
5. The Contracts Team shall generate notifications of non-renewal using a template approved by the General Counsel, and the notification must be delivered to the Network Provider at least thirty (30) days prior to the termination date of the Network Contract.
6. The Contracts Team shall generate the renewal contracts using templates approved by NCDHHS and follow Steps 9-16 in Section II above.
7. In the case of Subcontractors, the renewal of Open Network Contracts shall be conducted in Good Faith and in accordance with the Subcontractor's applicable policies and the terms and conditions of the Subcontractor Contract.

Section V: Provider Contracting Disputes

1. Vaya shall give written notice to any Applicant with whom it declines to contract within five (5) Business Days after Vaya makes its final decision. The notice shall include the reason for Vaya's decision, the Provider's right to appeal that decision, and how to request an appeal.
2. Closed Network Provider and, in the case of Medical Services, Open Network Provider dispute resolution shall be conducted in compliance with Vaya's applicable policies, including, but not limited to, Provider Dispute Resolution Policy, the Provider Operations Manual, and the Network Contract.
3. In the case of Subcontractors, Open Network Provider dispute resolution shall be conducted in compliance with respective Subcontractor's applicable policies, the terms and conditions of their contract with Vaya, and the terms and conditions of their contract with the provider.

Related Documents (all hyperlinked)
Forms:
Referenced Policies: Out of Network Authorizations and Contracting, Out of Network Authorizations and Contracting, Out of Network Authorizations and Contracting, Out of Network Authorizations and Contracting, Out of Network Authorizations and Contracting, Out of Network Authorizations and Contracting ; Out of Network Authorizations and Contracting
Other:

Standards:
NCQA: QI 3(A), QI 3(B)
URAC: N-NM-07, N-NM-08, N-NM-09, N-NM-10, N-NM-11
Supersedes: v.4 Network Provider Agreements