NETWORK PROVIDER PARTICIPATION AGREEMENT BY AND BETWEEN
VAYA HEALTH, A NORTH CAROLINA PREPAID HEALTH PLAN, ("Vaya"),
AND INSERT NAME, A NORTH CAROLINA INSERT ENTITY TYPE, ("Contractor")
(hereinafter individually referred to as a "Party", and collectively as the "Parties")

WHEREAS, on July 23, 2021 the North Carolina Department of Health and Human Services (the "Department" or "NCDHHS"), in furtherance of the State's transformation from a predominantly Medicaid fee-for-service to managed care, on July 23, 2021 awarded Vaya a contract to operate a Behavioral Health and Intellectual/Developmental Disabilities ("BH I/DD") Tailored Plan currently scheduled to launch December 1, 2022 ("Tailored Plan Launch Date"); and

WHEREAS, Vaya and Contractor desire to enter into this Contract, which sets forth the rights, responsibilities, terms, and conditions governing (i) the status of Contractor and (ii) Contractor's provision, or arrangement for provision, of Covered Services to Members, in exchange for payment; and

WHEREAS, this Contract, consisting of this Provider Participation Agreement along with all Attachments as defined herein, is designed to address the duties and obligations as between the Parties (as further set forth in **Articles I, II, V, VI, VII, and VIII**), the duties and obligations as to Contractor (as further set forth in **Article III**), duties and obligations as to Vaya (as further set forth in **Article IV**), and those duties and obligations as to Contractor (as further set forth in Exhibits A and B, Schedules A and B, and Addenda A-G and attachments thereto).

NOW THEREFORE, in consideration of the above recitals, the mutual covenants contained herein, and other good and valuable consideration, the receipt of which is hereby acknowledged, the Parties agree as follows:

ARTICLE I: DEFINITIONS

1.0 In this Contract, the following capitalized words, terms, and acronyms shall have the following special meanings, and the use of the singular of any of these words, terms, or acronyms herein shall be construed to include the plural and vice versa. If an identical term is defined in an Attachment, the definition in the Attachment shall control with respect to all or part of the Attachment. Any term not otherwise specified in the Contract shall have the same definition and meaning as in N.C.G.S. § 122C-3 or 42 CFR Part 438.

1.1 **"1115 Demonstration Waiver**" means the North Carolina Medicaid Reform Demonstration health plan waiver authorized and approved by the federal Centers for Medicare and Medicaid Services ("CMS") pursuant to Section 1115(a) of the Social Security Act for the transition of North Carolina's Medicaid program from fee-for-service to a managed care program.

1.2 "**1915(c) Innovations Waiver"** or **"Innovations Waiver**" means the North Carolina Home and Community Based Services ("HCBS") Innovations Waiver authorized and approved by CMS pursuant to Section 1915(c) of the Social Security Act.

1.3 **"1915(c) TBI Waiver"** or **"TBI Waiver"** means the North Carolina HCBS Traumatic Brain Injury waiver authorized and approved by CMS pursuant to Section 1915(c) of the Social Security Act.

1.4 **"Administrative Action"** means a decision, action, or inaction taken by Vaya, or one of its Subcontractors, against Contractor that does not result in a change to Contractor's status within the Vaya Network. This includes, but is not limited to, a claim denial, payment withholding, payment suspension, and Overpayment determination.

1.5 **"Advanced Medical Home"** or **"AMH"** means the State-designated primary care practices that have attested to meeting standards necessary to provide local care management services.

1.6 **"Advanced Medical Home Plus"** or **"AMH+"** means primary care practices certified by the Department as AMH Tier 3 practices, whose providers have experience delivering primary care services to the Tailored Plan eligible population or can otherwise demonstrate strong competency to serve that population and have been certified as such.

1.7 **"Adverse Benefit Determination"** means as defined in 42 CFR § 438.400(b).

1.8 **"Attachment"** means any addendum, attachment, exhibit, or schedule of the Contract.

1.9 **"Behavioral Health**" or **"BH"** refers to mental health and substance use disorder.

1.10 "**Behavioral Health I/DD Tailored Plan**" or **"Tailored Plan"** refers to the health plan specifically designed to provide integrated Medicaid and non-Medicaid care and services, as described in Section 4.(1) of N.C. Session Law 2015-245, as amended by Session Law 2018-48, and further amended from time to time, and as defined in N.C. Gen. Stat. § 108D-1(4).

1.11 "**Business day**" means a day Vaya is officially open for business, and does not include any Saturdays, Sundays, Vaya-recognized holidays, or days that Vaya is closed due to inclement weather.

1.12 **"Care Coordination"** means the act of organizing patient care activities and sharing information among all the participants involved with a member's care to achieve safer and more effective care. Through organized care coordination, member needs and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate, and effective care.

1.13 **"Care Management"** means a team-based, person-centered approach to effectively managing patients'

1.14 medical, social, and behavioral conditions. Care Management shall include, at a minimum, those care management functions listed in the Managed Care Contract.

1.15 **"Care Management Agency"** or **"CMA"** means a provider organization with experience delivering BH, I/DD, and/or TBI services to the Tailored Plan eligible population that will hold primary responsibility for providing Tailored Care Management to Members assigned to it, as certified by the NCDHHS (prior to the Tailored Plan Launch Date) or by Vaya (on or after Tailored Plan Launch Date).

1.16 **"Care Management for At-Risk Children"** means care management services provided to a subset of the Medicaid population ages 0-5 identified as being "high-risk."

1.17 **"Care Plan"** means a written, individualized, person-centered plan of care for Members with BH or I/DD needs, that is developed using a collaborative approach led by the Member or their LRP when appropriate, incorporates the results of a comprehensive assessment, and identifies the Member's desired outcomes and the training, therapies, services, strategies, and formal and informal supports needed for the Member to achieve those outcomes. For individuals enrolled in the Innovations Waiver, the Care Plan also documents the waiver services that a Member is authorized to receive.

1.18 **"Carve Out Services"** means services that are carved out of Medicaid Managed Care pursuant to N.C.G.S. § 108D-35; as specified in 42 CFR § 438.210; and as otherwise noted in *Section V.B.2. Table 1: Services Carved Out of Medicaid Managed Care* or elsewhere in the Managed Care Contract.

1.19 **"CHIP"** refers to and means the Children's Health Insurance Program administered by the U.S. Department of Health and Human Services ("HHS") under which a state receives federal funding, through Medicaid and/or a separate CHIP, to provide health assistance to low-income children.

1.20 "**Clean Claim**" means a Medical Claim or Pharmacy Claim for a Covered Service that (i) can be processed without obtaining additional information from the provider or from a third party, (ii) is timely received by Vaya, (iii) is on a completed, legible CMS 1500 form or UB 04 form, or electronic equivalent, and (iv) is true, complete, accurate. It does not include a claim from a provider who is under investigation for fraud or abuse, a claim under review for medical necessity, a claim subject to coordination of benefits, or a claim that cannot be successfully processed through NCTracks as an encounter. For purposes of Medicaid claims, "Clean Claim" means as defined in 42 CFR § 447.45(b).

1.21 "**Clinically Integrated Network"** is an entity with which provider practices can voluntarily choose to partner to share responsibility for specific functions and operational capabilities, including but not limited to functions of AMHs, performance metrics reporting, data aggregation, risk stratification, and Care Management.

1.22 **"Closed Network (or "Vaya Closed Network)**" means the network of providers who have been Credentialed in accordance with Controlling Authority and selected or retained, enrolled, and contracted with Vaya to furnish MH/SU/IDD/TBI Services to Members, or as defined in N.C.G.S. § 108D-1(6).

1.23 "**Contract**" means this Network Provider Participation Agreement by and between Vaya and Contractor, including any and all Attachments incorporated herein.

1.24 **"Contractor"** means [insert name of Contractor], the provider of healthcare services pursuant to this Contract.

1.25 **"Controlling Authority"** means any and all applicable federal, state, or local government constitution, charter, act, statute, regulation, code, ordinance, specified standards, guidance (including the terms and conditions of Vaya's Managed Care Contract, any bulletins from NCDHHS relating to Contractor's services, and all federal and state Early Periodic Screening, Diagnostic and Treatment ("EPSDT") requirements), or objective criteria contained in any applicable permit or approval, or other legislative or administrative action of the United States of America or any state, or any agency, department, political subdivision, or other instrumentality of either,

including but not limited to the NCDHHS, Centers for Medicare and Medicaid Services ("CMS"), or any standards or criteria promulgated by the National Committee for Quality Assurance (NCQA), URAC (f/k/a Utilization Review Accreditation Commission), or other nationally recognized accreditation organizations approved by Vaya; or any decree, judgment, or order of a court or other government tribunal. Controlling Authority may apply directly to Contractor, directly to Vaya, or indirectly to Contractor through its performance of services under the Contract. Controlling Authority includes, but is not limited to, the requirements listed in Section 2.3.

1.26 **"Covered Services"** means any and all Medically Necessary health care items, services, and/or supplies covered under a Vaya Benefit Plan for which (a) a Member is eligible for coverage and (b) claims are processed and paid by Vaya, rather than one of its Subcontractors, including the PBM and NEMT Broker.

1.27 **"Credentialing"** as used herein means a process to qualify Contractor to potentially be contracted with Vaya and to deliver Covered Services to Members. Credentialing shall also include the process to re-qualify Contractor to potentially continue being contracted with Vaya.

1.28 **"Credentialing Criteria"** means Vaya's criteria for the Credentialing or recredentialing of Providers.

1.29 "**Effective Date"** means the date this Contract becomes effective and as stated in Section 7.1.

1.30 "**Emergency Services**" means as defined in 42 CFR § 438.114.

1.31 "**Encounter Data**" means encounter information, data, and reports for Covered Services provided to a Member that meets the requirements for Clean Claims.

1.32 **"Exclusion List"** means lists or databases 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: (a) State Exclusion List; (b) U.S. Department of Health and Human Services, Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE); (c) The System of Award Management (SAM); (d) The Social Security Administration Death Master File (SSADMF); (e) National Plan and Provider Enumeration System (NPPES); and (f) Office of Foreign Assets Control (OFAC).

1.33 **"Federal Health Care Program"** means a federal health care program as defined in section 1128B(f) of the Act and includes Medicare, Medicaid, and CHIP.

1.34 **"Governmental Authority"** means the United States of America, the State of North Carolina, or any department or agency thereof having jurisdiction over Vaya, a provider or their respective affiliates, employees, subcontractors, or agents.

1.35 "**Health Services**" means those services, supplies, or items that a healthcare provider is licensed/ certified/ registered, equipped, and staffed to provide and which the provider customarily provides to or arranges for individuals.

1.36 "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, as amended by Section 1104 of the Patient Protection and Affordable Care Act of 2010 (Pub L. 111-148), amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), (together, the Affordable Care Act), and by the Health Information Technology for Economics and Clinical Health Act (HITECH Act) enacted as part of the American Recovery and Reinvestment Act of 2009, and their implementing regulations, including the HIPAA Administrative Simplification Rules codified at 45 CFR Parts 160, 162 and 164.

1.37 **"Ineligible Person"** means a Person who (a) is then-currently excluded, debarred, suspended or otherwise ineligible to participate in (i) a federal health care program and appears on an Exclusion List or (ii) Federal procurement or non-procurement programs, as may be identified in the System for Award Management maintained by the General Services Administration, (b) has been convicted of a criminal offense subject to U.S. HHS Office of Inspector General's ("OIG") mandatory exclusion authority for Federal Health Care Programs

described in section 1128(a) of the Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, (c) is then-currently excluded, debarred, suspended or otherwise ineligible to participate in (i) a state medical assistance programs, including Medicaid or NC Health Choice or (ii) State procurement or non-procurement programs as determined by a State Governmental Authority; or (d) is then-currently excluded, suspended or debarred by any Governmental Authority from conducting any business or activities contemplated by this Contract, whether under its current name or any additional name or former name, including the current or former name of another Person or its respective Owners and Managing Employees.

1.38 "**LME/MCO**" means a "Local management entity/managed care organization" as that term is defined at N.C.G.S. § 122C-3(20c).

1.39 **"Managing Employee"** means as defined at 42 CFR § 455.101.

1.40 **"Managed Care Contract"** means the contract between Vaya and the Department concerning Vaya's operation of the Tailored Plan and provision of health benefits coverage for Members.

1.41 **"MCO"** means Managed Care Organization as defined at 42 CFR § 438.2.

1.42 **"Medical Claim"** means a request for a payment that a Contractor submits to Vaya for rendered medical services, including physical health, behavioral health, pharmacy, I/DD, and TBI services. Claims for non-emergency medical transportation services are excluded from the scope of this Contract.

1.43 "**Medical Necessity**" or "**Medically Necessary**" is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. As required by 10A NCAC 25A.0201, a medically necessary service may not be experimental in nature.

1.44 **"Member**" includes the term "Enrollee" as referenced in 42 CFR Part 438 and also refers to any of the following, as applicable to the services arranged for delivery or delivered by Contractor: (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 the Tailored Plan, including, but not limited to, Innovations Waiver participants; (b) a State-funded Services recipient who is eligible for and enrolled in the Tailored Plan, including individuals who receive MH/SU/IDD/TBI services funded with state, county, and/or federal block grant dollars; or (c) the legally responsible person for a Member who is a minor or who has been adjudicated incompetent.

1.45 "**Member Expenses**" means copayments, coinsurance, deductibles, or other cost share amounts, if any, that a Member is required to pay for Covered Services under the Tailored Plan.

1.46 "**Menu"** or **"Sites and Services Menu"** means the billing codes, rates, credentialed sites, and reimbursable Covered Services identified in Contractor's MCIS profile and/or Provider Portal.

1.47 "**MH/SU/IDD/TBI Services**" means those mental health ("MH"), substance use ("SU"), intellectual and/or developmental disabilities ("I/DD" or "IDD"), and/or traumatic brain injury ("TBI") services furnished under this Contract.

1.48 "**NC Health Choice**" means the North Carolina Health Choice (NCHC) Health Insurance Program for Children authorized by G.S. §108A-70.25 and as set forth in the North Carolina State Plan of the Health Insurance Program for Children. NC Health Choice is a CHIP and a comprehensive health coverage program for low-income children who do not qualify for Medicaid, cannot afford private or employer-sponsored health insurance, and determined eligible by a county Department of Social Services in Vaya's Region.

1.49 "**NCTracks**" means the Department's Medicaid Management Information System (MMIS).

1.50 **"NEMT Broker"** means an entity that fulfills non-emergency medical transportation (NEMT) services through a subcontracted transportation provider network and processes claims from, and pays Clean Claims to, its

subcontracted transportation providers. The NEMT Broker is a "broker" as that term is defined at N.C.G.S. § 62-3(1a) and is also a "brokering transportation network company" as that term is defined at N.C.G.S. § 20-280.1. The NEMT Broker is a Subcontractor by virtue of its agreement with Vaya.

1.51 "**Network Provider**" or **"Participating Provider"** includes (a) a provider of physical health and/or pharmacy services that is enrolled and credentialed in accordance with Controlling Authority and has, or will have, a contract in effect with Vaya, or one of its Subcontractors, for participation in the Vaya Open Network and to order, refer, or render covered healthcare services, supplies, or items to Members, and also (b) a provider of MH/SU/IDD/TBI Services that is enrolled and credentialed in accordance with Controlling Authority and selected or retained by Vaya to provide services to Members and that has a contract, or will have, in effect for participation in the Vaya Closed Network. The types of Network Providers include, but are not limited to, the following: advanced medical homes ("AMH"), AMH+, CMAs, Division of State Operated Healthcare Facilities, federally qualified health centers, hospitals/health systems, Indian Health Care Providers, laboratories, licensed practitioners or group of licensed practitioners, local health departments, non-emergency medical transportation vendors or providers, pharmacies, prescribers, rural health centers, and x-ray centers. It also means a "participating provider" as that term is used by URAC, and "Network Provider" as that term is defined in 42 CFR § 438.2. All providers delivering healthcare services to State-funded Services recipients must be Network Providers. Contractor is a Network Provider.

1.52 "**Notice"** means a written communication between the Parties delivered as set forth in the Notice block on the Signature and Notice Page of the Contract or as otherwise specified in the Contract.

1.53 **"Overpayment"** means the payments a Provider receives from Vaya, or one of its Subcontractors, to which the Provider is not entitled, including but not limited to payments (a) for Health Services that are not Covered Services, (b) paid in error, (c) resulting from enrollment or encounters errors, (d) resulting from claims payment errors, data entry errors or incorrectly submitted claims, or (e) for claims paid when Vaya was the secondary payor and the Provider should have been reimbursed by the primary payor. An Overpayment also includes any payment Vaya makes to satisfy an obligation of a Provider, including refunds of improperly collected Member Expenses to a Member or reimbursement to a subcontracted Provider.

1.54 "**Owner**" means a person, limited liability company, partnership, association, or corporation with an ownership or control interest in the Contractor as set forth at 42 CFR § 455.101, including, but not limited to, all officers, members, directors, managers, and partners of Contractor.

1.55 **"Part 2 Program"** means as defined at 42 § CFR 2.11.

1.56 **"Pharmacy Benefit Manager"** or **"PBM"** means an entity which contracts with pharmacies on behalf of Vaya and administers or manages prescription drug benefits by performing at least the following functions in accordance with Controlling Authority: (a) processing claims for prescription drugs or medical supplies and (b) pays pharmacies or pharmacists for prescription drugs or medical supplies that are Medically Necessary and timely submitted as Clean Claims.

1.57 **"Pharmacy Claim"** means a request for payment that Contractor submits to Vaya for rendered pharmaceuticals or pharmacy services, including outpatient pharmacy (point-of-sale claims) as well as physician-administered (professional claims) drug claims. Pharmacy Claims handled by the PBM are excluded from the scope of this Contract.

1.58 **"PDM/CVO"** means a NCQA-certified "Provider Data Management/Credential Verification Organization" under contract with the Department, which will facilitate the provider enrollment process, including the collection and

verification of provider education, training, experience, and competency, for the Department's centralized credentialing process.

1.59 **"Person"** means any individual, corporation, estate, partnership, joint venture, association, joint stock company, limited liability company, trust, unincorporated association, or government or any agency or political subdivision thereof, or any other entity of whatever nature.

1.60 "**PHI**" means "protected health information," as that term is defined by HIPAA.

1.61 **"Post stabilization Services" or "Post stabilization Care Services**" mean as defined in 42 CFR § 422.113 and § 438.114.

1.62 **"Prepaid Health Plan"** means as defined at N.C.G.S. § 108D-1(30).

1.63 **"Program Integrity and Other Monitoring Activities"** mean activities to include, but not limited to, audits, claims adjudication reviews, investigations, post-payment reviews, routine post-payment monitoring, focused monitoring, utilization reviews, and pre-payment reviews.

1.64 **"Provider"** means (a) Contractor or (b) another Person that is employed or directly or indirectly subcontracted by Contractor to engage in the delivery of, or order or referring for the provision of, Covered Services to Members under this Contract.

1.65 "**Provider Communication**" means written communication(s) from Vaya specifically directed to Network Providers, including Contractor, in the form of electronic or hardcopy provider communication bulletins, news, announcements, and website postings.

1.66 **"Provider Credentialing Transition Period"** means the period before the PDM/CVO achieves full implementation.

1.67 **"Provider Grievance"** means any oral or written complaint or dispute by a Provider over any aspects of the operations, activities, or behavior of the Tailored Plan except for any dispute over for which the Provider has appeal rights.

1.68 **"Provider Portal"** means a Web based application by which Contractor can securely access data that relates (a) to the individuals receiving Covered Services from Contractor.

1.69 **"Provider Sanction"** means a decision, action, or inaction Vaya takes against Contractor, including against its Owners and/or Managing Employees, based on professional competence or conduct or resulting in a change to the Network Provider's status within the Vaya Network, including an adverse Credentialing action and a de-certification of AMH, AMH+ or CMA status. Neither a non-renewal of the Contract nor a non-renewal of participation as a Network Provider is a Provider Sanction, unless explicitly indicated prior to or on the effective date of the non-renewal.

1.70 **"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 of the Contract, Vaya's Region consists 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.

1.71 **"Sensitive Information"** includes, but is not limited to, information governed by: (i) HIPAA, (ii) the Confidentiality of Substance Use Disorder Patient Records laws and regulations codified at 42 U.S.C. 290dd-2 and 42 CFR Part 2, (iii) the N.C. Identity Theft Protection Act at N.C.G.S. §§ 75-61 et seq., (iv) N.C. confidentiality statutes at N.C.G.S. §§ 122C-52 through 122C-56 and implementing regulations, and (v) other applicable laws and regulations governing PHI and personally identifiable information, including, but not limited to, social security numbers and background check information.

1.72 **"Sensitive Information Laws**" mean applicable federal or State law, rule, or regulation against unwarranted disclosure of Sensitive Information.

1.73 **"Standard Plan"** means as defined in N.C.G.S. § 108D-1(36).

1.74 **"State-funded Services**" means BH, I/DD and/or TBI services supported by non-Medicaid funds, including but not limited to, Substance Abuse and Mental Health Services Administration (SAMHSA) block grants to the State, other federal discretionary funds, and State funding that is authorized by the North Carolina General Assembly.

1.75 "**SU"** means substance use, substance use recovery, or substance use disorder.

1.76 **"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 Provider is not considered a Subcontractor by virtue of a provider participation agreement with Vaya. Contractor is not a Subcontractor by virtue of this Contract.

1.77 **"Tailored Care Management"** means the Care Management model for Members under the Tailored Plan.

1.78 **"Telehealth"** means the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations.

1.79 **"Transition of Care"** means the process of assisting a member to transition between Tailored Plans, from Standard Plans to Tailored Plans, and/or between delivery systems, including transitions that result in the disenrollment from managed care. Transition of Care also includes the process of assisting a member to transition between providers upon a provider's termination (voluntary or involuntary) from the Vaya Network.

1.80 "**TBI**" means traumatic brain injury.

1.81 "**Vaya**" means Vaya Health or its successor, an LME/MCO.

1.82 "**Vaya Benefit Plan**" means an array of services and benefits offered by Vaya to eligible Members. Vaya will be contracted with the Department to manage the 1115 Demonstration Benefit Plan, the 1915(c) Innovations Waiver Benefit Plan, the State-funded Services Benefit Plan, the Medicaid Direct Benefit Plan, and the 1915(c) Traumatic Brain Injury Benefit Plan (when expanded to Vaya's Region). Vaya reserves the right to add additional Department-contracted Benefit Plans to this Contract as set forth in Section 2.2.4.2 of this Contract.

1.83 "**Vaya Network**" means the network of providers who have been enrolled and credentialed in accordance with Controlling Authority and selected and/or retained and contracted as a Network Provider with Vaya to furnish Covered Services to Members.

1.84 "**Vaya Provider Manual**" refers to the operational and administrative requirements, policies, procedures, guidelines, and instructions for Network Providers contained in the Provider Operations Manual published on the Vaya website and as further described in Sections 3.18 of this Contract.

ARTICLE II: CONSTRUCTION, PURPOSE, CONTROLLING AUTHORITY, CONFIDENTIALITY OF INFORMATION

2.1 **Construction**. The following rules of construction apply to this Contract: (a) the word "include", "including" or a variant thereof shall be deemed to be without limitation; (b) the word "or" is not exclusive; (c) the word "day" means calendar day unless otherwise specified; (d) all words used in this Contract will be construed to be of such gender/non-binary or number as the circumstances require; (e) references to specific laws, statutes, regulations, rules, or forms, such as CMS 1500 and UB-04 forms, include subsequent amendments or successors

to them; and (f) references to a government department or agency include any successor departments or agencies.

2.2 Purpose and Scope.

2.2.1 Contractor enters into this Contract with Vaya for the purpose of participating in the Vaya Network and arranging for, providing, and/or ordering Medically Necessary Covered Services to Vaya Member(s) in accordance with this Contract. The Parties understand, acknowledge, and agree that this Contract is required by 42 CFR § 438.206 and § 438.214, 10A NCAC 27A .0106, and/or the Managed Care Contract for Contractor to be reimbursed for Covered Services.

2.2.2 Contractor 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 CFR § 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.

2.2.3 Participation in the Vaya Network is not, and shall not be construed to mean, participation in the North Carolina Medical Assistance Program as contemplated in N.C.G.S. Chapter § 108C-2(1).

2.2.4 Contractor shall be a Network Provider for all Covered Services stated in its respective Sites and Services Menu made part of this Contract and accessible through the Vaya Provider Portal or MCIS.

2.2.4.1 Changes to Covered or Carve Out Services: Contractor shall immediately accept any changes to Covered Services or Carve Out Services that Vaya implements after Vaya receives notification of the change by the Department, unless otherwise indicated.

2.2.4.2 Changes to Benefit Plans: Material and substantial changes to any Vaya Benefit Plan(s) shall be posted on the Vaya website at least thirty (30) days in advance of any such change, unless a shorter time period is required due to a change in funding or other change imposed by any oversight authority, including CMS or the Department. From time to time during the Term of this Contract, Vaya may develop new benefit plan(s). In such instance, Contractor shall be provided with thirty (30) days' written notice via a Provider Communication prior to implementation of the new benefit plan(s). If Contractor does not object in writing to the implementation within such thirty (30) day notice period, Contractor shall be deemed to have accepted participation in the new benefit plan(s) as a Network Provider. In the event Contractor objects to any such new benefit plan, Vaya and Contractor shall confer in good faith to reach agreement on terms of participation. If such agreement cannot be reached, such new benefit plan shall not apply to this Contract. Notwithstanding the foregoing language in this Section 2.2.4.2 or other language to the contrary, if Contractor is a credentialed physician, physician extender, or other licensed health care practitioner (i.e., LCSW, LP, NP, LMFT, etc.), including as a licensed independent practitioner (LIP)/ or physician practice group, Contractor acknowledges, agrees, and understands that Vaya may in its sole discretion require Contractor, as a condition of contracting, including extending or renewing the Contract, to participate in one or more Vaya Benefit Plan(s), including any such new benefit plan.

2.2.5 This is not an exclusive agreement for either Party and there is no guarantee that any particular Vaya Benefit Plan will remain in effect. Vaya has the right to enter into a contract with any other provider of Covered

Services. Contractor shall have the right to enter into other contracts with any other PHP or third-party payor to furnish services.

2.2.6 Vaya may refer Members to Contractor for services based on Medical Necessity and the Member's individual choice. Vaya reserves the right to refer Members to Contractor and to any other providers, and no referrals or authorizations are guaranteed to take place under this Contract. Subject to Controlling Authority and other applicable laws, Vaya is not obligated to refer or assign a minimum number of Members to or maintain a minimum number of Members with Contractor.

2.2.7 Subject to Controlling Authority and other applicable laws, Vaya reserves the right, in its discretion, to develop and market distinct provider networks in which Contractor may not be selected to participate, or to lease or subcontract the Vaya Network to a third party, including, but not limited to, an accountable care organization, a health insurance organization, a health management organization, or other PHP or managed care organization, in any form.

2.2.8 Subject to Controlling Authority and other applicable laws, Vaya reserves the right to approve Contractor's participation under this Contract, or to terminate, suspend, or exclude Contractor from participation under this Contract or one or more particular Vaya Benefit Plan, pursuant to the terms of the Contract.

2.3 Controlling Authority. Contractor shall perform pursuant to this Contract in accordance with Controlling Authority, which shall include, but not be limited to:

2.3.1 Any and all applicable federal, state, or local government constitution, charter, act, statute, regulation, code, ordinance, specified standards, or guidance, including but not limited to Titles XIX and XXI of the Social Security Act (the "Act") and their implementing regulations; the North Carolina State Plan for Medical Assistance and of the Health Insurance Program for Children; all applicable Medicaid Waivers; 42 C.F.R. §§ 455 and 438; N.C.G.S. §§ 108A,108D, 122C, 131D, and 131E; Sensitive Information Laws; civil and criminal laws, rules, and regulations governing the provision of publicly-funded health care services, including, but not limited to, the Anti-Kickback law codified at 42 U.S.C. § 1320a-7b(b) and its implementing regulations; the federal False Claims Act, 31 U.S.C. §§ 3729 – 3733 and its implementing regulations; Early Periodic Screening, Diagnostic and Treatment ("EPSDT") requirements; Department medical and/or clinical coverage policies; Department's claims and billing assistance guide; any bulletins from NCDHHS relating to Contractor's performance pursuant to this Contract; the Department's Record Retention and Disposition Schedule for DMH/DD/SAS Provider Agency

2.3.2 The terms and conditions of Vaya's Managed Care Contract, Vaya *In Lieu of* Service Definitions approved by the NC Division of Health Benefits (DHB), and the Vaya Provider Manual;

2.3.3 All federal and state, objective criteria contained in any applicable permit or approval; or other legislative or administrative action of the United States of America or any state, or any agency, department, political subdivision, or other instrumentality of either, including but not limited to the NCDHHS, Centers for Medicare and Medicaid Services ("CMS"); or any standards or criteria promulgated by the National Committee for Quality Assurance (NCQA), URAC (f/k/a Utilization Review Accreditation Commission), or other nationally recognized accreditation organizations approved by Vaya; and any decree, judgment, or order of a court or other government tribunal;

2.4 Applicability. Controlling Authority may apply directly to Contractor, directly to Vaya, or indirectly to Contractor through its performance pursuant to this Contract.

2.5 Compliance. Contractor understands that Controlling Authority may be revised, amended, or updated during the Term (defined in Section 7.1 below) of this Contract, and Contractor agrees to maintain knowledge of Controlling Authority and any changes thereto, to deliver, or ensure delivery of, services in accordance with Controlling Authority, and to provide education and training on Controlling Authority to its Owners, Managing Employees, other employees, partners, representatives, affiliates, agents, and subcontractors of any tier to ensure compliance with same. If Contractor delivers Medicaid-reimbursable services, Contractor shall develop and implement a compliance program in accordance with Controlling Authority, including 42 U.S.C. §1396a(kk)(5), 42 CFR § 438.608 and the Deficit Reduction Act of 2005.

2.5.1 Compliance with State and Federal Laws: Contractor acknowledges, understands, and agrees that it is subject to, and shall comply with, 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 Managed Care Contract, and all persons and entities receiving State and federal funds. Contractor understands and agrees that any violation by Contractor of a State or federal law relating to the delivery of services pursuant to this Contract or any violation of the Managed Care Contract could result in liability for money damages, including liquidated damages, and/or civil or criminal penalties and sanctions under State and/or federal law.

2.5.2 Compliance with Vaya's Requirements: In performing its responsibilities and duties pursuant to this Contract, Contractor shall comply with Vaya's utilization management programs, quality management programs, and provider sanctions programs, provided that none of these shall override the professional or ethical responsibility of Contractor or interfere with Contractor's ability to provide information or assistance to its patients. Contractor shall cooperate with Vaya with respect to compliance with Controlling Authority and shall not knowingly take any action contrary to Vaya's obligations under Controlling Authority.

2.5.3 Department's External Quality Review: Contractor shall comply and cooperate with External Quality Review Organization ("EQRO") network adequacy validation and activities including: (a) Annual validation of the network adequacy and compliance with state and federal network requirements of the Tailored Plan Medicaid Program and state network requirements of the Tailored Plan State-Funded Program; and (b) Telephone surveys of Vaya Network Providers to verify the accuracy of reported data or other aspects of program requirements or performance.

2.5.4 E-Verify: Contractor shall comply the requirements of Article 2 of Chapter 64 of the State of North Carolina General Statutes. Further, if Contractor utilizes a subcontractor(s) of any tier, it shall require its subcontractor(s) of any tier to comply with the requirements of Article 2 of Chapter 64 of the North Carolina General Statutes.

2.5.5 N.C. Health Information Exchange: Contractor shall be connected to the North Carolina Health Information Exchange ("HIE") Network and shall submit data through the HIE Network pertaining to Covered Services rendered to Members and/or paid for with Medicaid, NC Health Choice, or other State health care funds in accordance with the timeline and other requirements set forth in N.C.G.S. § 90-414.4.

2.6 Communication with Members. Notwithstanding anything to the contrary in this Contract, Contractor may freely discuss matters relevant to a Member's health care or treatment and freely communicate with, provide information to, or advocate for, Members regarding any or all service, supply, or treatment options regardless of Vaya Benefit Plan coverage limitations. Vaya does not dictate or control clinical decisions respecting a Member's medical treatment or care. Medical care is the responsibility of the treating provider regardless of any coverage or payment

determination by Vaya. Nothing in this Agreement shall be interpreted to permit interference by Vaya with communications between Contractor and a Member regarding the Member's medical condition or available health care or treatment options.

2.7 Confidentiality of Protected Health Information and Sensitive Information. The Parties shall protect and maintain the confidentiality of any and all Members, including Member PHI, Sensitive Information, and/or other information protected by law from disclosure, and will not discuss, transmit, or narrate in any form any Member's information of a personal nature, medical or otherwise, received in the course of providing services or overseeing the provision of services hereunder, as authorized in writing by the Member or legally responsible person or as otherwise permitted or required under Sensitive Information Laws. This confidentiality requirement applies to any medium of communication, including, but not limited to, social media. The Parties understand, acknowledge, and agree that Vaya is a health plan, Contractor is a health care provider and as such, the Parties are considered "Covered Entities" pursuant to HIPAA and may share PHI related to Member(s) for the purposes of treatment, payment, or health care operations without the Member's consent. The Parties agree that such PHI shall be used solely to carry out the terms, conditions, and obligations of this Contract and shall be kept confidential and securely protected in accordance with all applicable Sensitive Information Laws. This Section 2.7 and all of its subparts shall survive suspension, expiration, or termination of this Contract.

2.7.6 Privacy and Security Officer: Contractor designated a HIPAA Privacy Officer and Security Officer as required by HIPAA in the provider contract request form completed prior to contracting with Vaya. Any changes to such information must be sent to Vaya at Provider.Info@vayahealth.com. Contractor's Security Officer, or designee, shall be responsible to validate those members of its staff who can access Vaya's Software Platforms as referenced in **Exhibit A**.

2.7.7 HIPAA Retention Period: Contractor shall maintain and retain for at least six (6) years following termination or expiration of this Contract such records as may be needed for an accounting of disclosures of PHI as required under HIPAA and for Vaya's evaluation of Contractor's compliance with this Contract.

2.7.8 Population Heath Activities: If a Party's population health management activities require the disclosure of substance use information, each Party acknowledges that, in receiving, storing, processing, or otherwise dealing with patient records from a Part 2 Program, it is fully bound by 42 C.F.R. Part 2, that applicable disclosures will include the notice required in 42 C.F.R. § 2.32, and that, if necessary, said Party will resist in judicial proceedings any efforts to obtain access to patient-identifying information related to substance use disorder diagnosis, treatment, or referral for treatment except as permitted by 42 C.F.R. Part 2.

2.7.9 Substance Use Consent: If Contractor is a Part 2 Program and provides substance use disorder services to a Member or provides any services to Members diagnosed with a substance use disorder, then Contractor shall obtain and maintain valid, signed patient consent forms allowing disclosure of such Members' PHI and substance use information to Vaya and the Department.

2.8 **Confidentiality of Non-Public Information; Nondisclosure.** This Section 2.8 and all of its subparts shall survive suspension, expiration, or termination of this Contract.

2.8.1 Confidential Information Belonging to Vaya: The Parties understand, acknowledge, and agree that Contractor may have access to information belonging to Vaya, which is a trade secret as that term is defined in N.C.G.S. §

66-152(3), or which is confidential, proprietary, or non-public, including, but not limited to, Vaya's finances, business operations and competitive health care information as described at N.C.G.S. § 122C-126.1, (collectively "Non-Public Information"). Contractor shall not disclose, share, or otherwise disseminate copies of this Contract or any of its terms and conditions to any Person or firm not a party to this Contract, other than to legal counsel retained by Contractor, or to authorized Department representatives. During and after the Term of this Contract, Contractor agrees that, except to the extent necessary to permit Contractor to perform its obligations under this Contract, Contractor shall not use such Non-Public Information, or disclose, divulge, reveal, report, publish, and/or transfer such Non-Public Information to any Person or firm not a party to this Contract, without the prior written consent of Vaya. Contractor agrees to promptly advise Vaya in writing of any unauthorized use or disclosure of Non-Public Information of which Contractor becomes aware, and Contractor shall provide reasonable assistance to Vaya to terminate such unauthorized use or disclosure. If disclosure of Non-Public Information is compelled by law or by a valid court or governmental order, Contractor shall immediately notify Vaya in writing, prior to disclosure, in sufficient time to permit Vaya to contest the disclosure, to seek a protective order, or to waive its objection to disclosure. If disclosure is authorized in such instance, then Contractor shall disclose only that portion of the Non-Public Information that its legal counsel advises is legally required, and Contractor shall notify Vaya in writing of the specific contents of the disclosure. Contractor agrees that the Non-Public Information shall remain the exclusive property of Vaya, and that no license under any trade secret law or copyright law or other law is granted by this Contract. Upon expiration or termination of this Contract, or within five (5) business days after written request by Vaya, Contractor shall return to Vaya all Non-Public Information, in whatever form, including all copies thereof and any documents containing or referencing the Non-Public Information, whether in the possession, custody, or control of Contractor, or another Person or firm. Vaya in its sole discretion may authorize Contractor to destroy the Non-Public Information and all copies thereof, provided that such authorization is in writing and Contractor confirms such destruction in writing to Vaya within five (5) business days of such destruction.

2.8.2 Confidential Information Belonging to Contractor: If Contractor discloses confidential information, as that term is defined in N.C.G.S. § 132-1.2, to Vaya in connection with Contractor's performance of this Contract, Vaya will protect the information from public disclosure to the extent permitted by N.C.G.S. § 132-1.2, provided Contractor complies with N.C.G.S. § 66-152(3). However, the Parties acknowledge that 1 NCAC 5B .1505 and 9 NCAC 6B .1001 specify that price information may not be designated as confidential. Vaya may serve as the custodian of the Contractor's trade secrets but not as an arbiter of claims against the Contractor's assertion of confidentiality. If an action is brought pursuant to N.C.G.S. § 132-9 to compel Vaya to disclose information marked confidential, Contractor, as applicable to the circumstance, agrees that they will intervene in the action through counsel and participate in defending Vaya, and the Department and its officials and employees against the action. Contractor agrees that they shall hold the State and its employees, officials, and agents and Vaya and its officials and employees harmless from any and all damages, costs, and attorneys' fees awarded against Vaya or the State in the action. Vaya agrees to give Contractor prompt written notice of any action seeking to compel the disclosure of Contractor's trade secrets. Vaya and the State shall have the right, at its option and expense, to participate in the defense of the action through its counsel. Vaya and the State shall have no liability to Contractor with respect to the disclosure of Contractor's trade secrets pursuant to an order issued by a court of competent jurisdiction pursuant to N.C.G.S. § 132-9 or any other applicable law.

ARTICLE III: OBLIGATIONS OF CONTRACTOR

3.1 **Credentialing.** The Parties acknowledge, agree, and understand that the Department will establish a centralized credentialing process including a standardized provider enrollment application and qualification verification process and that Vaya will accept provider credentialing and verified information from the Department, or designated Department vendor. The Parties further acknowledge, agree, and understand that Vaya may conduct Credentialing of Contractor before they begin providing Covered Services and may be required to re-Credential Contractor pursuant to the Managed Care Contract and other Controlling Authority. Contractor shall consent to and continuously comply with all Credentialing and re-Credentialing requirements mandated by Controlling Authority and/or any Vaya accrediting body and must meet the Department's applicable Objective Quality Standards, as defined by the Department, and Vaya's Credentialing Criteria.

3.1.1 Frequency of Re-Credentialing: Contractor shall undergo re-credentialing pursuant to Vaya's Credentialing Policy before contract renewal and in accordance with the following time periods:

3.1.1.1 During the Provider Credentialing Transition Period, no less frequently than once every five (5) years from the effective date of initial credentialing by Vaya; and

3.1.1.2 After the Provider Credentialing Transition Period, no less frequently than once every three (3) years from the effective date of initial credentialing by Vaya, unless otherwise changed by the Department.

3.1.2 Continual Enrollment in NC Medicaid: Contractor, and if required, its licensed health care practitioners, shall obtain National Provider Identifiers (NPIs) and shall enroll in, and maintain enrollment in, NCTracks and with the Department as a NC Medicaid provider as required by 42 C.F.R. § 455.410. Contractor shall promptly update all required fields in NCTracks, including but not limited to legal business name, "doing business as" names, NPIs, provider demographic information, zipcode+4 digits, taxonomy codes, service locations, sites, and services, with accurate, current information and may advise Vaya of any corresponding changes required in the MCIS. Failure to maintain enrollment shall result in any action up to and including immediate suspension or termination of this Contract, including automatic suspension and/or revocation of Contractor and/or any of its Owners and Managing Employees, in accordance with Section 7.6.

3.1.3 Tobacco-Free Policy: Contractor shall implement and enforce, a tobacco-free policy covering any portion of the property on which Contractor operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles, except for residential provider facilities as set forth below. A 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 participating providers from purchasing, accepting as donations, and/or distributing tobacco products (combustible and non-combustible products including electronic cigarettes) to the clients they serve. Residential facilities owned or controlled by Contractor and which provide ICF-IID services or residential services that are subject to the Home and Community Based Services ("HCBS") final rule, (1) indoor use of tobacco products shall be prohibited in all provider owned/operated contracted settings; and (2) for outdoor areas of campus, providers shall ensure access to common outdoor space(s) that are free from exposure to tobacco products/use and shall prohibit staff/employees from using tobacco products anywhere on campus.

3.1.4 Maintain Licenses: Contractor shall continuously maintain all licenses, certifications, accreditations, and registrations required for its facilities, employees, and subcontractors providing Covered Services under this Contract. Contractor understands, acknowledges, and agrees that failure to maintain required licenses, certifications, accreditations, or registrations, as applicable, may result in any action up to and including

immediate suspension or termination of this Contract, including automatic suspension and/or revocation of Contractor and/or any of its Owners and Managing Employees, in accordance with Section 7.6.

3.1.5 Practitioners: Contractor may submit claims for Covered Services delivered to Member(s) by Contractor's licensed practitioners upon approval by Vaya of the licensed practitioner's credentials retroactive to the later of the date the licensed practitioner is enrolled in NCTracks or the Effective Date of this Contract. Claims submitted for Contractor and/or its licensed practitioners who are not enrolled in NCTracks and included in the provider enrollment file Vaya receives from the Department will not be paid.

3.1.6 Disclosures: Contractor shall cooperate with Vaya and make any and all disclosures necessary for Vaya to check, prior to contracting, the exclusion status of all providers against the Exclusion Lists to ensure that Vaya does not pay federal funds to Ineligible Persons. Contractor agrees to disclose the required information, at the time of the enrollment application, and/or upon request, in accordance with the Managed Care Contract and 42 CFR § 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 Contractor agree to notify, in writing, Vaya and the Department of any criminal convictions within twenty (20) days of the date of the conviction.

3.1.7 Certification Regarding Exclusion: By executing this Contract, Contractor understands, acknowledges, agrees, and certifies that all information provided to the Department, or to Vaya, as part of the enrollment, credentialing, re-credentialing, or contracting process is true and correct, that any false or misleading information may be cause for denial, revocation, or termination of provider participation in the Vaya Network, and that neither Contractor, nor any of its employees, contractors, or agents, is an Ineligible Person. Contractor further understands, acknowledges, and agrees that a failure to notify Vaya of any change in circumstance following this certification as set forth in Section 3.2 of this Contract may result in immediate termination of this Contract.

3.1.8 Contracting and Enrollment: Contractor provides to Vaya all additional information necessary for Vaya to complete its contracting and enrollment processes and to meet Provider Directory requirements, that are not available through the provider enrollment file Vaya receives from the Department, such as Contractor's legal business name as listed on the N.C. Secretary of State's Office as applicable, and any assumed name (d/b/a) used in North Carolina, Federal tax identification numbers, completed IRS Form W-9, authorized clearing house/billing information, available accommodations, type of service provided, hospitals with admitting privileges (where applicable) and cultural and linguistic competency indicators.

3.2 Notice of Change. Contractor agrees to notify Vaya using a Vaya-approved change request form via email at CredentialingTeam@vayahealth.com within three (3) business days of any of the following changes to information provided in the Credentialing, re-Credentialing, contracting or enrollment processes:

3.2.1 Any change in status to Ineligible Person;

3.2.2 The date the Contractor is notified of a pending investigation for Medicaid fraud, or the filing or disposition of a lawsuit or claim based on malpractice, wrongful death, or other claim relating to the provision of Covered Services;

3.2.3 Issuance of any sanction from a Governmental Authority, PHP, or any other healthcare payor, in which case Contractor shall forward a copy of such notice to Vaya.

3.2.4 The date of any change affecting accreditation or facility or staff licensure, registration, or credentials, including, but not limited to, any sanction imposed by any applicable licensing board, certification, or registration agency, or by any accrediting body or other managed care organization.

3.2.5 Any change to enrollment or contracting information described in Section 3.1.8 above;

3.2.6 Any change to required insurance coverage; and

3.2.7 Any change in Contractor's ability to accept referrals.

3.3 Effect of Change of Ownership. If Contractor's ownership, separate existence, or Person construction (e.g., sole proprietorship, corporation, general partnership, limited partnership, limited liability company) is altered or affected in any way as a result of a merger, consolidation, acquisition, or sale of all or substantially all assets, including, but not limited to, an asset or stock purchase or sale or through any other means whatsoever, Contractor must notify Vaya as outlined in Section 3.2 of this Contract and this Contract shall continue to control with respect to Contractor's contractual obligations unless Vaya agrees otherwise in writing, notwithstanding any contrary outcome which may otherwise be allowed or required by law. If Contractor acquires an ownership interest in another Network Provider, then the existing separate contract between Vaya and such other Network Provider shall control for its duration unless Vaya agrees otherwise in writing.

3.4 Contractor Accessibility. Contractor shall maintain such offices, equipment, patient service personnel and allied health personnel (e.g., occupational therapists, diagnostic medical sonographers, radiographers, respiratory therapists, dieticians, etc.) as may be necessary to provide Medically Necessary Covered Services, which ensures continuity of care.

3.4.1 Start Date: Contractor shall begin serving Members within thirty (30) days from the date of execution of this Contract. If Contractor has not delivered services to Members within thirty (30) days from the date of execution of this Contract, Vaya may terminate this Contract with respect to the Contractor in accordance with Article VII.

3.4.2 Hours of Operation: Contractor shall offer the same hours of operation to all individuals served by Contractor, regardless of the individual's insurance coverage, i.e., the hours of operation offered to Members must be no fewer than the hours of operation that are offered to non-Members, such as commercial enrollees, or that are comparable to NC Medicaid Direct if the Member serves only Medicaid beneficiaries, and *vice versa*.

3.4.3 After Hours Coverage: Contractor shall make Covered Services available twenty-four (24) hours a day, seven (7) days a week, including holidays, when Medically Necessary, either via live coverage, an answering service, or association with another qualified provider. If Contractor or associated provider/ practitioner is not available, Contractor's after-hours message must include instructions for Members to contact the Vaya toll-free crisis and referral hotline, for example, "If your call is not returned by Contractor [or Contractor's designated after-hours service] within 30 minutes, please contact the Vaya toll-free crisis and referral hotline at 1-800-849-6127." Contractor shall not use the Vaya 24/7 Access to Care Line or 24/7 Behavioral Health Crisis Line as its sole mechanism for after-hours coverage.

3.4.4 Appointments and Access to Care Timeframes: Contractor shall comply with the appointment wait time standards for adult and pediatric providers, as applicable, as specified in the applicable Attachment and in the Vaya Provider Manual.

3.4.5 Referrals and Service Delivery: Contractor shall have a "no-reject policy" for referrals within capacity and parameters of their competencies. Subject at all times to the terms of this Contract, Contractor agrees to accept all referrals meeting criteria for Covered Services when there is available capacity and to provide Covered

Services to Members within the scope of the Contractor's competency to meet individual referral needs and in accordance with Controlling Authority, applicable Vaya Benefit Plan(s) and Contractor's licenses, certifications, credentialing privileges, prevailing practices, and standards of the profession. Failure to accept referrals or to provide Covered Services in accordance with this Section 3.4.5 shall be considered a material breach of this Contract and Vaya may terminate in accordance with Article VII.

3.4.6 EPSDT Screenings: All Providers who are primary care providers and specialists shall provide EPSDT screening services for Members less than twenty-one (21) years of age in accordance with the applicable Controlling Authority. Furthermore, all behavioral health Network Providers shall coordinate with primary care providers and specialists conducting EPSDT screenings.

3.4.7 Interpreting and Translation Services: Contractor must (i) provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Member and (ii) ensure Contractor's staff is trained to appropriately communicate with Members with various types of hearing loss. Contractor shall report to Vaya, in a form and format determined by Vaya, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.

3.5 Equitable Treatment of Members/ Non-Discrimination. Contractor shall comply with Controlling Authority, including the Americans With Disabilities Act of 1990; Titles VI and VII of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; Section 503 and 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; section 1557 of the Affordable Care Act; and subsequent amendments and regulations developed pursuant thereto, including, but not limited to, 45 CFR Part 92. Contractor agrees to render, or ensure the delivery of, Covered Services to Members with the same degree of care and skills as customarily provided to all other patients served by Contractor, according to generally accepted standards of medical practice. The Parties agree that Members and non-Members should be treated equitably. Contractor shall make services available to Members without discrimination and agree not to discriminate against Members on the basis of type of benefit plan, source of payment, race, color, creed, national origin, ancestry, age, sex, gender, gender identity or LGBTQ status, sexual orientation, religious affiliation, disability, national origin, pregnancy status, genetic information, health status, marital status, or parental status. As required by the Department, Contractor further agree that LGBTQ Members who obtain Covered Services shall not be subject to treatment or bias that does not affirm their orientation.

3.5.1 Referrals: Contractor shall not arbitrarily decline, refuse to serve, reject, or discharge Members from the Covered Services under this Contract. If Contractor declines a referral, refuses to serve, or rejects or discharges a specific Member, Contractor shall provide to Vaya notice and a written, detailed reason for the declination, refusal, rejection, or discharge via email to Provider.Info@vayahealth.com within one (1) business day of such action. Contractor's refusal to accept a referral based upon a Member's source of reimbursement may constitute adverse selection. Vaya may consider referral data and information regarding adverse selection in its evaluation of Contractor for termination or renewal of this Contract.

3.5.2 Physical Access: Contractor shall provide physical access, reasonable accommodations (including parking, exam and waiting rooms), and accessible equipment for Members with physical or mental disabilities.

3.6 Abuse, Neglect and Exploitation. Contractor shall ensure that Members are not abused, neglected, or exploited while in its care and shall maintain policies and procedures and conduct activities and monitoring in a manner that is designed to deter, prevent, and avoid abuse, neglect, and/or exploitation of Members in its care. Contractor shall

promptly report all allegations of abuse, neglect, and/or exploitation to the applicable county Department of Social Services ("DSS") as required by Controlling Authority.

3.7 Allegations or Charges Against Employees. Contractor will notify Vaya of any allegations of abuse, neglect or exploitation involving a Member that is made toward Contractor or any of its owners, officers, directors, managers, partners, employees, agents, representatives, or subcontractors within one (1) business day of such allegation, and shall immediately put into place protective measures to ensure that the accused person has no access to Members until the allegation is determined to be unsubstantiated. Contractor will notify Vaya within three (3) business days after receiving notice of any conviction of an owner, officer, director, or employee of Contractor of any crime, including, but not limited to, any conviction under a federal or state criminal drug statute that would result in non-compliance with the Drug Free Workplace Act of 1988.

3.8 Clinical Practice Guidelines. Following consultation with Vaya's Clinical Advisory Committee, Vaya adopts clinical practice guidelines, which are not a substitute for clinical professional judgment and are intended to assist Contractor and Members in making decisions about appropriate Health Services for specific clinical circumstances. Contractor's decisions covered by the clinical practice guidelines adopted by Vaya shall be consistent with such applicable clinical practice guidelines.

3.9 Telehealth Option. Contractor may provide Covered Services via Telehealth as an alternative service delivery model, if permitted by NC Medicaid Clinical Coverage Policy No. 1H or Department-approved Vaya clinical policy, to the extent necessary or required to meet the business operations needs of Contractor, if delivered in compliance with applicable state and federal laws, regulations, and rules including HIPAA and records retention requirements, and if in the best interest of Member(s). Contractor shall not use Telehealth to replace any face-to-face assessments or therapeutic interventions required by Controlling Authority.

3.10 Utilization Management. Contractor understands, acknowledges, and agrees that Vaya only pays for Medically Necessary Covered Services, that State-funded Services are subject to availability of funding, that authorization is not a guarantee of payment, and that authorizations may be overturned as a result of Program Integrity or Other Monitoring Activities. Contractor shall comply with the Vaya Utilization Management Policy and all Vaya utilization management requirements, including any requirements for prior authorization, Tailored Care Management, concurrent review, retrospective authorization, or retrospective utilization review of Covered Services provided to Members.

3.10.1 Member Eligibility: Contractor may be required to verify a Member's eligibility in a Vaya Benefit Plan as part of the authorization review process and prior to Contractor's delivery of service.

3.10.2 Direct Access to Contractor: Contractor shall obtain a referral for any Covered Services not provided by the Member's primary care physician, except for Emergency Services, family planning services and supplies and reproductive health services and supplies, services provided to female Members age 13 and older by an obstetrician-gynecologist within the Vaya Network, services to female Members by women's health specialists within the Network for covered care necessary to provide women's routine and preventive health care services in accordance with 42 CFR § 438.206(b)(2), children's screening services, Local Health Department services, primary care services, services rendered at school-based clinics, the first mental health or substance use

assessment completed in a twelve month period, and other services not requiring referrals or as otherwise specifically prohibited by Vaya, the Managed Care Contract, or Controlling Authority.

3.10.3 Prior Authorization: Contractor shall obtain prior authorization for Covered Services, except for Emergency Services, family planning services and supplies and reproductive health services and supplies, services to female Members by women's health specialists within the Network for covered care necessary to provide women's routine and preventive health care services in accordance with 42 CFR § 438.206(b)(2), obstetrical ultrasounds, children's screening services, Local Health Department services, primary care services, services rendered at school-based clinics, the first mental health or substance use assessment completed in a twelve month period, and other services, or where prior authorization is not required by Vaya. Except where expressly prohibited by Controlling Authority, Vaya may deny payment for Covered Services where Contractor fails to meet Vaya's requirements for prior authorization. Contractor must obtain authorization prior to service delivery as required by the applicable Vaya Benefit Plan or Controlling Authority and shall provide accurate and complete information requested so that service provision to Members is not unduly delayed or disrupted.

3.10.4 UM Documentation: Contractor shall promptly provide Vaya, or its Subcontractor, with all necessary documentation and clinical information requested as part of the utilization management/ utilization review process. It is the responsibility of Contractor to document the Medical Necessity of Covered Services requested for, or provided to, Members. All such documentation must be submitted electronically as outlined in Section 3.10.5.

3.10.5 Service Authorization Request ("SAR") Submission: Contractor must submit all requests for prior, concurrent, or retrospective authorization, and include with such request any current clinical documentation and other supporting documentation, including on the Member's physical health, LTSS, BH, I/DD, and TBI clinical and support needs, electronically through the Provider Portal, MCIS, or Vaya's Subcontractor's designated system, as applicable. Vaya, and any Subcontractor acting on its behalf, reserves the right to reject and decline to process SARs and supporting documentation submitted via email, other electronic format, paper, or facsimile.

3.10.6 General Timeframe: Contractor must submit all requests for prior authorization at least fourteen (14) days prior to the requested start date of the requested Covered Service, unless the request is for retrospective authorization, or inpatient hospitalization, crisis, or other request that meets criteria for expedited review.

3.10.7 Retrospective Timeframe: Contractor must submit all requests for retrospective authorization, including requests based on retroactive Medicaid eligibility, as soon as practicable, but in no event later than ninety (90) days from date Contractor knew, or should have known, of such eligibility determination.

3.10.8 Coverage Determinations: If Vaya, or one of its Subcontractors, determines that services, supplies, or other items are covered under the Vaya Benefit Plan(s), Vaya shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the Member's health condition that was knowingly made by the Member, Contractor, or other provider of the Covered Service, supply, or item.

3.11 Tailored Care Management and Care Coordination. Care Management is a crucial driver to help achieve integrated, whole-person care and foster coordination and collaboration among care team members across disciplines and settings. Contractor shall support all Member(s) receiving Covered Services by Contractor, in accordance with Controlling Authority, Department Tailored Care Management guidance, and the Vaya Provider Manual and shall cooperate fully with all Tailored Care Management ("TCM"), Care Coordination, Transition of Care, discharge planning

and integrated care activities of Vaya, including, but not limited to, coordination with Members' primary care provider(s) and Vaya-contracted providers facilitating engagement with community-based resources and social determinants of health; Vaya's approach, methodology, and process for assigning Members to Tailored Care Management; coordination with respect to the discharge of Members and Transition of Care; coordination with respect to commitment orders issued in accordance with N.C.G.S. Chapter 122C, Article 5; participation as a member of any multidisciplinary care team established by the Tailored Care Management organization; and participation in child and family team meetings, as applicable.

3.11.1 Access to Member(s): Contractor shall allow Vaya staff, any provider-based Tailored Care Management organization's staff, multidisciplinary care team members, and other Vaya-contracted providers to attend any treatment team, transition of care, and/or discharge planning meetings regarding Member(s) served under this Contract, with advance notice and consistent with the principles of integrated, whole-person care. Contractor shall allow Vaya staff, Vaya-contracted provider staff, and any Vaya-contracted provider-based Tailored Care Management organization staff direct access to any Member for Care Management or Care Coordination purposes, if requested by Member and the Member's treating physician, or if the treating therapist agrees or determines that it is clinically appropriate, and Vaya has available staff and funding to fulfill such request.

3.11.2 Treatment Planning and Discharge Meetings: Contractor shall regularly schedule treatment and discharge planning meetings for Member(s) to ensure that appropriate services have been arranged following discharge and to link Members with other providers or community assistance, shall coordinate with Vaya-contracted providers facilitating engagement with community-based services, and shall provide at least 24 hours prior notice to Vaya or the Tailored Care Management organization, if provider-based, of the date, time, and place of any treatment team or discharge planning meeting regarding a Member. Contractor shall designate qualified staff to participate in multidisciplinary care team meetings facilitated by Vaya or the Tailored Care Management organization, if provider-based, that involve Member(s) served under this Contract. Contractor shall provide information pertinent to the development of a person-centered Care Plan or shall directly participate in the planning process. Contractor shall be responsible for the development of treatment and/or supports strategies to address assigned areas of responsibility from the Care Plan.

3.11.3 Discharge from High Level Clinical Setting: Contractor shall work collaboratively with Vaya for effective and timely discharge planning beginning at admission and throughout the discharge planning process. Prior to a Member's discharge, the Parties shall coordinate any discharge planning meetings with Member's designated primary care practice, behavioral health home, and assigned TCM care manager. Once the discharge date has been determined, Contractor will call the designated community health service provider or the Vaya Member and Recipient Services department to schedule a follow-up appointment to occur between one (1) and seven (7) days of discharge.

3.11.4 Continuity of Care and Service Coordination: Contractor shall ensure all Members served under this Contract receive continuity of care. Contractor shall coordinate supports and services with other Providers and with other primary care providers for all Members served under this Contract. Contractor must collaborate with Vaya, the Member, the Member's provider-based Tailored Care Management organization, if applicable, and the Member's relatives and natural supports if applicable, to assure continuity of care with no disruption in services:

3.11.5 Notice of Outpatient Commitment Order: If Contractor delivers services under an outpatient commitment to a Member, Contractor shall notify Vaya of the outpatient commitment order upon receipt, and shall provide a copy of such order, if so requested.

3.11.6 Member Access to Medical Records: Upon request from a Member, Contractor agrees to provide or deliver a complete, legible copy of the medical records of such Member to the Member at Contractor's sole cost and expense. The provision or delivery of medical records to the Member must be made within a reasonable time following the request, but in no event more than five (5) days.

3.11.7 Transfer of Medical Records: Upon request from Vaya or Member, Contractor agrees to transfer a complete, legible copy of the medical records of any Member transferred to another provider for any legitimate reason, including termination of this Contract, and in accordance with Sensitive Information Laws, at Contractor's sole cost and expense. Such Member medical records shall include, but not be limited to: a minimum of the most recent thirty (30) days' worth of progress notes that reflect the most recent contacts with the Member; any information related to the Contractor's efforts to engage the Member with an alternate provider of Member's choice; Member's medication management information; a copy of the Member's most recent comprehensive clinical assessment and Care Plan with updates; any medical, psychiatric or psychological evaluation of the Member; current Member demographic information; and any other Member medical or health records required to be maintained by Controlling Authority. The transfer of medical records must be made within a reasonable time following the request, but in no event more than five (5) days except in cases of emergency, in which case it shall be sooner. All records requested by Vaya pursuant to this Section 3.11.7 shall be provided at no cost to Vaya or the Member.

3.11.8 Transitions of Care: The Parties will work collaboratively to resolve any problem(s) of continuity of care or in transferring the Member to another provider, PHP, Medicaid Direct, or payor. Contractor shall cooperate with Vaya's transitional care management functions, including its oversight of care transitions for Members who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, emergency department visits, absence of services, or other adverse outcomes. Contractor shall provide a Member's Tailored Care Management organization with notifications of each admission, discharge, or transition within a clinically appropriate time.

3.11.9 Consequence for Failure to Coordinate Services: A pattern of failure to coordinate services in a timely manner; to transfer or provide access to medical records to Vaya or a Member or their provider; or to ensure continuity of care for Members served by Contractor, without demonstrated corrections, may be considered a material breach of this Contract and may result in Administrative Actions or Provider Sanctions up to and including termination of this Contract, and/or termination, exclusion, or revocation of Contractor, and/or its respective Owners and/or Managing Employees, in accordance with Section 3.1.5

3.12 Documentation and Access to Records. Vaya shall have access to Contractor's books, documents, and records required to be retained by Controlling Authority, including, but not limited to, clinical, medical, financial, and personnel records and audited financial statements if available (collectively "records"). Unless otherwise stated herein, all records requested by federal or state authorities or Vaya pursuant to this Section 3.12 shall be provided at no cost and within fourteen (14) days of the date of the request, or earlier if specified in such request. This Section 3.12 and all its subparts shall survive suspension, expiration, or termination of this Contract.

3.12.1 Record Retention: Contractor shall retain all records according to the most stringent record retention schedule applicable under Controlling Authority and as further described in the Vaya Provider Manual, for each Member served, either in original paper form or in electronic/digital form.

3.12.2 Availability and Accessibility of Records: Contractor shall make all records available to Vaya and authorized federal and State personnel, including the Department, in connection with its regulation of Vaya, during the

entire Term of this Contract and for a period of ten (10) years thereafter, in accordance with 42 CFR § 438.3(h), unless there are any unresolved federal, state or Vaya Program Integrity and Other Monitoring Activities pending. Contractor shall maintain such records and documentation until all issues are finally resolved, or until such later period as is required under Controlling Authority. If for any reason Contractor can no longer maintain records of services provided to members, Contractor must contact the Vaya Records Custodian at Health.Information@vayahealth.com to facilitate resolution.

3.12.3 Minimum Member Record Documentation: Contractor shall prepare and maintain complete and accurate documentation supporting the provision of services to each Member, including medical records, in accordance with professional standards, as required by 42 CFR § 438.208(b)(5), and Controlling Authority, including, but not limited to, APSM 45-2, APSM 10-5, APSM 10-3, and any applicable DHB Clinical Coverage Policy or Vaya clinical coverage policy. Documentation must support medical necessity, the billing diagnosis, the number of units provided and billed, the location of the service, the standards of the billing code, and evidence of compliance with applicable Controlling Authority. Contractor shall maintain confidentiality of a Member's medical records and Sensitive Information as required by law, industry standards, and Vaya's standards. Subject to applicable Sensitive Information Laws, Contractor shall make true and accurate copies of such medical records available to, and shall share such medical records with, Vaya and the Department in conjunction with its regulation of Vaya as a Tailored Plan. Notwithstanding anything to the contrary herein, and unless the request for records specifies a longer timeframe, a Member's medical and other health records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to Vaya or the Department.

3.12.4 Records of Costs and Expenses: Contractor shall maintain, prepare, and make available to Vaya upon request, necessary records and accounts related to the Contract, including personnel records for all staff providing services under the Contract, financial records, audited financial statements, and detailed records of administrative costs and all other expenses incurred pursuant to the Contract, in accordance with Generally Accepted Accounting Principles, to assure a proper accounting of all public funds.

3.12.5 Location of Records: If records are not kept on-site where services are provided, they must be immediately available in the event of unannounced Program Integrity and Other Monitoring Activities. Upon request, Contractor shall provide Vaya with a list of locations where records required to be maintained under this Contract are stored.

3.12.6 Access by Federal and State Oversight Agencies: Contractor shall provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the Contract and any records, books, documents, and papers that relate to the Contract and/or Contractor'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 the Department deems necessary for Contract enforcement or to perform its regulatory functions: (i) HHS or its designee; (ii) the Comptroller General of the United States, or its designee; (iii) the Department, its Medicaid managed care personnel, its State-funded Services personnel, or their respective designee; (iv) OIG; (v) Medicaid Investigations Division of the North Carolina Attorney General's Office ("MID"); (iv) any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of the Department; (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 the Department, or any other entity engaged by the Department. Nothing in this Section 3.12.6 shall be construed to limit the ability of the federal government, CMS, OIG, 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.

3.12.7 Data Requests: Upon request, Contractor shall also provide data about Members to Vaya for research and study purposes, as permitted or required by the Department and Controlling Authority.

3.12.8 Failure to Provide Records: Contractor understands, acknowledges, and agrees that failure to maintain or provide timely, complete, and accurate documentation of services as required by this Contract may result in payment suspension, withholding of funds, overpayment determination, or other administrative action or sanction, up to and including termination of the Contract, and/or termination, exclusion, or revocation of Contractor and/or its Owners and/or Managing Employees.

3.13 Member Grievances and Appeals. Contractor shall promptly and fairly address all Member Grievances related to provision of Covered Services, and, in accordance with 42 CFR Part 438, Subpart F, and/or 10A NCAC 27G .0201(a)(18), as applicable.

3.13.1 Vaya's Member Grievance process is accessible to all Members, operates in a fair and impartial fashion, and requires Contractor to receive and respond timely to Member Grievances received regarding Contractor.

3.13.2 Contractor shall cooperate with the Member when providing support and assistance with the Member Grievance and appeal procedures. The Parties understand, acknowledge, and agree that Member Grievance, appeal, and fair hearing procedures and timeframes shall be administered as specified in 42 CFR § 438.400 through 42 CFR § 438.424 (for Medicaid and NC Health Choice Members) and the Managed Care Contract, as applicable. Contractor shall publish and make accessible to Members the Vaya toll-free telephone number for Members to report concerns, grievances, or complaints to Vaya; shall notify Members that they may contact Vaya directly about any concerns, grievances, or complaints; and shall cooperate with the Member in regard to appeals and Grievance procedures.

3.13.3 Grievance Documentation: Contractor shall maintain documentation to include, at a minimum, the date the Member Grievance was received, the concerns raised, the resolution/follow up provided, and the date the Member Grievance was resolved.

3.13.4 Resolution or Referral by Contractor: Contractor shall promptly address all grievances and complaints reported by Member(s) relating to the services provided pursuant to this Contract. Contractor shall promptly refer any unresolved grievances, or requests for change in provider, to Vaya.

3.13.5 Resolution and Investigation by Vaya: Vaya may receive grievances about Contractor directly from Member(s) or other individuals on behalf of the Member(s). Vaya is required to resolve and/or investigate such grievances within thirty (30) days of receipt or such other timeframe established by Controlling Authority. Contractor shall fully cooperate with all such resolution efforts and investigations, and Vaya shall provide Contractor, as applicable, with a written report of findings, which may include issues out of compliance with this Contract or Controlling Authority, after the conclusion of its investigation. Vaya may implement an expanded or comprehensive investigation and/or take action up to and including the Administrative Actions or Provider Sanctions stated in Section 3.15 against Contractor as the result of any such Member Grievance or complaint investigation.

3.14 Provider Grievance or Appeal. Contractor shall have the right to file a Provider Grievance or a Provider Appeal. Prior to filing a Provider Grievance, Contractor may, but is not required to, address and seek resolution through informal

means. Contractor understands that Vaya does not discriminate or retaliate against, or permit its Subcontractors to discriminate or retaliate against, any Provider based on any lawful action they take in regard to Provider Grievances, Provider Appeals, Member Grievances, or Member Appeals.

3.15 Program Integrity and Other Monitoring Activities. Contractor understands, acknowledges, and agrees that Vaya is required to investigate any and all credible allegations of fraud, waste, and abuse and that Vaya may conduct investigations into any matters that fall within the scope of this Contract, including, but not limited to, investigations into fraud, waste, provider abuse, overutilization, questionable billing practice(s), grievances, complaints, quality of care concerns, health and safety issues, and violations of this Contract or Controlling Authority. Contractor further understands, acknowledges, and agrees that Contractor is subject to, and shall cooperate fully with, Program Integrity and Other Monitoring Activities conducted by Vaya, or one of its Subcontractors on its behalf. This Section 3.15 and all its subparts shall survive suspension, expiration, or termination of this Contract.

3.15.1 Cooperation with Federal and State Program Integrity Activities: Contractor shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other program integrity activities conducted by the Department, CMS, OIG, MID, or the U.S. Department of Justice. In cooperating with federal or State investigations, Contractor shall provide such authorities with all requested documents, information, and/or data within seven (7) business days of the request, unless a different time is prescribed.

3.15.2 Fraud, Waste, and Abuse: Contractor shall comply with laws designed to prevent or ameliorate fraud, waste, and abuse, including applicable provisions of federal criminal law, the False Claims Act (31 USC §§ 3729 et. seq.), and the anti-kickback statute (section 1128B(b) of the Act). Contractor shall publicize and make accessible to Members Vaya's toll-free fraud and compliance hotline.

3.15.3 Reports of Regulatory Authorities: Contractor shall submit to Vaya copies of surveys, reviews, and/or audits performed by accrediting or regulatory authorities of Contractor, including, but not limited to, CMS, DHB, Division of MHDDSAS, and Division of Health Service Regulation within five (5) business days of receipt by Contractor.

3.15.4 Vaya Inspection of Records and Facilities: Contractor understands, acknowledges, and agrees that Vaya may inspect Contractor's facilities and premises where records are stored, or Members are served, to ensure compliance with Controlling Authority and/or Vaya accrediting body requirements. Vaya has the right to inspect, take photographs, scan, and make or request electronic or paper copies of all clinical, medical, personnel, and financial records concerning claims paid on behalf of Members and services provided to Members, including, but not limited to, records of staff who delivered or supervised the delivery of services to Members, and any other clinical or financial information which Vaya determines is necessary to assure compliance with the Contract. Any and all Program Integrity or Other Monitoring Activities, including, but not limited to, inspections and site visits, do not have to be arranged in advance with Contractor. If an unannounced site visit is performed by Vaya, Contractor shall provide all documentation and records requested by the conclusion of the site visit, except that Vaya may grant additional time to respond for good cause shown, depending upon the size and scope of the request. Any and all records obtained by Vaya during the course of Program Integrity or Other Monitoring Activities shall remain confidential, unless otherwise required by law to be disclosed.

3.15.5 Desk Audits: Vaya may also make a written request for documentation and records for Program Integrity or Other Monitoring Activities or to meet state, federal, or accrediting body monitoring requirements. In such event, Contractor shall provide the requested records to Vaya within fifteen (15) days of the date of the request,

except that Vaya may grant additional time to respond for good cause shown, depending upon the size and scope of the request. Contractor may satisfy any request for information by either paper or secure electronic means.

3.15.6 Billing Audits/ Post-Payment Reviews: Contractor will participate in any Program Integrity or Other Monitoring Activity for error, omission, fraud, waste, abuse, overutilization, underutilization, questionable billing practice(s), overpayment, and/or non-compliance with Controlling Authority or this Contract. Any such Program Integrity or Other Monitoring Activities may be unannounced or arranged with the Contractor in advance. Vaya shall provide Contractor with written documentation of findings within fifteen (15) days following the conclusion of any routine post-payment monitoring and within thirty (30) days following the conclusion of any other Program Integrity or Other Monitoring Activities. Contractor may be subject to additional pre-payment reviews or audits, post-payment reviews or audits, a plan of correction, the imposition of a Provider Sanction, or the imposition of an Administrative Action, including, but not limited to, an Overpayment determination or claim(s) denial. Vaya may use statistical sampling and may extrapolate audit results in accordance with Controlling Authority.

3.15.7 Self-Audits: Contractor shall conduct self-audits no less than annually, or more often in response to identification of questionable billing practices, failure to coordinate benefits, or staff ineligibility for billing, and shall report any overpayment(s) or erroneous and/or fraudulent activities discovered within five (5) business days of the conclusion of any such self-audit and shall remit Overpayment to Vaya within sixty (60) days of Contractor's identification of the Overpayment.

3.16 Overpayments. Contractor shall repay to Vaya any Overpayment identified through self-audit or identified by Vaya or NCDHHS. Overpayments may be based on claims submitted to Vaya by Contractor. Contractor understands, acknowledges, and agrees that any encounter claim(s) rejected, denied, or disallowed by NCDHHS shall be deemed an Overpayment and Contractor shall repay Vaya for any such rejected, denied, or disallowed claim(s), in accordance with the procedures and requirements set forth herein and in the Vaya Provider Manual. This Section 3.16 and all its subparts shall survive suspension, expiration, or termination of this Contract.

3.16.1 Contractor Recoupments: If Contractor has been reimbursed for a claim or portion of a claim that Vaya determines should be disallowed as a result of an error or omission by a Party, or for a claim or portion of an encounter claim that is disallowed in NCTracks, Vaya will readjudicate such claims and automatically recoup the Overpayment from payments for future claims related to errors or omissions. Contractor specifically understands, acknowledges, and agrees that Vaya shall automatically recoup all claims or invoices improperly paid due to error or omission, whether such error was attributable to Contractor, Vaya, NCTracks or the Department.

3.16.2 Written Notice of Overpayments: If Contractor has been reimbursed for a claim/ invoice or portion of a claim/ invoice that Vaya determines should be disallowed based on fraud, waste, abuse, overutilization, questionable billing practice(s), or non-compliance with Controlling Authority or this Contract, Vaya will provide written notice to the Contractor, as applicable of the identified Overpayment. The written notice shall identify the basis for the Overpayment and the requested amount of repayment due to Vaya and shall provide at least thirty (30) days' prior notice of any intent to collect the outstanding balance owed. For the Contractor, such notice shall identify the Member name(s) and date(s) of service in question, the determination made by Vaya as to each claim, and the requested amount of repayment due to Vaya, which may include recouping the Overpayment from payment for future claims.

3.16.2.1 Contractor, as applicable to the circumstance, shall have thirty (30) days from the date of such notification to request reconsideration, request in good faith approval for a payment plan, or remit the invoiced amount in full.

3.16.2.2 If Contractor does not elect one of the foregoing options or a payment plan is not approved, the Overpayment shall become final on the 31st day following the date of notification and Vaya may recoup the amount due, plus interest at the legal rate of eight percent (8%) per annum, plus a one-time late payment charge at the rate of ten percent (10%) of the outstanding balance owed, from reimbursement owed to Contractor, or Vaya may pursue any such other method of collection, as deemed appropriate by Vaya, for the reimbursement of the Overpayment, interest, and late payment charges.

3.16.2.3 If Contractor elects reconsideration and the reconsideration decision upholds the Overpayment in whole or in part, the amount due as set forth in the reconsideration decision shall become final on the 31st day following the date of the decision and Vaya may recoup the amount due, plus interest at the legal rate of eight percent (8%) per annum, plus a one-time late payment charge at the rate of ten percent (10%) of the outstanding balance owed, from reimbursement owed to Contractor, as applicable to the circumstance, or Vaya may pursue any such other method of collection, as deemed appropriate by Vaya, for the reimbursement of the overpayment, interest, and late payment charges.

3.16.3 Payment Plans: Vaya is not required to approve any request for a payment plan and may establish a payment plan at its sole discretion and on terms and conditions mutually agreed to by the Parties. All payment plans will require a signed promissory note and may require collateral to secure the amount owed and a signed agreement.

3.17 Administrative Actions and Provider Sanctions. Contractor understands, acknowledges, and agrees that Vaya may issue an educational or warning letter, require a plan of correction, or impose Administrative Actions or Provider Sanctions against Contractor. Such Administrative Actions and Provider Sanctions include but are not limited to increased monitoring/ probation, limitation or suspension of referrals, moratorium on site or service expansion, payment suspension or withholding, site- or service- specific suspension or termination, full contract suspension, full contract termination, and exclusion from participation in the Vaya Network. Contractor further understands, acknowledges, and agrees that Vaya is not required to issue an educational or warning letter or plan of correction prior to the imposition of Administrative Actions or Provider Sanctions. Contractor also understands, acknowledges, and agrees that Contractor's exclusion from participation in the Vaya Network automatically results in a revocation of Contractor's credentials with Vaya and may also result in a revocation of the credentials of any of Contractor's Owners or Managing Employees.

3.17.1 Suspensions for Health and Safety: In accordance with Vaya accrediting body requirements, Vaya may suspend this Contract in response to any serious health or safety risk to Members identified by Vaya in the sole discretion of the Vaya Chief Medical Officer, Deputy Chief Medical Officer, or other Senior Clinical Staff Person as such term is used by Vaya's accrediting body, and such suspension shall remain in effect during the pendency of any investigation into such health or safety risk.

3.17.2 Suspensions of Payment: Vaya shall suspend claims payment to Contractor for dates of services after the effective date within one (1) Business Day of receipt of a notice from the Department that payment must be suspended for Contractor's failure to meet a Department requirement. In the case of a credible allegation of

fraud (as determined by the Department), waste, or abuse, Vaya may immediately suspend or withhold payments for Covered Services provided by Contractor.

3.17.3 Prepayment Review: Vaya may place Contractor on prepayment review at any point during the Term of this Contract. Prepayment review is not a sanction but is a mechanism by which Vaya or its agent reviews all claims and supporting documentation prior to reimbursement to Contractor. There is no right to appeal a notice of prepayment review.

3.18 Vaya Policies and Procedures. Contractor agrees to comply with Vaya's non-discrimination, claims submission, reimbursement, quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, *in lieu of* services, opioid misuse prevention and treatment program, discharge planning, dispute resolution and other clinical, business, and administrative policies and procedures established and revised from time to time in the Vaya Provider Manual or which are set out in the Vaya provider portal, in bulletins or other written materials posted by electronic means on the Vaya website. Such policies and procedures shall not be construed to override the professional or ethical responsibilities of Contractor or interfere with Contractor's ability to provide information or assistance to Members it serves. Substantive or material changes to the Vaya Provider Manual as described in Section 4.3 of this Contract shall become binding upon Contractor thirty (30) days after notice of website publication via an electronic Provider Communication Bulletin.

3.19 Continuous Quality Improvement (CQI). Contractor shall engage in CQI and shall cooperate with Vaya's written quality management program and the organization's quality improvement ("QI") activities, including those designed to improve quality measure outcomes in the then-current Healthcare Effectiveness Data and Information Set (HEDIS), other quality or outcome measures, quality of care and services, and Member experience. Contractor shall implement QI projects and/or QI activities as directed by Vaya, including but not limited to dissemination of educational or training material to Members. Upon request, Contractor shall provide to Vaya evidence, data, and/or documentation ("data") necessary for QI, quality assessment, quality assurance, quality management, quality measure outcomes, risk management purposes, and/or performance improvement activities, including, but not limited to, data related to assessment of quality of care, best practices, effectiveness, and satisfaction with services and data necessary to satisfy requests from the Department. Contractor shall take corrective action on a timely basis to address problems found through the CQI process. Contractor understands that the Department intends to measure outcomes in at least the areas of quality of life, functional status, and member satisfaction and the measurement may involve the use of surveys administered by the Department or its vendor(s), Vaya or its Subcontractor(s), or Contractor. Contractor shall participate in provider and Member satisfaction and perception of care surveys and assessment projects conducted by the Department and/or Vaya as requested, including the distribution and collection of survey and assessment forms within given timelines and in accordance with confidentiality requirements.

3.19.1 Training: Contractor shall attend web-based, recorded, or virtual training provided by or on behalf of Vaya within thirty (30) days of joining the Vaya Network, and other training as determined by Vaya or requested by the Department. At a minimum required training will include the following topics: EPSDT, Vaya's prevention and population health management programs, Into the Mouth of Babes (IMB) program (as applicable), and infection control and prevention practices. Contractor shall also bear the cost of all trainings, including but not limited to, trainings mandated by Vaya or related to licensure and accreditation activity and must be able to demonstrate

to Vaya its application of the training information to its delivery of services, in compliance with the provisions of this Contract.

3.19.2 Clinical Information Data Submission: If Contractor is authorized to conduct an assessment of a referred Member, it shall electronically submit to Vaya all required data elements within five (5) business days of the last assessment session, using the protocol(s) and formats required by the Department and Vaya. In documented crisis and/or emergency situations, Contractor must still enroll the Member within five (5) calendar days after providing services and indicate the date of enrollment as the date that the emergency services were provided, even if the Member is referred to another provider. Contractor shall establish review procedures to ensure that a minimum of 90 percent of all data elements for each record are complete and accurate and a minimum of 85 percent of all data elements for each record are coded as something other than "Other" or "Unknown" within thirty (30) days of first submission.

3.20 Cultural Competence and Code of Ethics. Contractor will develop a Cultural Competency Plan that demonstrates cultural and linguistic competency. Contractor shall develop procedures for the implementation of systems to evaluate and/or measure adherence to its Cultural Competency Plan and shall ensure that its employees and contractors are trained on such procedures. Contractor shall complete the Cultural Competence Self-Assessment Tool no less than annually, which shall be evaluated by Vaya using a standard monitoring tool. Contractor shall comply with the Code of Ethics developed by the Vaya Provider Advisory Council and included in the Vaya Provider Manual.

3.21 Duties Related to Closure or Termination. Contractor shall provide at least ninety (90) days' prior written Notice to Vaya of the anticipated cessation of a service or closure of a site or Contractor's entire business operations. If Contractor is ceasing its business operations within all of the Region, whether due to retirement, bankruptcy, insolvency, dissolution, relocation, acquisition, or sale, or for any other reason, then Contractor shall submit to Vaya: (i) A plan for maintenance and storage of all records for Members in Vaya's Region which is subject to Vaya's approval or disapproval in its sole discretion; and (ii) A master log of all Members served within the Vaya Region, along with the storage location and the name and contact information of the records custodian. If the plan for maintenance and storage is not approved by Vaya, Contractor shall provide to Vaya copies of all medical records for Members served under this Contract and records supporting the provision of services within thirty (30) days of closure of operations, at no cost to Vaya. Contractor shall retain all original records as required by Controlling Authority. This Section 3.21 shall survive suspension, expiration, or termination of this Contract.

3.22 Provider Directory. Contractor understands, acknowledges, and agrees that Vaya may use the information contained in the provider contract request form or received through other methods to update Vaya's provider directory, and Contractor agrees that Vaya may list the name, assumed name (if one), address, telephone number, website, and other factual information about Contractor in Vaya's provider directory made available on its public-facing and Member-facing website or distributed to Members and in its marketing and informational materials.

3.23 Technology. Contractor understands, acknowledges, and agrees that to participate in the Network, Contractor shall have and maintain access to the internet, facsimile, and/or electronic mail.

ARTICLE IV: OBLIGATIONS OF VAYA

4.1 Network Contracting Exclusions.

4.1.1 Vaya shall not contract with an Ineligible Person or enroll into the Vaya Network a provider employed by or subcontracted with Contractor, who appears on any of the Exclusion Lists.

4.1.2 In accordance with N.C. Gen. Stat. § 108D-22, except as otherwise allowed under the Contract, Vaya will not exclude Contractor from its physical health network except under the following circumstances:

4.1.2.1 when Contractor, or one of its Provider, fails to meet the Department's applicable Objective Quality Standards for participation as a Medical-enrolled provider; or

4.1.2.2 when Contractor refuses to accept network rates.

4.1.3 No Restrictions on Contractor's Practice: Vaya shall not prohibit Contractor, or restrict Contractor, from acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is their patient regarding

4.1.3.1 The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

4.1.3.2 Any information the Member needs to decide among all relevant treatment options.

4.1.3.3 The risks, benefits, and consequences of treatment or non-treatment.

4.1.3.4 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.

4.2 ID Cards. Vaya shall issue identification cards to Medicaid and NC Health Choice Members and instruct them to present their cards to providers when seeking health care items and services.

4.3 Vaya Policies and Procedures. Prior to execution and annually thereafter, Vaya has provided, and shall continue to provide, in hard copy, electronic format, or by posting in the Vaya Provider Portal or on the Vaya website a copy of required policies and procedures. The policies and procedures of Vaya shall not conflict with or override any term of a Contract, including Contract fee schedules. In the event of a conflict between a policy or procedure and the language in a Contract, the Contract language shall prevail. Vaya will post any substantive or material changes to the Vaya Provider Manual on the Vaya website at least thirty (30) days prior to the effective date of any such changes and will notify Contractor of the website posting via an electronic Provider Communication Bulletin.

4.4 Reimbursement. Vaya shall reimburse Contractor for services provided to Members according to the terms and conditions outlined in this Contract, and as authorized by Vaya, except in those instances where authorization is not required. This Section 4.4 shall survive suspension, expiration, or termination of this Contract.

4.5 Data to Contractor. Vaya shall provide certain data and information to Contractor, such as: (i) Performance feedback reports or information to Contractor, if compensation is related to efficiency criteria; (ii) Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies; and (iii) Notification of changes in these requirements, allowing providers time to comply with such changes.

4.6 Communication. Vaya shall electronically publish or disseminate the Vaya Provider Manual. Along with Controlling Authority, the Vaya Provider Manual shall provide the Contractor with pertinent information necessary for the Contractor to perform its obligations under this Contract, including a description of the Vaya (1) clinical practice

standards and UM program, (2) Covered Services, additional services, and Carve Out Services, (3) provider responsibilities, (4) primary care physician responsibilities, (4) Vaya Network requirements, including nondiscrimination, cultural and linguistic competency expectations, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability; (6) Telehealth, virtual patient communications and remote patient monitoring; (7) Vaya Network adequacy and access standards; (8) billing, claim editing, SNIP editing and clearinghouse requirements; (9) cultural and linguistic competency and accessibility requirements; (10) authorization, utilization review, and Care Management requirements; (11) Care Coordination and discharge planning requirements; (12) Department-required documentation requirements; (13) Provider Appeals and Provider Grievance process; (14) Member Grievance investigation and resolution procedures; (15) notification of the availability of the Department's provider Ombudsman service where a provider may submit a complaint about Vaya, including instructions on how to submit the complaint; (16) performance improvement procedures including member satisfaction surveys, clinical studies, incident reporting (e.g., critical incident and death reporting), and outcomes requirements; (17) compensation and claims processing requirements, including required electronic formats, mandated timelines, transition of care obligations, and coordination of benefits requirements; (18) interest and penalty provisions for late or under-payment by Vaya; (19) Medicaid payor of last resort requirements; (20) Member rights and responsibilities; (21) Member cost sharing requirements; and (22) Provider program integrity requirements that address how to report suspected fraud, waste and abuse, and compliance with other federal and state requirements. Vaya shall also electronically publish or disseminate regular provider bulletins, which shall include updates of network activities, changes in fee schedules or contracting provisions, training opportunities, and other information deemed necessary or advisable in the sole discretion of Vaya.

4.7 **Training and Technical Assistance.** Vaya shall maintain information and forms useful to providers of Covered Services on its website or Provider Portal, offer training, facilitate a Provider Advisory Council, provide reasonable technical assistance to Contractor, establish a mechanism to receive suggestions and guidance from Network Providers on how the Network can best serve Members, and include Network Provider representation on committees that address clinical and provider payment policies, including, but not limited to, the Provider Network Participation Committee and Quality Improvement Committee.

4.8 **Verification of Member Eligibility.** Through the Provider Portal or other Vaya-designated mechanism or system, Vaya shall allow Contractor to verify Member eligibility in the applicable Vaya Benefit Plan, based on current information held by Vaya, before the Contractor renders Covered Services to a Member.

4.9 **Prior Authorization of Services.** Except for Emergency Services or where prior authorization is not required, Contractor shall obtain prior authorization for Covered Services in accordance with the Contract, the Provider Manual, and applicable clinical coverage policies. Except where not permitted by Controlling Authority, Vaya may deny payment for Covered Services where a Contractor fails to meet Vaya's requirements for prior authorization Vaya shall review requests for prior authorization and shall determine Medical Necessity for those Covered Services requiring prior authorization, as set forth in Controlling Authority. Vaya shall not utilize a definition of "medical necessity" that emphasizes cost or resource issues above clinical effectiveness. In conducting prior authorization, Vaya, and its Subcontractors, shall not require Contractor to resubmit any data or documents previously received by Vaya for a Member's presently authorized Covered Service.

4.9.1 Authorization Timeframe: For those Covered Services requiring prior authorization, Vaya shall issue a decision to approve or deny the request within the timeframes set forth in applicable Controlling Authority, including the timeframes governing requests for expedited review in which a licensed practitioner acting within the scope of his or her practice indicates, or Vaya, or a Subcontractor, determines, that adherence to the standard timeframe could seriously jeopardize a Member's life or health or ability to attain, maintain, or regain maximum function.

4.9.2 Retrospective Authorization: Vaya shall permit retroactive authorization of services in instances where the Member has been retroactively determined to be eligible for the Medicaid program, including requests for deceased Members, when all other criteria for authorization have otherwise been met, or where the Member has primary insurance or other third party coverage that denies a request for authorization.

4.9.3 Denial of Authorization Request: Upon the denial of a requested authorization, Vaya shall inform the Member's attending physician or ordering provider of the availability of a peer-to-peer conversation and shall provide written notice of the decision to the Member which includes notification of all appeal rights and an appeal form.

4.9.4 No Prior Authorization: Certain services, as indicated in the Vaya Provider Manual or authorization guidelines posted on the Vaya website, do not require prior authorization. However, all service delivery, regardless of any requirement for prior authorization or lack thereof, must comply with the documentation and record retention requirements set forth in the Contract and pursuant to Controlling Authority.

4.10 Provider Directory. During the Term of the Contract, Vaya shall include the name of Contractor in Vaya's provider directory distributed to Members and may include it in marketing or informational materials.

ARTICLE V: BILLING AND REIMBURSEMENT

5.1 Condition of Payment. Contractor understands, acknowledges, and agrees that reimbursement for services rendered is expressly conditioned upon compliance with all applicable Controlling Authority and all terms and conditions of this Contract.

5.1.1 Contractor shall comply with 42 CFR § 438.3(g), which mandates identification of provider-preventable conditions, and 42 CFR § 434(a)(12), which mandates compliance with reporting requirements set forth at 42 CFR § 438.26(d), as conditions of payment.

5.1.2 Contractor shall include its NPI number and taxonomy codes on claims or encounter data submitted under this Contract, as a condition of payment, and Vaya may deny payment for Covered Services where Contractor fails to meet these requirements.

5.1.3 Contractor must complete and submit an Electronic Funds Transfer ("EFT") form and W-9, along with all required documents described therein, to receive payment from Vaya. Contractor shall timely provide updated documents to Vaya as needed when information contained within the EFT and W-9 change.

5.2 Medicaid Eligibility and Enrollment. Contractor must verify each Member's Medicaid eligibility and enrollment with Vaya prior to submitting claims for Medicaid reimbursement to Vaya. Contractor shall report any change in county of residence to Vaya within three (3) business days of obtaining this information. Contractor shall also report any changes affecting the Member's eligibility for Medicaid to the county DSS office, including changes in household composition, family size, marital status, or residence, within five (5) business days of becoming aware of such information. If an individual presents for services who is not eligible for Medicaid and Contractor reasonably believes

that the individual meets Medicaid financial eligibility requirements, Contractor shall offer to assist the Member in applying for Medicaid.

5.2.1 Disenrollment: Contractor understands, acknowledges, and agrees that there are circumstances that may cause a Member to be disenrolled from or by Vaya, including, but not limited to, change in county of residence, admission to a correctional facility for more than thirty (30) days, change in Medicaid category of aid, or loss of Medicaid eligibility. If the disenrollment arises from a change in the Member's Medicaid county of residence, Vaya shall be responsible for claims for Member up to the effective date of the change in Medicaid county of residence. If the disenrollment arises from Member's loss of Medicaid eligibility, Vaya shall be responsible for claims for the Member up to and including the Member's last day of eligibility. In any instance of Member's disenrollment, preexisting authorizations will remain valid for any services actually rendered prior to the date of disenrollment.

5.3 NCTracks Encounter Claim Validation. Contractor shall not submit claim or encounter data for Covered Services directly to the Department. Contractor shall ensure that its enrollment information, and the enrollment information of its practitioners, if applicable, matches the information provided to Vaya to ensure successful submission of encounter claims by Vaya to the Department. If Contractor fails to ensure that its enrollment information, and the enrollment information of its health care practitioners, if applicable, matches any information provided to Vaya, Vaya reserves the right to deny claims submitted by Contractor, automatically recoup from Contractor claims paid in error in accordance with Section 3.16.1 of this Contract, and/or issue a notice of Overpayment in accordance with Section 3.16.2 of this Contract.

5.4 Third Party Billing. Contractor shall comply with all terms of this Contract even though a third party agent or clearinghouse may be involved in billing the claims to Vaya. It is a material breach of this Contract for Contractor to assign the right to payment under this Contract to a third party in violation of Controlling Authority, specifically 42 CFR § 447.10.

5.5 Sites and Services Menu. Contractor shall bill Vaya for only those sites and services identified in the Menu. Vaya will maintain an ongoing record of the Menu and will provide a copy of the Menu to Contractor within five (5) business days of receipt of a request from Contractor submitted to Contracts@vayahealth.com. Contractor understands, acknowledges, and agrees that it is the responsibility of Contractor to ensure that the sites, services, rates, and billing codes approved for Contractor to bill Vaya are accurate and listed on the Menu or in the applicable Attachment hereto. Contractor shall notify Vaya of any error in the Menu.

5.6 Claims Submission. Contractor must submit all claims electronically, either through HIPAA-Compliant Transaction Sets 837P – Professional claims, or 837I – Institutional claims, or via the Provider Portal. In order to be permitted to submit claims electronically, Contractor must execute the Trading Partner Addendum, attached hereto and incorporated herein as **Exhibit B**, request initiation of trading partner privileges by emailing Vaya at EDI@vayahealth.com, and successfully complete batch submission testing. Contractor agrees not to submit, and Vaya shall not accept, paper claims for the services provided under this Contract under any circumstances. Contractor's claims shall be compliant with the National Correct Coding Initiative ("NCCI") and the National Uniform Billing Committee ("NUBC") requirements which are in effect on the date of service, subject to state or local modifiers promulgated by

Vaya which are applicable to the submission method. Billing diagnoses submitted on claims must be consistent with the service provided and must comply with NCCI and NUBC coding standards. Vaya shall process claims in accordance with the requirements set forth in Vaya's Reimbursement Policy, and may deny payment for any claims that fail to meet Vaya's submission requirements for Clean Claims or that are received after the time limit in this Contract for filing Clean Claims.

5.6.1 Timeframe(s): Except as provided in Section 5.6.2 below, Contractor shall submit all claims to Vaya for processing and payments within one hundred-eighty (180) calendar days from the date of Covered Service or discharge (whichever is later). However, Contractor's failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for Contractor 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.

5.6.2 Exception(s): Contractor may submit claims subsequent to the 180-day limit in instances where: (i) the Member has been determined to be retroactively eligible for Medicaid, (ii) the Member has been determined to be retroactively eligible to enroll in a Vaya Benefit Plan based on county of residence, or (iii) the claim has been submitted to a third- party payor (such as Medicare or private insurance) which has not yet paid or which has denied the claim. In such instances as described in Section(s) 5.6.2(i) and/or (ii), Contractor may bill Vaya within 180 days of notification of the Member's Medicaid eligibility in NCTracks. In such instances as described in Section 5.6.2(iii) Contractor may bill Vaya within 180 days of the date Contractor receives a denial from a first- or third- party payor, if applicable. However, if Contractor fails to bill a third- party payor within the initial 180-day period, Vaya shall not accept a denial from the third- party payor based on untimely filing as a basis for overriding the initial 180-day limit.

5.6.3 Certification Regarding Claims Submission: Contractor acknowledges, agrees, understands, and certifies that:

5.6.3.1 All claims submitted by Contractor to Vaya for reimbursement shall be true, accurate, and complete, that payment of claims shall be from federal, state, and local tax funds and that any false claims, statements or documents or concealment of a material fact may be prosecuted as provided by law, and that Contractor may be fined or imprisoned as provided by law.

5.6.3.2 Contractor shall not submit claims for reimbursement for any services provided by Contractor during any period of revocation or suspension of required licensure or accreditation of Contractor or any of its facilities, or for any services provided by a member of Contractor's staff during any period of revocation or suspension of the staff member's required certification, licensure, or credentialing.

5.6.3.3 Contractor shall not submit claim or encounter data for Covered Services or other services covered by a Standard Plan or other Tailored Plan directly to the Department.

5.6.3.4 Contractor is prohibited from billing Members for Covered Services any amount greater than would be owed if Vaya provided the service directly as provided in 42 CFR §§ 438.106(c) and 438.108.

5.7 Electronic Visit Verification. Within the timeframes noted in Section 5.6.1, and its subparts, Contractor shall submit claims for any services requiring Electronic Visit Verification ("EVV") through the EVV SaaS Solution. Claims submissions for services requiring EVV shall include all data elements required by Controlling Authority.

5.8 Claims Reimbursement. Vaya shall only reimburse Contractor for approved Clean Claims for Medically Necessary Covered Services and that meet all other requirements of Controlling Authority. All claims shall be

adjudicated in accordance with Controlling Authority and this Contract, including Section 5.6.1. Reimbursement of Clean Claims to Contractor shall be made by EFT only.

5.8.1 Reimbursement Rates: Contractor understands, acknowledges, and agrees that reimbursement rates paid under this Contract are established by Vaya, accepted by Contractor, and may or may not align with the rates for services established by the Department. Reimbursement rates shall be those listed in the Vaya fee schedule posted on the Vaya website unless stated otherwise in Vaya's Sites and Services Menu or in **Schedule A, Schedule B** or a service-specific Addendum attached hereto. Subject to coordination of benefits requirements described in Section 5.9 of this Contract and provided that the claim submitted for payment is equal to or exceeds the established reimbursement rate, Vaya will pay the Contractor the rate established by Vaya and agreed to in this Contract. Contractor shall accept such compensation (plus wrap around payments from Governmental Authorities to qualified providers such as FQHCs or RHCs where applicable) as payment in full for Covered Services rendered to Members and all other activities of Contractor under this Contract.

5.8.2 Changes to Reimbursement Rates: Changes to the Vaya fee schedule or to the availability of public funds that would affect reimbursement to Contractor shall be posted on the Vaya website at least thirty (30) days in advance of any such change unless a shorter time period is required due to a change in funding or other change imposed by the Department. The Department has the authority to revise reimbursement rates unilaterally at any time.

5.8.3 Prompt Payment Standards: Vaya shall timely and promptly pay Contractor for Clean Claims in accordance with this Section 5.8.3.

5.8.3.1 For Medical Claims (including BH):

5.8.3.1.1 Vaya shall, within eighteen (18) calendar days of receiving a Medical Claim, notify Contractor whether the claim is clean or pend the claim and request from Contractor all additional information needed to process the claim.

5.8.3.1.2 Contractor shall pay or deny a Clean Claim at lesser of thirty (30) calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.

5.8.3.1.3 A medical pended claim shall be paid or denied within thirty (30) calendar days of receipt of the requested additional information.

5.8.3.2 For Pharmacy Claims:

5.8.3.2.1 Vaya shall within fourteen (14) calendar days of receiving a Pharmacy Claim pay or deny a Clean Claim or notify Contractor that more information is needed to process the claim.

5.8.3.2.2 A pharmacy pended claim shall be paid or denied within fourteen (14) calendar days of receipt of the requested information.

5.8.3.3 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. Vaya shall reprocess Medical Claims and Pharmacy Claims (including interest and penalties if applicable) in a timely and accurate manner as described in this Section 5.8, and its subparts.

5.8.3.4 If Vaya fails to pay a Clean Claim in full pursuant to Article V, Vaya shall pay Contractor interest and penalties. 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.

5.8.3.5 Failure to pay a Clean Claim within thirty (30) days of receipt will result in Vaya paying Contractor penalties 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.

5.8.3.6 Vaya shall pay the interest and penalties from Section 5.8.3.4 and 5.8.3.5 as provided in those sections and shall not require Contractor to request the interest or the penalties. The Parties agree that Vaya shall not be responsible for payment until all avenues for dispute mechanism are exhausted.

5.8.4 Retroactive Payment Adjustments: Vaya agrees to make retroactive payment adjustments to the effective date of the NC Medicaid Direct rate change as prescribed by the Department and will implement applicable rate changes within specific timelines prescribed by the Department. Payments made within the timelines prescribed by the Department shall not be considered late or be subject to interest, penalties, or liquidated damages.

5.8.5 Denial Reason and Claims Status: If Vaya denies payment of a claim, Vaya shall provide Contractor the ability to electronically access the specific denial reason. Status of a Medical Claim for Medicaid or NC Health Choice reimbursement shall be electronically available within eighteen (18) days of the date Vaya receives the claim, and for Pharmacy Claims, within fourteen (14) days of the date Vaya receives the claim.

5.8.6 Prohibited Reimbursement: Contractor acknowledges, agrees, and understands that:

5.8.6.1 Contractor shall comply with the prohibition against payment for provider-preventable conditions as set forth in 42 CFR §§ 434.6(a)(12) and 447.26 and acknowledges, agrees, and understands that Vaya shall not reimburse Contractor for: (i) services provided by non-credentialed, unqualified, or Ineligible Person(s), or (ii) for "provider-preventable conditions," which include "health care-acquired conditions" as those terms are defined at 42 CFR § 447.26, and which are also referred to as "serious reportable events" or "never events" as those terms are used by CMS in SMDL #08-004. Vaya shall not pay for items and services constituting "never events" as described in the Vaya Provider Manual or for Non-Contracted Services.

5.8.6.2 Contractor shall not be entitled to receive payment for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital): (i) furnished by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, XX, or XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act; (ii) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XX, or XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) or the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); or (iii) furnished by an individual or entity to whom the Department has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.

5.8.7 Remittance Advice: Contractor agrees to receive 835 remittances or participate in Vaya's web-based billing practices.

5.9 Coordination of Benefits. Contractor shall comply with Vaya's subrogation efforts and with N.C.G.S. §122C-146, which requires contracted providers to make every reasonable effort to identify and collect payments from third- party payors and to coordinate each Member's health care benefits to avoid undue delay in the provision of services and to ensure that public funds shall be used only if and when other sources of first- and third- party coverage have been

exhausted. If Vaya is not the primary payor for Covered Services provided to a Member, then when not prohibited by Controlling Authority, Vaya's payment to Contractor for such Covered Services shall not exceed the compensation in this Contract, less amounts payable by the primary payor or payors and less Member Expenses.

5.9.1 Payor of Last Resort: Medicaid is the payor of last resort, and Medicaid benefits payable through Vaya are secondary to benefits payable by any other payor, including Medicare, federal block grants, and state and local funding, even if the primary payor states that its benefits are secondary to Medicaid benefits or otherwise limits its payments to Medicaid beneficiaries. Notwithstanding the foregoing, and in accordance with 42 CFR § 136.61, the Indian Health Service shall be the payor of last resort for persons defined as eligible for "contract health services" under Title 42 of the Code of Federal Regulations, Part 136. Likewise, in instances where a Member is also accessing State-funded Services, the State-funded Services are the payor of last resort. Contractor shall develop and maintain policies and procedures recognizing and agreeing that Medicaid is the "payor of last resort" except in the circumstances described in this Section 5.9.1.

5.9.2 Payor of Last Resort: Medicaid is the payor of last resort, and Medicaid benefits payable through Vaya are secondary to benefits payable by any other payor, including Medicare, federal block grants, and state and local funding, even if the primary payor states that its benefits are secondary to Medicaid benefits or otherwise limits its payments to Medicaid beneficiaries. Notwithstanding the foregoing, and in accordance with 42 CFR § 136.61, the Indian Health Service shall be the payor of last resort for persons defined as eligible for "contract health services" under Title 42 of the Code of Federal Regulations, Part 136. Likewise, in instances where a Member is also accessing State-funded Services, the State-funded Services are the payor of last resort. Contractor shall develop and maintain policies and procedures recognizing and agreeing that Medicaid is the "payor of last resort" except in the circumstances described in this Section 5.9.2.

5.9.3 First- and Third-Party Coverage: Each time a Member receives services, Contractor shall obtain first and third-party coverage data, identify any first- and third- party payors, and either collect or make attempts at recovering all first- and third- party funds prior to submitting a claim to Vaya except for Medicare claims qualifying for direct submission. During an emergency, Contractor shall provide the necessary services and then assist to coordinate payment. Contractor shall report any third- party coverage of Members to the appropriate county DSS within five (5) business days of obtaining the information from a source other than DSS. Contractor shall provide Vaya with explanations of benefits and other documents and information in their possession regarding insurance covering a Member that is primary to the Member's benefit plan.

5.9.4 Medicare Billing Codes: Certain billing codes for which Medicare is the primary payor may be submitted directly to Vaya. Contractor may obtain a list of such codes from Vaya by contacting claims@vayahealth.com.

5.9.5 Claims Submission and Recoupment: Contractor shall indicate third- party reimbursement or denial information on all claims submitted to Vaya. Claims submitted without third- party payor information may be denied. If Contractor submits a claim to Vaya without first billing the appropriate third- party payors, Vaya shall treat this as an error and/or omission of Contractor and shall automatically recoup such funds from Contractor in accordance with Section 3.16.1 of this Contract.

5.9.6 Secondary Payment: Vaya makes secondary payments to supplement the primary payment if the primary payment is less than the lesser of: (i) the usual and customary charges for the service, or (ii) the rate established by Vaya. Vaya does not make a secondary payment if Contractor is either obligated to accept, or voluntarily accepts, as full payment, a primary payment that is less than its charges. If Contractor or Member receives a reduced primary payment because of failure to file a proper claim with the primary payor, the Vaya secondary

payment may not exceed the amount that would have been payable if the primary payor had paid on the basis of a proper claim. Contractor must inform Vaya that a reduced payment was made and must specify the amount that would have been paid if a proper claim had been filed.

5.9.7 Member Expenses: Contractor shall not bill Vaya for third party co-pays and/or deductibles unless there is an explicit exception permitted by Controlling Authority. Pursuant to 42 CFR § 457.505(d)(1), Contractor may not require Member Expenses for NC Health Choice member receiving well-child visits and age-appropriate immunizations. Consistent with 42 CFR § 447.56, Medicaid cost sharing does not apply to a subset of the population including children under age twenty-one (21), pregnant women, individuals receiving hospice care, federally-recognized American Indians/Alaska Natives, BCCCP beneficiaries, foster children, disabled children under Family Opportunity Act, 1915(c) waiver beneficiaries, and an individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs. Additionally, no cost sharing may be imposed for any MH/SU/IDD/TBI Services. Members who have a spend-down requirement imposed by NCDHHS as a condition of their Medicaid eligibility are required to meet the spend-down requirements prior to being considered eligible under the 1115 Demonstration Waiver.

5.9.8 Preservation of Public Funds: Contractor acknowledges, understands, and accepts that the funds used for Provider payments under this Contract are public government funds. Contractor shall demonstrate good faith efforts to seek alternate and/or supplemental sources of financing to reduce dependency on public government funding sources. If Contractor offers Health Services on an outpatient basis, it shall demonstrate good faith efforts to seek and/or maintain membership on Medicare panels and major commercial insurance panels. Contractor understands, acknowledges, and agrees that it is not entitled to reimbursement for any claims submitted for any licensed practitioner/Provider who was deemed ineligible for reimbursement by a primary payor for any reason whatsoever.

5.10 Acceptance of Medicaid as Payment in Full. Contractor understands, acknowledges, and agrees (i) that with the sole exception of any Member Expenses permitted by Controlling Authority, Contractor shall accept Vaya reimbursement as payment in full for all Covered Services provided under this Contract, and (ii) that in no event, including, but not limited to, denial of reimbursement by Vaya, shall Contractor bill, charge, collect a deposit from, seek compensation, remuneration, reimbursement from, or have any recourse against Members for Medicaid covered services provided under this Contract, except for specified and allowable Member Expenses.

5.10.1 Member Billing: Section 5.10, and its subparts, do not prohibit Contractor and a Member from agreeing in writing to continue non-Covered Services at the Member's own expense, provided that the Contractor has notified Member in advance that the Vaya may not continue covering specific services and the Member to receive the service and that the Member will be financially liable. Contractor shall be solely responsible for collecting applicable and lawful Member Expenses directly from Member. Vaya may, but is not required to, assist Contractor in collecting such Member Expenses from a Member.

5.10.2 Hold Member Harmless: Contractor agrees to hold the Member harmless for charges for any Covered Service. Contractor agrees not to bill a Member for Medically Necessary Covered Services covered by Vaya so long as the Member is eligible for coverage.

5.11 Underpayments. If Vaya determines, within the twelve (12) months following the date of submission of a Clean Claim, that Contractor has not been paid a claim or a portion of a claim that Vaya determines should be allowed, Vaya

shall make such payment within thirty (30) days of the date of determination of the underpayment. Within thirty (30) days of the final determination, not subject to further appeal, of any grievance, appeal, or litigation that determines that Vaya improperly failed to pay a claim or a portion of a claim to Contractor, Vaya shall remit the amount determined to be owed to Contractor.

5.12 Cost Savings. Contractor understands, acknowledges, and agrees that any savings achieved by Vaya through its management of the Vaya Network, of its capitated rate, or under any of the Vaya Benefit Plans are the sole and exclusive property of Vaya.

5.13 Claims for Non-Medicaid Services. Claims for services paid with non-Medicaid funds shall be reimbursed as set forth in **Addendum C**, if included and applicable. To the extent that any provisions of **Addendum C** conflict with the provisions of this Article V, the provisions of **Addendum C** shall control with respect to non-Medicaid reimbursement, and the provisions of this Article V shall control with respect to Medicaid and NC Health Choice reimbursement.

5.14 Effect of Termination. This Article V and all its Sections and subparts shall survive suspension, expiration, or termination of this Contract.

ARTICLE VI: INSURANCE REQUIREMENTS AND INDEMNIFICATION

6.1 Minimum Coverage Requirements. Contractor shall purchase and maintain insurance as listed below from a company, or a self-insurance program, which is licensed and authorized to do business in the State of North Carolina by the North Carolina Department of Insurance. All premiums and deductibles shall be at the sole expense of the Contractor. Failure to provide and maintain adequate insurance coverage is a material breach of this Contract by Contractor. All such insurance shall meet all laws, rules, regulations, and requirements of the State. The limits of coverage under each insurance policy maintained by Contractor shall not be interpreted as limiting Contractor's liability or obligations under this Contract.

6.1.1 Professional Liability: Contractor shall purchase and maintain Professional Liability Insurance protecting Contractor and its employee(s) performing work under the Contract for an amount not less than $1,000,000.00 per occurrence/$3,000,000.00 annual aggregate.

6.1.2 Comprehensive General Liability: Contractor shall purchase and maintain Comprehensive Liability Insurance, including coverage for bodily injury, property damage, and contractual liabilities and Indemnification herein assumed by Contractor under this Contract, protecting Contractor and its employees performing work under the Contract from claims of bodily injury or property damage arising from operations under the Contract for an amount of not less than $1,000,000.00 per occurrence/$3,000,000.00 annual aggregate.

6.1.3 Automobile Liability: If Contractor transports Members or subcontracts with a Person for Member transportation, Contractor shall purchase and maintain Automobile Bodily Injury and Property Damage Liability Insurance covering all owned, non-owned, and hired automobiles for an amount not less than $100,000.00 per person and $300,000.00 per occurrence or shall ensure that subcontractors purchase and maintain such coverage. Policies written on a combined single limit basis shall have a minimum limit of $600,000.00 for bodily injury and property damage. Any Contractor who does not transport Members shall return the attestation that is part of the Provider enrollment packet.

6.1.4 Workers' Compensation and Occupational Disease Insurance: Contractor shall purchase and maintain Workers' Compensation and Occupational Disease Insurance if it has employees, in such amounts and as required by Controlling Authority and N.C.G.S. Chapter 97. Any Contractor not required to obtain such coverage shall attest to the same in writing.

6.1.5 Employer's Liability Insurance: Contractor shall purchase and maintain Employer's Liability Insurance for an amount not less than $100,000.00 per accident for Bodily Injury by Accident, $100,000.00 per employee/disease for Bodily Injury by Disease, with a $500,000.00 Policy Limit, to the extent that the death of or injury to Contractor's employees are not covered by the Workers Compensation and/or Occupational Disease Insurance.

6.1.6 Cyber Liability: Contractor shall each maintain network risk and cyber liability coverage (including coverage for unauthorized access, failure of security, breach of privacy perils, as well at notification costs and regulatory defense) in an amount of not less than $1,000,000. Such insurance shall be maintained in force at all times during the term of the Contract and for a period of two years thereafter for services completed during the term of the Contract.

6.1.7 Tail Coverage: Liability insurance may be on either an occurrence basis or on a claims-made basis. If the policy is on a claims-made basis, Contractor shall purchase, at its sole cost, an extended reporting endorsement (tail coverage) for a period of not less than three (3) years after the end of the Contract Term (defined in Section 7.1 below), or an agreement to continue liability coverage with a retroactive date on or before the beginning of the Contract Term and shall also provide a copy of such policy to Vaya. This Section 6.1.7 shall survive suspension, expiration, or termination of this Contract.

6.1.8 Certificates of Insurance/Memorandum of Insurance: Contractor shall submit certificates of insurance/ memoranda of insurance ("COIs/MOIs") coverage to Vaya upon request. Prior to Vaya's execution of this Contract, Vaya may, at its sole discretion, require Contractor to have the insurance policies required herein endorsed to reflect the minimum standards stated above, as well as all other requirements in the insurance provisions of this Contract, and to provide Vaya with COIs/MOIs reflecting the aforementioned endorsements, the minimum standards stated above, as well as all other requirements in the insurance provisions of this Contract. The COIs/MOIs shall be on certificate form(s) as furnished by Contractor's insurer(s) and/or underwriter(s). Vaya's acceptance of COIs/MOIs which do not comply with the insurance requirements herein shall not be deemed a waiver of the insurance requirements. Vaya reserves the right to require certified copies of any or all policies.

6.1.9 Continuous Coverage and Notifications: Following execution of this Contract, Contractor shall:

a. Submit to Vaya new COIs/MOIs no later than ten (10) days after the expiration of any required insurance coverage to ensure documentation of continual coverage;
b. Notify Vaya in writing thirty (30) days prior to any cancellation or material change in coverage;
c. Provide evidence to Vaya of continual coverage at the policy limits stated above within forty-eight (48) hours if Contractor changes insurance carriers during the performance period of the Contract, including tail coverage as required for continual coverage; and
d. Notify Vaya in writing within ten (10) business days of knowledge or notice of a claim, suit, or criminal or administrative proceeding against Contractor or any licensed practitioner employed or subcontracted by Contractor relating to the quality of services provided under this Contract.

6.2 Waiver of Subrogation. Except for policies for Professional Liability Insurance and Workers' Compensation and Occupational Disease Insurance, Contractor shall have its insurers and underwriters waive their rights of subrogation

(whether by loan receipts, equitable assignment, or otherwise) against Vaya and its directors, officers, representatives, agents, employees, contractors, subcontractors of any tier, and the insurers, excess insurers, and underwriters of the foregoing (collectively "Vaya Group"). Contractor agrees to waive its rights of subrogation against Vaya Group.

6.3 **Additional Insured/Loss Payee.** Except for Workers' Compensation and Occupational Disease Insurance, all policies shall name as additional insureds or loss payees, as applicable depending on the terms of the policy, the members of the Vaya Group, as listed above, and all such insurance policies shall be specified as noncontributory and primary regardless of any other insurance carried by Vaya Group. All policies naming members of the Vaya Group as additional insureds or loss payees shall provide coverage to the additional insureds or loss payees on a broad form basis with such additional insured or loss payee coverage being just as broad as the coverage provided to the named insured including but not limited to, coverage for the sole or concurrent negligence of each additional insured and not be restricted to and/or contain exclusions for (a) "ongoing services," (b) coverage for vicarious liability, or (c) circumstances in which the named insured is partially negligent. Any policy that limits coverage afforded to Vaya Group as additional insureds or loss payees to liabilities arising out of acts or omissions of Contractor, or any similar limitation, shall not be in compliance with the requirements of this Contract. Contractor understands, acknowledges, and agrees that the insurance coverages required by this Contract shall not be invalidated as regards the interest of the Vaya Group by any act or neglect of the named insured or any member of Vaya Group.

6.4 **Liability.** Failure of Contractor to secure the insurance coverages, or to comply fully with any of the insurance provisions of this Contract, or to secure such endorsements on the policies as may be necessary to carry out the terms and provisions of this Contract shall be the responsibility of the Contractor and shall in no way act to relieve Contractor from the obligations of this Contract, any provisions hereof to the contrary notwithstanding. If liability for loss or damage is denied by the Contractor's insurer(s) and/or underwriter(s), in all or in part, for any reason whatsoever, including, but not limited to, breach of said insurance by Contractor or failure of Contractor or its respective subcontractors of any tier to maintain any of the insurance herein required, Contractor shall Indemnify all members of Vaya Group against all claims, demands, costs, and expenses, including, but not limited to, attorneys' fees and punitive damages, which would otherwise be covered by said insurance even if the liability arises out of the sole or concurrent negligence, strict liability, gross negligence, willful or wanton misconduct, or other fault of any member of Vaya Group.

6.5 **Certification Regarding Insurance.** By executing this Contract, Contractor understands, acknowledges, and agrees that: (i) any loss of insurance shall justify the termination of this Contract in Vaya's sole discretion; (ii) upon Contractor's notification to Vaya of a claim, suit, or criminal or administrative proceeding against Contractor or their respective licensed practitioner(s) employed or subcontracted relating to the quality of services provided under this Contract, Vaya in its sole discretion shall determine within ten (10) days of receipt of notification whether termination of the Contract or other sanction is required; and (iii) all insurance requirements of this Contract must be fully met unless specifically waived in writing by Vaya.

6.6 **No Liability Owed by Department.** Contractor understands and agrees that the Department does not assume liability for the actions of, or judgments rendered against, Vaya, its employees, agents, or Subcontractors. Further, Contractor understands and agrees that there is no right of subrogation, contribution, or indemnification against the Department for any duty owed to Contractor by Vaya or any judgment rendered against Vaya.

6.7 **Indemnification and Hold Harmless.** Contractor, and its successors, assigns, owners, members, partners, managers, officers, directors, employees, representatives, agents, and/or subcontractors of any tier, in their representative (and not individual) capacities, (collectively the "Contractor Indemnitors"), shall fully protect, release, defend, indemnify, and hold harmless, (collectively "Indemnification" or "Indemnify"), Vaya, and its officers, directors, employees, representatives, agents, assigns, successors, servants, suppliers, materialmen, and subcontractors of any tier, and any insurers, excess insurers, and underwriters of any of the foregoing, (collectively "Vaya Indemnitees") from and against any and all claims, demands, allegations, suits, losses, liabilities, expenses, costs (including reasonable or actual attorney's fees), judgments, settlements, obligations, damages (whether nominal, compensatory, consequential, punitive, treble, or exemplary), and causes of action of every kind and nature, whether known or unknown, whether contingent or liquidated, whether at law or in equity, whether or not involving a third party (including, but not limited to, claims alleged or brought by any affiliate of Trading Partner or any Health Care Clearinghouse associated with the Trading Partner), whether related to or on account of bodily/mental injury or infliction, death, property (real, personal, and/or intellectual) damage or loss, or any other injury, damage or loss, incurred or sustained by or made against any or all members of the Vaya Indemnitees, and whether arising from tort, contract, or otherwise, without limit, directly or indirectly arising out of, relating to, and/or resulting from: (1) any breach, material or non-material, of any representation or warranty, by any or all Contractor Indemnitors, contained in this Contract, (2) any breach, material or non-material, of any covenant, obligation, agreement, or duty under this Contract and/or under applicable laws, rules, and/or regulations, by any or all Contractor Indemnitors, and/or (3) the wrongful, intentional, grossly negligent, and/or ordinary negligent acts, errors, and/or omissions, by any or all Contractor Indemnitors in rendering services or performing their obligations, covenants, agreements, and/or duties pursuant to or in furtherance of this Contract, in each case whether or not caused by the negligence of any or all Vaya Indemnitees, (collectively "Contractor Claim"), and whether or not the relevant Contractor Claim has merit. Contractor Indemnitors expressly waive any defense of prematurity to a claim for Indemnification by any Vaya Indemnitee; and any Vaya Indemnitee shall have the right to a claim for Indemnification pursuant to this Section 6.7 prior to any loss being sustained by it.

Vaya, and its officers, directors, managing employees, representatives and agents, in their representative (and not individual) capacities, (collectively "Vaya Indemnitors") shall Indemnify Contractor, and its employees, affiliates, subcontractors or agents, (the "Contractor Indemnitees") from and against any and all of the following alleged or asserted by a third party: claims, demands, losses, liabilities, expenses, costs (including reasonable or actual attorney's fees), judgments, obligations, damages (whether nominal, compensatory, punitive, or treble), and causes of action of every kind and character, whether arising from tort, contract, or otherwise, whatsoever related to or on account of bodily injury, death, property damage or loss or any other damage or loss, incurred or sustained by or made against any or all members of the Contractor Indemnitees, without limit, directly or indirectly arising out of the negligent acts, errors, or omissions by or on behalf of any or all Vaya Indemnitors in performing their obligations pursuant to or in furtherance of this Contract.

Further, neither Party to this Contract shall be responsible for any obligation or liability assumed by the other Party or its employees, affiliates, subcontractors, or agents, unless expressly set forth in this Contract. Nothing contained in this Section 6.7 shall prevent either Party from filing and pursuing an action for damages against the other Party based on an alleged failure to satisfactorily render services or to perform obligations pursuant to this Contract. This Section 6.7 shall survive suspension, expiration, or termination of this Contract.

6.8 LIMITATION OF LIABILITY. NOTWITHSTANDING ANYTHING ELSE IN THIS CONTRACT OR OTHERWISE, NEITHER VAYA NOR ANY OF ITS OFFICERS, DIRECTORS, EMPLOYEES, REPRESENTATIVES, AGENTS, SERVANTS, SUPPLIERS, MATERIALMEN, AND SUBCONTRACTORS OF ANY TIER, AND ANY INSURERS, EXCESS INSURERS, AND UNDERWRITERS OF ANY OF THE FOREGOING, ("VAYA PARTY"), WILL BE LIABLE TO CONTRACTOR AND/OR ANY OF ITS SUCCESSORS, ASSIGNS, OWNERS, HEIRS, MEMBERS, PARTNERS, MANAGERS, OFFICERS, DIRECTORS, REPRESENTATIVES, AND/OR AGENTS ("CONTRACTOR PARTY'),UNDER ANY CONTRACT, TORT, NEGLIGENCE, STRICT LIABILITY, OR OTHER LEGAL OR EQUITABLE THEORY, FOR ANY SPECIAL, INDIRECT, CONSEQUENTIAL, INCIDENTAL, OR EXEMPLARY DAMAGES, INCLUDING, WITHOUT LIMITATION, LOST PROFITS, BUSINESS INTERRUPTION, AND LOSS OR INACCURACY OF INFORMATION, EVEN IF VAYA PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. TO THE FULLEST EXTENT PERMITTED BY LAW, AND NOTWITHSTANDING ANY OTHER PROVISION OF THIS CONTRACT TO THE CONTRARY, THE TOTAL LIABILITY, IN THE AGGREGATE, OF ANY VAYA PARTY TO ANY CONTRACTOR PARTY AND ANYONE CLAIMING BY OR THROUGH ANY CONTRACTOR PARTY FOR ANY AND ALL CLAIMS, LOSSES, COSTS (INCLUDING ATTORNEYS' FEES) OR DAMAGES, AND CLAIMS EXPENSES, RESULTING FROM OR IN ANY WAY RELATED TO THIS CONTRACT, SHALL NOT EXCEED THE TOTAL REIMBURSEMENT FOR CLEAN CLAIMS RECEIVED BY CONTRACTOR DURING THE TERM OF THIS CONTRACT AS OF THE DATE OF THE ALLEGED OFFENSE. IT IS INTENDED THAT THIS LIMITATION APPLY TO ANY AND ALL LIABILITY OR CAUSE(S) OF ACTION, HOWEVER ALLEGED OR ARISING, UNLESS OTHERWISE PROHIBITED BY LAW. IN NO EVENT WILL THE VAYA PARTY BE LIABLE TO THE CONTRACTOR PARTY FOR ANY MATTER BEYOND VAYA'S REASONABLE CONTROL. THIS SECTION 6.8 SHALL SURVIVE SUSPENSION, EXPIRATION OR TERMINATION OF THIS CONTRACT.

ARTICLE VII. TERM AND TERMINATION

7.1 Term. The term of this Contract shall begin on the launch date for Vaya's Tailored Plan, which is currently anticipated for **December 1, 2022** but may change at the direction of the Department or the General Assembly, shall extend through one year following this launch date (anticipated to be through November 30, 2023), and shall renew as expressly provided in Sections 7.1.1 and 7.1.2 of this Contract, unless terminated prior to the expiration of the specified term in accordance with the Notice block on the Signature and Notice Page of the Contract, regardless of any other term identified in any platform, application or elsewhere outside of this Contract for purposes of authorization continuity, ("Term"). Vaya reserves the right to impose shorter time limits on the Term of this Contract should Contractor fail to comply with the terms of this Contract. Vaya shall determine eligibility for retention as a Network Provider in accordance with Vaya's retention criteria set forth in its Credentialing and Recredentialing policy and Network Access Plan.

7.1.1 Renewal Term: Unless earlier terminated as set forth in the Contract, upon the expiration of the initial Term of this Agreement, this Contract shall automatically renew for three (3) consecutive one-year terms. The same terms and conditions of this Contract that apply to the initial Term shall apply to each renewal Term.

7.1.2 No Right of Renewal. Except as provided in Sections 7.1 and 7.1.1, there is no right of renewal of this Contract or right to be a Clinically Integrated Network or Network Provider in the Vaya Network following the expiration or termination of this Contract.

7.1.3 Extensions. In no event shall the term of this Contract, including the initial Term and the renewal Term(s), extend beyond the earlier of the term of the Managed Care Contract or November 30, 2026, without a written amendment executed by both Parties in the manner required in Section 8.6.

7.2 **Termination Due to Lack of Availability of Funds.** Vaya or the Contractor may terminate this Contract effective upon written Notice to the other Party if Federal, State and/or local funds allocated to Vaya are reduced, revoked, or terminated in a manner beyond the control of Vaya for any part of the Contract period. In such event, Vaya will provide payment to Contractor for Clean Claims timely submitted for Medically Necessary Covered Services provided to Members which were authorized by Vaya prior to the notification and for which Contractor is qualified and/or credentialed.

7.3 **Termination for Convenience without Cause.** This Contract may be terminated at any time upon mutual consent of Vaya and the Contractor with mutually agreed upon notice to Members, or by Vaya or Contractor for any reason or no reason at all (without cause) by giving at least sixty (60) days' prior written notice of termination to the other Party, or longer notice if required to ensure continuity of care for Members and/or to comply with Controlling Authority, including, but not limited to, N.C.G.S. § 122C-63. This Contract may be terminated as between Vaya and Contractor at any time upon mutual consent of Vaya and Contractor with mutually agreed upon notice to Members actively receiving services from Contractor, or by Vaya and Contractor for any reason or no reason at all (without cause) by giving at least sixty (60) days' prior written notice of termination to the other Party, or longer notice if required to ensure continuity of care for Members and/or to comply with Controlling Authority, including, but not limited to, N.C.G.S. § 122C-63.

7.4 **Termination for Cause by Contractor.** Upon termination of the Managed Care Contract, this Contract and Contractor's participation in the Vaya Network for the Vaya Benefit Plans shall automatically terminate. Additionally, (i) Contractor may terminate this Contract with cause with at least sixty (60) days' prior written notice to Vaya, or longer if required to ensure continuity of care for Members and (ii) a Contractor may terminate this Contract as to Contractor and Vaya with cause with at least sixty (60) days' prior written notice to Vaya, or longer if required to ensure continuity of care for Members actively receiving services from Contractor. Cause for termination by Contractor shall be documented in writing detailing the grounds for the termination and may include the bankruptcy or insolvency of Vaya or failure of Vaya to timely reimburse Contractor for Clean Claims for Medically Necessary Covered Services as established in Article V, Billing and Reimbursement, or to compensate Contractor as required in **Schedule A** or **B**.

7.5 **Immediate Suspension for Cause by Vaya.** Vaya shall be permitted to suspend some or all activities of Contractor, or any of its Providers, upon finding a credible allegation of fraud, waste, abuse, or serious quality of care concerns by Vaya or the Department.

7.6 **Termination for Cause by Vaya.** Vaya may terminate this Contract with Contractor for cause effective upon written Notice to Contractor and may terminate this Contract as between Vaya and Contractor upon written Notice to Contractor, immediately or on such other date as specified in the Notice. Additionally, upon the occurrence of cause, Vaya may in its sole discretion, take any action up to and including one or more of the following: (i) the suspension of all or any part of this Contract; (ii) the termination, suspension, exclusion and/or revocation of Contractor or any of its Providers, or any of their respective Owners' or Managing Employees', participation in the Vaya Network, credentialing by Vaya or in providing future services to any Member through an out-of-network arrangement; and/or (iii) any other action as specified herein or in the Vaya Provider Manual. Vaya shall document such cause in writing and detail the grounds for the termination and the grounds for any other of the (i)-(iii) aforementioned action(s) taken. For purposes of this Section 7.6 and for any action up to and including termination, exclusion, and/or revocation includes, cause shall

include, but not be limited to, a breach of any material term or condition of this Contract by Contractor, any action or inaction by or on behalf of Contractor that Vaya reasonably determines constitutes an immediate threat or risk to the health, safety, or welfare of a Member or creates serious quality of care concerns, or Contractor's failure or refusal to perform pursuant to this Contract in accordance with Controlling Authority. Examples of cause include the following, without limitation:

a. Contractor becomes an Ineligible Person or voluntarily withdraws from participation in applicable Vaya Benefit Plans;
b. A Provider employed or subcontracted with Contractor becomes an Ineligible Person and Contractor does not immediately terminate the Ineligible Person upon knowledge or good faith suspicion of such ineligibility;
c. Any other loss of, or sanction against, required facility or professional licensure, accreditation, or certification of the Contractor, or any of its Owners or Managing Employees; or
d. Determination by Vaya that Contractor, or any of its Owners or Managing Employees, fails to meet certification, accreditation or licensure standards prescribed by Controlling Authority, or fails to provide timely, complete, and accurate documentation of services as required by this Contract;
e. Determination by Vaya that Contractor, or any of its Owners or Managing Employees, is engaged in fraudulent or abusive billing, documentation, or clinical practices;
f. Determination by Vaya that Contractor, or any of its Owners or Managing Employees, has provided fraudulent, misleading, or misrepresented information to Vaya or any Member, including false information related to screening, credentialing, or enrollment in Vaya's Network or the State's Medicaid program;
g. Upon a confirmed finding of fraud, waste, or abuse by Vaya, the Department, the North Carolina Department of Justice Medicaid Investigations Division, or other applicable authority;
h. Contractor's insurance coverage as required by the Contract lapses for any reason;
i. Contractor, or any of their Owners or Managing Employees, fails to cooperate with any Program Integrity and Other Monitoring Activities;
j. Contractor fails to timely reimburse Vaya for overpayment(s) identified by Vaya or fails to comply with any payment plan authorized by Vaya for the repayment of any overpayment(s);
k. Contractor fails to provide prior, written notice to Vaya of intent to dissolve or cease operations and/or has dissolved or ceased operations, whether due to retirement, bankruptcy, insolvency, relocation, acquisition, merger, or sale, or for any other reason;
l. Contractor becomes insolvent, makes a general assignment for the benefit of creditors, files a voluntary petition in bankruptcy, has a receiver, trustee, custodian, or liquidator appointed for its business or assets because of Contractor's inability to pay its debts as they mature, or Contractor becomes subject to any proceeding under any bankruptcy or insolvency law;
m. Contractor fails to permit access to Contractor's facilities for any site visits required under 42 CFR § 455.432, unless Vaya determines that adverse action is not in the best interest of the Closed Network and Vaya documents that determination in writing;
n. Contractor fails to timely enroll, fails to maintain enrollment, or cannot enroll with the Department as a Medicaid provider; or

o. If the Parties executed the Contract pending the outcome of Department screening, enrollment, and revalidation, upon notification from the Department that Contractor cannot be enrolled, or the expiration of one (1) one hundred twenty (120) day period without enrollment of Contractor; or

7.7 Termination for Impossibility. If federal or state laws, rules or regulations are amended or judicially interpreted so as to render the fulfillment of the Contract on the part of any Party impossible, the Parties shall be discharged from further obligation under the terms of this Contract, except for settlement of the respective debts and claims incurred before the effective date of termination.

7.8 Effect of Termination or Expiration. In the event of expiration (including but not limited to, expiration due to non-renewal) of this Contract, or termination of this Contract as provided in Sections 7.2-7.7, this Contract shall forthwith become null and void and have no effect as to the Parties to the termination (hereinafter "Terminating Parties"), without any liability or obligation on the part of Terminating Parties, except as follows:

7.8.1 The obligations of the Terminating Parties under Sections 2.7 (Confidentiality of Protected Health Information and Sensitive Information), 2.8 (Confidentiality of Non-Public Information; Nondisclosure), 3.14 (Documentation and Access to Records), 3.17 (Program Integrity and other Monitoring Activities), 3.23 (Duties Related to Closure or Termination), Article V (Billing and Reimbursement), 6.1.7 (Tail Coverage), 6.7 (Indemnification and Hold Harmless), 6.8 (Limitation of Liability), 8.2 (Intellectual Property), 8.3 (Publicity), 8.10 (Dispute Resolution), 8.13 (Subcontracting), and 8.15 (Governmental Immunity), including any subparts thereof, of this Contract shall continue following termination or expiration of this Contract.

7.8.2 If Contractor is a Terminating Party, Contractor shall submit all remaining claims and registrations of putative Members within ninety (90) days of the date of Contract termination or expiration.

7.8.3 To ensure that a Transition of Care is undertaken in an orderly manner that maximizes Member's health, safety and continuity of care, upon expiration or termination of this Contract for any reason, except as otherwise determined by Vaya not to apply, Contractor, if a Terminating Party, shall (a) continue providing Covered Services to Members through (1) the lesser of the period of active treatment for a chronic or acute medical condition or up to ninety (90) days, (2) the postpartum period for Members in their second or third trimester of pregnancy, or (3) such longer period required by Controlling Authority, and (b) cooperate with Vaya for the transition of Members to another Provider, PHP, or Medicaid Direct. The terms and conditions of this Contract shall apply to any such post-expiration or termination activities, provided that Vaya shall pay Contractor for such Covered Services at 100% of the then-current Medicaid fee-for-schedule. The transition of care provisions in this Agreement shall survive expiration or termination of this Contract.

7.8.4 In the case of insolvency of Vaya and Contractor is a Terminating Party, when Contractor is paid on a prepaid basis for Covered Services under this Contract, Contractor shall continue to render inpatient care until the Member is ready for discharge.

7.8.5 Upon termination, Contractor, if a Terminating Party, shall notify Vaya of any Members who have received services in the sixty (60) days preceding the effective date of termination or who have scheduled appointments.

7.8.6 Following termination or expiration of this Contract, Vaya may perform a post-payment review of billing, documentation and other fiscal records, and any adjustments for amounts due or owed to Vaya or any other Terminating Party shall be added or deducted from any final reimbursement to such other Terminating Party. Vaya may hold payment of pending claims until completion of a post payment review. Vaya and Contractor shall

settle their debts and claims within sixty (60) days of the completion of any such post-payment review and/or receipt of all final billing and required documentation, unless the provider elects to request dispute resolution in accordance with Section 8.10 of this Contract.

7.8.7 All payments provided hereunder shall be adjusted so as not to exceed the amount due for services actually rendered prior to the date of termination or expiration. If advance payments have been made for services not provided as of the date of Contract termination or expiration, Contractor, if a Terminating Party, shall promptly refund all excess funds paid within the above-referenced sixty (60) days.

7.8.8 No such termination or expiration shall relieve Contractor, or any of its respective successors, assigns, owners, officers, directors, members, managers, partners, representatives, affiliates, employees, agents, subcontractors of any tier, and/or similarly situated individuals, from any liability or damages resulting from a material breach of any of its representations, warranties, covenants, conditions, or agreements set forth in this Contract.

ARTICLE VIII: GENERAL TERMS AND CONDITIONS

8.1 Relationship of the Parties. Contractor is an independent contractor of Vaya. This Contract is not intended and shall not be construed to create the relationship of principal-agent, master-servant, employer-employee, partnership, joint venture, or association between the Parties or any of their owners, officers, directors, members, managers, partners, representatives, employees, or agents. In performance of its duties hereunder, Contractor is at all times acting and performing as an independent contractor of Vaya, and neither Party, nor their respective past, present, and/or future owners, officers, directors, members, managers, partners, representatives, affiliates, employees, agents, or subcontractors of any tier, shall be considered the partner, agent, servant, associate, employee of, or joint venture with, the other Party. Further, neither Contractor, nor their respective past, present, and/or future owners, officers, directors, members, managers, partners, representatives, affiliates, employees, agents, or subcontractors of any tier, shall by virtue of this Contract or relationship between the Parties be considered an employee, representative, or agent of Vaya for any purpose, including, but not limited to, compensation for services, employee welfare and pension benefits, workers' compensation insurance, or any other fringe benefits of employment.

8.2 Intellectual Property. Contractor understands, acknowledges, and agrees that all language in all documents, and the documents themselves, that are authored, produced, developed, and/or prepared by Vaya and which are used and provided in connection with bids or negotiations for, executions of and performance under this Contract are the property of Vaya, along with all ideas and concepts represented by and manifested in the business practices or operations of Vaya. Vaya reserves all rights in said intellectual property. Contractor must obtain written permission of Vaya prior to using any of Vaya's intellectual property for purposes outside the performance of this Contract. This Section 8.2 shall survive suspension, expiration, or termination of this Contract.

8.3 Publicity. Neither Vaya, nor the Contractor, shall publish or disseminate any advertising or proprietary business material or information, whether in printed or electronic form (including photographs, films, and public announcements), or any business papers or documents which identify the other Party or its facilities without the prior written consent of that Party, except that Contractor consents to the inclusion of any of the following information in any and all marketing and administrative materials published or distributed in any medium by Vaya: name, address, telephone number, office hours, type of practice or specialty, hospital affiliation, website, languages spoken, available

practitioners (including any board certification, education, or training history) and services. This Section 8.3 shall survive suspension, expiration, or termination of this Contract.

8.4 Contract Negotiations. Contractor acknowledges that when Vaya offered the Contract to Contractor, Contractor had the opportunity to view applicable Vaya fee schedules for Covered Services and Vaya made available its schedule of fees.

8.5 Entire Agreement and Integration. This Contract constitutes the entire agreement between Vaya and Contractor for the provision of services to Member(s). Any Attachment referred to herein or attached hereto constitute a part of this Contract and are incorporated herein by reference to the same extent as if fully set forth herein. This Contract supersedes all prior statements, agreements, and understandings, whether written or oral, between Contractor and Vaya with respect to the subject matter hereof. Should the terms of the Vaya Provider Manual conflict with the terms of this Contract, the terms of this Contract shall govern, unless expressly provided otherwise herein. Should the terms of this Contract conflict with any Attachment, such Attachment shall govern, unless expressly provided otherwise herein.

8.6 Amendments. Except for changes to Controlling Authority published by CMS, Vaya, or the Department, its divisions, and/or its fiscal agent as referenced in Section 1.4, any alterations, amendments, or modifications to this Contract shall be in writing, signed by Vaya and Contractor, and attached hereto. Contractor understands, acknowledges, and agrees that Vaya may periodically make changes to the Vaya Provider Manual or other written policies and procedures as described in Section 3.18.

8.6.1 Vaya shall send any proposed Contract amendment to the Notice contact of Contractor. The proposed amendment shall be dated, labeled "Amendment," signed by Vaya, and include an effective date for the proposed Amendment. Unless otherwise agreed to by and between Vaya and Contractor, the proposed Amendment shall be effective if Contractor fails to object in writing within sixty (60) days of receipt of the proposed Amendment. If Contractor objects to the proposed Amendment in writing, the Amendment shall not become effective and Vaya shall be entitled to terminate this Contract upon sixty (60) days' notice to Contractor, if applicable.

8.7 Choice of Law and Forum Selection. This Contract has been accepted and executed and is to be performed in this State. Pursuant to N.C.G.S. § 1G-3, this Contract and the rights and obligations of the Parties hereto shall be construed under, interpreted in accordance with, governed by and enforced under the laws of the State, without giving effect to principles of conflict of laws. Contractor understands, acknowledges, and agrees that the sole venue for all administrative and legal actions upon this Contract shall be in the General Court of Justice, Superior Court Division of the Trial Courts for Buncombe or Wake County, North Carolina, or the U.S. District Court for the Western District of North Carolina or Eastern District of North Carolina. Contractor hereby consents to the jurisdiction of these state and federal courts located in Asheville, North Carolina.

8.8 Headings. The sections, subsections, and other headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

8.9 **Non-waiver.** No covenant, condition, or undertaking contained in the Contract may be waived except by the written agreement of the Parties. Forbearance or indulgence in any other form by either Party in regard to any covenant, condition, or undertaking to be kept or performed by the other Party shall not constitute a waiver thereof, and until complete satisfaction or performance of all such covenants, conditions, and undertakings, the other Party shall be entitled to invoke any remedy available under the Contract or at law or in equity, despite any such forbearance or indulgence.

8.10 **Dispute Resolution.** All disputes shall be resolved as outlined in the Vaya Provider Manual and in accordance with Vaya accreditation requirements, including, but not limited to, those of URAC and/or NCQA, as applicable. Contractor must avail themselves of the Vaya internal dispute resolution process prior to commencing any administrative or legal action pursuant to Section 8.10.1 or in accordance with Section 8.7. By executing this Contract, Contractor explicitly understands, acknowledges, and agrees that disputes based on this Contract are not subject to review by the NC Office of Administrative Hearings. This Section 8.10, and its subparts, shall survive suspension, expiration, or termination of this Contract.

8.10.1 Vaya's internal appeal process further described in the Vaya Provider Manual must be exhausted before Contractor may seek other legal or administrative remedies under state or federal law. Contractor may submit a request for reconsideration of overpayment determinations as outlined in the Vaya Provider Manual.

8.11 **Severability.** Any provision of this Contract which is determined by a court of competent jurisdiction to be prohibited, unenforceable, or not authorized shall be ineffective to the extent of such prohibition, unenforceability, or non-authorization without invalidating the remaining provisions hereof or affecting the validity, enforceability, or legality of such provision. In such case, such determination shall not affect any other provision of this Contract, and the remaining provisions of this Contract shall remain in full force and effect. If any provision or term of this Contract is susceptible to two or more constructions or interpretations, one or more of which would render the provision or term void or unenforceable, the Parties agree that a construction or interpretation which renders the term or provision valid shall be favored.

8.12 **Assignment and Delegation.** Contractor's duties and obligations under the Contract shall not be assigned, delegated, or transferred, or any interest hereunder, without prior written notice to and the prior written consent of Vaya. Any attempt by Contractor to assign, delegate, or transfer this Contract or its interest hereunder without complying with the terms of this Section 8.12 shall be null and void and of no effect, and Vaya, at its option, may elect to terminate this Contract, in accordance with the terms of Section 7.6, without advance notice. Vaya may assign, delegate, or transfer this Contract or any interest hereunder in whole or in part to any successor to the assets or operations of Vaya, or to any affiliate of Vaya, provided that Vaya notifies Contractor, in writing, of any duties or obligations that are to be delegated or transferred before the delegation or transfer.

8.13 **Subcontracting.** Contractor must obtain prior written permission from Vaya prior to subcontracting any of the services to be provided by Contractor under this Contract to such subcontractor. All services subcontracted shall continue to be subject to the terms of this Contract. Contractor must ensure that any subcontractors performing any obligations of this Contract meet all requirements of this Contract in their performance of such obligations. Contractor

hereby agrees to waive any non-compete provisions in its agreements with its subcontractors to the extent that, if enforced, would prohibit a subcontractor from contracting directly or indirectly with Vaya.

8.13.1 Authority. Contractor represents and warrants that it has full authority, under power of attorney granted by Contractor's subcontractor to the Contractor, to bind the subcontractor to this Contract, and all matters related to this Contract, including, but not limited to, the granting of any waivers of any of the terms of this Contract and entering into any amendments or modifications thereof. In the event of false representation or warranty, breach, or failure to comply with this covenant, Contractor, as applicable to the subcontractor, shall Indemnify Vaya against Indemnitees for Contractor Claims arising therefrom as set forth in Section 6.7 above. This Section 8.13, and its subpart, shall survive suspension, expiration, or termination of this Contract.

8.14 No Third- Party Beneficiaries. Nothing in this Contract shall be construed as creating or justifying any allegation, demand, claim, action, cause of action, argument, judgments, defense, liability, obligation, damages, losses, costs, attorneys' fees (reasonable or actual), loss of service, expenses, compensations, or nominal, compensatory, consequential, punitive, or treble damages of whatsoever kind or nature, whether known or unknown and whether contingent or liquidated, whether at law or in equity, however alleged or arising, by any third party against Vaya and Contractor, or the Department. Furthermore, nothing in this Contract shall be construed as creating or justifying any allegation, demand, claim, action, cause of action, argument, judgments, defense, liability, obligation, damages, losses, costs, attorneys' fees (reasonable or actual), loss of service, expenses, compensations, or nominal, compensatory, consequential, punitive, or treble damages of whatsoever kind or nature, whether known or unknown and whether contingent or liquidated, whether at law or in equity, however alleged or arising, by Contractor against the Department.

8.15 Governmental Immunity. Notwithstanding any provision in this Contract to the contrary, nothing contained in this Contract shall be deemed to constitute a waiver of the sovereign or governmental immunity of Vaya as a local political subdivision of the State of North Carolina, which immunity is hereby expressly and fully reserved to Vaya. This Section 8.15 shall survive suspension, expiration, or termination of this Contract.

8.16 Transfer of Vaya Duties and Records. In the event of Vaya's insolvency, administrative duties and records will be transferred to an organization experienced in the provision of administrative and management services to health plans.

8.17 Binding Effect. The rights and obligations of each Party under this Contract shall inure to the benefit of and shall be binding upon the heirs, successors, legal representatives, and assigns of such Party.

8.18 Authority of Representatives. The Parties represent and warrant that their undersigned representatives have been, and are, duly, properly, and fully authorized to sign and enter into this Contract on their behalf, and that they have not transferred, assigned, or conveyed to any other entity, person, or agency any of the obligations, claims, causes of action, rights, interest, or title which are the subject of this Contract.

8.19 Counterparts and Electronic Signature. This Contract may be executed in multiple counterparts, which together shall constitute one and the same Contract. The counterparts of this Contract, and any and all appendices, attachments, exhibits, and/or schedules, may be electronically executed and/or delivered by facsimile or other electronic means by

any Party to any other Party. The receiving Party may rely on the receipt of such document so executed and/or delivered as if an original had been duly executed and received.

8.20 **Incorporation of Recitals.** The recitals set forth above are an integral part of this Contract and shall have the same contractual significance as any other language herein.

ATTACHMENTS AND SIGNATURES TO FOLLOW

ATTACHMENTS

The following attachments, appendices, exhibits, and/or schedules are an integral part of this Contract and are deemed incorporated herein by this reference if so marked:

- ☐ Exhibit A – Vaya Software Platform Access/User Addendum (All Network Providers)
- ☐ Exhibit B – Trading Partner Addendum (All Network Providers)
- ☐ Schedule A – Compensation (Designated Providers) (All Network Providers)
- ☐ Schedule B – Value-Based Payment Arrangements (All Network Providers)
- ☐ Addendum A – Advanced Medical Home Addendum (All AMH or AMH+ Network Providers)
- ☐ Addendum B – Care Management Agency Addendum (All CMA Network Providers)
- ☐ Addendum C – Behavioral Health Provider Addendum (All MH/SU/IDD/TBI Closed Network Providers)
  - ☐ Addendum C-1 – Service-Specific Scope(s) of Work (All Network Providers receiving non-Medicaid funds on 1/12 basis for MH/SU/IDD/TBI Services)
  - ☐ Addendum C-2 – Non-Medicaid Funding Addendum (All Network Providers receiving non-Medicaid funds)
  - ☐ Addendum C-3 – DMH/DD/SAS Core Performance Indicators (All Network Providers receiving non-Medicaid funds)
  - ☐ Addendum C-4 – Consolidated Federal Certifications and Disclosures (All Network Providers receiving non-Medicaid funds)
  - ☐ Addendum C-5 – Financial Requirements (All Network Providers receiving non-Medicaid funds on 1/12 basis)
- ☐ Addendum D – Indian Health Care Provider Addendum (All IHCP Network Providers)
- ☐ Addendum E – Local Health Department Addendum (All LHD Network Providers)
- ☐ Addendum F – Physical Health Provider Addendum (All Primary Care and Specialty Care Network Providers)
- ☐ Addendum G – Pregnancy Management Provider Addendum (All Network Providers of Prenatal, Perinatal, and Postpartum Care)

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SIGNATURE AND NOTICE PAGE

Notice: Any notice to be given by either Party under this Contract shall be in writing and addressed to the address listed below, or to such other address as the Party may designate by notice to the other Party, or as otherwise specified herein. Notices will be considered effective upon receipt when delivery is by trackable mail, postage prepaid, by electronic means, or by hand delivery. All notices provided under this Contract shall be sent using one or more of the following methods and shall be deemed delivered: (i) five business days following the date the notice is placed, first-class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this Contract prohibits the use of an electronic medium for a communication other than an amendment, as agreed hereto by the Parties.

Email:	**VAYA HEALTH** Office of General Counsel 200 Ridgefield Court, Suite 218 Asheville, NC 28806 Contracts@vayahealth.com

IN WITNESS WHEREOF, each Party intends this Contract to be under "Seal" and has caused this Contract to be executed as the act of said Party, as of the Effective Date. Each individual electronically signing below certifies that he or she has been duly authorized to bind Vaya and Contractor to the terms of this Contract.

Vaya Health:	**Contractor Legal Business Name:**
By: _____ (ADOPTED SEAL) VAYA HEALTH DULY AUTHORIZED OFFICIAL	By: _____ (ADOPTED SEAL) CONTRACTOR DULY AUTHORIZED OFFICIAL
Name and Title: Brian Ingraham, Chief Executive Officer	Name: _____
Date: _____	Title: _____ Date: _____

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act, N.C.G.S. § 159-28.

_____ _____

Vaya Health Finance Officer, or designee Date

EXHIBIT A: VAYA SOFTWARE PLATFORM ACCESS/ USER ADDENDUM

THIS Vaya Software Platform Access/ User Addendum ("Platform Agreement"), is made and entered as of the Effective Date of the Network Provider Participation Agreement by and between Vaya Health, a Local Management Entity/Managed Care organization, with a primary business address at 200 Ridgefield Court, Asheville, North Carolina 28806 (hereinafter referred to as "Vaya"), and [INSERT LEGAL BUSINESS NAME FOR CONTRACTOR],with a primary business address at [INSERT CONTRACTOR ADDRESS], and including its employees, agents, and subcontractors of any tier (collectively "Agents") (hereinafter Contractor individually referred to as the "Contractor").

W I T N E S S E T H:

WHEREAS, this Platform Agreement is ancillary to the Network Provider Participation Agreement ("Contract") executed between the Parties, and the terms of the Contract are fully incorporated herein;

WHEREAS, any capitalized term not otherwise defined in this Platform Agreement shall have the same meaning and definitions as set forth in the Contract;

WHEREAS, Vaya operates a Provider Portal (defined in Section 1.70 of the Contract);

WHEREAS, Vaya licenses and operates the "Managed Care Information System" or "MCIS", which is a web-based, electronic authorization and claims processing and billing system required to be used by Contractor for all Covered Services and claims, except for covered pharmacy services, in accordance with the terms and conditions of this Platform Agreement;

WHEREAS, Vaya licenses and operates a "CCM Platform," which is a web-based, electronic complex care management platform, and includes its configuration, information, database, associated software, code, tables, application programming interfaces, and user interfaces, as well as any other applications Vaya developed, that capture, store, and analyze data and allow the querying and administration of such data for integrated Care Coordination and/or Care Management purposes, which is accessed and used by Contractor in accordance with the terms and conditions of the 'Vaya Software Platform Access/ User Addendum' attached hereto and incorporated herein as **Exhibit A**;

WHEREAS, Vaya licenses and operates "Vaya Custom Applications," which are defined as the applications developed by Vaya that capture, store, and analyze data and allow the querying and administration of such data for operational purposes, that may be accessed and used by Contractor in accordance with the terms and conditions of this Platform Agreement. These applications may include the configuration, information, database, associated software, code, tables, application programming interfaces, and user interfaces developed as custom applications by Vaya;

WHEREAS, the Provider Portal, MCIS, CCM Platform, and Vaya Custom Applications (collectively "Software Platforms") include database(s) of sensitive information that are confidential by law, regulation, or policy, or which is proprietary in nature (collectively the "Data"); and

WHEREAS, Contractor desires to enter into an agreement with Vaya to obtain access to Data within the Software Platforms for treatment, payment, or healthcare operations purposes that are related to Contractor's obligations under the Contract.

NOW THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the receipt of which is hereby acknowledged, Vaya and Contractor (hereinafter individually referred to as a "Party" and collectively as "Parties") agree to the following terms, obligations, and conditions, which are incorporated into and form a part of the Contract to which they are attached:

ARTICLE I

RIGHTS AND OBLIGATIONS OF VAYA

1.1 Access. Subject to Contractor's compliance with the obligations set forth in this Platform Agreement, Vaya agrees to provide Contractor with one or more User ID logins for Contractor's and its Agents' access to one or more Software Platforms for Data relating to the individuals receiving Covered Services from Contractor pursuant to the Contract.

1.2 System Availability Vaya shall use reasonable efforts to maintain the uptime of the Software Platforms, however, Contractor understands, acknowledges, and agrees that its access to the Software Platforms and the Data shall be limited by and subject to scheduled computer system downtime and unanticipated software and hardware maintenance issues.

1.3 No Warranty. VAYA EXPRESSLY DISCLAIMS ANY WARRANTY, EXPRESS OR IMPLIED, CONCERNING THE OPERATION OF THE SOFTWARE PLATFORMS AND THE ACCURACY AND COMPLETENESS OF THE DATA MAINTAINED THEREIN, INCLUDING, BUT NOT LIMITED TO, ANY WARRANTIES OF TITLE, OR MERCHANTABILITY, OR FITNESS FOR ANY PARTICULAR PURPOSE.

1.7 Expense Reimbursement. Vaya Group shall not be liable to Contractor or any Agent for any expenses paid or incurred by Contractor or any Agent in connection with the Contractor's or Agents' access to the Software Platforms.

1.8 Periodic Review. Periodically Vaya may run a report to identify Agents who have not logged into the Software Platforms for six (6) months. Agents identified as not having accessed the applicable portal within the last six (6) months shall be made inactive in such portal. Contractor or Agent shall be required to open a support ticket with the Vaya Service Desk to get its account reactivated.

ARTICLE II

RIGHTS AND OBLIGATIONS OF CONTRACTOR

2.1 Account Management.

a. Contractor shall determine which of its Agents shall need a User ID for access to the Provider Portal, which access shall be only for purposes related to Contractor's obligations under the Contract. Contractor shall ensure that each Agent successfully completes applicable training before User IDs are issued or allowed to be created for the Agent.
b. If Vaya determines that Contractor should be granted access to MCIS Platform or CCM Platform, Contractor shall determine which of its Agents shall need a User ID for access to the respective Software Platform, which access shall be only for purposes related to Contractor's obligations under the Contract. Contractor shall ensure that each Agent successfully completes CCM Platform orientation before Vaya will issue a User ID for the Agent.
c. Contractor shall determine which of its Agents shall need a User ID for access to Vaya Custom Applications, including but not limited to the Discharge Tracker, which access shall be only for purposes related to Contractor's obligations under the Contract. Contractor shall ensure that each Agent successfully completes Vaya-required training before Vaya will issue or allow the creation of a User ID for the Agent.
d. Contractor shall ensure that each Agent (i) understands and complies with the terms of this Platform Agreement; protects his or her User ID and password from disclosure; and (ii) does not share the assigned User ID and password with any other person.
e. Contractor shall identify a Systems Access Administrator contact within its organization for Vaya to contact regarding any User ID issued under this Platform Agreement. The Systems Access Administrator must be able to validate which of Contractor's staff shall have a User ID. Contractor shall notify Vaya of any changes to the Systems Access Administrator contact within one (1) business day of such change and shall communicate such changes by completing the Vaya-approved change request form on our website
f. Depending on the Software Platform, Contractor shall obtain User IDs by: (i) completing the Login Request Form on the Vaya website or (ii) having the Contractor's Systems Access Administrator create User IDs.
g. Contractor shall notify the Vaya ServiceDesk to terminate or disable an Agent's User ID within one business day from the occurrence of any termination of employment, contract, or subcontract between Contractor and such Agent, or upon the extended leave of an Agent for more than ninety (90) days, or at least five (5) business days prior to cessation of all or any part of Contractor's business operations. Contractor's Systems Access Administrator can perform this function within MCIS.
h. Vaya may periodically generate a list of Contractor's Agents with User IDs, and Contractor will confirm with Vaya whether the User IDs are still active within five (5) business days of receipt of the list, in accordance with the instructions provided by Vaya. Contractor shall maintain records of User IDs for a period of six (6) years from the date of disablement or termination of an Agent's User ID.
i. Contractor shall ensure that it and its Agents shall access only minimally necessary information in the Software Platforms about individuals receiving services from Contractor pursuant to the Contract.
j. Contractor shall ensure that it and its Agents shall not corrupt, damage, or sabotage any Data, or the Software Platforms.

2.2 Title to Intellectual Property. Contractor understands, acknowledges, and agrees that title, rights, and interest in and to Provider Portal, MCIS, CCM Platform, Vaya Custom Applications, and Data and other intellectual property shall be vested in Vaya, its vendors, or other third parties and shall not be vested in Contractor or any Agent.

2.3 Suspension of Connectivity. Contractor understands, acknowledges, and agrees that in the event of any incidents that Vaya determines in good faith present an unacceptably high risk to the Vaya information systems infrastructure, including, but not limited to, any Vaya data and information, that Vaya shall notify, and shall have the right to immediately suspend Contractor's access to the Vaya network and data until Vaya determines that the risk has been acceptably mitigated, at which time reasonable efforts will be taken to re-instate access in a timely manner. Contractor further understands, acknowledges, and agrees that in the event that access is suspended, Vaya will not be liable for any losses resulting from Contractor's loss of access to Vaya's network and data.

ARTICLE III
TERM AND TERMINATION

3.1 Effective Date and Term. This Platform Agreement shall become effective upon complete execution of the Contract and this Platform Agreement by all Parties and shall continue thereafter until termination or expiration of the Contract or until termination of this Platform Agreement as set forth herein, whichever is earlier.

3.2 General. Termination or suspension of access of this Platform Agreement under the terms set forth below shall not form the basis of any claim for loss of anticipated profits by either Party. The rights and remedies provided in this Article III shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Platform Agreement.

3.3 Voluntary Termination. Either Party may terminate this Platform Agreement without cause by giving ninety (90) days' prior written notice of termination to the other Party. This Platform Agreement may be voluntarily terminated at any time upon the mutual consent of both Parties. A voluntary termination of this Platform Agreement shall automatically result in a simultaneous voluntary termination of the Contract itself.

3.4 Involuntary Termination; Suspension of Access. Vaya may immediately, without prior notice, suspend or terminate Contractor's and all or some associated Agents' User IDs, or terminate the Contract and this Platform Agreement, if Vaya determines, in its sole discretion, that:

a. Contractor or any Agent has breached a material term of this Platform Agreement, or of the Contract between Vaya and Contractor, or of the Trading Partner Agreement, or of the Business Associate Agreement between Contractor and an Agent, if applicable;
b. Vaya's contract with the vendor(s) of one or more of the Software Platforms and corresponding access to the licensed software, is terminated;
c. Contractor's Contract with Vaya is terminated, suspended, or expired;
d. Contractor or any Agent has shared its login with any person, even if such person is another Agent of Contractor;
e. Contractor or any Agent has abused or sabotaged the Software Platforms or the Data;

f. Contractor fails to timely provide and/or satisfactorily perform any requirement under this Platform Agreement, including, but not limited to, timely submission of User ID deactivation requests, or required reports, records, or documentation;
g. Contractor or an Agent is not compliant with federal or state confidentiality laws, rules, or regulations;
h. Contractor has dissolved or ceased operations; or
i. Contractor has been convicted of any felony, or of any crime involving health care.

3.5 Opportunity to Cure Not Required. Upon a determination that Contractor meets a condition specified in Section 3.4, Vaya may, but is not required to, offer Contractor the opportunity to cure by providing Contractor with written notice of the material breach, specifying the breach and requiring it to be remedied within, in the absence of greater or lesser specification of time, fifteen (15) calendar days from the date of the notice; and if the breach is not timely cured, Vaya may terminate the Contract and this Platform Agreement effective upon written notice of termination. If Contractor and/or its Agent(s) breaches any provision of this Platform Agreement, Vaya shall have the right to withhold any payments due to Contractor under any contract or agreement with Vaya, including, but not limited to, the Contract, until such breach has been fully cured.

3.6 Effect of Termination or Expiration. Upon termination or expiration of the Contract or of this Platform Agreement pursuant to this Article III, Vaya shall disable any User IDs provided to Contractor. If Vaya terminates the Contract or suspends or terminates this Platform Agreement in whole or in part pursuant to Section 3.4 of this Platform Agreement, Vaya may: (1) deduct any and all expenses incurred by Vaya for damages caused by the Contractor and/or Agent's breach; and/or (2) pursue any of its remedies at law or in equity, or both, including damages, injunctive relief, and specific performance.

3.7 Incorporation of Recitals. The recitals set forth above are an integral part of this Platform Agreement and shall have the same contractual significance as any other language herein.

SIGNATURES

IN WITNESS WHEREOF, each Party intends this Contract to be under "Seal" and has caused this Vaya Software Platform Access/ User Addendum to be executed as the act of said Party, as of the Effective Date. Each individual electronically signing below certifies that he or she has been duly authorized to bind said Party to the terms of this Vaya Software Platform Access/ User Addendum.

Contractor Legal Name:

By: _____ (ADOPTED SEAL)
CONTRACTOR DULY AUTHORIZED OFFICIAL

Name: _____

Title: _____

Date: _____

Vaya Health:

By: _____ (ADOPTED SEAL)
Vaya DULY AUTHORIZED OFFICIAL

Name and Title: Brian Ingraham, Chief Executive Officer

Date: _____

EXHIBIT B: TRADING PARTNER ADDENDUM

THIS TRADING PARTNER ADDENDUM ("TPA") is made and entered into as of the Effective Date of the Network Provider Participation Agreement ("Contract") by and between Vaya Health, a Local Management Entity/Managed Care organization, (hereinafter referred to as "Vaya") and [INSERT LEGAL BUSINESS NAME FOR CONTRACTOR],with a primary business address at [INSERT CONTRACTOR ADDRESS] (hereinafter Contractor individually referred to as the "Trading Partner"), in compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and implementing regulations (45 CFR Parts 160, 162, and 164) and the Gramm-Leach-Bliley Act of 1999 (15 U.S.C. §6801, et seq. and implementing regulations (16 CFR Part 313))("GLBA").

WITNESSETH:

WHEREAS, this TPA is ancillary to the Contract and the terms of the Contract are fully incorporated herein;

WHEREAS, any capitalized term not otherwise defined in this TPA shall have the same meaning and definitions as set forth in the Contract;

WHEREAS, this TPA provides the terms and conditions governing electronic transfers of data between Vaya and Trading Partner, and/or its designated third party Health Care Clearinghouse, whether by direct digital, electronic transmission over communication lines, or any other electronic means, in relation to healthcare transactions as referenced in the Transaction Rules;

WHEREAS, Vaya and Trading Partner (hereinafter individually referred to as a "Party" and collectively as "Parties") intend to engage in direct exchange of Nonpublic Personally Identifiable Financial Information (as defined under GLBA and hereinafter "NPFI") and of Protected Health Information (as defined under HIPAA, including electronic Protected Health Information as defined under HIPAA, and hereinafter "PHI");

WHEREAS, Trading Partner wishes to submit claims for reimbursement to Vaya for Covered Services provided to Members, either as a Direct Submitter or via a third party Health Care Clearinghouse;

WHEREAS, Vaya engages in the electronic transfer of data with Network Providers, including Trading Partner, and provides reimbursement for Clean Claims submitted by or on behalf of Network Providers in accordance with the terms and conditions of the Contract and Controlling Authority;

WHEREAS, each Party is or will be equipped, at its own expense, with an Operating System and the trained personnel necessary to engage in the successful exchange of electronic data;

WHEREAS, the Parties are entering into this TPA to facilitate, through transmission via electronic means consistent with, or otherwise allowed by the Transaction Rules, the submission and processing of healthcare transactions;

WHEREAS, the Parties desire to protect the confidentiality and integrity of the NPFI and PHI exchanged between the Parties and to prevent inappropriate disclosure of NPFI or PHI; and

WHEREAS, Vaya anticipates that Trading Partner may, in the performance of this TPA, be conducting health care transactions as and/or on behalf of a covered entity.

NOW THEREFORE, in consideration of the mutual covenants contained in the Contract and other good and valuable consideration, the receipt of which is hereby acknowledged, the Parties agree to the following terms, obligations, and conditions:

ARTICLE I
GENERAL TERMS AND CONDITIONS

1.1 **Definitions**. In this TPA, the following words, terms, and acronyms shall have the following special meanings, and the use of the singular of any of these words, terms, or acronyms herein shall be construed to include the plural and vice versa:

1.1.1 **"ASC X12"** means the Accredited Standards Committee of the American National Standards Institute responsible for developing and approving uniform standards for the electronic interchange of business transactions.

1.1.2 **"Companion Guide"** means the guidance issued by Vaya and available on the Vaya website that provides Trading Partner, as a Direct Submitter or via a Health Care Clearinghouse, with guidelines for submitting electronic transactions. The Companion Guide documents assumptions, conventions, and other data issues that may be specific to Vaya's business processes when implementing the HIPAA ASC X12N Implementation Guides. The Companion Guide neither replaces the HIPAA ASC X12N Implementation Guides for transaction sets, nor attempts to amend any of the rules therein or impose any mandates on Trading Partner.

1.1.3 **"Direct Submitter"** is a Trading Partner that submits claims to Vaya without interfacing with a Health Care Clearinghouse.

1.1.4 **"Electronic Data Interchange" or "EDI"** means the automated exchange of business documents from one software application to another in the formats required or allowed by the Transaction Rules.

1.1.5 **"Envelope"** means a control structure in a format mutually agreeable to Vaya and Trading Partner for the electronic interchange of one or more encoded data transmissions between Vaya and Trading Partner, or its designated Health Care Clearinghouse.

1.1.6 **"Health Care Clearinghouse"** means as defined at 45 CFR § 160.103.

1.1.7 **"HIPAA ASC X12N Implementation Guides"** mean the guides produced by ASC X12.

1.1.8 **"Lost or Indecipherable Transmission"** means a data transmission that is not received or cannot be processed to completion by the receiving Party, or designee, because it is distorted or incomplete, regardless of how or why the data transmission was rendered distorted or incomplete.

1.1.9 **"National Standard Identifier" or "NSI"** means the standard unique health identifier for each Member, employer, health plan, and provider for use in the health care system pursuant to regulations implementing HIPAA.

1.1.10 **"Operating System"** means the equipment, hardware, and software necessary for a successful data transmission made pursuant to this TPA.

1.1.11 **"Proprietary Information"** means information used or created by the Parties in the conduct of their business activities that is not normally made available to the Parties' customers, competitors, or third parties, the disclosure of which will or may impair the Parties' competitive position or otherwise prejudice the Parties' ongoing business.

1.1.12 **"Security Access Codes"** means codes that Vaya assigns to Trading Partner to allow Trading Partner, and/or its designated Health Care Clearinghouse, access to MCIS and/or Vaya's Operating System for the purpose of successfully executing data transmissions or otherwise carrying out this TPA.

1.1.13 **"Source Documents"** mean documents containing data that are or may be required as part of a data transmission concerning (i) a claim for payment of charges for medical services that a provider furnishes to a Member or (ii) Member enrollment. Source Documents are subject to the security standards of this TPA. Examples of data contained within a Source Document include, without limitation, Member's name, address, and identification number; claim number; diagnosis codes or descriptions for the services rendered; dates of service; service procedure codes or descriptions; applicable charges for the services rendered; the provider's name and/or NSI; dependent information; and signature.

1.1.14 **"Testing"** means the process whereby Vaya validates the data content and format compliance of transaction sets sent to Vaya by Trading Partner, the stability of electronic connections to support data transfer, and the security configuration of data transfer.

1.1.15 **"Transaction Rules"** means Social Security Act § 1173 and the Standards for Electronic Transactions, 45 CFR Parts 160 and 162, as may be amended or recodified from time to time.

1.2 **General**.

1.2.1 **EDI Transaction** Sets. As applicable, the following EDI transaction sets are made part of this TPA. All transactions are to be implemented in accordance with the current HIPAA ASCX12N Implementation Guides and the Companion Guide.

- Professional Claim: ASCX12N837005010X222A1-Health Care Claim: Professional
- Institutional Claim: ASCX12N837005010X223A2-Health Care Claim: Institutional
- Health Care Payment and Remittance Advice: ASCX12N835005010X221A1- Health Care Payment/Advice
- Health Claim Status: ASCX12N276/277005010X212-Health Care Claim Status Request and Response
- Eligibility for a Health Plan: ASCX12N270/271005010X279A1-Health Care Eligibility Benefit Inquiry and Response
- Implementation Acknowledgment for Health Care Insurance: ASCX12999 005010X231- Transaction Set Acknowledgement
- Health Care Claim Acknowledgement: ASCX12277CA005010X214-Health Care Claim Acknowledgement

1.3 **Construction**. This TPA shall be construed to comply with any final regulation or amendment to a final regulation adopted by the U.S. Department of Health and Human Services concerning the subject matter of this TPA upon the effective date of the final regulation or amendment.

ARTICLE II
OBLIGATIONS OF THE PARTIES

2.1 **General**. This Section 2.1 and all its subparts shall survive expiration, suspension, or termination of the TPA.

2.1.1 **Governing Principles**. Notwithstanding any other provision to the contrary in the Contract, TPA, Companion Guide, or the Vaya Provider Manual, the Parties agree that in keeping with 45 CFR § 162.915 (or successor regulation), neither this TPA nor the Companion Guide shall be construed to permit Trading Partner, or its designated Health Care Clearinghouse, or Vaya to: (a) change the definition, data condition, or use of a data element or segment in a standard or operating rule; (b) add any data elements or segments to the maximum defined data set; (c) use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s); or (d) change the meaning or intent of the standard's implementation specifications.

2.1.2 **Verification of Eligibility**. The Parties agree that verification of an individual's eligibility provided by Vaya is only an indication of the enrollment status and benefits at the time of inquiry. Payment of services is contingent upon the confirmation of status at the time of claims processing and upon the terms and conditions of the participant's coverage as determined by Vaya.

2.1.3 **Data Transmission Accuracy and Security**. The Parties agree that transmitted EDI will not be considered as received and no responsibility shall be assigned until the EDI is accessible on the receiving Party's computer. The Parties will take reasonable care to ensure that data transmissions are timely, complete, accurate, and secure. Each Party will employ accuracy and security measures necessary to protect and successfully transmit data between them, in compliance with the Transaction Rules and any NCDHHS implementing regulations or guidelines and as set forth in this TPA. The Parties assume all risks and liabilities for their data transmissions, including, but not limited to, those associated with a rejection of a data transmission due to a failure to comply with this Section 2.1.3. Repeated violations by the Trading Partner with regard to security and accuracy requirements may result in an administrative action or sanction taken against the Trading Partner, up to and including the suspension or termination of the Contract and TPA pursuant to the terms of the Contract and/or TPA.

2.1.4 **Retransmission of Lost or Indecipherable Transmissions**. The Parties agree to notify the other Party within a reasonable timeframe if any transmitted data are received in an unintelligible form. Trading Partner will retransmit Lost or Indecipherable Transmissions pursuant to instructions provided in the Companion Guide. Vaya shall use best efforts to provide notice to Trading Partner if it has knowledge of Lost or Indecipherable Transmissions as articulated in the Companion Guide.

2.1.5 **Formats**. The Parties shall utilize the code sets, data elements, and formats for data transmissions defined by the Transaction Rules and, subject to Section 2.1.1 and 3.1.1 of this TPA, shall also follow the requirements set forth in the Companion Guide.

2.1.6 **Testing**. Each Party will reasonably cooperate with the other Party in validating the security, connectivity, and formatting of the data transmissions prior to acceptance into Vaya HIPAA production status, as outlined in the Companion Guide.

2.1.7 **National Standard Identifiers**. Vaya and Trading Partner will use NSIs in all data and data transmissions conducted between the Parties.

2.1.8 **Equipment**. The Parties will provide and maintain the equipment, software, services, and testing necessary to transmit and receive documents.

2.1.9 **Conduct**. The Parties will conduct business and perform as required by the Contract, TPA, Vaya Provider Manual, Companion Guide, and all applicable rules and regulations.

2.1.10 **Format Compliance**. The Parties will comply with the current national standard health care EDI formats published by ASC X12.

2.1.11 **Adverse Actions**. The Parties shall conform to HIPAA requirements and shall take no action which would adversely affect the other Party's HIPAA compliance.

2.2 **Confidentiality and Security**.

2.2.1 **Data Security**. Each Party will maintain reasonable security procedures to prevent unauthorized access to data, data transmissions, Security Access Codes, Envelope, backup files, Source Documents, or the other Party's Operating System, if such an attempt may have an adverse impact on the other Party. Such security procedures shall include maintaining a record of authorized personnel with the date access is granted and terminated, which shall be made available to the other Party upon request and using sufficient security procedures to ensure that the exchange of EDI and PHI is authorized and protected from improper access.

2.2.2 **Protected Health Information and Personally Identifiable Information**. Each Party will comply with all applicable privacy and security laws and regulations concerning the use and disclosure of PHI and personally identifiable information, including, but not limited to, the requirements of HIPAA and its implementing privacy regulations at 45 CFR Parts 160-164, and its implementing security regulations at 45 CFR Parts 160, 162, and 164; and state privacy and security laws and regulations, including the N.C. Identity Theft Protection Act at N.C.G.S. §§ 75-61, *et. seq*.

2.2.3 **Proprietary Information**. Each Party will treat the other Party's information obtained or learned in connection with this TPA as confidential and will not use the other Party's Proprietary Information for their own commercial benefit or any other purpose not authorized in this TPA. Each Party will safeguard the other Party's Proprietary Information against unauthorized disclosure and use. Notwithstanding the foregoing, this provision shall not prevent a Party from disclosing Proprietary Information that belongs to the other Party that (i) was previously known to such Party free of any obligation to keep it confidential as evidenced by written documentation; (ii) is or becomes generally available to the public by other than unauthorized disclosure; (iii) is developed by or on behalf of such Party independent of any information furnished under this TPA as evidenced by written documentation; (iv) is received from a third party whose disclosure does not violate any confidentiality obligation; or (v) is required to be disclosed by law, including without limitation, by applicable public records law, or by any governmental agency having jurisdiction pursuant to an order to produce or in the course of a legal proceeding pursuant to a lawful request for discovery.

2.2.4 **Data Access**. Each Party agrees that only its authorized employees will be granted access to data, data transmissions, Security Access Codes, Envelope, backup files, Source Documents, or the other Party's Operating System and that this access and any information obtained through this access is not transferable to any outside

person or entity, including, but not limited to, vendors, clearinghouses, and business associates, unless agreed to by Vaya.

2.2.5 **Chain of Trust**. Trading Partner and Vaya agree to protect the information electronically transmitted between them and shall cooperate with each other to maintain the integrity and confidentiality of such information and to provide all reasonable protection to prevent unauthorized disclosure or such information. Both Parties agree that they bear responsibility for protecting the integrity and confidentiality of information once it has passed to equipment owned or operated by or on behalf of the Party.

2.2.6 **Suspension of Network Connectivity**. The Parties agree that in the event of any incidents that Vaya determines in good faith present an unacceptably high risk to Vaya information systems infrastructure, including, but not limited to, Vaya data and information, Vaya shall notify, and shall have the right to suspend immediately, the affected Trading Partner-to-Vaya network connectivity until Vaya determines that the risk has been acceptably mitigated, at which time reasonable efforts will be taken to re-instate the connection in a timely manner. Trading Partner agrees that in the event that connectivity is suspended, Vaya will not be liable for any losses resulting from Trading Partner's loss of access to network connectivity.

ARTICLE III
OBLIGATIONS OF THE TRADING PARTNER

3.1 **General**. This Section 3.1 and all its subparts shall survive expiration, suspension, or termination of the TPA.

3.1.1 **Companion Guide**. Trading Partner agrees that it shall comply with the connectivity, transmission, security, and other requirements set forth in the Companion Guide, which is hereby incorporated into this TPA as if fully set forth herein. Unless otherwise required by changes in applicable law, Trading Partner agrees that Vaya may amend the Companion Guide at its sole discretion by updating it on the Vaya website, provided that Vaya must post any substantive or material changes on the Vaya website at least thirty (30) days prior to the effective date of any such changes. All changes to the Companion Guide shall become binding upon Trading Partner thirty (30) days after notice of website publication via an electronic Provider Communication Bulletin.

3.1.2 **Notice of Violations**. Trading Partner shall notify Vaya in writing within ten (10) business days of obtaining knowledge of any criminal investigation, indictment, information, or charge by any governmental entity (or communications indicating that the same may be contemplated) related to Trading Partner, including its affiliates, subsidiaries, heirs, successors, assigns, partners, directors, officers, members, managers, agents, representatives, employees, and subcontractors of any tier.

3.1.3 **Access to Information**. Trading Partner will access information, including, but not limited to, PHI, concerning services provided to Members by (i) Trading Partner and its employed providers, (ii) providers who are owners of Trading Partner, or (iii) providers who have contracted with Trading Partner for EDI services.

3.1.4 **Copying**. Trading Partner will not copy, reverse engineer, disclose, publish, distribute, de-identify, alter, or use data, data transmission or Envelopes for any purpose other than that for which Vaya has specifically authorized Trading Partner under the terms of this TPA.

3.1.5 **Limitation of Access**. Trading Partner will not obtain or attempt to obtain access by any means to data, data transmissions, Envelopes, or Vaya's Operating System for any purpose other than as Vaya has specifically granted Trading Partner access under this TPA. In the event that Trading Partner receives data or data transmissions from Vaya not intended for Trading Partner, Trading Partner will immediately notify Vaya and destroy the data.

3.1.6 **Limited Purpose**. Trading Partner acknowledges that access to and use of information, including, but not limited to, PHI, allowed under this TPA is limited to the purposes of treatment, payment, and healthcare operations as such terms are defined by HIPAA.

3.1.7 **Data Transmission Support**. Trading Partner shall, at its own expense, obtain and maintain its own Operating System necessary for timely, complete, accurate, and secure transmission of data pursuant to this TPA. Furthermore, Trading Partner shall pay its own costs for any and all charges related to data transmission under this TPA and specifically including, without limitation, charges for operating system equipment, hardware, software, and services, maintaining an electronic mailbox, connection time, terminals, connections, telephones, modems, and any applicable minimum use charges.

3.1.8 **Protection of Security Access Codes**. Trading Partner shall protect and maintain the confidentiality of Security Access Codes that Vaya issues to Trading Partner from unauthorized access. Trading Partner shall notify Vaya immediately whenever it has reason to believe that Access Codes issued by Vaya have been compromised or disclosed to unauthorized persons, including, but not limited to, former Trading Partner employees or Health Care Clearinghouses.

3.1.9 **Transactional Testing**. Trading Partner will complete testing for each of the transactions it will implement and shall not be allowed to exchange data with Vaya in production mode until testing is satisfactorily passed as determined by Vaya. Successful testing means the ability to successfully pass HIPAA compliance checking and to process electronic healthcare information transmitted by the Trading Partner to Vaya.

3.1.10 **Notification**. Trading Partner will promptly notify Vaya of any and all unlawful or unauthorized disclosures of PHI that comes to its attention and will cooperate with Vaya if any litigation arises concerning the unauthorized disclosure of PHI.

3.1.11 **Health Plan Participants**. Trading Partner shall establish and maintain procedures and controls to ensure that information concerning Members shall not be used by Trading Partner, including its affiliates, subsidiaries, heirs, successors, assigns, partners, directors, officers, members, managers, agents, representatives, employees, and subcontractors of any tier, other than for its intended purpose.

3.1.12 **Electronic Transactions**. Trading Partner shall inform Vaya within thirty (30) days if there is any change in the Trading Partner representative, location, or Health Care Clearinghouse (if the latter is applicable) where electronic transactions are sent or received.

3.1.13 **Reasonable Precautions**. Trading Partner must take all reasonable precautions, including, but not limited to, entering into appropriate agreements, to ensure that PHI is disclosed, used, reproduced, or transmitted only as necessary to perform the services contemplated under this TPA, and not in violation of HIPAA requirements or the terms of this TPA.

3.1.14 **Compliance by Health Care Clearinghouse**. Trading Partner shall ensure that any third party Health Care Clearinghouse which submits claims to Vaya for Trading Partner understands and complies with the obligations of Trading Partner as set forth in this TPA.

3.2 **Record Retention and Audit**. This Section 3.2 and all its subparts shall survive expiration, suspension, or termination of this TPA.

3.2.1 **Records Retention**. Trading Partner shall maintain complete, accurate, and unaltered copies of all Source Documents, including backup files, electronic tapes, or other sufficient means to recreate the data, from all data transmissions it receives from, or transmits to, Vaya for not less than six (6) years from the date

that they are received or transmitted. All retained records will be subject to the provisions of this TPA, including, but not limited to, the security measures as data and data transmissions.

3.2.2 **Certification**. If Vaya reasonably believes that Trading Partner has a practice or procedure that may violate applicable law or the terms of this TPA, Vaya may request, and Trading Partner agrees to promptly provide, written certification either confirming compliance with the applicable laws or terms or outlining the areas of noncompliance and describing a plan of action to achieve compliance.

3.2.3 **Cooperation in Outside Audits**. Trading Partner agrees to cooperate with U.S. Department of Health and Human Services, the N.C. Department of Health and Human Services, URAC, NCQA, and other regulatory and accreditation agencies, concerning their reviews or audits of Vaya. Vaya will notify Trading Partner upon Vaya's receipt of any request from a governmental or oversight authority for information or documents relating to this TPA, except to the extent such notification is prohibited by law.

ARTICLE IV
OBLIGATIONS OF VAYA

4.1 **Security Access Codes**. Vaya will provide Trading Partner with Security Access Codes that will allow Trading Partner, or its designated Health Care Clearinghouse, access to Vaya Operating System and MCIS for the purposes set forth in this TPA. The Parties understand, acknowledge, and agree that such Security Access Codes are confidential and subject, without limitation, to the restrictions contained in Section 2.2 of this TPA. Vaya reserves the right to change Security Access Codes at any time and in such manner as Vaya, in its sole discretion, deems necessary. The Parties agree that disclosure of Security Access Codes will be limited to authorized personnel of the respective Parties on a need-to-know basis. The Security Access Codes that Vaya issues to Trading Partner will, when affixed to data transmissions, be legally sufficient to verify the identity of the transmitter and to authenticate the data transmission, thereby establishing the data transmission's validity. Data transmissions having a Security Access Code affixed to them will be deemed to have been "written" or "signed" by the sender. Computer printouts of the information contained in such correspondence and documents that have been electronically or magnetically recorded and kept in the normal course of the sender's or receiver's business will be considered original business records admissible in any judicial, arbitration, mediation, or administrative proceedings to the same extent and under the same conditions as other business records originated and maintained in documentary form.

4.2 **Availability**. Vaya will make available to Trading Partner, via electronic means, data and data transmissions for which this TPA grants Trading Partner access or authorization, or as required by law; provided, however, that Trading Partner agrees that access to Vaya's Operating System provided by Vaya is without warranty of any kind, either express or implied, and Trading Partner further assumes the entire risk as to the performance of Vaya.

ARTICLE V
TERM AND TERMINATION

5.1 **Effective Date and Term**. This TPA shall become effective upon complete execution of the Contract and this TPA by all Parties and shall continue thereafter until termination or expiration of the Contract.

5.2 **General**. Termination or suspension of access of this TPA under the terms set forth below shall not form the basis of any claim for loss of anticipated profits by either Party. The rights and remedies provided in this Article V shall not be exclusive and are in addition to any other rights and remedies provided by law or under this TPA.

5.3 **Voluntary Termination**. Either Party may terminate this TPA without cause by giving sixty (60) days' prior written notice of termination to the other Party. This TPA may be voluntarily terminated at any time upon the mutual consent of both Parties. A voluntary termination of this TPA shall automatically result in a simultaneous voluntary termination of the Contract itself.

5.4 **Involuntary Termination; Suspension of Access**. Vaya may immediately, without prior notice, suspend Trading Partner's ability to submit health care transactions to Vaya, or terminate the Contract or this TPA, if Vaya determines, in its sole discretion, that:

5.4.1 Trading Partner, or its Health Care Clearinghouse, has breached a material term of this TPA, or of the Contract between Vaya and Trading Partner, or of the Vaya Software Platform Access/ User Addendum;

5.4.2 Trading Partner's Contract with Vaya has terminated or expired;

5.4.3 Trading Partner has abused or sabotaged the MCIS system or corrupted any data within the MCIS database;

5.4.4 Trading Partner, or its Health Care Clearinghouse, is not compliant with federal or state confidentiality laws, rules, or regulations or the Transaction Rules;

5.4.5 Trading Partner has dissolved or ceased operations; or

5.4.6 Trading Partner has been convicted of any felony, or of any crime involving health care.

5.5 **Opportunity to Cure Not Required**. Upon a determination that Trading Partner meets a condition specified in Section 5.4 of this TPA, Vaya may, but is not required to, offer Trading Partner the opportunity to cure by providing Trading Partner with written notice of the material breach, specifying the breach and requiring it to be remedied within, in the absence of greater or lesser specification of time, fifteen (15) calendar days from the date of the notice; and if the breach is not timely cured, Vaya may terminate the Contract and this TPA effective upon written notice of termination. If Trading Partner breaches any provision of this TPA, Vaya shall have the right to withhold any payments due to Trading Partner under any contract or agreement with Vaya, including, but not limited to, the Contract, until such breach has been fully cured.

5.6 **Effect of Termination or Expiration**. If Vaya terminates the Contract or this TPA or suspends this TPA in whole or in part as provided in Section 5.4 of this TPA, Vaya may: (1) deduct any and all expenses incurred by Vaya for damages caused by the Trading Partner's breach; and/or (2) pursue any of its remedies at law or in equity, or both, including damages, injunctive relief, and specific performance.

SIGNATURE

IN WITNESS WHEREOF, each Party intends this Contract to be under "Seal" and has caused this Trading Partner Addendum to be executed as the act of said Party, as of the Effective Date. Each individual electronically signing below certifies that he or she has been duly authorized to bind said Party to the terms of this Trading Partner Addendum.

Trading Partner Name:

By: _____ (ADOPTED SEAL)
TRADING PARTNER DULY AUTHORIZED OFFICIAL

Name: _____

Title: _____

Date: _____

Vaya Health:

By: _____ (ADOPTED SEAL)
VAYA DULY AUTHORIZED OFFICIAL

Name and Title: Brian Ingraham, Chief Executive Officer

Date: _____

SCHEDULE A
COMPENSATION (FEE FOR SERVICE and DIRECTED PAYMENTS)

THIS Schedule A - Compensation Attachment ("Compensation Schedule"), is made and entered as of the Effective Date of the Network Provider Participation Agreement by and between Vaya Health, a Local Management Entity/Managed Care organization, with a primary business address at 200 Ridgefield Court, Asheville, North Carolina 28806 (hereinafter referred to as "Vaya"), and [INSERT LEGAL BUSINESS NAME FOR CONTRACTOR],with a primary business address at [INSERT CONTRACTOR ADDRESS] (hereinafter "Contractor").

W I T N E S S E T H:

WHEREAS, this **Schedule A** is ancillary to the Contract, and the terms of the Contract are fully incorporated herein;

WHEREAS, any capitalized term not otherwise defined in this Compensation Schedule shall have the same meaning and definitions as set forth in the Contract; and

WHEREAS, this Compensation Schedule sets out the terms and certain compensation for Covered Services to be rendered by or on behalf of Contractor.

NOW THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the receipt of which is hereby acknowledged, Vaya and Contractor agree to the following terms, obligations, and conditions, which are incorporated into and form a part of the Contract to which they are attached:

1.0 **Background**: Vaya has established Contractor payment requirements to comply with Controlling Authority and encourage continued provider participation in the Vaya Benefit Plans to ensure Member access to Medically Necessary Covered Services.

2.0 **Scope**: The compensation rates set forth in this **Schedule A** apply for Vaya Benefit Plans. As set forth in Section 5.8.1 of the Contract, unless otherwise stated in this Compensation Schedule or in a provider-specific addendum to the Contract, reimbursement rates set forth in Contractor's Sites and Services Menu shall apply. Compensation shall be subject to and in accordance with the terms and conditions of the Contract, including this **Schedule A** and any provider-specific addendum made a part thereof.

3.0 **Compensation:** Fee for service compensation for Covered Services provided to Members shall be the lesser of Contractor's usual and customary billed charges or as set forth in Table 3.0, less amounts payable by the primary payor or payors and less Member Expense:

Table 3.0 [delete inapplicable rows]

Contractor Type	Reimbursement Rate for Covered Services
Primary Care Physicians and Physician Extenders	One Hundred (100%) percent of North Carolina Medicaid physician fee-for-service fee schedule rate or bundle, published on the Department's website on the date the Covered Services are rendered, subject to the terms of the Contract
Specialty Care Physicians and Physician Extenders	One Hundred (100%) percent of North Carolina Medicaid physician fee-for-service fee schedule rate or bundle, published on the Department's website on the date the Covered Services are rendered, subject to the terms of the Contract
Specialty Care Physician and Physician Extenders providing Obstetric services	One Hundred (100%) percent of North Carolina Medicaid fee-for-service rate floor obstetrics services, which includes an enhanced rate for all vaginal deliveries (equal to the Medicaid Fee for Service rate for caesarian deliveries), published on the Department's website on the date the Covered Services are rendered, subject to the terms of the Contract The Parties acknowledge, agree, and understand that obstetric services include reimbursement for the pregnancy risk screening and post-partum visit as defined in the Department's Clinical Coverage Policy 1E-6 and described in **Addendum G** Pregnancy Management Program attached to the Contract.
Teaching Hospital Faculty Physicians *(UNC Health System contract only)*	Vaya shall make additional, utilization-based, directed payments to certain faculty physicians affiliated with the teaching hospitals for each of the following University of North Carolina medical schools, in the following amount as prescribed by the Department (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)): [List hospitals and corresponding payment amounts]
Hospital Payments (Excluding BH and Pharmacy Claims)	For Vaya Network inpatient hospital services (excluding BH claims), no less than the applicable Medicaid Fee for Service rate specified below for inpatient and outpatient services (as allowed under 42 CFR § 438.6(c)(1)(iii)(A)), on the date the Covered Services are rendered, subject to the terms of the Contract. Vaya uses the following applicable Medicaid Fee for Service payment methodology: 1. The applicable rate floor and methodology for inpatient hospital services shall be one hundred percent (100%) of the hospital specific Medicaid Fee for Service rate using the Medicaid Fee for Service case weights and outlier methodology. 2. The applicable rate floor and methodology for outpatient hospital services, including emergency department, shall be the hospital charges multiplied by the hospital-specific Medicaid cost-to-charge ratio published on the Department's website. 3. The hospital rate floors shall apply for the following defined time periods, after which the BH I/DD Tailored Plan will have flexibility to negotiate reimbursement arrangements with the hospitals:

Contractor Type	Reimbursement Rate for Covered Services
	a. The Term for critical access hospitals and hospitals in economically depressed counties defined as Tier 1 or Tier 2 counties as designated by the North Carolina Department of Commerce for 2019 (https://files.nc.gov/nccommerce/ documents/files/2019-Tiers-memo_asPublished.pdf). b. The Initial Term and the first one-year renewal term for all other hospitals. The Parties acknowledge, agree, and understand that Vaya is not responsible for, and Contractor shall not seek compensation in any form from Vaya, for reimbursement for graduate medical education payments due under the Medicaid State Plan (as allowed under 42 C.F.R. § 438.60) or for Disproportionate Share Hospital Payments. Contractor further acknowledges, agrees, and understands that reimbursement for such payments shall be directed to the Department.
Hospital Payments *(UNC Health Care or Vidant Medical Center contracts only)*	Vaya shall make additional, utilization-based, directed payments to the following hospitals owned by UNC Health Care or Vidant Medical Center (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)), in the following amount as prescribed by the Department (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)): [List hospitals and corresponding payment amounts]
Hospital Payments for BH Claims *(for Vaya Closed Network Covered Services)*	For inpatient and outpatient (including emergency department) hospital services, the reimbursement rates set forth in Vaya's fee schedule, unless a Vaya-approved enhanced rate is set forth in the Contractor's Sites and Services Menu, subject to the terms of this Contract.
Federally Qualified Health Centers (FQHCs) / Rural Health Centers (RHCs)	No less than the following rates: 1. All ancillary services (i.e., radiology, etc.) shall be based on the North Carolina Medicaid Physician Fee Schedule on the date the Covered Services are rendered, subject to the terms of this Contract. 2. All core services shall be based on each FQHC's or RHC's respective North Carolina Medicaid Fee Schedule, which is defined as each FQHC or RHC's respective core rate or T1015 code, on the date the Covered Services are rendered, subject to the terms of this Contract.
Indian Health Care Provider (IHCP) Payments	In accordance with 42 C.F.R. § 438.14(c) and consistent with 42 C.F.R. § 438.14(b), Vaya shall reimburse IHCPs as follows: (a) Those IHCPs that are not enrolled as a federally qualified health center (FQHC), regardless of whether they participate in the Vaya Network; (i) The applicable encounter rate published annually in the Federal Register by the Indian Health Service, on the date the Covered Services are rendered, subject to the terms of this Contract; or

Contractor Type	Reimbursement Rate for Covered Services
	(ii) The Medicaid Fee for Service rate for services that do not have an applicable encounter rate, on the date the Covered Services are rendered, subject to the terms of this Contract. (b) For ancillary services (i.e., radiology, etc.) delivered by an IHCP that is enrolled as a FQHC, but does not participate in the Vaya Network, Vaya shall pay an amount based on the North Carolina Medicaid Physician Fee Schedule on the date the Covered Services are rendered, subject to the terms of this Contract. (c) For all core services delivered by an IHCP that is enrolled as a FQHC, but does not participate in the Vaya Network, Vaya shall pay an amount based on the FQHC's respective North Carolina Medicaid Fee Schedule, which is defined as each FQHC's respective core rate or T1015 code, on the date the Covered Services are rendered, subject to the terms of this Contract. The Parties understand, acknowledge, and agree that Vaya shall not reduce payments owed to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through cost sharing or other similar charges levied on the Tribal member.
Public Ambulance Provider	The base reimbursement shall be as set forth in Vaya's standard fee schedule available on its website, subject to the terms of this Contract subject to the terms of this **Schedule B**. In addition to base reimbursements, Vaya shall make additional utilization-based payments to Contractor for Medicaid Members only, (not NC Health Choice beneficiaries) as defined by the Department. The base reimbursement shall serve as payment in full for NC Health Choice Covered Services rendered by Contractor to a Member.
Nursing Facility	For nursing facilities (excluding those owned and operated by the State), a rate that is no less than the Medicaid Fee for Service rate in effect the first day of each quarter (e.g., January 1, April 1, July 1, and October 1)
Hospice	In accordance with section 1902(a)(13)(B) of the Social Security Act and state requirements, including but not limited to the following: (1) Rates shall be no less than the annual federal Medicaid hospice rates (updated each federal fiscal year (FFY)). (2) For hospice services provided to Members residing in nursing facilities, Vaya shall reimburse the hospice provider: i. Hospice rate, and ii. Ninety-five percent (95%) of the Medicaid Fee-for-Service nursing home room and board rate in effect at the time of service

Contractor Type	Reimbursement Rate for Covered Services
Ancillary (Audiology, Occupational Therapy, Physical Therapy, Speech Therapy, Respiratory Therapy, Laboratory Dialysis, Imaging - X-Ray/ Radiology, Ambulatory Surgery, Ambulatory Birth Center, Urgent Care)	One Hundred (100%) percent of North Carolina Medicaid of the North Carolina Medicaid Physician Fee Schedule, published on the Department's website, on the date the Covered Services are rendered, subject to the terms of the Contract.
Durable Medical Equipment Provider	One Hundred (100%) percent of North Carolina Medicaid of the North Carolina Medicaid Physician Fee Schedule, published on the Department's website, on the date the Covered Services are rendered, subject to the terms of the Contract.
Advanced Medical Homes (Tiers 1, 2, 3 and AMH+)	See **Addendum A** for reimbursement rates.
Care Management Agencies	See **Addendum B** for reimbursement rates.
Local Health Department	See **Addendum E** for reimbursement rates.

4.0 **Additional Directed Payments:** The Parties acknowledge, agree, and understand that, from time to time, additional directed payments are prescribed by the Department and approved by CMS. The types of payments may include but may not be limited to payment based on utilization of certain services multiplied by a Department-defined specific dollar amount or a percentage of the base payment. The Department remits this payment amount to Vaya for reimbursement of applicable Network Providers. In the event Contractor is designated as an applicable Network Provider to receive an additional directed payment, Vaya agrees to reimburse such Contractor the additional directed payment following receipt of the payment for Contractor by the Department and provided that Contractor timely submits Clean Claims for reimbursement no later than the 10th calendar day following the end of the calendar quarter for which the Contractor seeks an additional directed payment. Contractor acknowledges, agrees, and understands that the amount of the additional directed payment is prescribed by the Department and there are no appeal rights against Vaya for an additional directed payment not expressly prescribed by the Department or for which the additional directed payment is not received from the Department by Vaya.

5.0 **Reimbursement:**

5.1 Reimbursement is at all times subject to Vaya's Reimbursement Policy, which sets forth the details regarding claims bundling, claims editing, recognition of CPT modifiers, down coding, global surgery procedures, multiple surgical periods, and relationship of procedure code to diagnostic code. Vaya follows the Department's guidelines regarding modifiers and only reimburses modifiers reimbursed by the applicable Vaya Benefit Plan. Vaya, in its sole discretion, may apply current North Carolina Medicaid payment rules, policies and guidelines related to Contractor's claims.

5.2 Reimbursement is at all times subject to coordination of benefits and subrogation activities and adjustments.

5.3 The date of payment shall be the date of the EFT, check or other Vaya-form of payment.

5.4 The rate paid herein shall be adjusted for Contractor and /or Covered Service type delivered. The amount of compensation is based on the treating Provider's licensure, Vaya's credentialing requirements for that discipline, not on the Provider's academic credentials, and applicable Controlling Authority.

5.5 Vaya, in its sole discretion, may automatically update Vaya's rate and fee schedules without notice to Contractor or amendment to the Contract to include successor code numbers for the same services or delete retired codes, as such are revised or implemented by the Department or industry standards. Vaya will include in Vaya's Medicaid and NC Health Choice rate schedules those Covered Services and corresponding rates that are not included in the Department's North Carolina Medicaid and NC Health Choice rate schedule published on the Department's website.

SIGNATURE

IN WITNESS WHEREOF, the Parties hereby execute and deliver this Schedule A to the Contract, under "Seal", as of the Effective Date. Each individual electronically signing below certifies that he or she has been duly authorized to bind Vaya or Contractor, respectively, to the terms of this Schedule A.

Contractor Legal Name:

By: _____ (ADOPTED SEAL)
CONTRACTOR DULY AUTHORIZED OFFICIAL

Name: _____

Title: _____

Date: _____

Vaya Health

By: _____ (ADOPTED SEAL)
VAYA DULY AUTHORIZED OFFICIAL
Brian Ingraham, Chief Executive Officer

Date: _____

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act, N.C.G.S. § 159-28.

_____ _____
Vaya Health Finance Officer, or designee Date

SCHEDULE B
Value-Based Payment ("VBP") Provider Addendum

THIS Value-Based Payment Addendum ("VBP Addendum"), is made and entered as of the Effective Date of the Network Provider Participation Agreement by and between Vaya Health, a Local Management Entity/Managed Care organization, with a primary business address at 200 Ridgefield Court, Asheville, North Carolina 28806 (hereinafter referred to as "Vaya"), and [INSERT LEGAL BUSINESS NAME FOR CONTRACTOR],with a primary business address at [INSERT CONTRACTOR ADDRESS], (hereinafter referred to as "Contractor"). Vaya and Contractor are hereinafter individually referred to as a "Party" and collectively as "Parties".

W I T N E S S E T H:

WHEREAS, this VBP Addendum is ancillary to the Contract, and the terms of the Contract are fully incorporated herein;

WHEREAS, any capitalized term not otherwise defined in this VBP Addendum shall have the same meaning and definitions as set forth in the Contract;

WHEREAS, the Department has directed PHPs to assist their Network Providers to deliver care in new ways designed to drive Medicaid's value-based purchasing goals such that provider payments shall be increasingly based on value. Vaya's approach includes developing the people, processes, and technology solutions, in collaboration with Contractor and other VBP providers;

WHEREAS, Vaya intends to introduce value-based payment (VBP) contracting through issuance of a fee-for-service pay-for-performance contract to certain providers in its network, which falls within Category 2C of the Health Care Payment Learning & Action Network Alternative Payment Model Framework endorsed by the Department, which is available at the following link in effect at the time of contract execution: http://hcp-lan.org/workproducts/apm-framework-onepager.pdf ("HCP-LAN");

WHEREAS, this Addendum sets forth the terms, conditions and requirements for performance requirements, quality standards, and/or outcomes required for Contractor participating in Vaya's VBP contracting program (hereinafter a "VBP Provider") to be eligible for value-based performance incentive payments, as well as the conditions under which Vaya would impose a performance-based penalty against VBP Provider.

NOW THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the receipt of which is hereby acknowledged, Vaya and VBP Provider agree to the following terms, obligations, and conditions, which are incorporated into and form a part of the Contract to which they are attached:

ARTICLE I

DEFINITIONS AND BACKGROUND

1. In this Addendum, the following words, terms, and acronyms shall have the following special meanings: In the event of any conflict between the provisions in this VBP Addendum, including any Attachment hereto, and the Contract, this Addendum shall control; otherwise, the provisions of this Schedule are in addition to and supplement the provisions of the Contract.

   1.1. "Attributed Member" or "Attributed Population" means a Member (or Members) who chosen or been assigned a Contractor who is also a Primary Care Physician, in accordance with the Vaya Provider Manual.

   1.2. "Primary Care Provider" means a Provider who is a Physician, Nurse Practitioner, physician assistant, certified nurse midwife, or other duly licensed individual Provider who spends the majority of their clinical time providing Primary Care Services to patients and may include a Provider in the practice of family medicine, general medicine, internal medicine or pediatrics, or obstetrics and gynecology.

   1.3. "Performance Period" means the measurement period beginning on the Effective Date of the Contract and continue through the end of the Term. The initial Performance Period shall commence on the Effective Date through December 31, 2023, and thereafter the subsequent Performance Periods shall begin on January 1st of each then current calendar year.

   1.4. "PMPM" means a dollar amount for each Attributed Member per each month.

2. **Background**: In March 2021, the Department published **North Carolina's Medicaid Quality Measurement Technical Specifications Manual for Standard Plans and Behavioral Health Intellectual/Developmental Disability Tailored Plans Version 1.3** (the "Specifications Manual"). Measures included in this VBP Addendum are a subset of the measures (shown in Appendix A, Tables 4, 5, and 6 of the Specifications Manual) that have been identified by the Department as the priority focus for plan accountability.

ARTICLE II

VBP PROGRAM REQUIREMENTS

1. **General Obligations**: Contractor shall:

   1.1. Hold primary responsibility for providing improvements in health care quality, costs, and outcomes for Contractor, including its Primary Care Providers.

   1.2. Continually meet the VBP requirements set forth by the Department and Vaya.

2. **Performance Standards**

   2.1. Performance and Quality Standards: Contractor must meet the minimum performance and quality standards set forth in this VBP Addendum, which are designed to ensure Vaya's compliance with the performance benchmarks contained in the Managed Care Contract and with the Department's vision for value-based contracting. Award of performance-based payments shall be implemented by Vaya in accordance with the following criteria:

2.1.1. Measure Determination and Notification: Vaya will review the monthly performance data results and send a written notification to VBP Provider on or before the 10th business day of the month if any of the performance standards are not met for the specified period. If the notification indicates that one or more performance standards are not met, as determined in the sole discretion of Vaya, Contractor may request the data used to make the decision and Vaya shall provide such data within a reasonable time following the request. There are no appeal rights of the notification.

2.2. Changes to Measures: Vaya and Contractor understand, acknowledge, and agree that:

2.2.1. Vaya's VBP program must align with the Department's BH I/DD Tailored Plan Quality Strategy, as specified in the Specifications Manual or mandatory Department guidance or requirements.

2.2.2. The measures in Attachment 1, while consistent with the current Specifications Manual, are subject to change if directed by the Department; and that if the Department directs a change in measures or Vaya determines that a change is required to align with the Department's BH I/DD Tailored Plan Quality Strategy that Contractor or VBP Providers shall align with such change following thirty (30) days' notice of Vaya's implementation of the new measures.

2.3. No Dispute Resolution: Contractor understands, acknowledges, and agrees that the determination as to whether Contractor is designated as a VBP Provider and/or eligible for a VBP may not be appealed in any forum, and is explicitly not subject to Section 8.10 of the Contract.

3. **Performance Reporting and Metrics Requirements:** Contractor understands, acknowledges, and agrees that Vaya is required to submit routine and ad hoc reports to the Department on Tailored Care Management, and Contractor agrees to:

3.1. Cooperate and comply with any and all requests for any data, documentation, or information relating to VBP Contractor.

3.2. Measure, calculate, track, and report to Vaya, upon request and at the frequency requested, any VBP quality metrics requested for Vaya's CQI activities or reporting requirements to the Department. Vaya shall provide feedback on quality scoring results to Contractor.

4. **Payments to Contractor**:

4.1. For quality improvement VBPs, Vaya shall pay Contractor for achieving quality improvement measures pursuant to Attachment 1 of the Addendum, which is attached hereto, made a part hereof, and incorporated by reference.

4.2. Quality improvement performance incentive payments, if earned by Contractor shall be based on the metrics included as the metrics in the Department's Specifications Manual, once released, and are included in the AMH Addendum or CMA Addendum to this Contract, as applicable.

5. **Indemnification:** Vaya shall not be responsible for paying any person other than Contractor for any quality improvement VBP payment or any other payment for which Vaya and Contractor agree should be paid by Vaya to Contractor. Contractor shall Indemnify Vaya against all Contractor or third-party claims, demands, costs, and expenses, including, but not limited to, attorneys' fees, consequential damages, and punitive damages relating to any quality improvement VBP, performance incentive payment, or any other payment required to be distributed pursuant to the terms of this Contract or Controlling Authority from Vaya.

SIGNATURES

IN WITNESS WHEREOF, the Parties hereby execute and deliver this VBP Addendum, under "Seal", as of the Effective Date. Each individual electronically signing below certifies that he or she has been duly authorized to bind Vaya or Contractor, respectively, to the terms of this VBP Addendum.

Contractor Legal Name:

By: _____ (ADOPTED SEAL)
CONTRACTOR DULY AUTHORIZED OFFICIAL

Name: _____

Title: _____

Date: _____

Vaya Health

By: _____ (ADOPTED SEAL)
VAYA DULY AUTHORIZED OFFICIAL
Brian Ingraham, Chief Executive Officer

Date: _____

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act, N.C.G.S. § 159-28.

_____ _____
Vaya Health Finance Officer, or designee Date

Attachment 1 to VBP Addendum

1. **Measures.** Vaya and VBP Provider agree that this Attachment 1 represents the quality improvement measures for the first Performance Period, i.e. [add period]. Subject to the terms and conditions of the Contract and this VBP Addendum, which may be subject to change as described herein, the measures for the first Performance Period are as follows:

Measure	Description	Steward	Weight	Eligible Member
Immunization	• Childhood Immunization Status (Combo 10) - The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	NCQA	25%	Medicaid/ NC Health Choice
Screening	Cervical Cancer Screening - Assesses women who were screened for cervical cancer using any of the following criteria: • Women 21–64 years of age who had cervical cytology performed within the last 3 years. • Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years	NCQA	25%	Medicaid/ NC Health Choice

PCP Visits	• Well-Child Visits in the First 30 Months of Life - The percentage of members who had the following number of well-child visits during the last 15 months: ○ Children who turned 15 months old during the measurement year: Six or more well-child visits. ○ Children who turned 30 months old during the measurement year: Two or more well-child visits.	NCQA	25%	Medicaid/ NC Health Choice
Readmissions	• Plan All-Cause Readmissions - Assesses the rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge. As well as reporting observed rates, NCQA also specifies that plans report a predicted probability of readmission to account for the prior and current health of the member, among other factors.	NCQA	25%	Medicaid/ NC Health Choice

2. **Weights.** The Parties agree that the above measures shall each be weighted, and that the sum of the weights shall be equal to 100%. Some measures may be weighted more or less than the others, based on the degree of emphasis that Vaya may wish to place on particular measures.
3. **Quality Incentive Budget.** The quality incentive budget for the first Performance Period shall be $3.00 on a PMPM basis, or $3.00 PMPM per measure. The quality incentive budget will be allocated to create a PMPM target for each measure, whereby the sum of the allocated PMPMs by measure shall be equal to 100% of the Quality Incentive Budget.
4. **National Benchmarks.** The Parties agree that where possible, national benchmarks shall be used to measure performance; such benchmarks shall be the most recent reporting available from the Steward of the measure (i.e., NCQA, CMS, NCDHHS, etc.). For any given measure, Vaya will calculate the VBP Provider's performance relative to the percentiles published by the Steward.
   4.1. For any given measure, Vaya shall determine VBP Provider's performance as a percentile relative to the National Benchmarks. If VBP Provider meets or exceeds the 50th percentile for a measure, it is eligible to receive three dollars PMPM ($3.00 PMPM) per measure.

4.2. **Methodology.** Meeting or exceeding the 50% threshold will determine if the $3.00 PMPM incentive for the applicable member population assigned to the VBP Provider is payable for a specific measure. If the threshold results are below 50% no incentive is earned. The measurement period will be January 1st thru December 31st each year. NCQA normally publishes results for the measurement period in June/July following the measurement period. The incentives will be calculated and paid out 90 days after the release of the measurement period results. The below Table 4.2 is included for illustration purposes.

Table 4.2: Methodology Example For Illustration Purposes Only

Measure	**Threshold Result**	**Threshold Result**	**Example (A)**	**Example (B)**
Immunization	Equal to or greater than 50%=payment of $3.00 PMPM for eligible Members	Less than 50%=no payment earned	52% of threshold achieved=$3.00 PMPM	49% of threshold achieved=0 PMPM
Screening	Equal to or greater than 50%=payment of $3.00 PMPM for eligible Members	Less than 50%=no payment earned	46% of threshold achieved=$0 PMPM	88% of threshold achieved=$3.00 PMPM
PCP Visits	Equal to or greater than 50%=payment of $3.00 PMPM for eligible Members	Less than 50%=no payment earned	95% of threshold achieved=$3.00 PMPM	51% of threshold achieved=$3.00 PMPM
Readmissions	Equal to or greater than 50%=payment of $3.00 PMPM for eligible Members	Less than 50%=no payment earned	100% of threshold achieved=$3.00 PMPM	30% of threshold achieved=$0 PMPM
Sum for combined measures for their respective applicable populations for the applicable Performance Period	**12 PMPM for the eligible Member populations**	**No incentives earned when none of the threshold are met**	**$9.00 PMPM**	**$6.00 PMPM**

ADDENDUM A
Advanced Medical Home ("AMH") and AMH+ Provider Addendum

THIS Advanced Medical Home and AMH+ Provider Addendum ("AMH Appendix"), is made and entered as of the Effective Date of the Network Provider Participation Agreement by and between Vaya Health, a Local Management Entity/Managed Care organization, with a primary business address at 200 Ridgefield Court, Asheville, North Carolina 28806 (hereinafter referred to as "Vaya"), and [INSERT LEGAL BUSINESS NAME FOR CONTRACTOR],with a primary business address at [INSERT CONTRACTOR ADDRESS] (hereinafter Contractor is referred to as "AMH Contractor").

W I T N E S S E T H:

WHEREAS, this AMH Addendum is ancillary to the Contract, and the terms of the Contract are fully incorporated herein;

WHEREAS, any capitalized term not otherwise defined in this AMH Addendum shall have the same meaning and definitions as set forth in the Contract;

WHEREAS, Contractor serving as an AMH and/or AMH+ desires to enter into this AMH Addendum with Vaya to provide advanced medical home care for Members in its care and for wellness, prevention, treatment, payment, or healthcare operations purposes that are related to Contractor's obligations under the Contract; and

NOW THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the receipt of which is hereby acknowledged, Vaya and AMH Contractor (hereinafter individually referred to as a "Party" and collectively as "Parties") agree to the following terms, obligations, and conditions, which are incorporated into and form a part of the Contract to which they are attached:

ARTICLE I
Advanced Medical Home Program for Medicaid and NC Health Choice Members

1.1 **Background**: The Advanced Medical Home program refers to an initiative under which a Tailored Plan must pay Medical Home Fees to all participating primary care practices that act as PCPs. In the context of Tailored Plans, only AMH practices certified as AMH+ practices may provide Tailored Care Management. An AMH "practice" will be defined by a National Provider Identification (NPI) and service site location.

1.2 **Compliance**: Contractor serving as an AMH or AMH+ agrees to comply with the Department's Advanced Medical Home program.

1.3 **Definitions**:

1.3.1 **"Advanced Medical Home"** means Advanced Medical Home (AMH) and are State-designated primary care practices that have attested to meeting standards necessary to provide local care management services.

1.3.2 **"Advanced Medical Home Plus"** (AMH+) mean primary care practices certified by the Department as AMH Tier 3 practices, whose providers have experience delivering primary care services to Vaya eligible population or can otherwise demonstrate strong competency to serve that population and have certified by the State (prior to December 1, 2022) or Vaya (on or after December 1, 2022) as such.

1.3.3 **"Medical Home Fees"** means non-visit-based payments to AMH practices made in addition to fee for service payments, providing stable funding for primary care access and quality improvement at the practice level.

1.4 **Standard Terms and Conditions for AMH Providers**: AMH Contractor shall do as follows:

1.4.1 Accept Members and be listed as a primary care practice (PCP) in Vaya's Member-facing materials for the purpose of providing care to Members and managing their healthcare needs.

1.4.2 Provide primary care and patient care coordination services to each Member, in accordance with Vaya policies.

1.4.3 Provide or arrange for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.

1.4.4 Provide direct patient care a minimum of thirty (30) office hours per week.

1.4.5 Provide preventive services, in accordance with Section 4.0 of this AMH Addendum.

1.4.6 Maintain a unified patient medical record for each Member following Vaya's medical record documentation guidelines.

1.4.7 Promptly arrange referrals for medically necessary healthcare services that are not provided directly and document referrals for specialty care in the medical record.

1.4.8 Transfer the member's medical record to the receiving provider upon the change of PCP at the request of the new PCP or Vaya (if applicable) and as authorized by the member within thirty (30) days of the date of the request, free of charge.

1.4.9 Authorize care for the member or provide care for the member based on the standards of appointment availability as defined by Vaya's network adequacy standards.

1.4.10 Refer for a second opinion as requested by the member, based on Department guidelines and Vaya standards.

1.4.11 Review and use member utilization and cost reports provided by the Vaya for the purpose of AMH-level utilization management and advise the Vaya of errors, omissions, or discrepancies if they are discovered.

1.4.12 Review and use the monthly enrollment report provided by Vaya for the purpose of participating in Vaya or practice-based population health or care management activities.

1.5 **Required Preventive Services**: AMH Contractor shall perform the following requirements for Members served in the following age ranges identified in *Table 1.4: Required Preventive Services* below:

Table 1.4: Required Preventive Services	
	Member Age Ranges

Reference Number	AMH Preventative Health Requirements	0 to 3	0 to 6	0 to 11	0 to 18	0 to 21	0 to 121	3 to 17	7 to 120	11 to 18	11 to 121	18 to 121	21 to 121
1	Adult Preventative and Ancillary Health Assessment						Y		Y		Y	Y	Y
2	Blood Lead Level Screening	Y	Y	Y	Y	Y	Y						
3	Cervical Cancer Screening (applicable to Females only)						Y		Y		Y	Y	Y
4	Diphtheria, Tetanus Pertussis Vaccine (DTaP)	Y	Y	Y	Y	Y	Y	Y					
5	Haemophilus Influenzae Type B Vaccine Hib	Y	Y	Y	Y	Y	Y	Y					
6	Health Check Screening Assessment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
7	Hearing		Y	Y	Y	Y	Y	Y	Y	Y	Y		
8&9	Hemoglobin or Hematocrit	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Hepatitis B Vaccine	Y	Y	Y	Y	Y	Y	Y					
11	Inactivated Polio Vaccine (IPV)	Y	Y	Y	Y	Y	Y	Y					
12	Influenza Vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
13	Measles, Mumps, Rubella Vaccine (MMR)	Y	Y	Y	Y	Y	Y	Y					
14	Pneumococcal Vaccine	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y
15	Standardized Written Developmental	Y	Y	Y	Y	Y	Y	Y					
16	Tetanus			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
17	Tuberculin Testing (PPD Intradermal	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

	Injection/Mantoux Method)												
18	Urinalysis								Y		Y	Y	Y
19	Varicella Vaccine	Y	Y	Y	Y	Y	Y	Y					
20	Vision Assessment		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

1.6 **AMH Quality Metrics**: AMH Contractor agrees to measure, calculate, track, and report to Vaya, upon request and at the frequency requested, any AMH or AMH+ quality metrics requested for Vaya's CQI activities or reporting requirements to the Department. Vaya shall provide feedback on quality scoring results to AMH Contractor.

ARTICLE II
AMH+ Practice Requirements
(Applicable to Contractor only if Certified AMH+ in Vaya Network)

2.1 **Background**: Prior to the Effective Date of the Contract, all AMH+ are required to undergo the Department's certification process and be assessed against criteria set forth below. On and after the Effective Date, or any later date if postponed by the Department, Vaya shall assume responsibility for certifying provider organizations to deliver provider-based Tailored Care Management as AMH+ practices.

2.2 **Compliance**: In addition to Article I above, if AMH Contractor is serving as an AMH+, it agrees to comply with the Department's and Vaya's certification processes, as applicable, and be assessed against criteria established by the Department as set forth in this Addendum, the Managed Care Contract, the most up-to-date version of the Department's BH I/DD Tailored Plan Provider Manual for Tailored Care Management available on the Department's website, the Vaya Provider Manual, applicable Vaya Provider Communications, and any other applicable Department guidance, manual, or policy, including any subsequent amendment, revision, or replacement of any of the foregoing.

2.3 **Additional Controlling Authority**: In addition to the Controlling Authority set forth in the Contract, the Parties agree to comply with the conditions set forth as follows, including any and all subsequent revisions or amendments thereto, ("Additional Controlling Authority"), which may include but are not limited to the following:

2.3.1 the Department's BH I/DD Tailored Plan Provider Manual for Tailored Care Management (https://files.nc.gov/ncdma/DRAFT_Tailored-Care-Management-Provider-Manual_20191205.pdf); and
2.3.2 Department guidance, policy, operational manuals, and other program-specific requirements, as applicable, and within Department-specified timelines.

2.4 **General Contractor Obligations**: As a AMH Contractor serving as an AMH+ organization, AMH Contractor shall:

2.4.1 Hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model;
2.4.2 Be willing to consider offering integrated primary care and MH/SU/IDD/TBI services, if requested by Vaya;

2.4.5 Be a Network Provider;

2.4.6 Continually meet the AMH+ eligibility requirements set forth by the Department

2.4.7 Maintain at least one of the following specialty designation types:

a) MH and SUD
b) Adult
c) Child/adolescent
d) I/DD (not enrolled in the Innovations Waiver)
e) TBI (not enrolled in the TBI Waiver)
f) Innovations Waiver
g) TBI Waiver
h) Co-occurring I/DD and behavioral health;

2.4.8 Maintain active, working relationships with community providers that offer a wide scope of clinical and social services, including strong reciprocal relationships among relevant BH, I/DD, and primary care providers, to facilitate referrals among providers as well as provide formal and informal feedback and opportunities to share best practices;

2.4.9 Maintain the capacity and financial sustainability to establish care management as an ongoing line of business;

2.4.10 Ensure that AMH+ is recognized by AMH Contractor's leadership and governing body, if applicable, as integral to the mission of AMH Contractor and as such be supported by a budget and management team appropriate to maintain Tailored Care Management as a high-functioning service line;

2.4.11 Demonstrate that it has the appropriate structures in place to oversee the Tailored Care Management model; and

2.4.12 Have a strong governance structure.

2.5 **Staffing Requirements**: If AMH Contractor is serving as an AMH+, AMH Contractor must meet the staffing requirements specified in this Section 2.5 and must assign each member to a Tailored Care Management care manager who meets the qualifications specified in this Section 2.5.

2.5.1 The assigned care manager must not be related by blood or marriage or financially responsible for any of the members to whom they are assigned or have any legal power to make financial or health-related decisions for any of their assigned members.

2.5.2 All Tailored Care Management care managers serving members must have a bachelor's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area, or licensure as a registered nurse (RN); and at least two years of experience working directly with individuals with behavioral health conditions (if serving members with behavioral health needs) or with an intellectual/development disability (I/DD) or a traumatic brain injury (TBI) (if serving members with I/DD or TBI needs); and

2.5.3 All Tailored Care Management care managers serving members with long term services and supports (LTSS) needs must have at least two years of prior LTSS and/or home and community-based services (HCBS) coordination, care delivery monitoring, and care management experience, in addition to the requirements listed in Section 2.5.6. (This experience may be concurrent with the two years of experience working directly with individuals with behavioral health conditions, an I/DD, or a TBI.)

2.5.4 Supervising care managers serving members with behavioral health conditions must be either a master's-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), fully Licensed Marriage and Family Therapist (LMFT), or licensure as an

RN; and have at least three years of experience providing care management, case management, or care coordination to the population being served.

2.5.5 Supervising care managers serving members with an I/DD or a TBI must have one of the following minimum qualifications:

2.5.9.1 A bachelor's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area *and* five years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI; **or**

2.5.9.2 A master's degree in a field related to health, psychology, sociology, social work (e.g., LCSW), nursing, or another relevant human services area, or licensure as an RN *and* three years of experience providing care management, case management, or care coordination to complex individuals with an I/DD or a TBI.

2.5.6 Care manager extenders must be at least 18 years of age, have a high school diploma or equivalent; be trained in Tailored Care Management; be supervised by a care manager at an AMH+ practice; and meet one of the below requirements:

2.5.6.1 Be a person with lived experience with an I/DD or a TBI with demonstrated knowledge of and direct personal experience navigating the North Carolina (NC) Medicaid delivery system; or

2.5.6.2 Be a person with lived experience with a behavioral health condition who is a Certified Peer Support Specialist; or

2.5.6.3 Be a parent or guardian of an individual with an I/DD or a TBI or a behavioral health condition who has at least two years of direct experience providing care for and navigating the Medicaid delivery system on behalf of that individual (parent/guardian cannot serve as an extender for their family member); or

2.5.6.4 Has two years of paid experience performing care manager extender functions with at least one year of paid experience working directly with the Tailored Care Management-eligible population.

2.5.7 If a member is dually diagnosed with a behavioral health condition and an I/DD or a TBI, the AMH+ practice must ensure that the supervising care manager is qualified to oversee the member's care manager.

2.5.8 Each care manager must be supervised by a supervising care manager. One supervising care manager must not oversee more than eight (8) care managers. Supervisors must not carry a member caseload and must provide coverage for care manager vacation, sick leave, and staff turnovers. Supervisors must review all Tailored Care Management care plans and Individual Support Plans (ISPs) and provide guidance to care managers on how to meet members' needs.

2.5.9 Care manager extenders must be supervised by a care manager and remain within the scope delineated in *Guidance on the Use of Care Manager Extenders in Tailored Care Management*.

2.5.10 Care managers must supervise no more than two (2) FTE care manger extenders.

2.5.11 When an AMH+ practice relies on a Clinically Integrated Network ("CIN:") or Other Partner-employed care managers to carry out Tailored Care Management, the AMH+ practice must demonstrate that care management is sufficiently integrated with the organization's practice team and have managerial control of care management staff, defined as the opportunity, at a minimum, to approve the hiring and/or placement of a care manager or extender and require a replacement for any care manager or extender whose performance the AMH+ practice deems unsatisfactory.

2.5.12 AMH+ practices with arrangements with CINs or Other Partners must demonstrate strong clinical leadership at the CIN or Other Partner level that has deep experience in NC Medicaid or NC Health Choice and/or has supported similar efforts in other states.

2.5.13 All supervising care managers, care managers, and care manager extenders must participate and complete the Tailored Plan's Tailored Care Management training curriculum.

2.5.14 Care managers and supervising care managers must also complete training on in-reach and transition services.

2.5.15 The AMH+ practice must establish a multidisciplinary care team for each member. Depending on the member's needs, the required members of a multidisciplinary care team must include the member, the member's care manager, and the following individuals:

- 2.5.15.1 Caretaker(s)/legal guardians;
- 2.5.15.2 Supervising care manager;
- 2.5.15.3 Care manager extenders (e.g., community navigators, community health workers, individuals with lived experience with an I/DD or a TBI, parents or guardians of an individual with an I/DD or a TBI or a behavioral health condition);
- 2.5.15.4 Certified peer support specialist employed by the AMH+ practice or CIN or Other Partner, as applicable;
- 2.5.15.5 Primary care provider;
- 2.5.15.6 Behavioral health provider(s);
- 2.5.15.7 I/DD and/or TBI providers, as applicable;
- 2.5.15.8 Other specialists;
- 2.5.15.9 Nutritionists;
- 2.5.15.10 Pharmacists and pharmacy techs;
- 2.5.15.11 The member's obstetrician/gynecologist (for pregnant women);
- 2.5.15.12 In-reach and transition staff, as applicable; and
- 2.5.15.13 Other providers and individuals, as determined by the care manager and member.

2.5.16 The AMH+ practice must establish a plan to activate relationships with primary care providers and other key interdisciplinary agencies/providers.

2.5.17 The AMH+ practice must have written policies and procedures to ensure that multidisciplinary care team formation and communication occur in a timely manner and that the care team is documented in the care plan and is regularly updated. The AMH+ practice must conduct regular case conferences with members of the multidisciplinary care team, as appropriate based on member needs.

2.5.18 AMH+ practices must have access to clinical consultants to access expert support appropriate for the needs of the panel under Tailored Care Management. The AMH+ practice may employ or contract with consultants or do so through a CIN or Other Partner, and the consultant must be available by phone to staff within AMH+ practices to advise on complex clinical issues on an ad hoc basis. The AMH+ practice must have access to at least the following experts:

- 2.5.18.1 A general psychiatrist or child and adolescent psychiatrist;
- 2.5.18.2 A neuropsychologist or psychologist; and
- 2.5.18.3 For CMAs, a primary care physician (PCP) to the extent the member's PCP is not available for consultation.

2.6 **Population Health and Quality Measurement Requirements.** AMH+ practices must meet the following population health and health information technology (HIT) requirements:

2.6.1 The AMH+ practice must have implemented an electronic health record (EHR) or a clinical system of record that is in use by the AMH+ practice's providers that may electronically record, store, and transmit member clinical information.

2.6.2 The AMH+ practice must use a care management data system, whether or not integrated within the same system as the EHR (or clinical system of record), that can:

2.6.2.1 Maintain up-to-date documentation of Tailored Care Management member lists and assignments of individual members to care managers;
2.6.2.2 Electronically document and store the care management comprehensive assessment and re-assessment;
2.6.2.3 Electronically document and store the care plan or ISP;
2.6.2.4 Consume claims and encounter data;
2.6.2.5 Provide access to – and electronically share, if requested – member records with the member's care team to support coordinated care management, as well as the member, in accordance with federal, state, and Department privacy, security, and data-sharing requirements;
2.6.2.6 Track referrals;
2.6.2.7 Help schedule and prepare members (via, e.g., reminders and transportation) for appointments; and
2.6.2.8 Allow care managers to identify risk factors for individual members, develop actionable care plans and ISPs, monitor and quickly respond to changes in a member's health status, track a member's referrals and provide alerts where care gaps occur, monitor a member's medication adherence, transmit and share reports and summary of care records with care team members, support data analytics and performance, and transmit quality measures (where applicable).

2.6.3 The AMH+ practice must be able to receive and use enrollment data from the Tailored Plan to empanel the population in Tailored Care Management. To support outreach, engagement, assessment, and care planning, the AMH+ practice (or CIN or Other Partner on its behalf) must be able to:
2.6.3.1 Receive, in a machine-readable format specified by the Department, and maintain up-to-date records of acuity tiers by member, as determined by the Department and shared by the Tailored Plan;
2.6.3.2 Receive, in a machine-readable format, and maintain up-to-date records of any other risk scoring completed and shared by the Tailored Plan; and
2.6.3.3 Electronically reconcile the Tailored Care Management assignment lists received from the Tailored Plan with its list of members for whom it provides Tailored Care Management.

2.6.4 The AMH+ practice must access admission, discharge, transfer (ADT) data that correctly identifies when members are admitted, discharged, or transferred to or from an emergency department (ED) or a hospital in real time or near-real time.

2.6.5 The AMH+ practice must implement a systematic, clinically appropriate process with designated staffing for responding to certain high-risk ADT alerts, including:
2.6.5.1 Real-time (within minutes/hours) response to notifications of ED visits, for example by contacting the ED to arrange rapid follow-up;
2.6.5.2 Same-day or next-day outreach for designated high-risk subsets of the population; and
2.6.5.3 Additional outreach within several days after the alert to address outpatient needs or prevent future problems for other patients who have been discharged from a hospital or an ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post-discharge).

2.6.6 AMH+ practices must:
2.6.6.1 Use NCCARE360 as their community-based organization and social service agency resource repository to identify local community-based resources;
2.6.6.2 Refer members to the community-based organizations and social service agencies available on NCCARE360; and
2.6.6.3 Track closed-loop referrals.

2.6.7 AMH+ practices must use the Department's acuity tiers as the primary method for segmenting and managing their populations during the first two years of the Tailored Care Management model.

2.6.7.1 Tailored Plans may establish their own risk stratification methodologies beyond acuity tiering; if they do so, they must share all risk stratification results and methodologies used with AMH+ practices.

2.6.7.2 By the third year of the Tailored Care Management model, AMH+ practices shall develop their own risk stratification approach, refining the data and risk stratification scores they receive from Tailored Plans to incorporate critical clinical, unmet health-related resource, and other data to which they have access. Additionally, AMH+ practices may use patient registries to track patients by condition type/cohort.

2.6.8 Annually, the AMH+ practice must evaluate the Tailored Care Management services it provides to ensure that the services are meeting the needs of empaneled members and refine the services as necessary. The AMH+ practice must use a combination of clinical data, care management encounter data, and quality scores to generate a set of internal targets and set annual goals for improvement.

2.6.9 AMH+ practices must gather, process, and share data with Tailored Plans for the purpose of quality measurement and reporting.

2.7 **Delivery of Tailored Care Management**

2.7.1 Communication: AMH+ practices must develop policies for communicating and sharing information with members and their families and other caregivers with appropriate consideration for language, literacy, and cultural preferences, including sign language, closed captioning, and/or video capture. “Robocalls” or automated telephone calls that deliver recorded messages will not be an acceptable form of contacting members.

2.7.2 AMH+ practices must meet the following contact requirements for members with behavioral health needs:

2.7.2.1 High acuity: At least contacts per month, including at least one in-person contact with the member.

2.7.2.2 Moderate acuity: At least three contacts per month and at least one in-person contact with the member quarterly (includes care management comprehensive assessment if it was conducted in-person).

2.7.2.3 Low acuity: At least two contacts per month and at least two in-person contacts with the member per year, approximately six months apart (includes the care management comprehensive assessment if it was conducted in-person).

2.7.3 AMH+ practices must meet the following contact requirements for members with an I/DD or a TBI:

2.7.3.1 High acuity: At least three contacts per month, including two in-person contacts and one telephonic contact with the member.

2.7.3.2 Moderate acuity: At least three contacts per month and at least one in-person contact with the member quarterly.

2.7.3.3 Low acuity: At least one telephonic contact per month and at least two in person contacts per year, approximately six months apart.

2.7.3.4 For members with an I/DD or a TBI who have a guardian, telephonic contact may be with a guardian in lieu of the member, only where appropriate or necessary. In-person contact must involve the member.

2.7.4 Care Management Comprehensive Assessment: The AMH+ practice must make a best effort attempt to complete the care management comprehensive assessment in person, in a location that meets the member’s needs. “Best effort” is defined as including at least three documented strategic follow-up attempts to contact the member if the first attempt is unsuccessful (e.g., going to the home or working with a known provider to meet the member at an appointment). The care management comprehensive assessment must include, at a minimum, the following domains:

2.7.4.1 Immediate care needs;

2.7.4.2 Current services and providers across all health needs;
2.7.4.3 Functional needs, accessibility needs, strengths, and goals;
2.7.4.4 Other state or local services currently used;
2.7.4.5 Physical health conditions, including dental conditions;
2.7.4.6 Current and past mental health and substance use status and/or disorders, including tobacco use disorders;
2.7.4.7 Physical, intellectual, or developmental disabilities;
2.7.4.8 Detailed medication history – a list of all medicines, including over-the-counter medication and medication that has been prescribed, dispensed, or administered – and known allergies;
2.7.4.9 Advance directives, including psychiatric advance directives;
2.7.4.10 Available informal, caregiver, or social supports;
2.7.4.11 Standardized unmet health-related resource need questions (to be provided by the Department) covering four priority domains: Housing instability; Transportation insecurity; Food insecurity; and Interpersonal violence/toxic stress;
2.7.4.12 Any other ongoing conditions that require a course of treatment or regular care monitoring;
2.7.4.13 For adults only, exposure to adverse childhood experiences (ACEs) or other trauma;
2.7.4.14 Risks to the health, well-being, and safety of the member and others (including sexual activity and potential abuse/exploitation, or exposure to secondhand smoke/aerosols and other substances);
2.7.4.15 Cultural considerations (ethnicity, religion, language, reading level, health literacy, etc.);
2.7.4.16 Employment/community involvement;
2.7.4.17 Education (including individualized education plan and lifelong learning activities);
2.7.4.18 Justice system involvement (adults) or juvenile justice involvement and/or expulsions or exclusions from school (children and adolescents);
2.7.4.19 Risk factors that indicate an imminent need for LTSS;
2.7.4.20 The caregiver's strengths and needs;
2.7.4.21 Upcoming life transitions (changing schools, changing employment, moving, etc.);
2.7.4.22 Self-management and planning skills;
2.7.4.23 Receipt of and eligibility for entitlement benefits;
2.7.4.24 For members with an I/DD or a TBI: Financial resources and money management; and Alternative guardianship arrangements, as appropriate;
2.7.4.25 For children ages zero up to three, incorporate questions related to Early Intervention (EI) services for children, including: Whether the child is receiving EI services; The child's current EI services; Frequency of EI services provided; Which local Children's Developmental Service Agency (CDSA) or subcontracted agency is providing the services; and Contact information for the CDSA service coordinator; and
2.7.4.26 For children ages three up to 21 with a mental health disorder and/or substance use disorder (SUD), including members with a dual I/DD and mental health diagnosis, incorporate a strengths assessment process that promotes the identification of the functional strengths of each youth, family, and community.

2.7.5 Initial Assessment Timeframe Year One: During the first year of Tailored Plan operation, the AMH+ practice must undertake best efforts to complete the care management comprehensive assessment within the following timeframes:

2.7.5.1 Members identified as high acuity: Best efforts to complete it within forty-five (45) calendar days of assignment to Tailored Care Management and no longer than sixty (60) Calendar Days after assignment to Tailored Care Management.

2.7.5.2 Members identified as moderate/low acuity: Members identified as medium/low acuity: Within ninety (90) Calendar Days of assignment to Tailored Care Management.

2.7.6 Initial Assessment Timeframe Year Two: During the second and subsequent years of Tailored Plan operation, the AMH+ practice shall undertake best efforts to complete the care management comprehensive assessment within 60 days of assignment to Tailored Care Management.

2.7.7 Ongoing Assessment Timeframes: The AMH+ practice must attempt a care management comprehensive assessment for members already engaged in care management:

2.7.7.1 At least annually;

2.7.7.2 When the member's circumstances, needs, or health status changes significantly;

2.7.7.3 After significant changes in scores on State-approved level-of-care determination and screening tools (e.g., Level of Care Utilization System (LOCUS) and Child and Adolescent LOCUS (CALOCUS), American Society of Addiction Medicine (ASAM), Child and Adolescent Needs and Strengths (CANS), SIS);

2.7.7.4 At the member's request; or

2.7.7.5 After "triggering events", defined as follows:

2.7.7.5.1 Inpatient hospitalization for any reason;

2.7.7.5.2 Two emergency department visits since the last care management comprehensive assessment (including reassessment);

2.7.7.5.3 An involuntary treatment episode;

2.7.7.5.4 Use of behavioral health crisis services;

2.7.7.5.5 Arrest or other involvement with law enforcement/the criminal justice system, including the Division of Juvenile Justice;

2.7.7.5.6 Becoming pregnant and/or giving birth;

2.7.7.5.7 A change in member circumstances that requires an increased need for care, a decreased need for care, transition into or out of an institution, or loss of a family/friend caretaker, or any other circumstance the plan deems to be a change in circumstance;

2.7.7.5.8 Loss of housing; and

2.7.7.5.9 Foster care involvement.

2.7.8 The AMH+ practice must ensure that the results of the care management comprehensive assessment are made available to the member's primary care, behavioral health, I/DD, TBI, and LTSS providers and the Tailored Plan within 14 days of completion to inform care planning and treatment planning, with the member's consent (to the extent required by law).

2.7.9 Care Plan and ISP: The AMH+ practice must develop a care plan for each member with behavioral health needs and/or an ISP for each member with I/DD and TBI needs. Each care plan and ISP must be individualized, person-centered, and developed using a collaborative approach including member and family participation where appropriate. Care plans and ISPs must incorporate the results of the care management comprehensive assessment (including unmet health-related resource need questions), claims analysis and risk scoring, any available medical records, and screening and/or level of care determination tools, including the following, as appropriate, unless modified by the Department:

2.7.9.1 LOCUS and CALOCUS;

2.7.9.2 CANS;

2.7.9.3 ASAM criteria;

2.7.9.4 For Innovations waiver enrollees: SIS; and

2.7.9.5 For TBI waiver enrollees: Rancho Los Amigos Levels of Cognitive Functioning Scale (as applicable).

2.7.10 For Tailored Plan members ages three to 21 with mental health conditions and/or SUD who are receiving mental health or substance use services, the AMH+ practice must follow System of Care requirements, including:
- 2.7.10.1 Involving a Child and Family Team (CFT) in facilitating the care planning process and developing the care plan or ISP;
- 2.7.10.2 Using the strengths assessment to build strategies included in the care plan or ISP that address the critical needs and unique strengths of the youth and family as identified by and in cooperation with the CFT; and
- 2.7.10.3 Regularly updating the care plan or ISP to respond to changes with the youth and family, as well as the results of the supports and services provided, and document the shift of activity from formal supports to informal supports for greater self-sufficiency.

2.7.11 AMH+ practices must ensure that all care plans and ISPs developed under Tailored Care Management include the following minimum elements:
- 2.7.11.1 Names and contact information of key providers, care team members, family members, and others chosen by the member to be involved in planning and service delivery;
- 2.7.11.2 Measurable goals;
- 2.7.11.3 Clinical needs, including any behavioral health, I/DD-related, TBI-related, or dental needs;
- 2.7.11.4 Interventions including addressing medication monitoring, including adherence;
- 2.7.11.5 Intended outcomes;
- 2.7.11.6 Social, educational, and other services needed by the member;
- 2.7.11.7 Strategies to increase social interaction, employment, and community integration;
- 2.7.11.8 An emergency/natural disaster/crisis plan;
- 2.7.11.9 Strategies to mitigate risks to the health, well-being, and safety of the members and others;
- 2.7.11.10 Information about advance directives, including psychiatric advance directives, as appropriate;
- 2.7.11.11 A life transitions plan to address instances where the member is changing schools, experiencing a change in caregiver/natural supports, changing employment, moving or entering another life transition; and
- 2.7.11.12 Strategies to improve self-management and planning skills.
- 2.7.11.13 For members with I/DD, TBI, or serious emotional disturbance (SED), the ISP should also include caregiver supports, including connection to respite services, as necessary.

2.7.12 Initial Care Plan Timeframe: The AMH+ practice must make best efforts to complete an initial care plan or ISP within 30 days of the completion of the care management comprehensive assessment. “Best effort” is defined as including at least three documented strategic follow-up attempts to contact the member if the first attempt is unsuccessful. The AMH+ practice must not delay the provision of needed services to a member in a timely manner, even if that member is waiting for a care plan or ISP to be developed.

2.7.13 Ongoing Care Plan Timeframes: The AMH+ practice must regularly and comprehensively update the care plan or ISP, incorporating input from the member and members of the care team, as part of ongoing care management:
- 2.7.13.1 At minimum every 12 months;
- 2.7.13.2 When the member’s circumstances or needs change significantly;
- 2.7.13.3 At the member’s request;
- 2.7.13.4 Within 30 days of care management comprehensive (re)assessment; and/or
- 2.7.13.5 After triggering events as set forth in Section 2.7.7.5.

2.7.14 The AMH+ practice must ensure that each care plan or ISP is documented, stored, and made available to the member and the following representatives within 14 days of completion of the care plan or ISP:

2.7.14.1 Care team members, including the member's PCP and behavioral health, I/DD, TBI, and LTSS providers;
2.7.14.2 The Tailored Plan;
2.7.14.3 Other providers delivering care to the member;
2.7.14.4 The member's legal representative (as appropriate);
2.7.14.5 The member's caregiver (as appropriate, with consent);
2.7.14.6 Social service providers (as appropriate, with consent); and
2.7.14.7 Other individuals identified and authorized by the member.

2.7.15 Care Coordination: The AMH+ practice must ensure the member has an ongoing source of care and coordinate the member's health care and social services, spanning physical health, behavioral health, I/DD, TBI, LTSS, pharmacy services, and services to address unmet health-related resource needs. In delivering care coordination the AMH+ practice must:
2.7.15.1 Follow up on referrals and work with the member's providers to help coordinate resources during any crisis event as well as provide assistance in scheduling and preparing members for appointments (e.g., reminders and arranging transportation) and
2.7.15.2 Provide referral, information, and assistance in obtaining and maintaining community-based resources and social support services, including LTSS; I/DD and TBI services (including Innovations and TBI waiver services); and any State-funded services.

2.7.16 Twenty-four-Hour Coverage: The AMH+ practice must provide or arrange for coverage for services, consultation or referral, and treatment for emergency medical conditions, including behavioral health crisis, 24 hours per day, seven days per week. The AMH+ practice must:
2.7.16.1 Share information such as care plans and psychiatric advance directives, and
2.7.16.2 Coordinate care to place the member in the appropriate setting during urgent and emergent events. Automatic referral to the hospital ED for services does not satisfy this requirement.

2.7.17 Annual Physical Exam: The AMH+ practice must ensure that the member has an annual physical exam or well-child visit, based on the appropriate age-related frequency.

2.7.18 Continuous Monitoring: The AMH+ practice must conduct continuous monitoring of progress toward goals identified in the care plan or ISP through face-to-face and collateral contacts with the member and his or her support member(s) and routine care team reviews. The AMH+ practice must support the member's adherence to prescribed treatment regimens and wellness activities.

2.7.19 Medication Monitoring: The AMH+ practice must conduct medication monitoring, including regular medication reconciliation (conducted by the appropriate care team member) and support of medication adherence. A community pharmacist at the CIN level, in communication with the AMH+ practice, may assume this role.

2.7.20 System of Care: The AMH+ practice must utilize strategies consistent with a System of Care philosophy for children and youth, including knowledge of child welfare, school, and juvenile justice systems. For children and youth receiving behavioral health services, care management must include:
2.7.20.1 Promotion of family-driven, youth-guided service delivery and development of strategies built on social networks and natural or informal supports;
2.7.20.2 Development of, with families and youth, strategies that maximize the skills and competencies of family members to support youth and caregivers' self- determination and enhance self-sufficiency;
2.7.20.3 Verifiable efforts for services and supports to be delivered in the community within which the youth and family live, using the least restrictive settings possible to preserve community and family connections and manage costs; and

2.7.20.4 Development and implementation of proactive and reactive crisis plans in conjunction with the care plan or ISP that anticipate crises and utilize family, team, and community strengths to identify and describe who does what and when; every member of the CFT must be provided a copy of the plan.

2.7.21 Individual and Family Supports: The AMH+ practice must incorporate individual and family supports by performing the following activities at a minimum:

2.7.21.1 Educate the member in self-management;

2.7.21.2 Educate and provide guidance on self-advocacy to the member, family members, and support members;

2.7.21.3 Connect the member and caregivers to education and training to help the member improve function, develop socialization and adaptive skills, and navigate the service system;

2.7.21.4 Provide information and connections to needed services and supports including but not limited to self-help services, peer support services, and respite services;

2.7.21.5 Provide information to the member, family members, and support members about the member's rights, protections, and responsibilities, including the right to change providers, the grievance and complaint resolution process, and fair hearing processes;

2.7.21.6 Promote wellness and prevention programs;

2.7.21.7 Provide information on establishing advance directives, including psychiatric advance directives as appropriate, and guardianship options/alternatives, as appropriate;

2.7.21.8 Connect members and family members to resources that support maintaining employment, community integration, and success in school, as appropriate; and

2.7.21.9 For high-risk pregnant women, inquiring about broader family needs, offering guidance on family planning, and beginning discussions about the potential for an Infant Plan of Safe Care.

2.7.22 Health Promotion: The AMH+ practice must:

2.7.22.1 Educate the member on members' chronic conditions;

2.7.22.2 Teach self-management skills and sharing self-help recovery resources;

2.7.22.3 Educate the member on common environmental risk factors including but not limited to the health effects of exposure to second and third hand tobacco smoke and e-cigarette aerosols and liquids and their effects on family and children;

2.7.22.4 Conduct medication reviews and regimen compliance; and

2.7.22.5 Promote wellness and prevention programs.

2.7.23 Unmet Health-Related Resource Needs: The AMH+ practice must ensure that Tailored Care Management addresses unmet health-related resource needs by performing the following activities at a minimum:

2.7.23.1 Provide referral, information, and assistance in obtaining and maintaining community-based resources and social support services, including: Disability benefits; Food and income supports; Housing; Transportation; Employment services; Education; Financial literacy programs; Child welfare services; After-school programs; Rehabilitative services; Domestic violence services; Legal services; Services for justice-involved populations; and Other services that help individuals achieve their highest level of function and independence.

2.7.23.2 Provide comprehensive assistance securing health-related services, including assistance at initial application and renewal with filling out and submitting applications and gathering and submitting required documentation, including in-person assistance when it is the most efficient and effective approach, at a minimum, for: Food and Nutrition Services; Temporary Assistance for Needy Families; Child Care Subsidy; Low Income Energy Assistance Program; NC ABLE Accounts (for individuals with

disabilities); Women, Infants, and Children (WIC) Program; and Other programs managed by the Tailored Plan that address unmet health- related resource needs.

2.7.23.3 Provide referral, information, and assistance in connecting members to programs and resources that can assist in: Securing employment; Supported employment (such as through the Individual Placement and Support - Supported Employment (IPS-SE) program); Volunteer opportunities; Vocational rehabilitation and training; or other types of productive activity that support community integration, as appropriate.

2.8 Transitions, Community Inclusion, and Diversions

2.8.1 Transitional Care Management: AMH+ practices must manage care transitions for members under care management transitioning from one clinical setting to another, including the following activities:

2.8.1.1 Assign a care manager to manage the transition;

2.8.1.2 Have a care manager or care team member visit the member during his/her stay in the institution and be present on the day of discharge;

2.8.1.3 Conduct outreach to the member's providers;

2.8.1.4 Obtain a copy of the discharge plan and review the discharge plan with the member and facility staff;

2.8.1.5 Facilitate clinical handoffs;

2.8.1.6 Assist the member in obtaining needed medications prior to discharge, ensure an appropriate care team member conducts medication reconciliation/management, and support medication adherence;

2.8.1.7 Prior to discharge from a residential or an inpatient setting, in consultation with the member, facility staff, and the member's care team, create and implement a 90-day transition plan as an amendment to the member's care plan or ISP that outlines how the member will maintain or access needed services and supports, transition to the new care setting, and integrate into his or her community. The 90-day transition plan must incorporate any needs for training of parents and other adults to care for a child with complex medical needs post-discharge from an inpatient setting;

2.8.1.8 Communicate with and educate the member and the member's caregivers and providers to promote understanding of the 90-day transition plan;

2.8.1.9 Facilitate arrangements for and scheduling of transportation, in-home services, and follow-up outpatient visits with appropriate providers within a maximum of seven calendar days, unless required within a shorter time frame;

2.8.1.10 Ensure that the assigned care manager follows up with the member within 48 hours of discharge;

2.8.1.11 Arrange to visit the member in the new care setting after discharge/transition;

2.8.1.12 Conduct a care management comprehensive assessment within 30 days of the discharge/transition, or update the current assessment; and

2.8.1.13 Update the member's care plan or ISP in coordination with the care team within 90 days of the discharge/transition.

2.8.2 Community Inclusion Activities: AMH+ practices must conduct the community inclusion and transition-related responsibilities outlined in *In-Reach Activities* and *Transition Activities* below for the following members (as appropriate):

2.8.2.1 Children and youth admitted to a state psychiatric hospital, psychiatric residential treatment facility (PRTF), or Residential Treatment Levels II/Program Type, III, and IV as defined in the Department's Clinical Coverage Policy 8-D-2 ("Residential Treatment Levels"); and

2.8.2.2 Adult members admitted to a state psychiatric hospital or an Adult Care Home (ACH) who are eligible for Tailored Care Management and who are not transitioning to supportive housing.

2.8.3 In-Reach Activities: AMH+ practices must conduct in-reach activities for assigned members under 18 admitted to or residing in a state psychiatric hospital and members admitted to or residing in a PRTF or congregate child residential treatment settings who may be able to have their needs safely met in a community setting. For members newly admitted to one of these facilities, in-reach activities must begin within seven days of admission. Care managers must identify and engage such members and conduct the following in-reach activities:

2.8.3.1 Provide age and developmentally appropriate education and ensure that the member and their family and/or guardians are fully informed about the available community-based options; this may include accompany them on visits to community-based services;

2.8.3.2 Identify and attempt to address barriers to relocation to a community setting;

2.8.3.3 Provide the member and their family and/or guardians opportunities to meet with other individuals with similar diagnoses and shared lived experience, who are living, working, and receiving services in community settings;

2.8.3.4 Ensure that the member and their family and/or guardians who may be eligible for supportive housing are fully informed about the available options; and

2.8.3.5 Identify any specific trainings that facility staff may benefit from to support smooth transitions for members to live and work in community settings.

Not all members will be able or willing to continue with the in-reach process or begin transition planning. For those members, care managers must make best efforts to address member concerns and arrange for peer-to-peer meetings, when appropriate, and continue to engage the member and their family and/or guardians on a regular basis about the opportunity to transition to a more integrated setting.

2.8.4 Transition Activities: AMH+ practices will be responsible for transition activities for assigned members under age 21 residing in a state psychiatric hospital and all members residing in an ACH who are not transitioning to supportive housing and assigned members in a PRTF or Residential Treatment Levels II/Program Type, III, and IV. Care managers must plan for effective and timely transition of members to the community and perform the following transition activities:

2.8.4.1 Collaborate with the appropriate individuals, specialists, and providers needed to facilitate a smooth transition to the community, including but not limited to, facility providers and discharge planners, the member's community-based primary care provider (PCP), education specialists, and other community providers and specialists as relevant to the member's needs;

2.8.4.2 Assist the member with selecting a community-based PCP and other clinical and behavioral health specialists prior to discharge and actively engage them in the transition planning process;

2.8.4.3 Arrange for individualized supports and services that are needed to be in place upon discharge;

2.8.4.4 Collaborate with the member and their family and/or guardians to identify and schedule post-discharge appointments for the critical services necessary to address the member's specific needs, such as complex behavioral health, primary care, and medical needs;

2.8.4.5 Work to identify any specific training needs by receiving providers and/or agencies to ensure a seamless transition for the member;

2.8.4.6 Address any barriers to discharge planning to the most integrated setting possible, such as transportation, housing, and training for family members and/or guardians prior to discharge;

2.8.4.7 Work with the facility providers to arrange for any post-discharge services, when applicable;

2.8.4.8 Review the discharge plan with the member and their family and/or guardians and facility staff and assist the member in obtaining needed prescription on the day of discharge; and

2.8.4.9 Convene and engage the member's Child and Family Team through the entire transition process.

2.8.5 Diversion: AMH+ practices must identify members who are at risk of entry into an adult care home or an institutional setting, such as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), psychiatric hospital, or psychiatric residential treatment facility, and performing diversion activities. Care managers must perform the following Diversion activities:

2.8.5.1 Screen and assess members for eligibility for community-based services;

2.8.5.2 Educate members on the choice to remain in the community and the services that would be available;

2.8.5.3 Facilitate referrals and linkages to community support services for assistance;

2.8.5.4 Determine whether a member is eligible for supported housing, if needed; and

2.8.5.5 Develop a Community Integration Plan that clearly documents that the member's decision to remain in the community was based on informed choice, and the degree to which the member's decision has been implemented.

2.9 **Additional Tailored Care Management Requirements for Members Enrolled in the Innovations Waiver or TBI Waiver**: AMH+ practices that are certified to provide Tailored Care Management to individuals enrolled in the 1915(c) Innovations and TBI waivers will be responsible for coordinating these individuals' waiver services in addition to performing the Tailored Care Management requirements. The Department also intends to release additional guidance on 1915(i) care coordination requirements. AMH+ practices serving members in the Innovations or TBI waiver must:

2.9.1 Support completion of assessments beyond the care management comprehensive assessment and incorporate results into the care management comprehensive assessment.

2.9.2 Complete preliminary intake and screenings for the waivers, including NC Innovations Risk/Support Needs Assessment and TBI Risk/Support Needs Assessment, to see if the waiver can meet the individual's needs;

2.9.3 Support enrollee in completing person-centered information toolkits and self-direction assessments; and

2.9.4 Complete Level of Care (LOC) re-evaluation annually.

2.9.5 Facilitate provider choice and assignment process for Innovations and TBI waiver enrollees.

2.9.6 Help enrollee make informed choices of care team participants, provide information about providers, and arrange provider interviews as needed; and

2.9.7 Convene an in-person (as clinically indicated) care team planning meeting.

2.9.8 Coordinate information and resources for self-directed services for Innovations waiver enrollees, as applicable.

2.9.9 Ensure that waiver enrollees interested in self-directed services receive relevant information and training;

2.9.10 Assist in appointing a representative to help manage self-directed services, as applicable;

2.9.11 Assess employer of record and manage employer and representative, as applicable; and

2.9.12 Provide self-directed budget information.

2.9.13 Perform additional responsibilities related to developing and monitoring implementation of the ISP for Innovations and TBI waiver enrollees beyond those required for other individuals engaged in Tailored Care Management.

2.9.14 Complete the ISP so that the Tailored Plan receives it within 60 calendar days of LOC determination. As part of developing the ISP:

2.9.14.1 Explain options regarding the services available, and discuss the duration of each service;

2.9.14.2 Include a plan for coordinating waiver services;

2.9.14.3 Ensure enrollee completes Freedom of Choice statement in ISP annually;

2.9.14.4 Submit service authorization request to Tailored Plan for each service; and

2.9.14.5 Ensure that delivery of waiver services begins within 45 days of ISP approval.

2.9.14.6 Monitor ISP implementation and resolve or escalate issues as needed:

2.9.14.6.1 Complete monthly ISP monitoring checklist (e.g., waiver service utilization, provider choice, HCBS compliance setting, etc.);

2.9.14.6.2 Monitor at least quarterly to ensure that any restrictive interventions (including protective devices used for behavioral support) are written into the ISP and the Positive Behavior Support Plan; and

2.9.14.6.3 Notify Tailored Plan of LOC determination updates.

2.10 **Tailored Care Management Oversight and Monitoring Requirements**: If AMH Contractor is serving as an AMH+, AMH Contractor shall be accountable to all elements of the Tailored Care Management model contained in this Contract and as prescribed by the Department. The AMH+ practice must comply with oversight requirements established by the Tailored Plan and the Department, including reporting requirements and corrective action plans.

2.10.1 AMH Contractor shall cooperate with and comply with any technical assistance or Program Integrity and Other Monitoring Activities relating to its Tailored Care Management activities, and AMH Contractor serving as an AMH+ shall require and allow CIN or Other Partner to cooperate and comply with any and all of Vaya's requests relating to such oversight activities. However, to the extent that a CIN or Other Partner contracts with Vaya on behalf of AMH Contractor as an AMH+ practice(s), AMH Contractor understand, acknowledge, and agree that Vaya shall conduct oversight of the CIN for those Tailored Care Management activities it is performing on AMH Contractor's behalf and that the AMH Contractor shall remain subject to Vaya's oversight and Program Integrity and Other Monitoring Activities for all other activities, duties and obligations set forth in this Addendum and elsewhere in the Contract. Furthermore, to the extent AMH Contractor as an AMH+ practice(s) contract with a CIN or Other Partner, the requirements and capabilities applicable to AMH+ practice(s) apply to the CIN or Other Partner.

2.10.2 Vaya shall monitor the Contractor's AMH+ practice performance against requirements contained in this Contract. However, to the extent that a CIN or Other Partner contracts with Vaya on behalf of AMH Contractor as an AMH+ practice(s), AMH Contractor understands, acknowledges, and agrees that Vaya shall monitor the CIN or Other Partner directly as it relates to the Tailored Care Management activities performed by the CIN or Other Partner and that AMH Contractor shall remain subject to Vaya's Program Integrity and Other Monitoring Activities for all other activities, duties and obligations set forth in the Contract.

2.10.2.1 In the event of underperformance by the AMH Contractor or its AMH+ practice(s) relative to the requirements for Tailored Care Management required by the Contract or Controlling Authority, the AMH+ practice(s)will receive notice of underperformance, identifying the underperformance and providing the AMH Contractor's AMH+ practice(s) and AMH Contractor thirty (30) days, or more if mutually agreed upon in writing, to remediate any identified issues through a Corrective Action Plan (CAP). As part of its CAP, AMH Contractor and AMH Contractor's AMH+ practice(s) (and CIN or Other Partner, if applicable) shall be shall be required to address and to ensure that there are no gaps in care management functions for members assigned to the AMH+ practice(s).

2.10.2.2 In the event of continued underperformance by AMH Contractor, AMH Contractor's AMH+ practice(s), or its CIN or Other Partner, that is not corrected after the time limit set forth on the CAP, Vaya may take any other action, up to and including, termination of the Contract and exclusion of AMH Contractor, the AMH+ practice(s), CIN, Other Partner, or other entity from the Vaya Network.

2.11 **Other Tailored Care Management Requirements**: AMH Contractor shall:

2.11.1 Develop and maintain policies for communicating and sharing information with Members and their families and other caregivers with appropriate consideration for language, literacy, and cultural preferences, including sign language, closed captioning, and/or video capture. "Robocalls" or automated telephone calls that deliver recorded messages will not be an acceptable form of contacting beneficiaries.

2.11.2 Meet the same Member contact requirements that apply to Vaya's Tailored Care Management program.

2.11.3 Meet the same requirements for Care Management Comprehensive Assessment that apply to Vaya's Tailored Care Management program.

2.11.4 Meet the same requirements for Care Plans that apply to Vaya's Tailored Care Management program.

2.11.5 Meet the same requirements for the composition of a care team that apply to Vaya's Tailored Care Management program.

2.11.6 Continue to demonstrate the ability to electronically, safely, and securely transmit the Care Plan to each member of the Member's multidisciplinary care team.

2.11.7 Meet the same requirements for ongoing care management that apply to Vaya's Tailored Care Management program.

2.11.8 Meet the same requirements related to addressing Unmet Health- Related Resource Needs that apply at Vaya level.

2.11.9 Meet the same requirements for transitional care management that apply to Vaya's Tailored Care Management program.

2.11.10 Require care managers based in the AMH+, as well as in any supporting CIN or Other Partners, to meet the same initial, annual, and ongoing training requirements as care managers based at Vaya.

2.11.11 Assist Vaya with reconciliation of AMH+ and PCP data with the Department's 834 files and addressing discrepancies of such data, upon Vaya's request.

2.11.12 No care managers (whether employed or contracted by the AMH Contractor, AMH+ practice(s), or CIN or Other Partner on the AMH Contractor's behalf) may be related by blood or marriage or financially responsible for any of the Members to whom they are assigned or have any legal power to make financial or health-related decisions for any of their assigned Members.

ARTICLE III
REPORTING, METRICS, AND APPEALS

3.1 **Performance Reporting Requirements**: AMH Contractor acknowledges, agrees, and understands that Vaya is required to submit routine and ad hoc reports to the Department on Tailored Care Management, and AMH Contractor agrees to cooperate and comply with any and all requests for any data, documentation, or information relating to AMH Contractor's Tailored Care Management and AMH+ activities. Specifically, AMH Contractor may be required to share:

3.1.1 The number of Members assigned to and actively engaged in care management at each AMH+ practice by acuity tier and disability group (SMI/SED, SUD, I/DD, TBI) on a monthly basis.

3.1.2 The number and type of care management contacts and core Health Home services provided per month for each Member on a monthly basis.

3.1.3 AMH+ performance on defined quality measures on a monthly, quarterly, and/or annual basis.

3.1.4 Percentage of Members actively engaged in AMH Contractor's Tailored Care Management that are receiving care management on at least a quarterly basis.

3.1.5 A roster listing the name of the contracted CIN or Other Partner, if applicable, on a monthly basis.

3.1.6 The number of care managers and supervising care managers employed by AMH Contractor, or CIN or Other Partner, on at least a quarterly basis.

3.2 **Screening Information**: AMH Contractor serving as an AMH+ shall send, within one (1) Business Day of completing the screening, all screening information and applicable medical record information for Members in care management for high-risk pregnancies to Vaya and the LHD that are contracted for the provision of providing care management services for high-risk pregnancy.

ARTICLE IV
PAYMENTS

4.1 **Background:** The majority of primary care practices serving Medicaid beneficiaries are participating in the Advanced Medical Home (AMH) program in Tiers 1-3.

4.1.1 **Payments to Certified Advanced Medical Home Plus (AMH+) Practices**: To access the per member per month (PMPM) payment for any given member, the AMH+ practice must deliver at least one care management contact during the month for that member (i.e., providers will not be paid in months in which there were no member contacts). The AMH+ practice must submit a claim to the Tailored Plan, and the Tailored Plan must pay the provider the PMPM rate after the month of service.

4.1.1.1 For Tailored Care Management, Vaya shall pay AMH Contractor serving as AMH+ practice(s) each of the following components:

4.1.1.2 Tailored Care Management payment for each month in which the AMH+ practice performed Tailored Care Management for each Member. The Tailored Care Management payment shall be a fixed rate prescribed by the Department and acuity tiered. These fixed rates shall apply for both Medicaid and Health Choice Members.

4.1.1.3 Tailored Care Management payment for any month in which the Member is assigned to the AMH+ and engaged in care management.

4.1.1.4 Performance incentive payment, if earned by AMH Contractor if serving as an AMH+. The performance incentive payment shall be based on the metrics included as the AMH+ metrics in the Department's Technical Specifications Manual, once released.

4.1.2 **Payments of Medical Home Fees to Advanced Medical Homes**: In addition to the payment for services provided, Vaya shall pay AMH Contractor serving as an AMH practice a Medical Home Fee. "AMH practice" means a practice participating in the AMH program for the purposes of contracting with Vaya, including, but not limited to, an AMH practice also certified as an AMH+ practice for the purposes of Tailored Care Management. Vaya shall pay Medical Home Fees to AMH Tiers 1 – 3 practices for any month in which the member is assigned to that AMH practice as their PCP. Medical Home Fees for AMH Tiers 1 –3 practices may be prorated for partial months and shall be no less than the following amounts for services rendered through June 30, 2024. Thereafter, the Medical Home Fee will be determined by Vaya.:

4.1.2.1 $1.00 per member per month ("PMPM") for Tier 1 practices and

4.1.2.2 $x.00 PMPM for all Tailored Plan members in Tier 2 and 3 practices.

4.1.3 Vaya in its sole discretion may, but is not required to, develop methodologies for the calculation of AMH Performance Incentive Payments that utilize the AMH metrics. The Parties acknowledge and agree that currently there are no AMH performance incentive payments available for AMH Tiers 1-3 practices.

SIGNATURES

IN WITNESS WHEREOF, the Parties hereby execute and deliver this AMH Addendum to the Contract, under "Seal", as of the Effective Date. Each individual electronically signing below certifies that he or she has been duly authorized to bind Vaya and AMH Contractor, respectively, to the terms of this AMH Addendum.

Contractor Legal Name:

By: _____ (ADOPTED SEAL)
CONTRACTOR DULY AUTHORIZED OFFICIAL

Name: _____

Title: _____

Date: _____

Vaya Health

By: _____ (ADOPTED SEAL)
VAYA DULY AUTHORIZED OFFICIAL
Brian Ingraham, Chief Executive Officer

Date: _____

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act, N.C.G.S. § 159-28.

_____ _____
Vaya Health Finance Officer, or designee Date

ADDENDUM B
Care Management Agency ("CMA") Provider Addendum

THIS Care Management Agency Provider Addendum ("CMA Addendum"), is made and entered as of the Effective Date of the Network Provider Participation Agreement by and between Vaya Health, a Local Management Entity/Managed Care organization, with a primary business address at 200 Ridgefield Court, Asheville, North Carolina 28806 (hereinafter referred to as "Vaya"), and [INSERT LEGAL BUSINESS NAME FOR CONTRACTOR],with a primary business address at [INSERT CONTRACTOR ADDRESS], (hereinafter referred to as "CMA Contractor" or "Contractor").

W I T N E S S E T H:

WHEREAS, this CMA Addendum is ancillary to the Contract, and the terms of the Contract are fully incorporated herein;

WHEREAS, any capitalized term not otherwise defined in this CMA Addendum shall have the same meaning and definitions as set forth in the Contract; and

WHEREAS, Contractor desires to enter into this CMA Addendum with Vaya as a CMA for Members in its care and for wellness, prevention, treatment, payment, or healthcare operations purposes that are related to Contractor's obligations under the Contract.

NOW THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the receipt of which is hereby acknowledged, Vaya and CMA Contractor (hereinafter individually referred to as a "Party" and collectively as "Parties") agree to the following terms, obligations, and conditions, which are incorporated into and form a part of the Contract to which they are attached:

ARTICLE I
CMA Requirements

1.1 **Background**: Prior to the Effective Date of the Contract, all CMA Contractors are required to undergo the Department's certification process and be assessed against criteria set forth below. On and after the Tailored Plan Launch, or any later date if postponed by the Department, Vaya shall assume responsibility for certifying provider organizations to deliver provider-based Tailored Care Management as CMA practices. CMA Contractors shall be provider organizations with experience delivering Behavioral Health, I/DD, and/or TBI services to the Tailored Plan eligible population that will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. The "CMA" designation is unique to providers serving the Tailored Plan population.

1.2 **Compliance**: CMA Contractor agrees to comply with the Department's and Vaya's:

1.2.1 Certification process, as applicable, and be assessed against criteria established by the Department as set forth in this Addendum, the Managed Care Contract, the BH I/DD Tailored Plan Provider Manual for Tailored Care Management (https://files.nc.gov/ncdma/DRAFT_Tailored-Care-Management-Provider-Manual_20191205.pdf), Vaya's

Provider Manual, applicable Vaya Provider Communications, and any other applicable Department guidance, manual, or policy, including any subsequent amendment, revision, or replacement of any of the foregoing.

1.2.2 Data system requirements, including but not limited to, data exchanges and interfaces, file formats, data exchange frequencies, data exchange protocols and transports, source and target systems, file size (i.e. number of records per file), and other technical specifications for the submission, exchanging, CMA assignment, risk stratification, or transferring of information relevant to the services delivered by Contractor pursuant to the Contract, including but not limited to, Tailored Care Management and Covered Services.

1.3 **Additional Controlling Authority**: In addition to the Controlling Authority set forth in the Contract, the Parties agree to comply with the conditions set forth as follows, including any and all subsequent revisions or amendments thereto, ("Additional Controlling Authority"), which may include but are not limited to the following:

1.3.1 BH I/DD Tailored Plan Provider Manual for Tailored Care Management (https://files.nc.gov/ncdma/DRAFT_Tailored-Care-Management-Provider-Manual_20191205.pdf); and

1.3.2 Department guidance, policy, operational manuals, and other program-specific requirements, as applicable, and within Department-specified timelines.

1.4 **General CMA Contractor Obligations**: If Contractor is serving as a Care Management Agency, it shall:

1.4.1 Hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model.

1.4.1 Be willing to consider offering integrated primary care and behavioral health or I/DD services, if requested by Vaya.

1.4.2 Be a Network Provider.

1.4.3 Continually meet the CMA eligibility requirements set forth by the Department.

1.4.4 Maintain at least one of the following specialty designation types:

- 1.4.4.1 Mental health and SUD
- 1.4.4.2 Adult
- 1.4.4.3 Child/adolescent
- 1.4.4.4 I/DD (not enrolled in the Innovations Waiver)
- 1.4.4.5 TBI (not enrolled in the TBI Waiver)
- 1.4.4.6 Innovations Waiver
- 1.4.4.7 TBI Waiver
- 1.4.4.8 Co-occurring I/DD and behavioral health
- 1.4.4.9 Adult
- 1.4.4.10 Child/adolescent

1.4.5 Maintain active, working relationships with community providers that offer a wide scope of clinical and social services, including strong reciprocal relationships among relevant BH, I/DD, and primary care providers, in order to facilitate referrals among providers as well as provide formal and informal feedback and opportunities to share best practices.

1.4.6 Maintain the capacity and financial sustainability to establish care management as an ongoing line of business.

1.4.7 Be recognized by Contractor's leadership and governing body, if applicable, as integral to the mission of Contractor and as such be supported by a budget and management team appropriate to maintain Tailored Care Management as a high-functioning service line.

1.4.8 Demonstrate that it has the appropriate structures in place to oversee the Tailored Care Management model.

1.4.9 Have a strong governance structure.

1.5 **Staffing Requirements**: CMA Contractor must meet the staffing requirements specified in this Section 1.5 and must assign each member to a Tailored Care Management care manager who meets the qualifications specified in this Section 1.5.

1.5.1 The assigned care manager must not be related by blood or marriage or financially responsible for any of the members to whom they are assigned or have any legal power to make financial or health-related decisions for any of their assigned members.

1.5.2 All Tailored Care Management care managers serving members must have a bachelor's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area, or licensure as a registered nurse (RN); and at least two years of experience working directly with individuals with behavioral health conditions (if serving members with behavioral health needs) or with an intellectual/development disability (I/DD) or a traumatic brain injury (TBI) (if serving members with I/DD or TBI needs); and

1.5.3 All Tailored Care Management care managers serving members with long term services and supports (LTSS) needs must have at least two years of prior LTSS and/or home and community-based services (HCBS) coordination, care delivery monitoring, and care management experience, in addition to the requirements listed in Section 2.5.6. (This experience may be concurrent with the two years of experience working directly with individuals with behavioral health conditions, an I/DD, or a TBI.)

1.5.4 Supervising care managers serving members with behavioral health conditions must be either a master's-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), fully Licensed Marriage and Family Therapist (LMFT), or licensure as an RN; and have at least three years of experience providing care management, case management, or care coordination to the population being served.

1.5.5 Supervising care managers serving members with an I/DD or a TBI must have one of the following minimum qualifications:

1.5.5.1 A bachelor's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area ***and*** five years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI; **or**

1.5.5.2 A master's degree in a field related to health, psychology, sociology, social work (e.g., LCSW), nursing, or another relevant human services area, or licensure as an RN ***and*** three years of experience providing care management, case management, or care coordination to complex individuals with an I/DD or a TBI.

1.5.6 Care manager extenders must be at least 18 years of age, have a high school diploma or equivalent; be trained in Tailored Care Management; be supervised by a care manager at an AMH+ practice; and meet one of the below requirements:

1.5.6.1 Be a person with lived experience with an I/DD or a TBI with demonstrated knowledge of and direct personal experience navigating the North Carolina (NC) Medicaid delivery system; or

1.5.6.2 Be a person with lived experience with a behavioral health condition who is a Certified Peer Support Specialist; or

1.5.6.3 Be a parent or guardian of an individual with an I/DD or a TBI or a behavioral health condition who has at least two years of direct experience providing care for and navigating the Medicaid delivery system on behalf of that individual (parent/guardian cannot serve as an extender for their family member); or

1.5.6.4 Has two years of paid experience performing care manager extender functions with at least one year of paid experience working directly with the Tailored Care Management-eligible population.

1.5.7 If a member is dually diagnosed with a behavioral health condition and an I/DD or a TBI, the AMH+ practice must ensure that the supervising care manager is qualified to oversee the member's care manager.

1.5.8 Each care manager must be supervised by a supervising care manager. One supervising care manager must not oversee more than eight (8) care managers. Supervisors must not carry a member caseload and must provide coverage for care manager vacation, sick leave, and staff turnovers. Supervisors must review all Tailored Care Management care plans and Individual Support Plans (ISPs) and provide guidance to care managers on how to meet members' needs.

1.5.9 Care manager extenders must be supervised by a care manager and remain within the scope delineated in *Guidance on the Use of Care Manager Extenders in Tailored Care Management*.

1.5.10 Care managers must supervise no more than two (2) FTE care manger extenders.

1.5.11 When CMA Contractor relies on a Clinically Integrated Network ("CIN") or Other Partner-employed care managers to carry out Tailored Care Management, the CMA Contractor must demonstrate that care management is sufficiently integrated with the organization's practice team and have managerial control of care management staff, defined as the opportunity, at a minimum, to approve the hiring and/or placement of a care manager or extender and require a replacement for any care manager or extender whose performance the CMA Contractor deems unsatisfactory.

1.5.12 CMA Contractor with arrangements with CINs or Other Partners must demonstrate strong clinical leadership at the CIN or Other Partner level that has deep experience in NC Medicaid or NC Health Choice and/or has supported similar efforts in other states.

1.5.13 All supervising care managers, care managers, and care manager extenders must participate and complete the Tailored Plan's Tailored Care Management training curriculum.

1.5.14 Care managers and supervising care managers must also complete training on in-reach and transition services.

1.5.15 The CMA Contractor must establish a multidisciplinary care team for each member. Depending on the member's needs, the required members of a multidisciplinary care team must include the member, the member's care manager, and the following individuals:

1.5.15.1 Caretaker(s)/legal guardians;

1.5.15.2 Supervising care manager;

1.5.15.3 Care manager extenders (e.g., community navigators, community health workers, individuals with lived experience with an I/DD or a TBI, parents or guardians of an individual with an I/DD or a TBI or a behavioral health condition);

1.5.15.4 Certified peer support specialist employed by the AMH+ practice or CIN or Other Partner, as applicable;

1.5.15.5 Primary care provider;

1.5.15.6 Behavioral health provider(s);

1.5.15.7 I/DD and/or TBI providers, as applicable;

1.5.15.8 Other specialists;

1.5.15.9 Nutritionists;

1.5.15.10 Pharmacists and pharmacy techs;
1.5.15.11 The member's obstetrician/gynecologist (for pregnant women);
1.5.15.12 In-reach and transition staff, as applicable; and
1.5.15.13 Other providers and individuals, as determined by the care manager and member.

1.5.16 The CMA Contractor must establish a plan to activate relationships with primary care providers and other key interdisciplinary agencies/providers.

1.5.17 The CMA Contractor must have written policies and procedures to ensure that multidisciplinary care team formation and communication occur in a timely manner and that the care team is documented in the care plan and is regularly updated. The AMH+ practice must conduct regular case conferences with members of the multidisciplinary care team, as appropriate based on member needs.

1.5.18 CMA Contractor must have access to clinical consultants to access expert support appropriate for the needs of the panel under Tailored Care Management. CMA Contractor may employ or contract with consultants or do so through a CIN or Other Partner, and the consultant must be available by phone to staff within AMH+ practices to advise on complex clinical issues on an ad hoc basis. CMA Contractor must have access to at least the following experts:
1.5.18.1 A general psychiatrist or child and adolescent psychiatrist;
1.5.18.2 A neuropsychologist or psychologist; and
1.5.18.3 A primary care physician (PCP) to the extent the member's PCP is not available for consultation.

1.6 <u>Population Health and Quality Measurement Requirements</u>. CMA Contractor must meet the following population health and health information technology (HIT) requirements:

1.6.1 CMA Contractor must have implemented an electronic health record (EHR) or a clinical system of record that is in use by the CMA Contractor's providers that may electronically record, store, and transmit member clinical information.

1.6.2 CMA Contractor must use a care management data system, whether or not integrated within the same system as the EHR (or clinical system of record), that can:
1.6.2.1 Maintain up-to-date documentation of Tailored Care Management member lists and assignments of individual members to care managers;
1.6.2.2 Electronically document and store the care management comprehensive assessment and re-assessment;
1.6.2.3 Electronically document and store the care plan or ISP;
1.6.2.4 Consume claims and encounter data;
1.6.2.5 Provide access to – and electronically share, if requested – member records with the member's care team to support coordinated care management, as well as the member, in accordance with federal, state, and Department privacy, security, and data-sharing requirements;
1.6.2.6 Track referrals;
1.6.2.7 Help schedule and prepare members (via, e.g., reminders and transportation) for appointments; and
1.6.2.8 Allow care managers to identify risk factors for individual members, develop actionable care plans and ISPs, monitor and quickly respond to changes in a member's health status, track a member's referrals and provide alerts where care gaps occur, monitor a member's medication adherence, transmit and share reports and summary of care records with care team members, support data analytics and performance, and transmit quality measures (where applicable).

1.6.3 CMA Contractor must be able to receive and use enrollment data from the Tailored Plan to empanel the population in Tailored Care Management. To support outreach, engagement, assessment, and care planning, the CMA Contractor (or CIN or Other Partner on its behalf) must be able to:

1.6.3.1 Receive, in a machine-readable format specified by the Department, and maintain up-to-date records of acuity tiers by member, as determined by the Department and shared by the Tailored Plan;

1.6.3.2 Receive, in a machine-readable format, and maintain up-to-date records of any other risk scoring completed and shared by the Tailored Plan; and

1.6.3.3 Electronically reconcile the Tailored Care Management assignment lists received from the Tailored Plan with its list of members for whom it provides Tailored Care Management.

1.6.4 CMA Contractor must access admission, discharge, transfer (ADT) data that correctly identifies when members are admitted, discharged, or transferred to or from an emergency department (ED) or a hospital in real time or near-real time.

1.6.5 CMA Contractor must implement a systematic, clinically appropriate process with designated staffing for responding to certain high-risk ADT alerts, including:

1.6.5.1 Real-time (within minutes/hours) response to notifications of ED visits, for example by contacting the ED to arrange rapid follow-up;

1.6.5.2 Same-day or next-day outreach for designated high-risk subsets of the population; and

1.6.5.3 Additional outreach within several days after the alert to address outpatient needs or prevent future problems for other patients who have been discharged from a hospital or an ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post-discharge).

1.6.6 CMA Contractor must:

1.6.6.1 Use NCCARE360 as their community-based organization and social service agency resource repository to identify local community-based resources;

1.6.6.2 Refer members to the community-based organizations and social service agencies available on NCCARE360; and

1.6.6.3 Track closed-loop referrals.

1.6.7 CMA Contractor must use the Department's acuity tiers as the primary method for segmenting and managing their populations during the first two years of the Tailored Care Management model.

1.6.7.1 Tailored Plans may establish their own risk stratification methodologies beyond acuity tiering; if they do so, they must share all risk stratification results and methodologies used with AMH+ practices.

1.6.7.2 By the third year of the Tailored Care Management model, AMH+ practices shall develop their own risk stratification approach, refining the data and risk stratification scores they receive from Tailored Plans to incorporate critical clinical, unmet health-related resource, and other data to which they have access. Additionally, AMH+ practices may use patient registries to track patients by condition type/cohort.

1.6.8 Annually, CMA Contractor must evaluate the Tailored Care Management services it provides to ensure that the services are meeting the needs of empaneled members and refine the services as necessary. CMA Contractor must use a combination of clinical data, care management encounter data, and quality scores to generate a set of internal targets and set annual goals for improvement.

1.6.9 CMA Contractor must gather, process, and share data with Tailored Plans for the purpose of quality measurement and reporting.

1.7 Delivery of Tailored Care Management

1.7.1 Communication: CMA Contractor must develop policies for communicating and sharing information with members and their families and other caregivers with appropriate consideration for language, literacy, and cultural preferences, including sign language, closed captioning, and/or video capture. “Robocalls” or automated telephone calls that deliver recorded messages will not be an acceptable form of contacting members.

1.7.2 CMA Contractor must meet the following contact requirements for members with behavioral health needs:

1.7.2.1 High acuity: At least contacts per month, including at least one in-person contact with the member.

1.7.2.2 Moderate acuity: At least three contacts per month and at least one in-person contact with the member quarterly (includes care management comprehensive assessment if it was conducted in-person).

1.7.2.3 Low acuity: At least two contacts per month and at least two in-person contacts with the member per year, approximately six months apart (includes the care management comprehensive assessment if it was conducted in-person).

1.7.3 CMA Contractor must meet the following contact requirements for members with an I/DD or a TBI:

1.7.3.1 High acuity: At least three contacts per month, including two in-person contacts and one telephonic contact with the member.

1.7.3.2 Moderate acuity: At least three contacts per month and at least one in-person contact with the member quarterly.

1.7.3.3 Low acuity: At least one telephonic contact per month and at least two in person contacts per year, approximately six months apart.

1.7.3.4 For members with an I/DD or a TBI who have a guardian, telephonic contact may be with a guardian in lieu of the member, only where appropriate or necessary. In-person contact must involve the member.

1.7.4 Care Management Comprehensive Assessment: CMA Contractor must make a best effort attempt to complete the care management comprehensive assessment in person, in a location that meets the member’s needs. “Best effort” is defined as including at least three documented strategic follow-up attempts to contact the member if the first attempt is unsuccessful (e.g., going to the home or working with a known provider to meet the member at an appointment). The care management comprehensive assessment must include, at a minimum, the following domains:

1.7.4.1 Immediate care needs;

1.7.4.2 Current services and providers across all health needs;

1.7.4.3 Functional needs, accessibility needs, strengths, and goals;

1.7.4.4 Other state or local services currently used;

1.7.4.5 Physical health conditions, including dental conditions;

1.7.4.6 Current and past mental health and substance use status and/or disorders, including tobacco use disorders;

1.7.4.7 Physical, intellectual, or developmental disabilities;

1.7.4.8 Detailed medication history – a list of all medicines, including over-the-counter medication and medication that has been prescribed, dispensed, or administered – and known allergies;

1.7.4.9 Advance directives, including psychiatric advance directives;

1.7.4.10 Available informal, caregiver, or social supports;

1.7.4.11 Standardized unmet health-related resource need questions (to be provided by the Department) covering four priority domains: Housing instability; Transportation insecurity; Food insecurity; and Interpersonal violence/toxic stress;

1.7.4.12 Any other ongoing conditions that require a course of treatment or regular care monitoring;

1.7.4.13 For adults only, exposure to adverse childhood experiences (ACEs) or other trauma;
1.7.4.14 Risks to the health, well-being, and safety of the member and others (including sexual activity and potential abuse/exploitation, or exposure to secondhand smoke/aerosols and other substances);
1.7.4.15 Cultural considerations (ethnicity, religion, language, reading level, health literacy, etc.);
1.7.4.16 Employment/community involvement;
1.7.4.17 Education (including individualized education plan and lifelong learning activities);
1.7.4.18 Justice system involvement (adults) or juvenile justice involvement and/or expulsions or exclusions from school (children and adolescents);
1.7.4.19 Risk factors that indicate an imminent need for LTSS;
1.7.4.20 The caregiver's strengths and needs;
1.7.4.21 Upcoming life transitions (changing schools, changing employment, moving, etc.);
1.7.4.22 Self-management and planning skills;
1.7.4.23 Receipt of and eligibility for entitlement benefits;
1.7.4.24 For members with an I/DD or a TBI: Financial resources and money management; and Alternative guardianship arrangements, as appropriate;
1.7.4.25 For children ages zero up to three, incorporate questions related to Early Intervention (EI) services for children, including: Whether the child is receiving EI services; The child's current EI services; Frequency of EI services provided; Which local Children's Developmental Service Agency (CDSA) or subcontracted agency is providing the services; and Contact information for the CDSA service coordinator; and
1.7.4.26 For children ages three up to 21 with a mental health disorder and/or substance use disorder (SUD), including members with a dual I/DD and mental health diagnosis, incorporate a strengths assessment process that promotes the identification of the functional strengths of each youth, family, and community.

1.7.5 Initial Assessment Timeframe Year One: During the first year of Tailored Plan operation, CMA Contractor must undertake best efforts to complete the care management comprehensive assessment within the following timeframes:
1.7.5.1 Members identified as high acuity: Best efforts to complete it within forty-five (45) calendar days of assignment to Tailored Care Management and no longer than sixty (60) Calendar Days after assignment to Tailored Care Management.
1.7.5.2 Members identified as moderate/low acuity: Members identified as medium/low acuity: Within ninety (90) Calendar Days of assignment to Tailored Care Management.

1.7.6 Initial Assessment Timeframe Year Two: During the second and subsequent years of Tailored Plan operation, CMA Contractor shall undertake best efforts to complete the care management comprehensive assessment within 60 days of assignment to Tailored Care Management.

1.7.7 Ongoing Assessment Timeframes: CMA Contractor must attempt a care management comprehensive assessment for members already engaged in care management:
1.7.7.1 At least annually;
1.7.7.2 When the member's circumstances, needs, or health status changes significantly;
1.7.7.3 After significant changes in scores on State-approved level-of-care determination and screening tools (e.g., Level of Care Utilization System (LOCUS) and Child and Adolescent LOCUS (CALOCUS), American Society of Addiction Medicine (ASAM), Child and Adolescent Needs and Strengths (CANS), SIS);
1.7.7.4 At the member's request; or
1.7.7.5 After "triggering events", defined as follows:
1.7.7.5.1 Inpatient hospitalization for any reason;

1.7.7.5.2 Two emergency department visits since the last care management comprehensive assessment (including reassessment);
1.7.7.5.3 An involuntary treatment episode;
1.7.7.5.4 Use of behavioral health crisis services;
1.7.7.5.5 Arrest or other involvement with law enforcement/the criminal justice system, including the Division of Juvenile Justice;
1.7.7.5.6 Becoming pregnant and/or giving birth;
1.7.7.5.7 A change in member circumstances that requires an increased need for care, a decreased need for care, transition into or out of an institution, or loss of a family/friend caretaker, or any other circumstance the plan deems to be a change in circumstance;
1.7.7.5.8 Loss of housing; and
1.7.7.5.9 Foster care involvement.

1.7.8 CMA Contractor must ensure that the results of the care management comprehensive assessment are made available to the member's primary care, behavioral health, I/DD, TBI, and LTSS providers and the Tailored Plan within 14 days of completion to inform care planning and treatment planning, with the member's consent (to the extent required by law).

1.7.9 Care Plan and ISP: CMA Contractor must develop a care plan for each member with behavioral health needs and/or an ISP for each member with I/DD and TBI needs. Each care plan and ISP must be individualized, person-centered, and developed using a collaborative approach including member and family participation where appropriate. Care plans and ISPs must incorporate the results of the care management comprehensive assessment (including unmet health-related resource need questions), claims analysis and risk scoring, any available medical records, and screening and/or level of care determination tools, including the following, as appropriate, unless modified by the Department:
1.7.9.1 LOCUS and CALOCUS;
1.7.9.2 CANS;
1.7.9.3 ASAM criteria;
1.7.9.4 For Innovations waiver enrollees: SIS; and
1.7.9.5 For TBI waiver enrollees: Rancho Los Amigos Levels of Cognitive Functioning Scale (as applicable).

1.7.10 For Tailored Plan members ages three to 21 with mental health conditions and/or SUD who are receiving mental health or substance use services, CMA Contractor must follow System of Care requirements, including:
1.7.10.1 Involving a Child and Family Team (CFT) in facilitating the care planning process and developing the care plan or ISP;
1.7.10.2 Using the strengths assessment to build strategies included in the care plan or ISP that address the critical needs and unique strengths of the youth and family as identified by and in cooperation with the CFT; and
1.7.10.3 Regularly updating the care plan or ISP to respond to changes with the youth and family, as well as the results of the supports and services provided, and document the shift of activity from formal supports to informal supports for greater self-sufficiency.

1.7.11 CMA Contractor must ensure that all care plans and ISPs developed under Tailored Care Management include the following minimum elements:
1.7.11.1 Names and contact information of key providers, care team members, family members, and others chosen by the member to be involved in planning and service delivery;
1.7.11.2 Measurable goals;

1.7.11.3 Clinical needs, including any behavioral health, I/DD-related, TBI-related, or dental needs;
1.7.11.4 Interventions including addressing medication monitoring, including adherence;
1.7.11.5 Intended outcomes;
1.7.11.6 Social, educational, and other services needed by the member;
1.7.11.7 Strategies to increase social interaction, employment, and community integration;
1.7.11.8 An emergency/natural disaster/crisis plan;
1.7.11.9 Strategies to mitigate risks to the health, well-being, and safety of the members and others;
1.7.11.10 Information about advance directives, including psychiatric advance directives, as appropriate;
1.7.11.11 A life transitions plan to address instances where the member is changing schools, experiencing a change in caregiver/natural supports, changing employment, moving or entering another life transition; and
1.7.11.12 Strategies to improve self-management and planning skills.
1.7.11.13 For members with I/DD, TBI, or serious emotional disturbance (SED), the ISP should also include caregiver supports, including connection to respite services, as necessary.

1.7.12 Initial Care Plan Timeframe: CMA Contractor must make best efforts to complete an initial care plan or ISP within 30 days of the completion of the care management comprehensive assessment. "Best effort" is defined as including at least three documented strategic follow-up attempts to contact the member if the first attempt is unsuccessful. CMA Contractor must not delay the provision of needed services to a member in a timely manner, even if that member is waiting for a care plan or ISP to be developed.

1.7.13 Ongoing Care Plan Timeframes: CMA Contractor must regularly and comprehensively update the care plan or ISP, incorporating input from the member and members of the care team, as part of ongoing care management:
1.7.13.1 At minimum every 12 months;
1.7.13.2 When the member's circumstances or needs change significantly;
1.7.13.3 At the member's request;
1.7.13.4 Within 30 days of care management comprehensive (re)assessment; and/or
1.7.13.5 After triggering events as set forth in Section 2.7.7.5.

1.7.14 CMA Contractor must ensure that each care plan or ISP is documented, stored, and made available to the member and the following representatives within 14 days of completion of the care plan or ISP:
1.7.14.1 Care team members, including the member's PCP and behavioral health, I/DD, TBI, and LTSS providers;
1.7.14.2 The Tailored Plan;
1.7.14.3 Other providers delivering care to the member;
1.7.14.4 The member's legal representative (as appropriate);
1.7.14.5 The member's caregiver (as appropriate, with consent);
1.7.14.6 Social service providers (as appropriate, with consent); and
1.7.14.7 Other individuals identified and authorized by the member.

1.7.15 Care Coordination: CMA Contractor must ensure the member has an ongoing source of care and coordinate the member's health care and social services, spanning physical health, behavioral health, I/DD, TBI, LTSS, pharmacy services, and services to address unmet health-related resource needs. In delivering care coordination the AMH+ practice must:
1.7.15.1 Follow up on referrals and work with the member's providers to help coordinate resources during any crisis event as well as provide assistance in scheduling and preparing members for appointments (e.g., reminders and arranging transportation) and

1.7.15.2 Provide referral, information, and assistance in obtaining and maintaining community-based resources and social support services, including LTSS; I/DD and TBI services (including Innovations and TBI waiver services); and any State-funded services.

1.7.16 Twenty-four-Hour Coverage: CMA Contractor must provide or arrange for coverage for services, consultation or referral, and treatment for emergency medical conditions, including behavioral health crisis, 24 hours per day, seven days per week. CMA Contractor must:

1.7.16.1 Share information such as care plans and psychiatric advance directives, and

1.7.16.2 Coordinate care to place the member in the appropriate setting during urgent and emergent events. Automatic referral to the hospital ED for services does not satisfy this requirement.

1.7.17 Annual Physical Exam: CMA Contractor must ensure that the member has an annual physical exam or well-child visit, based on the appropriate age-related frequency.

1.7.18 Continuous Monitoring: CMA Contractor must conduct continuous monitoring of progress toward goals identified in the care plan or ISP through face-to-face and collateral contacts with the member and his or her support member(s) and routine care team reviews. CMA Contractor must support the member's adherence to prescribed treatment regimens and wellness activities.

1.7.19 Medication Monitoring: CMA Contractor must conduct medication monitoring, including regular medication reconciliation (conducted by the appropriate care team member) and support of medication adherence. A community pharmacist at the CIN level, in communication with CMA Contractor, may assume this role.

1.7.20 System of Care: CMA Contractor must utilize strategies consistent with a System of Care philosophy for children and youth, including knowledge of child welfare, school, and juvenile justice systems. For children and youth receiving behavioral health services, care management must include:

1.7.20.1 Promotion of family-driven, youth-guided service delivery and development of strategies built on social networks and natural or informal supports;

1.7.20.2 Development of, with families and youth, strategies that maximize the skills and competencies of family members to support youth and caregivers' self- determination and enhance self-sufficiency;

1.7.20.3 Verifiable efforts for services and supports to be delivered in the community within which the youth and family live, using the least restrictive settings possible to preserve community and family connections and manage costs; and

1.7.20.4 Development and implementation of proactive and reactive crisis plans in conjunction with the care plan or ISP that anticipate crises and utilize family, team, and community strengths to identify and describe who does what and when; every member of the CFT must be provided a copy of the plan.

1.7.21 Individual and Family Supports: CMA Contractor must incorporate individual and family supports by performing the following activities at a minimum:

1.7.21.1 Educate the member in self-management;

1.7.21.2 Educate and provide guidance on self-advocacy to the member, family members, and support members;

1.7.21.3 Connect the member and caregivers to education and training to help the member improve function, develop socialization and adaptive skills, and navigate the service system;

1.7.21.4 Provide information and connections to needed services and supports including but not limited to self-help services, peer support services, and respite services;

1.7.21.5 Provide information to the member, family members, and support members about the member's rights, protections, and responsibilities, including the right to change providers, the grievance and complaint resolution process, and fair hearing processes;

1.7.21.6 Promote wellness and prevention programs;

1.7.21.7 Provide information on establishing advance directives, including psychiatric advance directives as appropriate, and guardianship options/alternatives, as appropriate;

1.7.21.8 Connect members and family members to resources that support maintaining employment, community integration, and success in school, as appropriate; and

1.7.21.9 For high-risk pregnant women, inquiring about broader family needs, offering guidance on family planning, and beginning discussions about the potential for an Infant Plan of Safe Care.

1.7.22 Health Promotion: CMA Contractor must:

1.7.22.1 Educate the member on members' chronic conditions;

1.7.22.2 Teach self-management skills and sharing self-help recovery resources;

1.7.22.3 Educate the member on common environmental risk factors including but not limited to the health effects of exposure to second and third hand tobacco smoke and e-cigarette aerosols and liquids and their effects on family and children;

1.7.22.4 Conduct medication reviews and regimen compliance; and

1.7.22.5 Promote wellness and prevention programs.

1.7.23 Unmet Health-Related Resource Needs: CMA Contractor must ensure that Tailored Care Management addresses unmet health-related resource needs by performing the following activities at a minimum:

1.7.23.1 Provide referral, information, and assistance in obtaining and maintaining community-based resources and social support services, including: Disability benefits; Food and income supports; Housing; Transportation; Employment services; Education; Financial literacy programs; Child welfare services; After-school programs; Rehabilitative services; Domestic violence services; Legal services; Services for justice-involved populations; and Other services that help individuals achieve their highest level of function and independence.

1.7.23.2 Provide comprehensive assistance securing health-related services, including assistance at initial application and renewal with filling out and submitting applications and gathering and submitting required documentation, including in-person assistance when it is the most efficient and effective approach, at a minimum, for: Food and Nutrition Services; Temporary Assistance for Needy Families; Child Care Subsidy; Low Income Energy Assistance Program; NC ABLE Accounts (for individuals with disabilities); Women, Infants, and Children (WIC) Program; and Other programs managed by the Tailored Plan that address unmet health- related resource needs.

1.7.23.3 Provide referral, information, and assistance in connecting members to programs and resources that can assist in: Securing employment; Supported employment (such as through the Individual Placement and Support - Supported Employment (IPS-SE) program); Volunteer opportunities; Vocational rehabilitation and training; or other types of productive activity that support community integration, as appropriate.

1.8 Transitions, Community Inclusion, and Diversions

1.8.1 Transitional Care Management: CMA Contractor must manage care transitions for members under care management transitioning from one clinical setting to another, including the following activities:

1.8.1.1 Assign a care manager to manage the transition;

1.8.1.2 Have a care manager or care team member visit the member during his/her stay in the institution and be present on the day of discharge;

1.8.1.3 Conduct outreach to the member's providers;

1.8.1.4 Obtain a copy of the discharge plan and review the discharge plan with the member and facility staff;

1.8.1.5 Facilitate clinical handoffs;

1.8.1.6 Assist the member in obtaining needed medications prior to discharge, ensure an appropriate care team member conducts medication reconciliation/management, and support medication adherence;

1.8.1.7 Prior to discharge from a residential or an inpatient setting, in consultation with the member, facility staff, and the member's care team, create and implement a 90-day transition plan as an amendment to the member's care plan or ISP that outlines how the member will maintain or access needed services and supports, transition to the new care setting, and integrate into his or her community. The 90-day transition plan must incorporate any needs for training of parents and other adults to care for a child with complex medical needs post-discharge from an inpatient setting;

1.8.1.8 Communicate with and educate the member and the member's caregivers and providers to promote understanding of the 90-day transition plan;

1.8.1.9 Facilitate arrangements for and scheduling of transportation, in-home services, and follow-up outpatient visits with appropriate providers within a maximum of seven calendar days, unless required within a shorter time frame;

1.8.1.10 Ensure that the assigned care manager follows up with the member within 48 hours of discharge;

1.8.1.11 Arrange to visit the member in the new care setting after discharge/transition;

1.8.1.12 Conduct a care management comprehensive assessment within 30 days of the discharge/transition, or update the current assessment; and

1.8.1.13 Update the member's care plan or ISP in coordination with the care team within 90 days of the discharge/transition.

1.8.2 Community Inclusion Activities: CMA Contractor must conduct the community inclusion and transition-related responsibilities outlined in *In-Reach Activities* and *Transition Activities* below for the following members (as appropriate):

1.8.2.1 Children and youth admitted to a state psychiatric hospital, psychiatric residential treatment facility (PRTF), or Residential Treatment Levels II/Program Type, III, and IV as defined in the Department's Clinical Coverage Policy 8-D-2 ("Residential Treatment Levels"); and

1.8.2.2 Adult members admitted to a state psychiatric hospital or an Adult Care Home (ACH) who are eligible for Tailored Care Management and who are not transitioning to supportive housing.

1.8.3 In-Reach Activities: CMA Contractor must conduct in-reach activities for assigned members under 18 admitted to or residing in a state psychiatric hospital and members admitted to or residing in a PRTF or congregate child residential treatment settings who may be able to have their needs safely met in a community setting. For members newly admitted to one of these facilities, in-reach activities must begin within seven days of admission. Care managers must identify and engage such members and conduct the following in-reach activities:

1.8.3.1 Provide age and developmentally appropriate education and ensure that the member and their family and/or guardians are fully informed about the available community-based options; this may include accompany them on visits to community-based services;

1.8.3.2 Identify and attempt to address barriers to relocation to a community setting;

1.8.3.3 Provide the member and their family and/or guardians opportunities to meet with other individuals with similar diagnoses and shared lived experience, who are living, working, and receiving services in community settings;

1.8.3.4 Ensure that the member and their family and/or guardians who may be eligible for supportive housing are fully informed about the available options; and

1.8.3.5 Identify any specific trainings that facility staff may benefit from to support smooth transitions for members to live and work in community settings.

Not all members will be able or willing to continue with the in-reach process or begin transition planning. For those members, care managers must make best efforts to address member concerns and arrange for peer-to-peer meetings, when appropriate, and continue to engage the member and their family and/or guardians on a regular basis about the opportunity to transition to a more integrated setting.

1.8.4 Transition Activities: CMA Contractor will be responsible for transition activities for assigned members under age 21 residing in a state psychiatric hospital and all members residing in an ACH who are not transitioning to supportive housing and assigned members in a PRTF or Residential Treatment Levels II/Program Type, III, and IV. Care managers must plan for effective and timely transition of members to the community and perform the following transition activities:

- 1.8.4.1 Collaborate with the appropriate individuals, specialists, and providers needed to facilitate a smooth transition to the community, including but not limited to, facility providers and discharge planners, the member's community-based primary care provider (PCP), education specialists, and other community providers and specialists as relevant to the member's needs;
- 1.8.4.2 Assist the member with selecting a community-based PCP and other clinical and behavioral health specialists prior to discharge and actively engage them in the transition planning process;
- 1.8.4.3 Arrange for individualized supports and services that are needed to be in place upon discharge;
- 1.8.4.4 Collaborate with the member and their family and/or guardians to identify and schedule post-discharge appointments for the critical services necessary to address the member's specific needs, such as complex behavioral health, primary care, and medical needs;
- 1.8.4.5 Work to identify any specific training needs by receiving providers and/or agencies to ensure a seamless transition for the member;
- 1.8.4.6 Address any barriers to discharge planning to the most integrated setting possible, such as transportation, housing, and training for family members and/or guardians prior to discharge;
- 1.8.4.7 Work with the facility providers to arrange for any post-discharge services, when applicable;
- 1.8.4.8 Review the discharge plan with the member and their family and/or guardians and facility staff and assist the member in obtaining needed prescription on the day of discharge; and
- 1.8.4.9 Convene and engage the member's Child and Family Team through the entire transition process.

1.8.5 Diversion: AMH+ practices must identify members who are at risk of entry into an adult care home or an institutional setting, such as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), psychiatric hospital, or psychiatric residential treatment facility, and performing diversion activities. Care managers must perform the following Diversion activities:

- 1.8.5.1 Screen and assess members for eligibility for community-based services;
- 1.8.5.2 Educate members on the choice to remain in the community and the services that would be available;
- 1.8.5.3 Facilitate referrals and linkages to community support services for assistance;
- 1.8.5.4 Determine whether a member is eligible for supported housing, if needed; and
- 1.8.5.5 Develop a Community Integration Plan that clearly documents that the member's decision to remain in the community was based on informed choice, and the degree to which the member's decision has been implemented.

1.9 <u>Additional Tailored Care Management Requirements for Members Enrolled in the Innovations Waiver or TBI Waiver</u>: CMA Contractor that are certified to provide Tailored Care Management to individuals enrolled in the 1915(c) Innovations and TBI waivers will be responsible for coordinating these individuals' waiver services in addition to performing the Tailored Care Management requirements. The Department also intends to release additional guidance on 1915(i) care coordination requirements. CMA Contractors serving members in the Innovations or TBI waiver must:

1.9.1 Support completion of assessments beyond the care management comprehensive assessment and incorporate results into the care management comprehensive assessment.
1.9.2 Complete preliminary intake and screenings for the waivers, including NC Innovations Risk/Support Needs Assessment and TBI Risk/Support Needs Assessment, to see if the waiver can meet the individual's needs;
1.9.3 Support enrollee in completing person-centered information toolkits and self-direction assessments; and
1.9.4 Complete Level of Care (LOC) re-evaluation annually.
1.9.5 Facilitate provider choice and assignment process for Innovations and TBI waiver enrollees.
1.9.6 Help enrollee make informed choices of care team participants, provide information about providers, and arrange provider interviews as needed; and
1.9.7 Convene an in-person (as clinically indicated) care team planning meeting.
1.9.8 Coordinate information and resources for self-directed services for Innovations waiver enrollees, as applicable.
1.9.9 Ensure that waiver enrollees interested in self-directed services receive relevant information and training;
1.9.10 Assist in appointing a representative to help manage self-directed services, as applicable;
1.9.11 Assess employer of record and manage employer and representative, as applicable; and
1.9.12 Provide self-directed budget information.
1.9.13 Perform additional responsibilities related to developing and monitoring implementation of the ISP for Innovations and TBI waiver enrollees beyond those required for other individuals engaged in Tailored Care Management.
1.9.14 Complete the ISP so that the Tailored Plan receives it within 60 calendar days of LOC determination. As part of developing the ISP:
    1.9.14.1 Explain options regarding the services available, and discuss the duration of each service;
    1.9.14.2 Include a plan for coordinating waiver services;
    1.9.14.3 Ensure enrollee completes Freedom of Choice statement in ISP annually;
    1.9.14.4 Submit service authorization request to Tailored Plan for each service; and
    1.9.14.5 Ensure that delivery of waiver services begins within 45 days of ISP approval.
    1.9.14.6 Monitor ISP implementation and resolve or escalate issues as needed:
        1.9.14.6.1 Complete monthly ISP monitoring checklist (e.g., waiver service utilization, provider choice, HCBS compliance setting, etc.);
        1.9.14.6.2 Monitor at least quarterly to ensure that any restrictive interventions (including protective devices used for behavioral support) are written into the ISP and the Positive Behavior Support Plan; and
        1.9.14.6.3 Notify Tailored Plan of LOC determination updates.

1.10 **Other Tailored Care Management Requirements**: CMA Contractor shall:
1.10.1 Develop and maintain policies for communicating and sharing information with Members and their families and other caregivers with appropriate consideration for language, literacy, and cultural preferences, including sign language, closed captioning, and/or video capture. "Robocalls" or automated telephone calls that deliver recorded messages will not be an acceptable form of contacting beneficiaries.
1.10.2 Meet the same Member contact requirements that apply to Vaya's Tailored Care Management program.
1.10.3 Meet the same requirements for Care Management Comprehensive Assessment that apply to Vaya's Tailored Care Management program.
1.10.4 Meet the same requirements for Care Plans that apply to Vaya's Tailored Care Management program.
1.10.5 Meet the same requirements for the composition of a care team that apply to Vaya's Tailored Care Management program.

1.10.6 Continue to demonstrate the ability to electronically, safely, and securely transmit the Care Plan to each member of the Member's multidisciplinary care team.

1.10.7 Meet the same requirements for ongoing care management that apply to Vaya's Tailored Care Management program.

1.10.8 Meet the same requirements related to addressing Unmet Health- Related Resource Needs that apply at Vaya level.

1.10.9 Meet the same requirements for transitional care management that apply to Vaya's Tailored Care Management program.

1.10.10 Require care managers based in the CMA, as well as in any supporting CIN or Other Partners, to meet the same initial, annual, and ongoing training requirements as care managers based at Vaya.

1.10.11 Assist Vaya with reconciliation of CMA and PCP data with the Department's 834 files and addressing discrepancies of such data, upon Vaya's request.

1.10.12 No care managers (whether employed or contracted by the Contractor, CMA, or CIN or Other Partner on the Contractor's behalf) may be related by blood or marriage or financially responsible for any of the Members to whom they are assigned or have any legal power to make financial or health-related decisions for any of their assigned Members.

ARTICLE II
REPORTING, METRICS, AND APPEALS

2.1 **Performance Reporting Requirements**: CMA Contractor acknowledges, agrees, and understands that Vaya is required to submit routine and ad hoc reports to the Department on Tailored Care Management, and CMA Contractor agrees to cooperate and comply with any and all requests for any data, documentation, or information relating to Contractor's, or its CIN or Other Partner's, Tailored Care Management and CMA activities. Specifically, CMA Contractor may be required to share:

2.1.1 The number of Members assigned to and actively engaged in care management at Contractor and each of its Care Management Agency practice(s) by acuity tier and disability group (SMI/SED, SUD, I/DD, TBI) on a monthly basis.

2.1.2 The number and type of care management contacts and core Health Home services provided per month for each Member on a monthly basis.

2.1.3 CMA performance on defined quality measures on a monthly, quarterly, and/or annual basis.

2.1.4 Percentage of Members actively engaged in Contractor's Tailored Care Management that are receiving care management on at least a quarterly basis.

2.1.5 Roster of CMA practices and contracted CIN or Other Partner, if applicable, on at least a monthly basis.

2.1.6 The number of care managers and supervising care managers employed by Contractor, or its CIN or Other Partner, if applicable, on at least a quarterly basis.

2.2 **Screening Information**: CMA Contractor shall send, within one (1) Business Day of completing the screening, all screening information and applicable medical record information for Members in care management for high-risk pregnancies to Vaya and the LHD that are contracted for the provision of providing care management services for high-risk pregnancy.

2.3 **Tailored Care Management Oversight and Monitoring Requirements**:

2.3.1 CMA Contractor shall be accountable to all elements of the Tailored Care Management model contained in this Contract and as prescribed by the Department. CMA Contractor must comply with oversight requirements established by the Tailored Plan and the Department, including reporting requirements and corrective action plans.

2.3.2 CMA Contractor shall cooperate with and comply with any technical assistance or Program Integrity and Other Monitoring Activities relating to its Tailored Care Management activities, and with any and all of Vaya's requests relating to such oversight activities. However, to the extent that a CIN or Other Partner contracts with Vaya on behalf of CMA Contractor as a CMA practice(s), the CMA Contractor acknowledges, agrees, and understands that Vaya shall conduct oversight of the CIN or Other Partner for those Tailored Care Management activities it is performing on Contractor's behalf and that that Contractor shall remain subject to Vaya's oversight and Program Integrity and Other Monitoring Activities for all other activities, duties and obligations set forth in the Contract. Furthermore, to the extent CMA Contractor as a CMA practice(s) contract with a CIN or Other Partner, the requirements and capabilities applicable to the Contractor and CMA apply to the CIN or Other Partner.

2.3.3 Vaya shall monitor the CMA Contractor's performance against requirements contained in this Contract. However, to the extent that a CIN or Other Partner contracts with Vaya on behalf of CMA Contractor as a CMA practice(s), Contractor understands, acknowledges, and agrees that Vaya shall monitor the CIN or Other Partner directly as it relates to the Tailored Care Management activities performed by the CIN or Other Partner and that Contractor shall remain subject to Vaya's Program Integrity and Other Monitoring Activities for all other activities, duties and obligations set forth in the Contract.

2.3.3.1 In the event of underperformance by the Contractor or its CMA practice(s) or CIN relative to the requirements for Tailored Care Management required by the Contract or Controlling Authority, the CMA will receive notice of underperformance, identifying the underperformance and providing the Contractor's CMA practice(s) and Contractor thirty (30) days, or more if mutually agreed upon in writing, to remediate any identified issues through a Corrective Action Plan (CAP). As part of its CAP, Contractor and Contractor's CMA practice(s) (and CIN or Other Partner, if applicable) shall be required to address and to ensure that there are no gaps in care management functions for members assigned to the CMA.

2.3.3.2 In the event of continued underperformance by the Contractor or its CMA practice(s) Contractor, or its CIN or Other Partner, that is not corrected after the time limit set forth on the CAP, Vaya may take any other action, up to and including, termination of the Contract and exclusion of Contractor, CIN, Other Partner, or other entity from the Vaya Network.

ARTICLE III
PAYMENTS

3.1 **Payments to Certified Care Management Agencies (CMAs)**: For Tailored Care Management, Vaya shall pay CMA Contractor each of the following components, as applicable:

3.1.1 Tailored Care Management payment for each month in which the CMA Contractor performed Tailored Care Management for each Member. The Tailored Care Management payment shall be a fixed rate prescribed by the Department and acuity-tiered. These fixed rates shall apply for both Medicaid and Health Choice Members.

3.1.2 Tailored Care Management payment for any month in which the Member is assigned to the CMA Contractor and engaged in care management.

3.1.3 Performance incentive payment, if earned by the CMA Contractor. The performance incentive payment shall be based on the metrics included as the CMA metrics in the Department's Technical Specifications Manual, once released.

SIGNATURES

IN WITNESS WHEREOF, the Parties hereby execute and deliver this CMA Addendum, under "Seal", as of the Effective Date. Each individual electronically signing below certifies that he or she has been duly authorized to bind Vaya and CMA Contractor, respectively, to the terms of this CMA Addendum.

Contractor Legal Name:

By: _____ (ADOPTED SEAL)
CONTRACTOR DULY AUTHORIZED OFFICIAL

Name: _____

Title: _____

Date: _____

Vaya Health

By: _____ (ADOPTED SEAL)
VAYA DULY AUTHORIZED OFFICIAL
Brian Ingraham, Chief Executive Officer

Date: _____

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act, N.C.G.S. § 159-28.

_____ _____
Vaya Health Finance Officer, or designee Date

ADDENDUM C
Behavioral Health Program Addendum

THIS Behavioral Health Program Addendum ("BH Addendum"), is made and entered as of the Effective Date of the Network Provider Participation Agreement by and between Vaya Health, a Local Management Entity/Managed Care organization, with a primary business address at 200 Ridgefield Court, Asheville, North Carolina 28806 (hereinafter referred to as "Vaya"), "), and [INSERT LEGAL BUSINESS NAME FOR CONTRACTOR],with a primary business address at [INSERT CONTRACTOR ADDRESS] (hereinafter referred to as "MBH Contractor" or "Contractor").

W I T N E S S E T H:

WHEREAS, this BH Addendum is ancillary to the Contract executed between the Parties, and the terms of the Contract are fully incorporated herein;

WHEREAS any capitalized term not otherwise defined in this BH Addendum shall have the same meaning and definitions as set forth in the Contract;

WHEREAS, "Closed Network" means MH/SU/IDD/TBI as set forth in the Contract; and

WHEREAS, MBH Contractor desires to participate in Vaya's Behavioral Health Program, consisting of a Closed Network providing Medically Necessary mental health, substance use disorder, intellectual/developmental disability, and traumatic brain injury ("MH/SU/IDD/TBI") Covered Services to Members.

NOW THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the receipt of which is hereby acknowledged, Vaya and MBH Contractor (hereinafter individually referred to as a "Party" and collectively as "Parties") agree to the following terms, obligations, and conditions, which are incorporated into and form a part of the Contract to which they are attached:

ARTICLE I
Behavioral Health Program Requirements for Members

1.1 **Scope:** The scope of this BH Addendum covers additional requirements for MBH Contractor offering MH/SU/IDD/TBI Covered Services Members participating in one or more Vaya Benefit Plan.

1.2 **Compliance**: MBH Contractor shall comply with treatment protocols and requirements for person-centered planning and shall implement evidence-based practices as defined by DMH/DD/SAS and/or Vaya.

1.3 **Additional Controlling Authority**: In addition to the Controlling Authority set forth in the Contract, the Parties agree to comply with the conditions set forth as follows, including any and all subsequent revisions or amendments thereto, ("Additional Controlling Authority"), which may include but are not limited to the following:

1.3.1 1915(i) Service Definitions approved by DHB, DMH/DD/SAS State Service Definitions, Vaya Alternative Service Definitions approved by DMH/DD/SAS, Transitions to Community Living Initiative (TCLI) fidelity requirements for Assertive Community Treatment (ACT) and Individual Placement and Support – Supported Employment (IPS-SE) services, and applicable implementation updates, bulletins, and manuals issued by the Department;

1.3.2 The terms of any funding allocation letters issued by DMH/DD/SAS to Vaya, as applicable to the funding stream for the service(s) provided;

1.3.3 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;

1.3.4 Applicable federal and state record retention laws, regulations, rules, manuals, and guidance, including but not limited to, DMH/DD/SAS Records Management and Documentation Manual, APSM 45-2, and the NCDHHS Records Retention and Disposition Schedule for Grants;

1.3.5 Applicable provisions of 42 §§ USC 300x, et seq., including but not limited to requirements and reporting obligations related to the Substance Abuse Treatment Block Grant (SAPTBG), Community Mental Health Services Block Grant (CMHSBG), Social Services Block Grant (SSBG), and accompanying state Maintenance of Effort (MOE) requirements; Project to Assist in the Transition from Homelessness (PATH) formula grant; Strategic Prevention Framework – State Incentive Grant (SPF-SIG), Safe and Drug Free Schools and Communities Act (SDFSCA), and all other state, county, and federal grant program funding compliance requirements, as applicable; and

1.3.6 Vaya's Individual and Family Directed Services ("IFDS") Employer Handbook (applicable only if Contractor is a provider of Innovations Waiver Community Navigator or Financial Support Services under an IFDS option).

1.4 **Credentialing:** In addition to the credentialing provisions contained in the Contract, MBH Contractor acknowledges, agrees, and understands that:

1.4.1 To provide MH/SU/IDD/TBI Covered Services, it must be credentialed and enrolled with Vaya as a Network Provider and that Vaya applies more stringent selection and retention criteria for its Closed Network than its criteria for physical health and pharmacy-related services providers;

1.4.2 All attending psychiatrists of Psychiatric Residential Treatment Facilities ("PRTFs") must be credentialed prior to the PRTF services being provided. Individuals providing Applied Behavioral Analysis ("ABA") Therapy services under this Contract, must be credentialed as a Board-Certified Behavioral Analysts ("BCBA") prior to providing such services. Claims submitted for MBH Contractor's LPs and/or LPAs, including attending psychiatrists and BCBAs, who are not credentialed as outlined in this Section 1.4.2 will not be paid.

1.4.3 Vaya reserves the right to deny, limit, or revoke credentials of MBH Contractor and/or its LPs and LPAs and/or terminate MBH Contractor's participation in the Closed Network, if MBH Contractor and/or its LPs and LPAs required fail to enroll or maintain enrollment in NCTracks or ensure that its NCTracks enrollment information matches the information provided to Vaya.

1.5 **Access to Care Wait Times:** MBH Contractor shall ensure that Members with scheduled appointments are seen by the appointed or other qualified staff no more than sixty (60) minutes after the appointed meeting time, and that Members who walk in without an appointment are seen within two hours after the Member's arrival. If a same-day

appointment is not possible, MBH Contractor must schedule an appointment for the next available day. MBH Contractor must also comply with the Department's "immediacy of need" protocol, such that services are available to Members within the following Access to Care timeframes, unless a more stringent standard is set forth in the Vaya Provider Manual or Controlling Authority:

1.5.1 Emergency Services: MBH Contractor must provide face-to-face emergency services within two (2) hours after a request for emergency care is received by MBH Contractor from Vaya or directly from a Member; MBH Contractor must provide face-to-face emergency care immediately for life threatening emergencies.

1.3.1. Urgent Need Services: MBH Contractor must provide initial face-to-face assessments and/or treatment within forty-eight (48) hours after the date and time a request for urgent care is received by MBH Contractor from Vaya or directly from a Member.

1.3.2. Routine Need Services: MBH Contractor must provide initial face-to-face assessments and/or treatment within fourteen (14) days of the date a request for routine care is received by MBH Contractor from Vaya or directly from a Member.

1.6 **Human Rights:** MBH Contractor shall ensure compliance with applicable federal and state laws, rules, and regulations governing human rights and/or client rights, including, but not limited to, N.C.G.S. Chapter 122C, Article 3, Part 1 and the DMH/DD/SAS Client Rights Rules in Community Mental Health, Developmental Disabilities & Substance Abuse Services, APSM 95-2, dated July 2003 or as thereafter amended. If required by N.C.G.S. § 122C-64, MBH Contractor shall establish, maintain, and support a Human Rights Committee.

1.6.1 **Event Reporting**: MBH Contractor shall comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations and shall report all Level II and Level III incidents, as those terms are defined in 10A NCAC 27G .0602, in the NC Incident Response Improvement System (IRIS) as required by Controlling Authority. MBH Contractor shall also promptly report to Vaya in writing all suspected sentinel events and other suspected instances involving abuse, neglect, or exploitation of Members. Vaya may conduct its own investigation of any events or incidents. MBH Contractor shall cooperate fully with all such investigations. If an investigation is performed, Vaya will provide MBH Contractor with a written summary of its findings no later than fifteen (15) business days following the completion of such investigation. Vaya may require a plan of correction or may impose an administrative action or sanction, up to and including termination of this MBH Contract and/or termination, exclusion, or revocation of MBH Contractor, and/or its Owners and/or Managing Employees, if the investigation cites MBH Contractor as being out of compliance with this Contract or with Controlling Authority and/or Additional Controlling Authority.

1.6.2 **Restrictive Intervention**: MBH Contractor shall not use restrictive interventions except as specifically permitted by the individual Member's treatment/habilitation plan or on an emergency basis. When a restrictive intervention is used, MBH Contractor shall follow all applicable Controlling Authority and Additional Controlling Authority governing seclusion and restraint for behavior management, including, but not limited to, 42 CFR § 482.12, 42 CFR § 483.350, *et seq.*, N.C.G.S. § 122C-60, 10A NCAC 13B.1924, 10A NCAC 27E, and the Vaya Provider Manual.

1.7 "**NC-TOPPS**" means the Department's web-based system for gathering outcome and performance data on behalf of individuals receiving a qualified service in the State's public system of MH/SU treatment services.

1.7.1 **Clinical Outcome Requirements and Measures**: MBH Contractor must complete any required outcomes and/or assessments on Members in accordance with applicable guidelines issued by the Department and any subsequent changes thereto, including but not limited to: (i) collection and submission of NC-TOPPS data for designated populations, as specified in the NC-TOPPS Guidelines and any subsequent changes thereto; and (b) collection and submission of outcome data for special populations such as Members eligible for the TCLI resulting from the August 2012 U.S. Department of Justice Settlement Agreement with the State of North Carolina. MBH Contractor shall submit outcome instruments required by the Department: (i) within the time frames set by Vaya; and (ii) to the Department's policy. Guidelines for MBH Contractor to obtain and submit the outcomes data shall be specified in the Vaya Provider Manual and/or Provider Communication(s). The appropriate outcome instrument to be used for a specific Member will depend upon the age and primary disability category of the Member.

1.8 **Telehealth:** MBH Contractor shall ensure that its use of Telehealth, including telepsychiatry/ telemedicine, is in accordance with the provisions outlined below, as applicable:

1.8.1 Psychiatric Residential Treatment Facility: In the event that MBH Contractor operates a PRTF covered under this Contract, MBH Contractor shall ensure that the attending psychiatrist meets face-to-face, not via telepsychiatry/ telemedicine, with assigned Member(s) to review and evaluate the Member's progress toward defined treatment goals, to lead team meetings, and to manage and assist in directing the treatment milieu, no less often than weekly.

1.8.2 Inpatient Services: If MBH Contractor provides inpatient services covered under this Contract, MBH Contractor shall ensure that an attending psychiatrist is physically present for daily rounding.

1.8.3 Facility Based Crisis: If MBH Contractor provides facility-based crisis services covered under this Contract, MBH Contractor shall ensure that the service delivery plan includes on-site physician involvement and engagement with the treatment team a minimum of three (3) times a week.

1.8.4 ACT Services: If MBH Contractor provides ACT services covered under this Contract, MBH Contractor shall ensure that the psychiatrist is out of the office and in the community at least fifty percent (50%) of the time, directly evaluating patients and guiding the team.

1.8.5 Opioid Treatment Centers: If MBH Contractor operates an opioid treatment center covered under this Contract, regular physician oversight is required, including monthly treatment plan reviews and face-to-face evaluations when treatment goals are not being achieved.

1.9 **Residential Substance Use Disorder Treatment Providers:** If MBH Contractor is a residential substance use disorder treatment provider, MBH Contractor shall provide medication assisted treatment on-site or refer the Member to a Network MAT Provider.

1.10 **MBH Contractor of IDD Services:** If MBH Contractor serves Members with intellectual or developmental disabilities, then MBH Contractor shall provide sixty (60) days' written notice of closure of a facility or discharge of a Member to the Member and Vaya as required by N.C.G.S. § 122C-63.

1.11 **MBH Contractor of ICF-IID Services (if applicable)**: Contracted facilities that are owned or controlled by MBH Contractor and which provide Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) services or

residential services that are subject to the Home and Community-Based Services (HCBS) final rule are exempt from tobacco-free policy, however, the policy shall minimally require the following:

1.11.1 Indoor use of tobacco products shall be prohibited in all MBH Contractor owned or operated settings.

1.11.2 For outdoor areas, MBH Contractor shall:

1.11.2.1 Ensure access to common outdoor space(s) that are free from exposure to tobacco products or use.

1.11.2.2 Prohibit staff and employees from using tobacco products anywhere in MBH Contractor owned or operated settings.

1.12 **MBH Contractors of TCLI Services:** MBH Contractor shall work collaboratively with Vaya: (i) for effective and timely discharge planning beginning at admission and throughout the discharge planning process and (ii) to address identified barriers to transitions, including, but not limited to, transportation, housing, need for further clinical assessment, resource identification, and referrals to qualified providers.

1.13 **First Responder for Crisis/Emergency**: If MBH Contractor delivers a service with defined first responder responsibilities or is designated as a first responder in the person-centered plan (which must include a comprehensive crisis plan), it shall act as first responder to Members referred by Vaya if and when the Member and/or a relative/ natural support initiates contact for assistance involving a psychiatric crisis or emergency. Only those Members whose distress represents a clear and present danger to self or others, and/or those Members whose level of distress is not alleviated following reasonable efforts to implement the established crisis plan, shall be referred to Vaya's crisis service. MBH Contractor shall also post on its website and make available in the lobby of all of its offices, its after-hours' telephone number for accessing crisis/emergency services, as well as the telephone number for Vaya's 24-hour Behavioral Health Crisis Line at 1-800-849-6127. Emergency (including crisis) and post-stabilization care services do not require prior authorization from Vaya.

1.14 **Response to Survivors of Disasters and other Hazards**: MBH Contractor, under the direction of Vaya and in coordination with the local Emergency Management agencies, shall deploy behavioral health disaster responders to deliver behavioral health disaster services to survivors and other responders within the counties served by Vaya. Behavioral health disaster services may be required at the site of a disaster, in emergency shelters, on the telephone/TTY machine, and at other sites in which other disaster response agencies provide information or services to survivors and responders (e.g., FEMA Disaster Application Centers, emergency medical intervention, decontamination, or quarantine sites). When it is determined that survivors or other disaster responders need longer-term MH/SU/IDD/TBI services, MBH Contractor's behavioral health disaster responders shall refer such persons in need to Vaya or its designee for further assistance.

IN WITNESS WHEREOF, the Parties hereby execute and deliver this BH Addendum to the Contract, under "Seal", as of the Effective Date. Each individual electronically signing below certifies that he or she has been duly authorized to bind Vaya and MBH Contractor, respectively, to the terms of this BH Addendum.

Contractor Legal Name:

By: _____ (ADOPTED SEAL)
CONTRACTOR DULY AUTHORIZED OFFICIAL

Name: _____

Title: _____

Date: _____

Vaya Health

By: _____ (ADOPTED SEAL)
VAYA DULY AUTHORIZED OFFICIAL

Name and Title: Brian Ingraham, Chief Executive Officer

Date: _____

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act, N.C.G.S. § 159-28.

_____
Vaya Health Finance Officer, or designee Date

Addendum C-1 – Statement of Work

This **Addendum C-1 – Statement of Work** is an integral part of the Contract by and between Vaya and Contractor subject to the provisions of this Addendum A. This **Addendum C-1** is effective during the Term. Contractor identified below agrees to comply with all applicable terms and conditions of this Contract, including all applicable Exhibits, Schedules and Addendums and provide MH/SU/IDD/TBI services to eligible Members as set forth in the Contract (including the provisions in this **Addendum C-1** and in accordance with all requirements set forth or referenced in Controlling Authority, including but not limited to the Vaya Provider Manual, applicable federal and state laws, rules, and regulations, applicable DMH/DD/SAS Service Definitions (available at https://www.ncdhhs.gov/divisions/mhddsas/servicedefinitions), NC Medicaid and NC Health Choice Clinical Coverage Policies (available at https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/behavioral-health-clinical-coverage-policies), and implementation updates, bulletins and manuals issued by the Department governing the provision of services in this **Addendum C-1**, and all subsequent revisions to the foregoing. Any capitalized term not otherwise defined in this **Addendum C-1** shall have the same meaning and definitions as set forth in other portions of the Contract.

I. **Name of Contractor:** [Insert Full name of Contractor subject to Addendum C-1]

II. **Name/Description of Service(s), Program, or Initiative: [**Insert full name of service(s) and billing code(s)] *(if one exists).*

   A. **Description or Explanation of Program or Initiative, if applicable:** [Insert optional text]

II. **County or Counties Served:** [Insert County(ies)]

III. **Service Definitions: Contractor shall deliver the service(s) identified herein in accordance with the following NC Medicaid and NC Health Choice Clinical Coverage Policy, DMH/DD/SAS Service Definition and/or Vaya in lieu of service definition and the Additional Service Requirements listed herein: [**Insert full name and effective date of applicable Service Definition(s) OR N/A]

IV. **Additional Service Requirements**

   A. **Staffing Patterns and Infrastructure [**Insert Staffing Patterns and Infrastructure or N/A]
   B. **Staff Training Requirements** [Insert Staff Training Requirements or N/A]
   C. **Best Practices/Model Fidelity** [Insert Best Practices/Model Fidelity or N/A]
   D. **Service Delivery Requirements above and beyond requirements of applicable NC Medicaid Clinical Coverage Policy, DMH/DD/SAS Service Definition or Vaya in lieu of service definition** [Insert Service Delivery Requirements or N/A]

V. Documentation Requirements

A. [Insert additional documents required to be followed that are above and beyond those identified in the RMDM, applicable Service Definition(s) or CCP(s)]

VI. Community Collaboration [Insert community collaboration efforts]

VII. Funding and Financial Requirements [Insert funding and financial requirements]

A. In addition to the requirements set forth in this Contract, including any attachments, Contractor shall adhere to the following additional financial requirements:

1. Example
    a. [Insert example]

B. Specifically see Attachments [Identify applicable Addendum C-2 and Addendum C-5]

VIII. Reporting & Performance Outcomes

A. Reporting Requirements: [Insert reporting requirements from allocation letters or as required by Vaya]

B. Performance Outcomes: [Insert performance requirements from allocation letters or as required by Vaya]

ADDENDUM C-2
Non-Medicaid Funding Addendum

THIS NON-MEDICAID FUNDING ADDENDUM ("NMFA") is made and entered into as of the Effective Date of the Network Provider Participation Agreement ("Contract") by and between Vaya Health, a Local Management Entity/Managed Care organization (hereinafter referred to as "Vaya"), and [INSERT LEGAL BUSINESS NAME FOR CONTRACTOR],with a primary business address at [INSERT CONTRACTOR ADDRESS] (hereinafter referred to as "NMBH Contractor" or "Contractor").

WITNESSETH:

WHEREAS, this NMFA is ancillary to the Contract and the terms of the Contract are fully incorporated herein;

WHEREAS, any capitalized term not otherwise defined in this NMFA shall have the same meaning and definitions as set forth in the Contract;

WHEREAS, Contractor desires to participate in Vaya's non-Medicaid Behavioral Health Program, consisting of a provider network providing MH/SU/IDD/TBI Covered Services funded with non-Medicaid revenue sources, including federal block grant, state and/or local (county) funding. This NMFA provides terms and conditions governing such service provision and reimbursement, in addition to the terms and conditions of the Contract;

NOW THEREFORE, in consideration of the mutual covenants contained in the Contract and other good and valuable consideration, the receipt of which is hereby acknowledged, Vaya and NMBH Contractor (hereinafter individually referred to as a "Party" and collectively as "Parties") agree to the following terms, obligations, and conditions, which are incorporated into and form a part of the Contract to which they are attached:

ARTICLE I
GENERAL TERMS AND CONDITIONS

1.1 State Performance Standards: NMBH Contractor shall meet or exceed any and all benchmarks set by the State as set forth in Attachment A-1, attached hereto, made part of, and incorporated herein, by reference.

1.2 Vaya Performance Standards: NMBH Contractor shall meet or exceed any and all performance requirements established by Vaya and set forth in **Schedule B**, if attached to the Contract. The Parties understand, agree, and acknowledge that NMBH Contractor may receive an enhanced reimbursement rate in consideration of meeting such contract requirements, and that these requirements are intended to enhance the overall quality of care provided to

Members. These requirements will be monitored, reviewed, and enforced within the required timeframes set forth in **Schedule B**. If NMBH Contractor fails to meet the requirements set forth in **Schedule B**, Vaya may, in its sole discretion, provide technical assistance, issue a plan of correction, reduce reimbursement rates, implement adverse action, up to and including termination of this Contract, or take any other action it deems necessary and advisable to ensure high quality of care to Members.

1.3 Governmental Requirements: NMBH Contractor, by signing this Contract, agrees to comply with all governmental requirements applicable to the services being provided and to its operations, including, but not limited to, Controlling Authority, Area Program Budgeting and Procedures Manual dated July 1, 1995 at APSM 75-1, the Certification Regarding Environmental Tobacco Smoke; Certification Regarding Lobbying; Certification Regarding Drug-Free Workplace Requirements; and Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion-Lower Tier Covered Transactions, as set forth in **Addendum C-4**, attached hereto, made part of and incorporated herein by reference.

ARTICLE II
RESTRICTIONS ON THE EXPENDITURE OF FEDERAL GRANT FUNDS

2.1 Acronyms. For purposes of this NMFA, "SAPTBG" shall refer to the Substance Abuse Prevention and Treatment Block Grant, "CMHSBG" shall refer to the Community Mental Health Services Block Grant, "MHBG" shall refer to the Mental Health Block Grant, and "PATH" shall refer to the Projects for Assistance in Transition from Homelessness Formula Grant Funds (collectively "federal grant funds").

2.2 Restrictions. The following restrictions apply to all federal grant funds received by NMBH Contractor from Vaya:

2.2.1 CMHSBG funds shall not be used to provide or purchase inpatient services;

2.2.2 SAPTBG funds are prohibited to be used to provide or purchase inpatient hospital services, except that SAPTBG funds may be used with prior written approval from an authorized representative of DMH/DD/SAS for the exception described in 45 CFR § 96.135 (c);

2.2.3 SAPTBG and MHBG funds are prohibited to be used to make, or to allow to be made, any cash payments to any recipients or intended recipients of health or behavioral health services. The provision of cash or cash cards is strictly prohibited, as is the provision of gift cards, which are considered to be cash equivalents.

2.2.4 SAPTBG, CMHSBG, and MHBG funds are prohibited to be used for the purchase or improvement of land, purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility, or purchase of major equipment, including medical equipment;

2.2.5 SAPTBG, CMHSBG, and MHBG funds are prohibited to be used to satisfy any requirement for the expenditure of non-Federal funds as a condition of receipt of Federal funds. (i.e., Federal funds may not be used to satisfy any condition for any state, local, or other funding match requirement);

2.2.6 SAPTBG, CMHSBG, and MHBG funds are prohibited to be used to provide financial assistance to any entity other than a public or nonprofit private entity;

2.2.7 SAPTBG funds are prohibited to be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs;

2.2.8 SATBG funds are prohibited to be used to provide individuals with treatment services in penal or correctional institutions of the State, which includes but is not limited to jails, prisons, adult and juvenile detention centers, juvenile training schools, and holding facilities;

2.2.9 SAPTBG, CMHSBG, and MHBG funds are prohibited to be used towards the annual salary of any contractor or subcontractor, including Vaya, NMBH Contractor, or contractor employee, consultant, or other individual that is in excess of Level I of the most current US Office of Personnel Management federal Executive Salary Schedule;

2.2.10 Agencies or organizations receiving federal grant funds must receive prior written approval from an authorized representative of DMH/DD/SAS regarding the use of evidence-based program incentives, including the specification of the type(s) and equivalent dollar value(s) of any such nominal incentives offered, and the manner of utilization of any such approved incentives for clients, recipients, students, or other persons. "Nominal incentives" are restricted to those of no more than twenty-five dollars ($25.00) in value per recipient, per event. Programs are strictly prohibited from utilizing any incentive items that could potentially be converted to cash, or that could be used for the purchase of any age-restricted product, such as tobacco, alcohol, drugs, weapons, or lottery tickets or any sexually oriented materials.

2.2.11 Federal grant funds shall not be utilized for law enforcement activities;

2.2.12 No part of any federal grant funding shall be used for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress or any State legislature, except in presentation to the Congress or any state legislative body itself;

2.2.13 No part of any federal grant funding shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any state legislature.

2.2.14 PATH funds shall not be expended on any of the following: (1) to support emergency shelters or construction of housing facilities; (2) for inpatient psychiatric treatment costs or inpatient substance abuse treatment costs; or (3) to make cash payments to intended recipients of mental health or substance abuse services, except as permitted by 45 CFR § 96.135(c).

ARTICLE III
FINANCIAL REQUIREMENTS

3.1 Reimbursement and Compensation. The amount and conditions of reimbursement to NMBH Contractor for non-Medicaid services rendered by NMBH Contractor is set forth in the Vaya fee schedule for services delivered on a fee-for-service basis and in **Addendum C-5** for all other services. If this Contract is deemed to be a financial assistance Contract, additional reporting requirements are listed in the Scope(s) of Work attached to the Contract as **Addendum C-1**. By accepting State and/or federal grant funds, NMBH Contractor agrees to appropriately use such funds and accepts Vaya's oversight, monitoring, and evaluation of NMBH Contractor. The Parties understand, acknowledge, and agree that reimbursement for non-Medicaid services is dependent upon the appropriation, allocation, or availability of funds by the State of North Carolina to Vaya for such purpose. If the State of North Carolina reduces funding for non-Medicaid services at any time after the execution of this NMFA or if at any time Vaya determines, in its sole discretion and in view of Vaya's total operations, that the appropriation, allocation or availability of funds by the State of North Carolina to Vaya for non-Medicaid services is insufficient for continuation of such services at the level and/or rates contemplated herein, Vaya may amend its fee schedule, issue an amendment to **Addendum C-1** and/or reduce or discontinue authorization and/or funding for specific service lines.

3.2 Submission and Adjudication of Fee-for-Service Claims. NMBH Contractor shall submit all claims for services provided under this NMFA to Vaya via MCIS or electronic submission of HIPAA-compliant 837P transaction sets. NMBH Contractor shall submit all such claims within one hundred eighty (180) days of the date of service, or earlier if required by timely filing deadlines set by the State. Vaya shall adjudicate claims within eighteen (18) calendar days after receipt and shall electronically notify NMBH Contractor within that timeframe if the claims, or any portion of the claims, are approved or denied. Vaya shall pay approved and undisputed portions of the claims for services performed by NMBH Contractor within thirty (30) calendar days after receipt. Such payment constitutes full and final payment for all services represented by such claim(s).

3.3 Submission and Reimbursement of Non-UCR Invoices. NMBH Contractor shall submit an invoice for all non-Unit Cost Reimbursement ("UCR") expenses within forty-five (45) days after the month in which the expenses were paid, except for services rendered in June of each year. NMBH Contractor shall submit non-UCR invoices on the current SFY Invoice Template approved by Vaya. For services rendered in June, NMBH Contractor shall submit non-UCR invoices no later than July 20 of the same year except for invoices funded with non-UCR State Special Categorical Funds. NMBH Contractor shall submit all invoices for non-UCR State Special Categorical Funds within three (3) business days prior to the Final State Financial Status Report submission deadline established by DMH/DD/SAS for the applicable State fiscal year to allow sufficient time for Vaya to process invoices and complete all required reporting. As determined in the sole discretion of Vaya, failure to submit non-UCR invoices within the timeframes specified in this Section 3.3 may result in denial of the invoice, issuance of a plan of correction, referral for monitoring or other program integrity activities, or adverse action up to and including termination of the Contract. Non-UCR invoices are reviewed for accuracy by Vaya's Provider Network Operations Department, and, if approved, are paid within ten (10) business days following approval.

3.4 Submission and Adjudication of Shadow Claims. For purposes of this Contract, a "shadow claim" is a claim submitted by NMBH Contractor and adjudicated through MCIS that is then submitted as an encounter record/ claim to NCTracks. Such claims cannot be credited to any fee-for-service account. Programs or services requiring NMBH Contractor to submit shadow claims are identified in **Addendum C-5** of this Contract, if applicable. Vaya shall process and adjudicate shadow claims in accordance with applicable federal and state laws, rules, regulations, and policies. NMBH Contractor must submit shadow claims as outlined herein:

a. Shadow claims must be submitted regularly, but not less often than monthly, and do not require prior authorization.
b. In its sole discretion, Vaya shall settle shadow claims earnings upon the earlier of: (i) the date specified on **Addendum C-5** or (ii) for the entire Contract year in aggregate, i.e., the total of all shadow claims will be valued and measured against one earnings target. Shadow claims will not be settled by individual service or program unless otherwise specified on **Addendum C-5**.
c. NMBH Contractor shall submit shadow claims for applicable services rendered and shall attempt to correct and resubmit all denied claims.
d. All shadow claims must be submitted by NMBH Contractor to Vaya either electronically, on the American National Standards Institute 837 Format, or entered manually into the MCIS provider portal. No paper claims will be accepted.

e. Year to date earnings target(s) shall be established and shadow claims value shall be measured against those targets for release of each monthly, 1/12th payment, as detailed on the schedule set forth in Table 1.0 below.
f. Value will be given to shadow claims only when services are provided in accordance with the applicable service definition. NMBH Contractor is responsible for ensuring services are carried out in compliance with the requirements of the approved service definition.
g. Each month Vaya will send NMBH Contractor a communication indicating the value of the aggregate amount of clean shadow claims submitted year-to-date.
h. Vaya will review earnings targets no less than quarterly and will determine and communicate in writing whether NMBH Contractor has met or not met the minimum expected earnings level and whether any adjustments to earnings targets should be made or any payment amount will be withheld or reduced.
i. Any adjustments to earnings targets must be in writing as an Amendment to this Contract and signed by all Parties.
j. If a 1/12th payment, in part or in whole, is withheld due to below-target earnings, shadow claims value will be measured in subsequent months to determine if the payment can be released due to increased earnings. In no event shall payment be made in excess of the earnings target.
k. Vaya reserves the right to take any appropriate action in its sole discretion, including, but not limited to, withholding (in full or in part) payment, terminating NMBH Contractor's programs and services requiring shadow claims submission, and/or terminating this Contract, if NMBH Contractor fails to regularly submit shadow claims data in accordance with the above requirements.

3.5 1/12 Payment Schedule. On or before the 15th of each month, Vaya shall pay 1/12 of the maximum compensation identified in **Addendum C-5**, with the first payment beginning on or before the fifteenth day of the month following the month in which the Contract is fully executed. If the 15th falls on a weekend or holiday, payment will be made on or before the last scheduled working day prior to the 15th of the month. Vaya reserves the right to withhold any monthly 1/12 payment, or portion thereof, if NMBH Contractor fails to meet required shadow claims targets or fails to timely submit invoice(s) or quarterly balance sheet and income statements as set forth in this Article.

3.6 Earnings/Expenses. Vaya shall identify the amount of compensation to be settled on an expense basis and the amount to be settled on an earnings basis. To be good stewards of its limited financial resources and to meet DMH/DD/SAS audit requirements, Vaya shall also measure and settle NMBH Contractor's actual net expenses.

3.7 Shadow Claims Settlement. Unless otherwise outlined in **Addendum C-5**, the procedures for settlement of Contract payments made to NMBH Contractor against NMBH Contractor's shadow claims earnings and actual net expenses shall be as follows:

a. Settlement will be based on a combination of shadow claims earnings and actual net expenses from financial reports submitted by NMBH Contractor, as compared to the "shadow claims target" as defined in Table 1.0, Column 3, below.
b. The last allowable date for NMBH Contractor to submit shadow claims for final settlement is thirty-one (31) calendar days following the earlier of: (i) the date specified on **Addendum C-5** or (ii) the date this Contract expires or terminates.

c. For purposes of this Contract, net expenses are defined as "All direct and indirect expenses associated with the program/service being reported after those expenses have been adjusted/reduced by all other revenue sources supporting those expenses. Other revenue sources include, but are not limited to, payments from Medicaid, Medicare, Health Choice, other third-party coverage, first-party coverage, contracts, and grants."
d. If 100% or greater than 100% of the shadow claims target is earned, no repayment will be due to Vaya.
e. If less than 100% of the shadow claims target is earned, NMBH Contractor will owe a repayment to Vaya that is the difference between NMBH Contractor's net expenses and 100% of Contract payments.
f. Vaya will notify NMBH Contractor in writing when final settlement is complete, whether an overpayment has been identified, and the amount of the repayment. Vaya will strive to send this notification within sixty (60) days of the last allowable date for shadow claims submission of final settlement.
g. If a NMBH Contractor owes a repayment to Vaya, Vaya will send an invoice to NMBH Contractor. Payment will be due to Vaya within thirty (30) calendar days from the date of the invoice.

3.8 Schedule of Fees. NMBH Contractor shall be responsible for the adoption, assessment, collection, and disposition of Member fees for non-Medicaid services in accordance with the Vaya Provider Manual and all applicable laws and regulations.

3.9 Audits. NMBH Contractor shall adhere to Generally Accepted Accounting Principles. When required or requested by Vaya, NMBH Contractor shall make available its accounting records relating to services provided to or on behalf of Vaya under this Contract for the purpose of audit by Vaya or by NCDHHS for Federal authorities. NMBH Contractor shall have an annual audit by an independent certified public accountant (CPA) and shall submit a copy of such audit to Vaya on or before November 30 of each year.

3.10 Purchase of Equipment. If this Contract includes capital expenditures of $5,000.00 or more, ownership of the assets purchased in whole or in part under this Contract is vested with NMBH Contractor so long as NMBH Contractor continues to provide the services covered under the Contract. If such services are discontinued, disposition of the assets shall occur as approved by Vaya and in accordance with 10A NCAC 27A.0112. Non-UCR funds shall not be used for capital expenditures without written permission from Vaya pursuant to 10A NCAC 27A.0204.

3.11 Financial Statements. If required by **Addendum C-5**, NMBH Contractor shall submit on a quarterly basis both balance sheet and income statements no later than the last working day of the month following the end of the quarter being reported. Income statements shall contain both budget and actual month and year-to-date data for revenues and expenses. Income statements shall be submitted for program groupings as identified in **Addendum C-5** for each program requiring shadow claims submissions. Revenues (including all first- and third-party revenue, including, but not limited to, Medicare, Medicaid, and private insurance) shall be disclosed on an accrual basis with an estimated allowance. If available, NMBH Contractor shall also submit annual audited financial statements to Vaya upon request. The balance sheet, income statements and financial statements shall be signed either by NMBH Contractor's chief executive officer or its chief financial officer attesting that the financial data reported is true and accurate to the best of their knowledge and belief.

3.12 Document Submission. Any financial documents required to be submitted by NMBH Contractor under this Article III shall be sent electronically to Payables@vayahealth.com.

TABLE 1.0

1 **For services delivered through the last day of:**	**2** **LME will value claims submitted by the last day of:**	**3** **Expected clean shadow claims submission**	**4** **NMBH Contractor notified of shadow claims status by the 15th of:**
Jul	Aug	1/12	Sep
Aug	Sep	2/12	Oct
Sep	Oct	3/12	Nov
Oct	Nov	4/12	Dec
Nov	Dec	5/12	Jan
Dec	Jan	6/12	Feb
Jan	Feb	7/12	Mar
Feb	Mar	8/12	Apr
Mar	Apr	9/12	May
Apr	May	10/12	June
May	Jun	11/12	Jul
Jun	Jul	12/12	Aug

SIGNATURES

IN WITNESS WHEREOF, the Parties hereby execute and deliver this NMFA, under "Seal", as of the Effective Date. Each individual electronically signing below certifies that he or she has been duly authorized to bind Vaya and NMBH Contractor, respectively, to the terms of this NMFA.

Contractor Legal Name:

By: _____ (ADOPTED SEAL)
CONTRACTOR DULY AUTHORIZED OFFICIAL

Name: _____

Title: _____

Date: _____

Vaya Health

By: _____ (ADOPTED SEAL)
Vaya DULY AUTHORIZED OFFICIAL

Name and Title: Brian Ingraham, President and Chief Executive Officer

Date: _____

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act, N.C.G.S. § 159-28.

_____ _____
Vaya Health Finance Officer, or designee Date

ADDENDUM C-3

DIVISION OF MH/DD/SAS CORE PERFORMANCE INDICATORS FOR PROVIDERS OF MH/SU/IDD/TBI SERVICES

NMBH Contractor shall meet the following benchmarks set by DMH/DD/SAS:

1. NMBH Contractor shall be responsible for full participation in the Vaya program integrity/ monitoring/ review/ investigation process that may include monitoring or review by DMH/DD/SAS. Frequency of reviews and corrective requirements are determined by demonstration of acceptable compliance with quality and performance indicators.

2. NMBH Contractor shall recognize, adequately respond to, document internally and report 100% of all Level I Incidents, as such incidents are defined by 10A NCAC 27G .0602. NMBH Contractor shall report such incidents in aggregate form quarterly to Vaya, unless Vaya and NCDHHS specifically waive this requirement in writing.

3. NMBH Contractor shall recognize, adequately respond to, document internally and report in the State's Incident Response Improvement System (IRIS) 100% of all Level II Incidents as such incidents are defined by 10A NCAC 27G .0602. NMBH Contractor shall report such incidents in IRIS within seventy-two (72) hours of the date and time the incident becomes known to the NMBH Contractor. An aggregate total for the quarter will be part of the NMBH Contractor's quarterly report to Vaya, unless Vaya and NCDHHS specifically waive this requirement in writing.

4. NMBH Contractor shall recognize, adequately respond to, document internally and report in IRIS 100% of all Level III Incidents as defined by 10A NCAC 27G .0602. NMBH Contractor shall report such incidents verbally to Vaya immediately, and via IRIS within seventy-two (72) hours of the date and time the incident becomes known to the NMBH Contractor. NMBH Contractor shall convene an incident review committee within twenty-four (24) hours of notification of the incident. NMBH Contractor shall report deaths that occur within seven (7) days of seclusion or restraint to Vaya. An aggregate total for the quarter will be part of the NMBH Contractor's quarterly report to Vaya, unless Vaya and NCDHHS specifically waive this requirement in writing.

5. NMBH Contractor shall implement policies, procedures, and practices to attempt to achieve 0% client rights violations. NMBH Contractor shall report 100% of all substantiated client rights violations through the Incident reporting process to the Vaya Incidents Report Team and show evidence of adequately responding to such violations.

6. NMBH Contractor shall promptly address 100% of all quality of care issues identified by Vaya, through the development and initiation of a corrective action plan submitted for approval to Vaya within the time limits specified in the Vaya Provider Manual.

7. NMBH Contractor shall give a representative sample of Members the opportunity to express their *perception of care satisfaction* for services received through the implementation of an empirical process no less often than annually. NMBH Contractor shall submit survey results to Vaya in the timeframe specified by Vaya as needed to meet NCDHHS requirements. NMBH Contractor may meet this requirement by full participation in the Vaya Consumer Satisfaction Surveys. NMBH Contractor is also required to participate in the NCDHHS annual Consumer Perception of Care Satisfaction Survey.

8. NMBH Contractor shall meet no less than 90% of established time frames for initial face-to-face Member contact as stated in Section 9 of this **Addendum C-3**.

9. NMBH Contractor shall ensure that 90% of Members with scheduled appointments are seen by the appointed or other qualified staff no more than sixty (60) minutes after the appointed meeting time and that 90% of Members who walk in without an appointment are seen within two (2) hours after the Member's arrival.

10. NMBH Contractor shall adhere to access to care, engagement, and follow up after discharge from inpatient or community crisis performance benchmarks set by DMH/DD/SAS and located in the Community Systems Progress Reports on the Division's website at: http://www.ncdhhs.gov/mhddsas/statspublications/ Reports/Division Initiative Reports/communitysystems/index.htm. Additional outcomes may be required under other provisions of this Contract.

11. NMBH Contractor shall demonstrate 100% compliance with Vaya requirements for established Outcome Measures for each eligible Member (NC-TOPPS) and federal Mental Health Block Grant and Substance Abuse Prevention & Treatment Block Grant, as applicable. As applicable to the service population, NMBH Contractor shall participate in the annual Core Indicators survey (IDD Members and families).

12. NMBH Contractor shall demonstrate a CQI process by identifying a minimum of three improvement projects acted upon per year, one of which must cover service accessibility, gaps, and needs. NMBH Contractor shall report projects and results to Vaya as outlined in the Vaya Provider Manual.

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ADDENDUM C-4

Consolidated Federal Certifications and Disclosures

The undersigned states that:

(a) He or she is the duly authorized representative of the Provider/ Vendor named below;

(b) He or she is authorized to make, and does hereby make, the following certifications on behalf of the Provider/ Vendor, as set out herein:

i. The Certification Regarding Nondiscrimination;
ii. The Certification Regarding Drug-Free Workplace Requirements;
iii. The Certification Regarding Environmental Tobacco Smoke;
iv. The Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions; and
v. The Certification Regarding Lobbying;

(c) He or she has completed the Certification Regarding Drug-Free Workplace Requirements by providing the addresses at which the contract work will be performed;

(d) He or she **has not completed** a **Disclosure Of Lobbying Activities** because the Provider/ Vendor **has not made**, and **has no agreement to make**, any payment to any lobbying entity for influencing or attempting to influence any officer or employee of a Federal agency, any Member of Congress, any officer or employee of Congress, or any employee of a Member of Congress in connection with a covered Federal action.

(e) The Provider/ Vendor shall require its subcontractors, if any, to make the same certifications and disclosure.

Provider/ Vendor Legal Name:

Signature of Provider/ Vendor's Authorized Agent Date

Printed Name of Provider/ Vendor's Authorized Agent Title

This Certification Must Be Signed by the Same Individual Who Signed the Contract

I. Certification Regarding Nondiscrimination

The Vendor certifies that it will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color, or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental, or financing of housing; (h) the Food Stamp Act and USDA policy, which prohibit discrimination on the basis of religion and political beliefs; and (i) the requirements of any other nondiscrimination statutes which may apply to this Agreement.

****

II. Certification Regarding Drug-Free Workplace Requirements

1. **The Vendor certifies** that it will provide a drug-free workplace by:

   A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Vendor's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

   B. Establishing a drug-free awareness program to inform employees about:

      (1) The dangers of drug abuse in the workplace;

      (2) The Vendor's policy of maintaining a drug-free workplace;

      (3) Any available drug counseling, rehabilitation, and employee assistance programs; and

      (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

   C. Making it a requirement that each employee be engaged in the performance of the agreement be given a copy of the statement required by paragraph (a);

   D. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the agreement, the employee will:

      (1) Abide by the terms of the statement; and

(2) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction;

E. Notifying the Department within ten (10) days after receiving notice under subparagraph (d)(2) from an employee or otherwise receiving actual notice of such conviction;

F. Taking one of the following actions, within thirty (30) days of receiving notice under subparagraph (d)(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and including termination; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

G. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

2. The sites for the performance of work done in connection with the specific agreement are listed below (list all sites; add additional lines if necessary):

Site 1 (Address, City, State, Zip):
_____

Site 2 (Address, City, State, Zip):
_____

Site 3 (Address, City, State, Zip):
_____

Site 4 (Address, City, State, Zip):
_____

3. Vendor will inform Vaya of any additional sites for performance of work under this agreement.

4. False certification or violation of the certification may be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment. 45 CFR 82.510.

****

III. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000.00 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Vendor certifies that it will comply with the requirements of the Act. The Vendor further agrees that it will require the language of this certification be included in any subawards that contain provisions for children's services and that all subgrantees shall certify accordingly.

****

IV. Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion Lower Tier Covered Transactions

Instructions

[The phrase "prospective lower tier participant" means the Provider/ Vendor]

1. By signing and submitting this document, the prospective lower tier participant is providing the certification set out below.

2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was executed. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originate may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant will provide immediate written notice to the person to whom this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive order 12549, 45 CFR Part 76. You may contact the person to whom this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this document that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion-Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.

Certification

1. **The prospective lower tier participant certifies,** by submission of this document, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

****

V. Certification Regarding Lobbying

The Vendor certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any Federal agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any Federal agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federally funded contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form SF-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award document for subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) who receive federal funds of $100,000.00 or more and that all subrecipients shall certify and disclose accordingly.

(4) This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000.00 and not more than $100,000.00 for each such failure.

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ADDENDUM C-5
FINANCIAL REQUIREMENTS

Attachment B - "XXXXXXXXXXX" FY 2022/2023

Services Effective December 1, 2022 - November 30, 2023 unless otherwise noted below

		SOURCE OF FUNDS							REPORTING EXPECTATION						Internal Use ONLY				
Programs/Services		State/Federal Funding	Federal Non-UCR Funding	State Special Category Non UCR	County Funding	ABC Funds	Total Funding		Amount To Be Earned Through Shadow Claims	Expenditure Portion of Programs Requiring Shadow Claims	Submit Invoice with Actual Expenditures for Payment	County/ABC Funds Submit Annual Expenditures Report	Total Funding	Payment Method	Fed Non-UCR Funding CFDA #	(Accounting use only) Account Number	(Accounting use only) Account Number	Allocation Letter # or Single stream funds	Updated UM plan
	A						$ -						$ -						
	B						$ -						$ -						
	C						$ -						$ -						
	D						$ -						$ -						
							$ -						$ -						
	E						$ -						$ -						
							$ -						$ -						
							$ -						$ -						
TOTAL CONTRACT AMOUNT		$ -	$ -	$ -		$ -	$ -		$ -	$ -	$ -	$ -	$ -						

Program		Earnings	Subsidy
Psychiatry/Walk-In/Basic		50%	50%
Mobile Crisis/Emergency		60%	40%
Facility Based Crisis		100%	0%
All Other Programs Requiring Earnings		80%	20%
Peer Bridger		40%	60%

ADDENDUM D
ADDENDUM FOR INDIAN HEALTH CARE PROVIDERS

1. **Purpose of Addendum; Supersession.**

The purpose of this BH I/DD Tailored Plan Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the network IHCPs agreement by and between _____(herein "BH I/DD Tailored Plan") and

_____(herein "Indian Health Care Provider (IHCP)").

To the extent that any provision of the Tailored Plan's network IHCP agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions. [1]

2. **Definitions.**

For purposes of this Addendum, the following terms and definitions shall apply:

a. "Indian" means any individual defined at 25 U.S.C. §§ 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual is a member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:

i. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member;

ii. Is an Eskimo or Aleut or other Alaska Native;

iii. Is considered by the Secretary of the Interior to be an Indian for any purpose;

iv. Is determined to be an Indian under regulations issued by the Secretary.

The term "Indian" also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

b. "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).).

c. "Managed Care Plan" includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Management (PCCM) or Primary Case Managed Care Entity (PCCM entity) as those terms are used and defined in 42

C.F.R. 438.2, and any subcontractor or instrumentality of such entities that is engaged in the operation of a Medicaid Managed Care contract.

d. "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCIA Section 601, 25 U.S.C. § 1661.

e. "Indian tribe" has the meaning given in the IHCIA Section 4(14), 25 U.S.C. § 1603(14).).

f. "Tribal health program" has the meaning given in the IHCIA Section 4(25), 25 U.S.C. § 1603(25).

g. "Tribal organization" has the meaning given in the IHCIA Section 4(26), 25 U.S.C. § 1603(26).).

h. "Urban Indian organization" has the meaning given in the IHCIA Section 4(29), 25 U.S.C. § 1603(29).).

3. **Description of IHCP.**

The IHCP identified in Section 1 of this Addendum is (check the appropriate box):

□ IHS.

□ An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. §450 et seq.

□ A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C.§ 450 et seq.

□ A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).

□ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.

4. **Cost Sharing Exemption for Indians; No Reduction in Payments.**

The Tailored Plan shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, and 42 C.F.R. 447.53 and §457.535. Section 1916(j) of the Social Security Act, and 42 C.F.R. 447.53 and §457.535.

5. **Member Option to Select the IHCP as Primary Health Care IHCP.**

The Tailored Plan shall allow any Indian otherwise eligible to receive services from an IHCP to choose the IHCP as the Indian's primary health care provider if the IHCP has the capacity to provide primary care services to such Indian, and any referral from such IHCP shall be deemed to satisfy any coordination of

care or referral requirement of the Tailored Plan. Section 1932(h)(1) of the Social Security Act, 42 C.F.R. § 438.14(b)(3) and 457.1209.

6. **Agreement to Pay IHCP.**

The Tailored Plan shall pay the IHCP for covered Medicaid Managed Care services in accordance with the requirements set out in Section 1932(h) of the Social Security Act and 42 C.F.R. §§ 438.14 and 457.1209.

7. **Persons Eligible for Items and Services from IHCP.**

a. Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136.

b. No term or condition of the Tailored Plan's network IHCP agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Tailored Plan acknowledges that pursuant to 45 C.F.R. § 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

8. **Applicability of Federal Laws not Generally Applicable to other Providers.**

Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving BH I/DD Tailored Plan members. Applicable provisions may include, but are not limited to, those laws cited within this Addendum.

9. **Non-Taxable Entity.**

To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a BH I/DD Tailored Plan to collect or remit any federal, state, or local tax.

10. **Insurance and Indemnification.**

a. Indian Health Service. The IHS shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the BH I/DD Tailored Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.

b. Indian Tribes and Tribal Organizations. A provider which is an Indian tribe or a tribal organization operating under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the BH I/DD Tailored Plan will be held harmless from liability. This is because Indian tribes and

tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, are covered by the FTCA, which means the United States consents to be sued in place of employees of a tribe or tribal organization (including contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the BH I/DD Tailored Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate such provider, any employee of such provider, or any personal services contractor to perform any act outside the scope of his/her employment.

c. Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the BH I/DD Tailored Plan will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the BH I/DD Tailored Plan network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

11. **Licensure and Accreditation.**

Pursuant to 25 USC §§ 1621t and 1647a, the BH I/DD Tailored Plan shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the BH I/DD Tailored Plan shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located if the professional is licensed in another State.

12. **Dispute Resolution.**

In the event of any dispute arising under the BH I/DD Tailored Plan's network IHCP agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the BH I/DD Tailored Plan's network agreement, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

13. **Governing Law.**

The BH I/DD Tailored Plan's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail.

Nothing in the BH I/DD Tailored Plan's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

14. **Medical Quality Assurance Requirements.**

To the extent the BH I/DD Tailored Plan imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the

IHCIA, 25 U.S.C. § 1675.

15. **Claims Format.**
The BH I/DD Tailored Plan shall process claims from the IHCP in accordance with Section 206(h) of the IHCIA, 25 U.S.C. § 1621e(h), which does not permit an issuer to deny a claim submitted by a IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

16. **Payment of Claims.**
The BH I/DD Tailored Plan shall pay claims from the IHCP in accordance Section 1932(h)(2) of the Act and 42 C.F.R. §§ 438.14(c)(2) and 457.1209 and shall pay at either the rate provided under the State plan in a Fee- for-Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.

17. **Hours and Days of Service.**
The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the BH I/DD Tailored Plan as to its hours and days of service. At the request of the BH I/DD Tailored Plan, such IHCP shall provide written notification of its hours and days of service.

18. **Coordination of Care/Referral Requirements.**
The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the BH I/DD Tailored Plan.

19. **Sovereign Immunity.**
Nothing in the BH I/DD Tailored Plan's network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

20. **Endorsement.**
IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the BH I/DD Tailored Plan.

APPROVALS

For the BH I/DD Tailored Plan:	**For the IHCP:**
Date:	*Date:*
Signature:	*Signature:_*

Applicable Federal Laws Referenced in Section 8 of this Addendum

a. The IHS as an IHCP:
   (1) Anti-Deficiency Act, 31 U.S.C. § 1341;
   (2) ISDEAA, 25 U.S.C. § 450 et seq.;
   (3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
   (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
   (5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
   (6) IHCIA, 25 U.S.C. § 1601 et seq.

b. An Indian tribe or a Tribal organization that is an IHCP:
   (1) ISDEAA, 25 U.S.C. § 450 et seq.;
   (2) IHCIA, 25 U.S.C. § 1601 et seq.;
   (3) FTCA, 28 U.S.C. §§ 2671-2680;
   (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
   (5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;

c. An urban Indian organization that is an IHCP:
   (1) IHCIA, 25 U.S.C. § 1601 et seq.
   (2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
   (3) HIPAA, 45 C.F.R. Parts 160 and 164.

ADDENDUM E
Local Health Department Provider Addendum

THIS Local Health Department Provider Addendum ("LHD Addendum"), is made and entered as of the Effective Date of the Network Provider Participation Agreement by and between Vaya Health, a Local Management Entity/Managed Care organization, with a primary business address at 200 Ridgefield Court, Asheville, North Carolina 28806 (hereinafter referred to as "Vaya"), and [INSERT LEGAL BUSINESS NAME FOR CONTRACTOR],with a primary business address at [INSERT CONTRACTOR ADDRESS] (hereinafter referred to as "LHD Contractor" or "Contractor").

W I T N E S S E T H:

WHEREAS, this LHD Addendum is ancillary to the Contract, and the terms of the Contract are fully incorporated herein;

WHEREAS, any capitalized term not otherwise defined in this LHD Addendum shall have the same meaning and definitions as set forth in the Contract;

WHEREAS, LHD Contractor desires to enter into this LHD Addendum with Vaya to provide care management for high-risk pregnancy and for at-risk children for the care and wellness, prevention, treatment, payment, or healthcare operations purposes that are related to LHD Contractor's obligations under the Contract; and

WHEREAS, LHD Contractor agrees to comply with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy.

NOW THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the receipt of which is hereby acknowledged, Vaya and LHD Contractor (hereinafter individually referred to as a "Party" and collectively as "Parties") agree to the following terms, obligations, and conditions, which are incorporated into and form a part of the Contract to which they are attached:

ARTICLE I
CARE MANAGEMENT FOR HIGH-RISK PREGNANCY FOR MEDICAID AND NC HEALTH CHOICE MEMBERS

1.1 **Background**: Care Management for High-Risk Pregnancy refers to care management services provided to a subset of high-risk pregnant women by Local Health Departments ("LHDs").

1.2 **Scope**: The scope of this LHD Addendum covers the agreement between Vaya and LHD Contractor offering Care Management for High-Risk Pregnancy, as outlined below.

1.3 **Compliance**: LHD Contractor agrees to comply with the Department's Care Management for High-Risk Pregnancy Policy.

1.4 **Referrals**: LHD Contractor shall accept referrals from Vaya for Care Management for High-Risk Pregnancy services.

1.5 **Care Management for High-Risk Pregnancy: Outreach**:

1.5.1 LHD Contractor shall refer potentially Medicaid-eligible pregnant women for prenatal care and Medicaid eligibility determination, including promoting the use of presumptive eligibility determination and other strategies to facilitate early access to Medicaid coverage during pregnancy.

1.5.2 LHD Contractor shall contact patients identified as having a priority risk factor through claims data (emergency department utilization, antepartum hospitalization, utilization of Labor and Delivery triage unit) for referral to prenatal care and to engage in care management.

1.6 **Care Management for High-Risk Pregnancy: Population Identification and Engagement**:

1.6.1 LHD Contractor shall review and enter all pregnancy risk screenings received from Pregnancy Management Program providers covered by the pregnancy care managers into the designated care management documentation system within five (5) Calendar Days of receipt of risk screening forms.

1.6.2 LHD Contractor shall utilize risk screening data, patient self-report information and provider referrals to develop strategies to meet the needs of those patients at highest risk for poor pregnancy outcomes.

1.6.3 LHD Contractor shall accept pregnancy care management referrals from non-Pregnancy Management Program prenatal care providers, community referral sources (such as Department of Social Services or WIC programs) and patient self-referral and provide appropriate assessment and follow-up to those patients based on the level of need.

1.6.4 LHD Contractor shall review available Vaya data reports identifying additional pregnancy risk status data, including regular, routine use of the Obstetric Admission, Discharge and Transfer (OB ADT) report, to the extent the OB ADT report remains available to LHD.

1.6.5 LHD Contractor shall collaborate with out-of-county Pregnancy Management Program providers and Care Management for High-Risk Pregnancy teams to facilitate cross-county partnerships to ensure coordination of care and appropriate care management assessment and services for all patients in the target population.

1.7 **Care Management for High-Risk Pregnancy: Assessment and Risk Stratification**: LHD Contractor shall conduct a prompt, thorough assessment by review of claims history and medical record, patient interview, case review with prenatal care provider and other methods, on all patients with one or more priority risk factors on pregnancy risk screenings and all patients directly referred for care management for level of need for care management support.

1.7.1 LHD Contractor shall utilize assessment findings, including those conducted by Vaya to determine level of need for care management support.

1.7.2 LHD Contractor shall document assessment findings in the care management documentation system.

1.7.3 LHD Contractor shall ensure that assessment documentation is current throughout the period of time the care manager is working with the patient and should be continually updated as new information is obtained.

1.7.4 LHD Contractor shall assign case status based on level of patient need.

1.8 **Care Management for High-Risk Pregnancy: Interventions**:

1.8.1 LHD Contractor shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients and meeting their needs. This includes face-to-face encounters (practice visits, home visits, hospital visits, community encounters), telephone outreach, professional encounters and /or other interventions needed to achieve care plan goals.

1.8.2 LHD Contractor shall provide care management services based upon level of patient need as determined through ongoing assessment.

1.8.3 LHD Contractor shall develop patient-centered care plans, including appropriate goals, interventions, and tasks.

1.8.4 LHD Contractor shall utilize NCCARE360 and identify additional community resources once the Department has certified it as fully functional.

1.8.5 LHD Contractor shall refer identified population to childbirth education, oral health, behavioral health, or other needed services included in the Vaya Network.

1.8.6 LHD Contractor shall document all care management activity in the care management documentation system.

1.9 **Care Management for High-Risk Pregnancy: Integration with Vaya and Healthcare Providers**:

1.9.1 LHD Contractor shall assign a specific care manager to cover each Pregnancy Management Program provider within the county or serving residents of the county.

1.9.2 LHD Contractor shall ensure that an embedded or otherwise designated care manager has an assigned schedule indicating their presence within the Pregnancy Management Program.

1.9.3 LHD Contractor shall establish a cooperative working relationship and mutually agreeable methods of patient-specific and other ongoing communication with the Pregnancy Management Program providers.

1.9.4 LHD Contractor shall establish and maintain effective communication strategies with Pregnancy Management Program providers and other key contacts within the practice within the county or serving residents of the county.

1.9.5 LHD Contractor shall assure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of patients in the target population.

1.9.6 LHD Contractor shall ensure awareness of Vaya Members' "in network" status with providers when organizing referrals.

1.9.7 LHD Contractor shall ensure understanding of Vaya's prior authorization processes relevant to referrals.

1.10 **Care Management for High-Risk Pregnancy: Collaboration with Vaya**:

1.10.1 LHD Contractor shall work with Vaya to ensure program goals are met.

1.10.2 LHD Contractor shall review and monitor Vaya reports created for the Pregnancy Management Program and Care Management for High-Risk Pregnancy services to identify individuals at greatest risk.

1.10.3 LHD Contractor shall communicate with Vaya regarding challenges with cooperation and collaboration with Pregnancy Management Program and non-Pregnancy Management Program prenatal care providers.

1.10.4 LHD Contractor shall participate in pregnancy care management and other relevant meetings hosted by Vaya.

1.11 **Care Management for High-Risk Pregnancy: Training**:

1.11.1 LHD Contractor shall ensure that pregnancy care managers and their supervisors attend pregnancy care management training offered by Vaya and/or the Department, including webinars, new hire orientation or other programmatic training.

1.11.2 LHD Contractor shall ensure that pregnancy care managers and their supervisors attend continuing education sessions coordinated by Vaya and/or the Department.

1.11.3 LHD Contractor shall ensure that pregnancy care managers and their supervisors pursue ongoing continuing education opportunities to stay current in evidence-based care management of pregnancy and postpartum women at risk for poor birth outcomes.

1.11.4 LHD Contractor shall ensure that pregnancy care managers and their supervisors utilize Motivational Interviewing and Trauma Informed Care techniques on an ongoing basis.

1.12 **Care Management for High-Risk Pregnancy: Staffing**:

1.12.1 LHD Contractor shall employ care managers meeting pregnancy care management competencies defined as having at least one of the following qualifications:

a) Registered nurses;

b) Social workers with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education accredited social work degree program.

c) Care Managers for High- Risk Pregnancy hired prior to September 1, 2011 without a bachelor's or master's degree in social work may retain their existing position; however, this grandfathered status does not transfer to any other position.

1.12.2 LHD Contractor shall ensure that Community Health workers for Care Manager for High-Risk Pregnancy services work under the supervision and direction of a trained care manager.

1.12.3 LHD Contractor shall include both registered nurses and social workers to best meet the needs of the Target Population with medical and psychosocial risk factors.

1.12.4 If the LHD Contractor only has a single Care Manager for High-Risk Pregnancy, the LHD Contractor shall ensure access to individual (s) to provide needed resources, consultation, and guidance from the non-represented professional discipline.

1.12.5 LHD Contractor shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with a pregnant population at high risk for poor birth outcome. This skill mix should reflect the capacity to address the needs of patients with both medically and socially complex conditions.

1.12.6 LHD Contractor shall ensure that Pregnancy Care Managers must demonstrate:

a) A high level of professionalism and possess appropriate skills needed to work effectively with a pregnant population at high risk for poor birth outcomes

b) Proficiency with the technologies required to perform care management functions

c) Motivational interviewing skills and knowledge of adult teaching and learning principles;
d) Ability to effectively communicate with families and providers; and
e) Critical thinking skills, clinical judgment, and problem-solving abilities.

1.12.7 LHD Contractor shall provide qualified supervision and support for pregnancy care managers to ensure that all activities are designed to meet performance measures, with supervision to include:
a) Provision of program updates to care managers.
b) Daily availability for case consultation and caseload oversight.
c) Regular meetings with direct service care management staff.
d) Utilization of reports to actively assess individual care manager performance.
e) Compliance with all supervisory expectations delineated in the Care Management for High-Risk Pregnancy Program Manual.

1.12.8 LHD Contractor shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following Vaya/Department guidance about communication with Vaya about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by Vaya.

ARTICLE II
CARE MANAGEMENT FOR AT-RISK CHILDREN

2.1 **Background**: Care Management for At-Risk Children are care management services provided by Local Health Departments to a subset of the Medicaid population ages 0-5 identified as being "high-risk". Children enrolled in Care Management for At-Risk Children will not be eligible for Tailored Care Management while enrolled in Care Management for At-Risk Children because the two programs provide duplicative services.

2.2 **Scope**: The scope of this LHD Addendum covers the required terms that must be in agreements between Vaya and Local Health Department providers offering Care Management for At-Risk Children outlined below and in the Contract.

2.3 **Compliance**: LHD Contractor agrees to comply with the Department's Care Management for At-Risk Children Policy.

2.4 **Referrals**: LHD Contractor shall accept referrals from Vaya for children identified as requiring Care Management for At-Risk Children.

2.5 **Care Management for At-Risk Children: General Requirements**:

2.5.1 LHD Contractor shall collaborate with out-of-county organizations providing Tailored Care Management—AMH+ practices, CMAs, and BH I/DD Tailored Plans—to facilitate cross-county partnerships to optimize care for patients who receive services from outside their resident county.

2.5.2 LHD Contractor shall identify or develop, if necessary, a list of community resources available to meet the specific needs of the population.

2.5.3 LHD Contractor shall utilize NCCARE360 to identify and connect members with additional community resources.

2.6 **Care Management for At-Risk Children: Outreach**:

2.6.1 LHD Contractor shall educate patients, Advanced Medical Homes, other practices, and community organizations about the benefits of the Care Management for At-Risk Children Program and target populations for referral; disseminate the Care Management for At-Risk Children Referral Form either electronically and/or in a paper version to potential referral sources.

2.6.2 LHD Contractor shall communicate regularly with the Advanced Medical Homes and other practice serving children, to ensure that children served by that medical home are appropriately identified for Care Management for At-Risk Children services.

2.6.3 LHD Contractor shall collaborate with out-of-county Advanced Medical Homes and other practices to facilitate cross-county partnerships to optimize care for patients who receive services from outside their resident county.

2.6.4 LHD Contractor shall identify or develop, if necessary, a list of community resources available to meet the specific needs of the population.

2.6.5 LHD Contractor shall utilize the NC Resource Platform, when operational, and identify additional community resources and other supportive services once the platform has been fully certified by the Department.

2.7 **Care Management for At-Risk Children: Population Identification**:

2.7.1 LHD Contractor shall use any claims-based reports and other information provided by Vaya, as well as Care Management for At-Risk Children Referral Forms received to identify priority populations.

2.7.2 LHD Contractor shall establish and maintain contact with referral sources to assist in methods of identification and referral for the target population.

2.7.3 LHD Contractor shall communicate with the medical home and other primary care clinician about the Care Management for At-Risk Children target group and how to refer to the Care Management for At-Risk Children program.

2.8 **Care Management for At-Risk Children: Family Engagement**:

2.8.1 LHD Contractor shall involve families (or legal guardian when appropriate) in the decision-making process through a patient-centered, collaborative partnership approach to assist with improved self-care.

2.8.2 LHD Contractor shall foster self-management skill building when working with families of children.

2.8.3 LHD Contractor shall prioritize face-to-face family interactions (home visit, Primary Care Provider ((“PCP”)) office visit, hospital visit, community visit, etc.) over telephone interactions for children in active case status, when possible.

2.9 **Care Management for At-Risk Children: Assessment and Stratification of Care Management Service Level**:

2.9.1 LHD Contractor shall use the information gathered during the assessment process to determine whether the child meets the Care Management for At-Risk Children target population description.

2.9.2 LHD Contractor shall review and monitor Vaya reports created for Care Management for At-Risk Children, along with the information obtained from the family, to assure the child is appropriately linked to preventive and primary care services and to identify individuals at risk.

2.9.3 LHD Contractor shall use the information gained from the assessment to determine the need for and the level of service to be provided.

2.10 **Care Management for At-Risk Children: Plan of Care**:

2.10.1 LHD Contractor shall provide information and/or education to meet families' needs and encourage self-management using materials that meet literacy standards.

2.10.2 LHD Contractor shall ensure children/families are well-linked to the child's PCP.

2.10.3 LHD Contractor shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients, meeting their needs, and achieving care plan goals.

2.10.4 LHD Contractor shall identify and coordinate care with community agencies/resources to meet the specific needs of the child; use any locally developed resource list (including NCCARE360) to ensure families are well linked to resources to meet the identified need.

2.10.5 LHD Contractor shall provide care management services based upon the patient's level of need as determined through ongoing assessment.

2.11 **Care Management for At-Risk Children: Integration with Vaya and Health Providers**:

2.11.1 LHD Contractor shall collaborate with the member's PCP to facilitate implementation of patient-centered plans and goals targeted to meet individual child's needs.

2.11.2 LHD Contractor shall ensure that changes in the care management level of care, need for patient support and follow up and other relevant updates (especially during periods of transition) are communicated to the PCP and/or Vaya.

2.11.3 LHD Contractor shall ensure awareness of Vaya Member's "in network" status with providers when organizing referrals.

2.11.4 LHD Contractor shall ensure understanding of Vaya's prior authorization processes relevant to referrals.

2.12 **Care Management for At-Risk Children: Service Provision**:

2.12.1 LHD Contractor shall document all care management activities in the care management documentation system in a timely manner.

2.12.2 LHD Contractor shall ensure that the services provided by Care Management for At-Risk Children meet a specific need of the family and work collaboratively with the family and other service providers to ensure the services are provided as a coordinated effort that does not duplicate services.

2.13 **Care Management for At-Risk Children: Training**:

2.13.1 LHD Contractor shall participate in Department/Vaya-sponsored webinars, trainings and continuing education opportunities as provided.

2.13.2 LHD Contractor shall pursue ongoing continuing education opportunities to stay current in evidence-based care management of high-risk children.

2.14 **Care Management for At-Risk Children: Staffing**:

2.14.1 LHD Contractor shall hire care managers meeting Care Management for At-Risk Children care coordination competencies and with at least one of the following qualifications:

a) Registered nurses;

b) Social workers with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education accredited social work degree program

c) Non-degreed social workers cannot be the lead care manager providing Care Management for At-Risk Children even if they qualify as a Social Worker under the Office of State Personnel guidelines.

2.14.2 LHD Contractor shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with high-risk children. This skill mix must reflect the capacity to address the needs of patients with both medically and socially complex conditions.

2.14.3 LHD Contractor shall ensure that Care Management for At-Risk Children Care Managers must demonstrate:

a) Proficiency with the technologies required to perform care management functions – particularly as pertains to claims data review and care management documentation system;

b) Ability to effectively communicate with families and providers;

c) Critical thinking skills, clinical judgment, and problem-solving abilities.

d) Motivational interviewing skills, Trauma Informed Care, and knowledge of adult teaching and learning principles.

2.14.4 LHD Contractor shall ensure that the team of Care Management for At-Risk Children care managers shall include both registered nurses and social workers to best meet the needs of the target population with medical and psychosocial risk factors.

2.14.5 If the LHD Contractor has only has a single Care Management for At-Risk Children care manager, the LHD Contractor shall ensure access to individual(s) to provide needed resources, consultation, and guidance from the non- represented professional discipline.

2.14.6 LHD Contractor shall maintain services during the event of an extended vacancy.

2.14.7 In the event of an extended vacancy, LHD Contractor shall complete and submit the vacancy contingency plan that describes how an extended staffing vacancy will be covered and the plan for hiring if applicable.

2.14.8 LHD Contractor shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following Department guidance regarding vacancies or extended staff absences and adhering to NCDHHS guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than sixty (60) days will be subject to additional oversight.

2.14.9 LHD Contractor shall ensure that Community Health Workers and other unlicensed staff work under the supervision and direction of a trained Care Management for At-Risk Children Care Manager.

2.14.10 LHD Contractor shall provide qualified supervision and support for Care Management for At-Risk Children care managers to ensure that all activities are designed to meet performance measures, with supervision to include:

a) Provision of program updates to care managers.

b) Daily availability for case consultation and caseload oversight.

c) Regular meetings with direct service care management staff.

d) Utilization of monthly and on-demand reports to actively assess individual care manager performance.

2.14.11 LHD Contractor shall ensure that supervisors who carry a caseload must also meet the Care Management for At-Risk Children care management competencies and staffing qualifications.

ARTICLE III
ADDITIONAL LHD CONTRACTOR RESPONSIBILITIES

3.1 LHD Contractor shall conduct Refugee Health Assessments outlined in Clinical Coverage Policy 1D-1: Refugee Health Assessments provided in LHDs.

3.2 Care Manager Pilot Program Responsibilities. Vaya will utilize care managers to execute key Pilot program functions. Care managers with Pilot program responsibilities may be employed by or under contract with Vaya's Tailored Plan, or an AMH+, CMA, Local Health Department (for some members excluded from Tailored Care Management) or High-Fidelity Wraparound (for some members excluded from Tailored Care Management). For care managers with Pilot program responsibilities and employed by LHD Contractor, LHD Contractor shall ensure the care managers assigned to Vaya members residing in Pilot program Regions:

a) Evaluate members using a forthcoming Department-developed Pilot Program Eligibility and Assessment form to assess whether they meet baseline Pilot eligibility criteria.
b) Integrate a member's need for, authorization of, referral to and status of Pilot services into the member's Care Plan.
c) Secure determination of Pilot program enrollment and authorization of Pilot services from Vaya.
d) Obtain authorized members' Pilot program participation consent, including related to enrollment, Pilot services and information sharing, based on guidance to be developed by the Department.
e) Communicates approved Pilot enrollment determination and service authorization to members.
f) Refer members approved for Pilot program enrollment and specific Pilot services to HSOs in the Lead Pilot Entity's network for approved Pilot services and track Pilot services delivered to Pilot participants by conducting "closed-loop referrals," using the NCCARE360 platform.
g) Conduct a reassessment of:
    a. Eligibility for specific Pilot services no less frequently than every three (3) months, or earlier if a member experiences a change in eligibility for an identified service, resource or program that can meet the member's Pilot service need, including those managed directly by Vaya; and,
    b. Eligibility for the Pilot program and services no less frequently than every six (6) months.
h) Support the Department's Pilot program oversight and evaluation efforts by providing information and data on Pilot participants and Pilot program operations in accordance with guidance to be developed by the Department.
i) Meet any other Pilot-related requirements outlined by the Department.

3.3 For members excluded from Tailored Care Management and residing in Pilot program Regions, Vaya will:

a) Conduct the above Pilot-related care manager responsibilities directly for those members obtaining Assertive Community Treatment services;

b) Require that the above Pilot-related care manager responsibilities are conducted by the LHD Contractor for members receiving CMARC and excluded from Tailored Care Management; and

c) Require that the above Pilot-related care manager responsibilities are conducted by the High-fidelity Wraparound team for members receiving High-fidelity Wraparound services.

d) Exclude individuals receiving Intermediate Care Facilities for Individuals with Intellectual Disabilities services from Pilot program eligibility, following Pilot eligibility and enrollment procedures to be defined in Department guidance.

3.4 In the event of underperformance by LHD Contractor, Vaya will follow standard procedures specified by the Department. In the event of continued underperformance by LHD Contractor that is not corrected, Vaya will be permitted to terminate the contract with LHD Contractor and the LHD Contractor shall have the right to appeal the termination. Vaya will notify the Department of underperformance by or contract termination of LHD Contractor. The Department reserves the right to specify the timing and format of this notification.

ARCTICLE IV
LOCAL HEALTH DEPARTMENT PAYMENTS

4.1 Vaya will reimburse LHD Contractor no lower than base rates specified in the North Carolina Medicaid LHD fee schedule. Vaya will reimburse LHD Contractor in accordance with this schedule for Early and Periodic Screening, Diagnostic and Treatment ("EPSDT") well child exams, low-risk family planning and obstetrical services or sexually transmitted disease ("STD") exams provided by enhanced role nurses.

4.2 For the Initial Term, or until June 2023, whichever is earlier, Vaya will pay LHD Contractor for Care Management for At- Risk Children services an amount substantially similar to or no less than the amount paid in the fee-for-service program prior to the start of Vaya contract ($4.56 PMPM for all enrolled children ages 0-5). The Department reserves the right to further prescribe the Care Management for At-Risk Children reimbursement amount or methodology or to change the methodology in Contract Renewal Terms after December 2022.

4.4 For the Initial Term, or until November 2023, whichever is earlier, Vaya will pay LHD Contractor for Care Management for High-Risk Pregnant Women services an amount substantially similar to or no less than the amount paid in the fee-for-service program prior to the start of Vaya contract ($4.96 PMPM for all enrolled women, ages 14 to 44). LHD Contractor acknowledges, agrees, and understands, that the Department reserves the right to further prescribe the Care Management for High-Risk Pregnant Women reimbursement amount or methodology as allowed under 42 C.F.R. § 438.6(c) or to change the methodology in Contract Renewal Terms covering December 1, 2023, through November 30, 2025.

4.5 In addition to base reimbursements, Vaya will make additional, utilization-based, directed payments to LHD Contractor as defined by the Department and in accordance with **Schedule A**, the compensation schedule, made part of the Contract.

4.6 Vaya will reimburse LHD Contractor for its provision of lab services, as defined by the Department's Laboratory Fee Schedule, at no less than 100% of the Medicare Fee Schedule (as allowed under 42 C.F.R. § 438.6(c).

SIGNATURES

IN WITNESS WHEREOF, the Parties hereby execute and deliver this LHD Addendum to the Contract, under "Seal", as of the Effective Date. Each individual electronically signing below certifies that he or she has been duly authorized to bind Vaya and LHD Contractor, respectively, to the terms of this LHD Addendum.

Contractor Legal Name:

By: _____ (ADOPTED SEAL)
CONTRACTOR DULY AUTHORIZED OFFICIAL

Name: _____

Title: _____

Date: _____

Vaya Health

By: _____ (ADOPTED SEAL)
VAYA DULY AUTHORIZED OFFICIAL
Brian Ingraham, Chief Executive Officer

Date: _____

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act, N.C.G.S. § 159-28.

ADDENDUM F
Physical Health Provider Addendum

THIS Physical Health Provider Addendum ("PH Addendum"), is made and entered as of the Effective Date of the Network Provider Participation Agreement by and between Vaya Health, a Local Management Entity/Managed Care organization, with a primary business address at 200 Ridgefield Court, Asheville, North Carolina 28806 (hereinafter referred to as "Vaya"), and [INSERT LEGAL BUSINESS NAME FOR CONTRACTOR],with a primary business address at [INSERT CONTRACTOR ADDRESS] (hereinafter referred to as "PH Contractor" or "Contractor").

W I T N E S S E T H:

WHEREAS, this PH Addendum is ancillary to the Contract, and the terms of the Contract are fully incorporated herein;

WHEREAS, any capitalized term not otherwise defined in this PH Addendum shall have the same meaning and definitions as set forth in the Contract;

WHEREAS, PH Contractor desires to enter into this PH Addendum with Vaya to provide primary, specialty, home, and/ or facility care services for the care and wellness, prevention, treatment, payment, or healthcare operations purposes that are related to Contractor's obligations under the Contract;

NOW THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the receipt of which is hereby acknowledged, Vaya and PH Contractor (hereinafter individually referred to as a "Party" and collectively as "Parties") agree to the following terms, obligations, and conditions, which are incorporated into and form a part of the Contract to which they are attached:

ARTICLE I
Definitions

1.1 **Definitions.** In addition to the definitions set forth in Article 1 of the Base Contract, the following capitalized words, terms, and acronyms shall have the following special meanings, and the use of the singular of any of these words, terms, or acronyms herein shall be construed to include the plural and vice versa. If an identical term is defined in an Attachment, the definition in the Attachment shall control with respect to all or part of the Attachment. Any term not otherwise specified in the Contract shall have the same definition and meaning as in N.C.G.S. § 122C-3 or 42 CFR Part 438.

"Assigned Member" means a Member who selects or is assigned by Health Plan to a Primary Care Provider or (if required by Laws or Program Requirements) an allied health care practitioner supervised by a Physician, as the Member's primary care provider.
"Covering Physician" means a Provider who provides health care items and services to another Provider's patients when the other Provider is not available.
"Nurse Practitioner" means a Provider who is licensed as a nurse practitioner and certified in advanced or specialized nursing practice, in accordance with applicable state Laws.
"Physician" means a Provider who is a Doctor of Medicine or osteopathy.
"Primary Care Provider" means a Physician, Nurse Practitioner, physician assistant, certified nurse midwife, or other duly licensed Provider who spends the majority of his/her clinical time providing Primary Care Services to patients and may include a Provider in the practice of family medicine, general medicine, internal medicine or pediatrics, or obstetrics and gynecology.
"Primary Care Services" means health care items or services available from Primary Care Provider within the scope of their medical or professional licenses or certifications, and shall include primary care items and services required by the Vaya Provider Manual or Controlling Authority, which may include (i) assuring the timeliness of urgent, emergent, sick and preventive care to Members; (ii) conducting initial health assessments of new Members when such assessments are Covered Services under the applicable Vaya Benefit Plan; (iii) informing Members of specific health care needs that require follow up; (iv) instructing Members on measures they may take to promote their own health; (v) providing the coordination necessary for the referral of Members to specialists; or (vi) monitoring and follow-up of care provided by other providers for diagnosis and treatment.
"Specialty Provider" means a Provider who provides Specialty Services.
"Specialty Services" means health care items and services within the scope of a particular medical specialty, including but not limited to: Allergy/Immunology, Anesthesiology, Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Infections Disease, Hematology, Nephrology, Neurology, Oncology, Ophthalmology, Optometry, Orthopedic Surgery, Pain Management (Board Certified), Pulmonology, Radiology, Rheumatology, and Urology.

ARTICLE II
General Provisions Regarding Member Services by Physical Health Providers

2.1 Scope of Practice. Subject to and in accordance with the terms of this Contract and Controlling Authority, PH Contractor shall provide or arrange for the provision of all Covered Services available from Providers that are within the scope of their medical or professional licenses or certifications.

2.2 Assuring Member Services. If PH Contractor employs or subcontracts with Providers to provide Covered Services, PH Contractor shall be responsible to ensure that (a) Primary Care Providers render Primary Care Services to Members, including their Assigned Members, and (b) Specialty Providers provide Specialty Services to Members upon appropriate referral, except in the case of Emergency Services.

2.3 Primary Care Services.

2.3.1 PH Contractor provides or arranges for the provision of Primary Care Services to Assigned Members, and shall have the primary responsibility for arranging and coordinating the overall health care of Assigned Members, including (i) the provision of Primary Care Services from Primary Care Provider and

appropriate referral to other Participating Providers, or if a Participating Provider is unavailable to any health care provider upon authorization of Health Plan and (ii) managing and coordinating the performance of administrative functions relating to the delivery of Covered Services to Assigned Members.

2.3.2 PH Contractor shall ensure Primary Care Provider make all reasonable efforts to (i) establish satisfactory provider-patient relationships with their Assigned Members and (ii) instruct their Assigned Members on measures they may take to promote their own health.

2.4 Specialty Services.

2.4.1 PH Contractor provides or arranges for the provision of Specialty Services to Members, and shall ensure that Specialty Provider (i) care for common medical conditions in their medical specialty, (ii) provide consultation summaries or appropriate periodic progress notes to the Member's Primary Care Provider on a timely basis, after a referral or routinely scheduled consultative visit, and (iii) notify the Member's Primary Care Provider when scheduling a hospital admission or other procedure requiring the Primary Care Provider's approval.

2.5 Authorization Requirements. Except for emergency services, when a Member requires a hospital admission by a Primary Care Provider or other Provider that the Primary Care Provider has referred a Member to, the Primary Care Provider shall, or shall arrange for the other Provider to, secure authorization for such admission from Health Plan prior to the admission. PH Contractor shall seek further authorization for any extension of the initial length of stay approved for the Member in accordance with the Provider Manual.

2.6 Patient Referrals. Subject to Controlling Authority regarding provider to patient ratios, an individual Provider shall accept Members as patients as long as the Provider is accepting new patients. PH Contractor shall give Vaya 60 days' prior notice in advance of any circumstance where a Provider is not available to accept Members as patients.

ARTICLE II

Regular Wellness Visits to All Children Enrolled in Medicaid Under the Age of Twenty-one (21)

3.1 Wellness Visits: Primary Care Providers shall cover regular wellness visits to all children enrolled in Medicaid under the age of twenty-one (21) to carefully monitor a child's overall health and development and to identify and address health concerns as early as possible.

3.2 Primary Care Providers shall include all of the following components in each medical screening:

3.2.1 Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents".

3.2.2 Screening for developmental delay at each visit through the 5th year; and

3.2.3 Screening for Autistic Spectrum Disorders per AAP guidelines;

3.2.4 Comprehensive, unclothed physical examination;

3.2.5 All appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices.

3.2.6 Laboratory testing (including blood lead screening appropriate for age and risk factors);
3.2.7 Health education and anticipatory guidance for both the child and caregiver.

3.3 Preventive Care: Primary Care Providers shall perform, during preventive service visits and as necessary at any visit, oral health assessments, evaluations, prophylaxis, and oral hygiene counseling for children under twenty-one (21) years of age in accordance with the Department's Oral Health Periodicity Schedule. They shall refer infant Medicaid Members to a dentist or a dental professional working under the supervision of a dentist at age one (1), per requirements of the Department's Oral Health Periodicity Schedule.

3.4 VFC Program: If serving a Member under the age of 19, Primary Care Providers is encouraged to participate in the Vaccines for Children ("VFC") program.
3.4.1 The VFC program allows providers to receive vaccines at no cost for children eligible for Medicaid who are under age nineteen (19).
3.4.2 Primary Care Providers shall administer vaccines consistent with the American Academy of Pediatrics (AAP)/ Bright Future periodicity schedule. Vaya will only pay for the vaccine administration fee for VFC eligible children.
3.4.3 Vaccines provided for children enrolled in Medicaid outside of VFC are not an allowed expense.
3.4.4 Vaccines provided for children enrolled in NC Health Choice are not covered by the VFC program. Vaya will reimburse the provider for both the vaccine and administration fee for NC Health Choice Members.

3.5 EPSDT Screenings**:** Primary Care Providers shall perform Early and Periodic Screening, Diagnostic and Treatment ("EPSDT") 42 U.S.C. § 1396d(r), and 42 C.F.R.§ 441.50-62 screenings for Members less than twenty-one (21) years of age in accordance with Controlling Authority.

ARTICLE IV
Appointment and Access to Care Standards

4.1 PH Contractor shall meet the Department standards for timely access to care and services, taking into account the urgency of need for services.

4.2 PH Contractor shall meet the following appointment wait-time standards for adult and pediatric providers separately, which vary by the type of service, and are set forth in Table 4.2 below:

Table 4.2: Appointment Wait Time Standards

Primary Care			
Reference Number	**Visit Type**	**Description**	**Standard**
1	Preventive Care Service – adult, 21 years of age and older	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms, and pap smears	Within thirty (30) Calendar days
1a	Preventive Care Services – child, birth through 20 years of age		Within fourteen (14) Calendar days for Member less than Six (6) months of age

			Within thirty (30) Calendar days for Members six (6) months or age and older.
2	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within twenty-four (24) hours
3	Routine/Check-up without Symptoms	Non-symptomatic visits for routine health check-up.	Within thirty (30) Calendar days
4	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately and without prior authorization (available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Prenatal Care			
5	Initial Appointment – 1st or 2nd Trimester	Care provided to a Member while the Member is pregnant to help keep Member and future baby healthy, such as checkups and prenatal testing.	Within fourteen (14) Calendar days
5a	Initial Appointment – high risk pregnancy or 3rd Trimester		Within five (5) Calendar days
Specialty Care			
6	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non- resolving headache.	Within twenty-four (24) hours
7	Routine/Check-up without Symptoms	Non-symptomatic visits for health check.	Within thirty (30) Calendar days
8	After-Hours Access – Emergent and Urgent Instructions	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

4.3 Failure to comply with the timely access requirements described above may result in a Provider Sanction, including up to and including termination of Contract, against PH Contractor.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK; SIGNATURES TO FOLLOW

SIGNATURES

IN WITNESS WHEREOF, the Parties hereby execute and deliver this PH Addendum to the Contract, under "Seal", as of the Effective Date. Each individual electronically signing below certifies that he or she has been duly authorized to bind Vaya and PH Contractor, respectively, to the terms of this PH Addendum.

Contractor Legal Name:

By: _____ (ADOPTED SEAL)
CONTRACTOR DULY AUTHORIZED OFFICIAL

Name: _____

Title: _____

Date: _____

Vaya Health

By: _____ (ADOPTED SEAL)
VAYA DULY AUTHORIZED OFFICIAL
Brian Ingraham, Chief Executive Officer

ADDENDUM G
Pregnancy Management Provider Addendum

THIS Pregnancy Management Provider Addendum ("PMP Addendum"), is made and entered as of the Effective Date of the Network Provider Participation Agreement by and between Vaya Health, a Local Management Entity/Managed Care organization, with a primary business address at 200 Ridgefield Court, Asheville, North Carolina 28806 (hereinafter referred to as "Vaya"), and [INSERT LEGAL BUSINESS NAME FOR CONTRACTOR],with a primary business address at [INSERT CONTRACTOR ADDRESS] (hereinafter referred to as "PMP Contractor" or "Contractor").

W I T N E S S E T H:

WHEREAS, this PMP Addendum is ancillary to the Contract executed between the Parties, and the terms of the Contract are fully incorporated herein;

WHEREAS, any capitalized term not otherwise defined in this PMP Addendum shall have the same meaning and definitions as set forth in the Contract;

WHEREAS, PMP Contractor desires to provide improved quality of pregnancy care, and improved maternal and infant outcomes, for the prevention, treatment, payment, or healthcare operations purposes that are related to PMP Contractor's obligations under the Contract;

NOW THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the receipt of which is hereby acknowledged, Vaya and PMP Contractor (hereinafter individually referred to as a "Party" and collectively as "Parties") agree to the following terms, obligations, and conditions, which are incorporated into and form a part of the Contract to which they are attached:

ARTICLE I
Pregnancy Management Program Requirements for Medicaid and NC Health Choice Members

1.1. **Background**: The Pregnancy Management Program is a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes, and reducing healthcare costs among participating providers.

1.2 **Scope**: The scope of this PMP Addendum covers the requirements for PMP Contractor offering prenatal, perinatal, and postpartum services and thus are part of the Pregnancy Management Program outlined below.

1.3 **Compliance**: PMP Contractor agrees to comply with the Department's Pregnancy Management Program policy and other Department guidance, policy, operational manuals, and other program-specific requirements, as applicable, as may be amended from time to time.

1.3.1 During the Initial Term of the Contract, when a high-risk pregnancy is referred to Vaya by a PMP provider, member, family, or another entity, Vaya shall be responsible for arranging enrollment of the member into Care Management for High-Risk Pregnancy and shall inform the PMP Contractor, as Member's PMP provider, that the Member has entered the program.

1.4 **Pregnancy Management Program ("PMP") Requirements**: PMP Contractor shall provide the following for prenatal, perinatal, and postpartum care:

1.4.1 Complete the standardized risk-screening tool at each initial visit. The standardized risk-screening tool adopted by Vaya and required to be used by PMP providers is currently used in practices, with modifications, as determined by the Department;

1.4.2 Allow Vaya or Vaya's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators.

1.4.3 Commit to maintaining or lowering the rate of elective deliveries prior to thirty-nine (39) weeks' gestation.

1.4.4 Commit to decreasing the cesarean section rate among nulliparous women.

1.4.5 Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation.

1.4.6 Complete a high-risk screening on each pregnant Vaya member in the program and integrate the plan of care with Tailored Care Management and/or Care Management for High-Risk Pregnancy.

1.4.7 Decrease the primary cesarean delivery rate if the rate is over the Department's designated cesarean rate, which is set annually and will be at or below twenty (20) percent.

1.4.8 Ensure comprehensive postpartum visits occur within fifty-six (56) days of delivery.

1.4.9 Within one (1) Business Day of the provider completing the screening, send all screening information and applicable medical record information for members in care management for high-risk pregnancies to Vaya, Advanced Medical Home+ ("AMH+") practices or Care Management Service ("CMS") (as applicable), and the Local Health Departments ("LHD") that are contracted for the provision of providing care management services for high-risk pregnancy.

1.5 **Reporting Requirements**: PMP Contractor shall measure, calculate, track, and report to Vaya, upon request and at the frequency requested, any PMP quality or other metrics requested by Vaya for its CQI activities or its reporting requirements to the Department.

IN WITNESS WHEREOF, the Parties hereby execute and deliver this PMP Addendum to the Contract, under "Seal", as of the Effective Date. Each individual electronically signing below certifies that he or she has been duly authorized to bind Vaya and PMP Contractor, respectively, to the terms of this PMP Addendum.

Contractor Legal Name:

By: _____ (ADOPTED SEAL)
CONTRACTOR DULY AUTHORIZED OFFICIAL

Name: _____

Title: _____

Date: _____

Vaya Health

By: _____ (ADOPTED SEAL)
VAYA DULY AUTHORIZED OFFICIAL

Name and Title: Brian Ingraham, Chief Executive Officer

Date: _____

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act, N.C.G.S. § 159-28.

_____ _____
Vaya Health Finance Officer, or designee Date